

[ORIGINAL]

E-001-18

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****RECEIVED**

This Section must be completed for all projects.

JAN 10 2018

Facility/Project Identification

Facility Name: MacNeal Hospital		
Street Address: 3249 South Oak Park Avenue		
City and Zip Code: Berwyn, IL 60402		
County: Cook	Health Service Area: 007	Health Planning Area: A-06

**HEALTH FACILITIES &
SERVICES REVIEW BOARD****Applicant(s)** [Provide for each co-applicant (refer to Part 1130.220)]

Exact Legal Name: Gottlieb Community Health Services Corporation
Street Address: 701 West North Avenue
City and Zip Code: Melrose Park, Illinois 60160
Name of Registered Agent: CT Corporation
Registered Agent Street Address: 208 South LaSalle Street
Registered Agent City and Zip Code: Chicago, Illinois 60604
Name of Chief Executive Officer: Larry M. Goldberg
CEO Street Address: 2160 South First Avenue
CEO City and Zip Code: Maywood, Illinois 60153
CEO Telephone Number: (708) 216-3215

Type of Ownership of Applicants

- | | |
|--|--|
| <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 |

- 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]

Name: Edward J. Green, Esq.
Title: Attorney
Company Name: Foley & Lardner LLP
Address: 321 North Clark Street, Suite 2800, Chicago, Illinois 60654
Telephone Number: (312) 832-4375
E-mail Address: egreen@foley.com
Fax Number: (312) 832-4700

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: MacNeal Hospital		
Street Address: 3249 South Oak Park Avenue		
City and Zip Code: Berwyn, IL 60402		
County: Cook	Health Service Area: 007	Health Planning Area: A-06

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

Exact Legal Name: Loyola University Health System	
Street Address: 2160 South First Avenue	
City and Zip Code: Maywood, Illinois 60153	
Name of Registered Agent: CT Corporation	
Registered Agent Street Address: 208 South LaSalle Street	
Registered Agent City and Zip Code: Chicago, Illinois 60604	
Name of Chief Executive Officer: Larry M. Goldberg	
CEO Street Address: 2160 South First Avenue	
CEO City and Zip Code: Maywood, Illinois 60153	
CEO Telephone Number: (708) 216-3215	

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City and Zip Code: Berwyn, IL 60402		
County: Cook	Health Service Area: 007	Health Planning Area: A-06

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

Exact Legal Name: Trinity Health Corporation		
Street Address: 20555 Victor Parkway		
City and Zip Code: Livonia, Michigan 46152		
Name of Registered Agent: The Corporation Company		
Registered Agent Street Address: 30600 Telegraph Road		
Registered Agent City and Zip Code: Bingham Farms, Michigan 48025		
Name of Chief Executive Officer: Dr. Richard J. Gilfillan		
CEO Street Address: 20555 Victor Parkway		
CEO City and Zip Code: Livonia, Michigan 46152		
CEO Telephone Number: (734) 343-1000		

Type of Ownership of Applicants

- | | |
|--|--|
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City and Zip Code: Berwyn, IL 60402		
County: Cook	Health Service Area: 007	Health Planning Area: A-06

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

Exact Legal Name: VHS of Illinois, Inc., d/b/a MacNeal Hospital
Street Address: 3249 South Oak Park Avenue
City and Zip Code: Berwyn, Illinois 60402
Name of Registered Agent: CT Corporation
Registered Agent Street Address: 208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago, Illinois 60604
Name of Chief Executive Officer: Ronald A. Rittenmeyer
CEO Street Address: 1445 Ross Avenue, Suite 1400
CEO City and Zip Code: Dallas, Texas 75202
CEO Telephone Number: (469) 893-2000

Type of Ownership of Applicants

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
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City and Zip Code: Berwyn, IL 60402		
County: Cook	Health Service Area: 007	Health Planning Area: A-06

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

Exact Legal Name: Tenet Healthcare Corporation	
Street Address: 1445 Ross Avenue, Suite 1400	
City and Zip Code: Dallas, Texas 75202	
Name of Registered Agent: CT Corporation	
Registered Agent Street Address: 208 South LaSalle Street, Suite 814	
Registered Agent City and Zip Code: Chicago, Illinois 60604	
Name of Chief Executive Officer: Ronald A. Rittenmeyer	
CEO Street Address: 1445 Ross Avenue, Suite 1400	
CEO City and Zip Code: Dallas, Texas 75202	
CEO Telephone Number: (469) 893-2000	

Type of Ownership of Applicants

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Fax Number: (312) 832-4700

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: Jill M. Rappis
Title: Senior Vice President & General Counsel
Company Name: Loyola University Health System
Address: 2160 South First Avenue, Maywood, Illinois 60153
Telephone Number: (708) 216-8073
E-mail Address: jrappis@lumc.edu
Fax Number: (708) 216-8059

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: VHS of Illinois, Inc. d/b/a MacNeal Hospital
Address of Site Owner: 3249 South Oak Park Avenue, Berwyn, Illinois, 60402
Street Address or Legal Description of Site: 3249 South Oak Park Avenue, Berwyn, Illinois, 60402
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: VHS of Illinois, Inc. d/b/a MacNeal Hospital		
Address: 3249 South Oak Park Avenue, Berwyn, Illinois, 60402		
<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input checked="" type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none">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.o 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)]

Part 1110 Classification:

- ☒ 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

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.

Gottlieb Community Health Services Corporation ("GCHS"), Loyola University Health System ("LUHS"), Trinity Health Corporation ("Trinity"), VHS of Illinois, Inc. d/b/a MacNeal Hospital ("VHS"), and Tenet Healthcare Corporation ("Tenet"), hereby seek a Certificate of Exemption ("COE") from the Illinois Health Facilities and Services Review Board (the "Review Board") to allow consummation of a proposed transaction (the "Transaction") between GCHS, LUHS, and Trinity, on the one hand, and VHS and Tenet, on the other hand.

The Transaction contemplates a 100% change in the ownership of MacNeal Hospital, a 374 bed general acute care hospital located at 3249 South Oak Park Avenue, Berwyn, Illinois, 60402, pursuant to that certain Asset Sale Agreement, dated October 10, 2017 (the "Asset Sale Agreement"). Under the terms of the Asset Sale Agreement, GCHS will be acquiring MacNeal Hospital, and certain other affiliated entities (e.g., the membership interests in MacNeal Health Providers Inc. d/b/a Chicago Health System), from VHS for Two Hundred Seventy Million Dollars (\$270,000,000), subject to adjustments for working capital, assumed indebtedness, and prorations (the "Purchase Price"). The Purchase Price paid to Tenet will be funded with cash.

GCHS is an Illinois not for profit corporation. GCHS's sole corporate member is LUHS. LUHS is a leading Catholic academic medical center with a multidisciplinary focus on delivering outstanding patient care, leading-edge research and rigorous medical, nursing and graduate education. LUHS operates Foster G. McGaw Hospital-Loyola University Medical Center in Maywood, Illinois, and Gottlieb Memorial Hospital in Melrose Park, Illinois.

Trinity, the sole corporate member of LUHS, is one of the largest Catholic health care system in the country. Based in Livonia, Michigan, Trinity operates 93 acute-care hospitals and 109 continuing care locations in twenty two states. Employing more than 131,000 colleagues (including 7,500 employed physicians and clinicians), Trinity reported \$17.6 billion in operating revenues in fiscal year 2017. As a not-for-profit health system, Trinity, through its ministry and operations, invests in its communities through programs which serve the poor and uninsured, manage chronic conditions such as diabetes, help educate residents on health care and health related issues, and provide outreach for the elderly. In fiscal year 2017, this included nearly \$1.1 billion in such community benefits.

Trinity is also the sole corporate member of Mercy Health System, which operates Mercy Hospital and Medical Center in Chicago.

VHS is a Delaware corporation. In addition to owning MacNeal Hospital, VHS owns three other hospitals in the Chicagoland area (i.e., Louis A. Weiss Memorial Hospital, Westlake Hospital, and West Suburban Medical Center). Only MacNeal Hospital is being acquired by GCHS.

VHS is a wholly owned subsidiary of Tenet. Tenet, a Nevada corporation, is a diversified healthcare services company with nearly 130,000 employees united around a common mission: to help people live happier, healthier lives. Through its subsidiaries, partnerships and joint ventures, including United Surgical Partners International, Tenet operates general acute care and specialty hospitals, ambulatory surgery centers, urgent care centers and other outpatient facilities in the United States and the United Kingdom.

The Transaction is contingent upon the approval of the Review Board. The Transaction is currently scheduled to close on March 1, 2018, subject to the Review Board granting this COE.

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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Purchase Price: <u>\$270,000.00</u> (aggregate price of assets/interests being acquired; land was not separately valued) Fair Market Value: <u>\$ As above</u>
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 \$ <u>N/A</u> .

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: <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>March 1, 2018</u> (subject to Review Board approval)
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Financial commitment will occur after permit issuance.
APPEND DOCUMENTATION AS <u>ATTACHMENT 8</u> , 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: <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.

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

SIGNATURE



Larry M. Goldberg
PRINTED NAME

SIGNATURE

Lori Price
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

President
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 17th day of January, 2018

Notarization:

Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

Signature of Notary

Seal

OFFICIAL SEAL
JILL M. RAPPIS
Insert EXACT legal name of the applicant
Notary Public - State of Illinois
My Commission Expires Aug 25, 2018

CERTIFICATION

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

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SIGNATURE

Larry M. Goldberg
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

SIGNATURE

Lori Price
PRINTED NAME

President
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 27th day of January, 2018

Signature of Notary

OFFICIAL SEAL
JILL M RAPPIS
Seal Notary Public - State of Illinois
My Commission Expires Aug 25, 2018

CERTIFICATION

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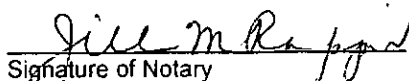

SIGNATURE

Larry M. Goldberg
PRINTED NAME

President & Chief Executive Officer
PRINTED TITLE

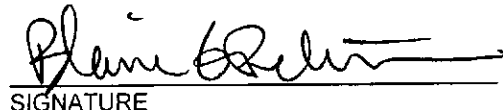
Notarization:

Subscribed and sworn to before me
this 8th day of January, 2018


Signature of Notary

Seal

OFFICIAL SEAL
JILL M. RAPPIS
Notary Public - State of Illinois
My Commission Expires Aug 25, 2018

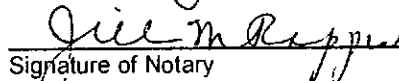

SIGNATURE

Blaine Petersen
PRINTED NAME

Executive Vice President & Regional CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 8th day of January, 2018


Signature of Notary

Seal

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

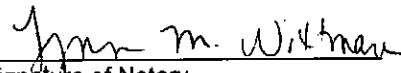

SIGNATURE

Richard J. Gilfillan, M.D.
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 3rd day of January


Signature of Notary

Seal

LYNN M. WITTMAN
Notary Public, State of Michigan
County of Oakland
My Commission Expires Sep. 25, 2023
Acting in the County of Wayne

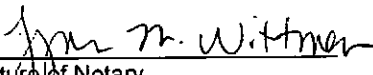

SIGNATURE

Paul G. Neumann, Esq.
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 3rd day of January


Signature of Notary

Seal

LYNN M. WITTMAN
Notary Public, State of Michigan
County of Oakland
My Commission Expires Sep. 25, 2023
Acting in the County of Wayne

*Insert EXACT legal name of the applicant

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SIGNATURE

Paul Costanzo

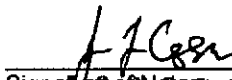
PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of January 2018


Signature of Notary

Seal



JENNIFER L COSSA
My Commission Expires
June 13, 2019

*Insert EXACT legal name of the applicant



SIGNATURE

Douglas Rabe

PRINTED NAME

Vice President

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of January 2018


Signature of Notary

Seal



JENNIFER L COSSA
My Commission Expires
June 13, 2019

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 manager 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 Tenet Healthcare Corporation*

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



SIGNATURE

Paul Costam

PRINTED NAME

Deputy General Counsel

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of January 2018

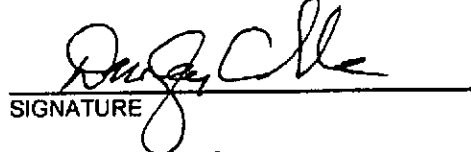
L. J. Costa
Signature of Notary

Seal



JENNIFER L. COSSA
My Commission Expires
June 13, 2019

*Insert EXACT legal name of the applicant



SIGNATURE

Douglas Rabe

PRINTED NAME

Vice President

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of January 2018

L. J. Costa
Signature of Notary

Seal



JENNIFER L. COSSA
My Commission Expires
June 13, 2019

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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	X

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

Application for Change of Ownership Among Related Persons

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

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

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

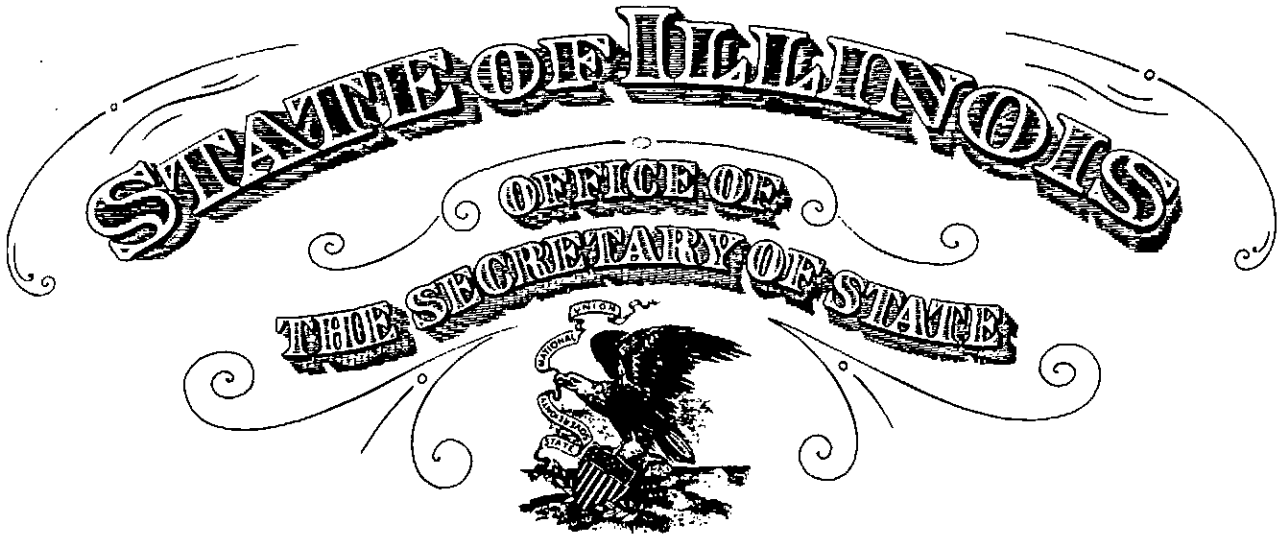
A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE			
	Year	Year	Year
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.

Section I
Attachment 1
Applicant Identification

The Certificates of Good Standing for Gottlieb Community Health Services Corporation ("GCHS"), Loyola University Health System ("LUHS"), Trinity Health Corporation ("Trinity"), VHS of Illinois, Inc. d/b/a MacNeal Hospital ("VHS"), and Tenet Healthcare Corporation ("Tenet"), are attached at 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 I am the keeper of the records of the Department of Business Services. I certify that

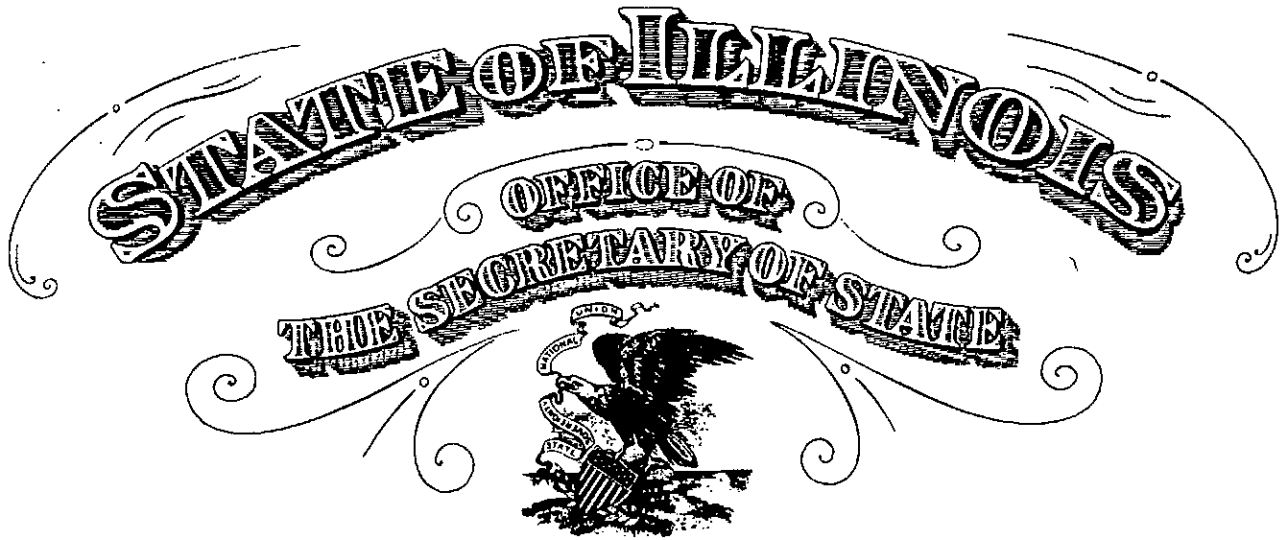
GOTTLIEB COMMUNITY HEALTH SERVICES CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 13, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC 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 21ST
day of DECEMBER A.D. 2017 .***

Jesse White

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

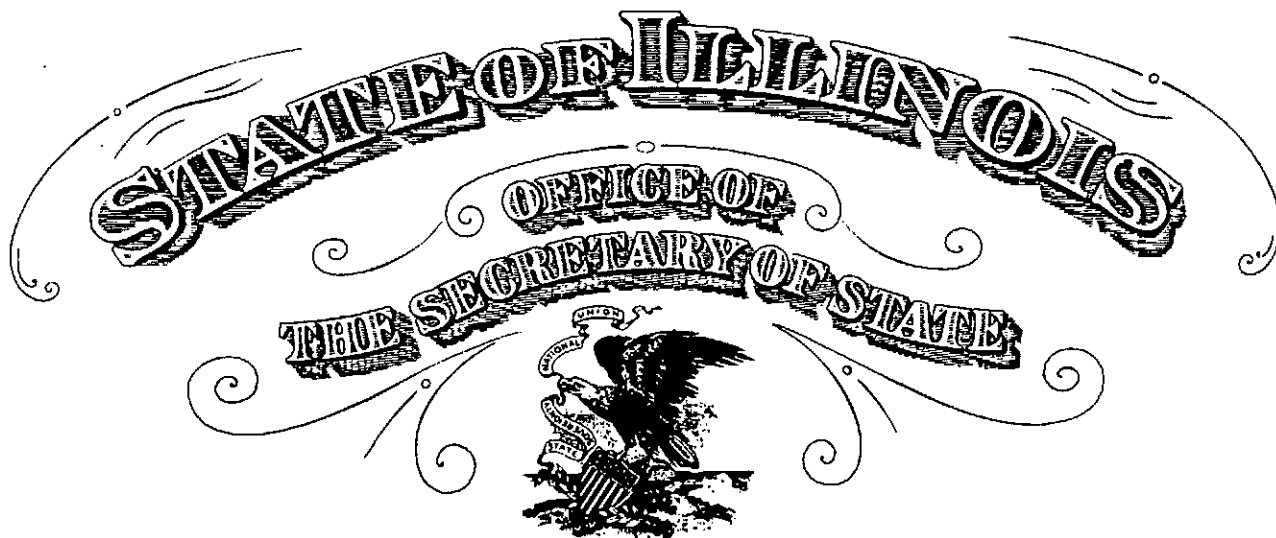
LOYOLA UNIVERSITY HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 11, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE 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 1ST
day of NOVEMBER A.D. 2017 .

Jesse White

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

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



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 1ST
day of NOVEMBER A.D. 2017 .***

Jesse White

SECRETARY OF STATE

Authentication #: 1730501968 verifiable until 11/01/2018
Authenticate at: <http://www.cyberdriveillinois.com>

**State of Indiana
Office of the Secretary of State**

CERTIFICATE OF EXISTENCE

To Whom These Presents Come, Greeting:

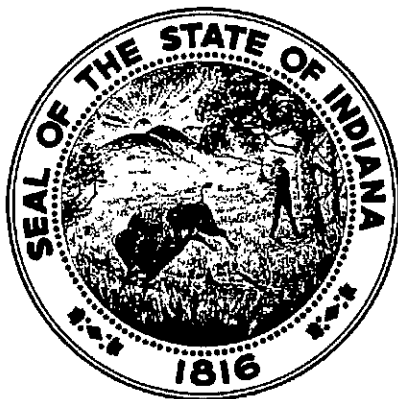
I, CONNIE LAWSON, Secretary of State of Indiana, do hereby certify that I am, by virtue of the laws of the State of Indiana, the custodian of the corporate records and the proper official to execute this certificate.

I further certify that records of this office disclose that

TRINITY HEALTH CORPORATION

duly filed the requisite documents to commence business activities under the laws of the State of Indiana on November 10, 1978, and was in existence or authorized to transact business in the State of Indiana on November 01, 2017.

I further certify this Domestic Nonprofit Corporation has filed its most recent report required by Indiana law with the Secretary of State, or is not yet required to file such report, and that no notice of withdrawal, dissolution, or expiration has been filed or taken place.



In Witness Whereof, I have caused to be affixed my signature and the seal of the State of Indiana, at the City of Indianapolis, November 01, 2017

Connie Lawson

CONNIE LAWSON
SECRETARY OF STATE

197811-279 / 2017440355

Verify this certificate: <https://bsd.sos.in.gov/ValidateCertificate>

Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "VHS OF ILLINOIS, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIRST DAY OF NOVEMBER, A.D. 2017.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "VHS OF ILLINOIS, INC." WAS INCORPORATED ON THE TWENTY-SECOND DAY OF SEPTEMBER, A.D. 1999.

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



3100647 8300

SR# 20176878667

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

A handwritten signature in black ink, appearing to read "JBullock", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

Authentication: 203495087

Date: 11-01-17

0027

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 I am the keeper of the records of the Department of Business Services. I certify that

TENET HEALTHCARE CORPORATION, INCORPORATED IN NEVADA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON JULY 01, 2013, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



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

Jesse White

SECRETARY OF STATE

Section I
Attachment 2
Site Ownership

VHS currently owns the land, buildings, and other real estate comprising the campus of MacNeal Hospital.

Following the Transaction, LUHS will own the land, buildings, and other real estate comprising the campus of MacNeal Hospital.

Following the Transaction, GCHS will be the licensee and operator of MacNeal Hospital.

LUHS and GCHS will enter into a multi-year lease pursuant to which GCHS will pay fair market value rent and will be responsible for all of the costs and expenses associated with the land, buildings, and other real estate comprising the campus of MacNeal Hospital.

Section I
Attachment 3
Operating Entity/Licensee

VHS is currently licensee and operator of MacNeal Hospital. Copies of MacNeal Hospital's general acute care hospital license and Joint Commission accreditation are attached at ATTACHMENT 3.

GCHS will be the licensee and operator of MacNeal Hospital following the Transaction.

The Certificate of Good Standing for GCHS is attached at ATTACHMENT 3.



**Illinois Department of
PUBLIC HEALTH**

HF112316

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.

Niray D. Shah, M.D., J.D.
Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE 1/31/2018	CATEGORY	I.D. NUMBER 0005082
General Hospital		
Effective: 02/01/2017		

VHS of Illinois
dba MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

← **DISPLAY THIS PART IN A
CONSPICUOUS PLACE**

Exp. Date 1/31/2018

Lic Number 0005082

Date Printed 12/16/2016

VHS of Illinois
dba MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402

FEE RECEIPT NO.

Vanguard Health Systems of Illinois, Inc.

MacNeal Hospital

Berwyn, IL

has been Accredited by




The Joint Commission

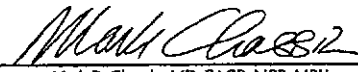
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

March 11, 2017

Accreditation is customarily valid for up to 36 months.


Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #7246
Print/Reprint Date: 07/26/2017


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

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





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

GOTTLIEB COMMUNITY HEALTH SERVICES CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 13, 1984, 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 21ST
day of DECEMBER A.D. 2017 .***

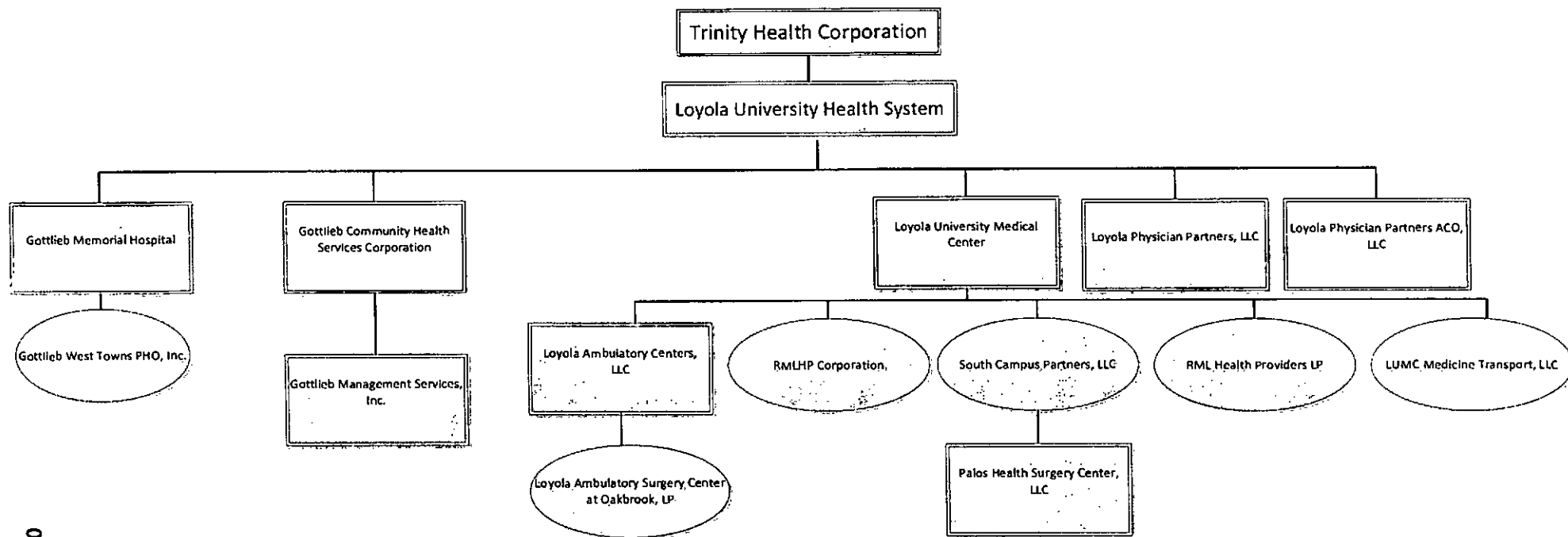
Jesse White

SECRETARY OF STATE

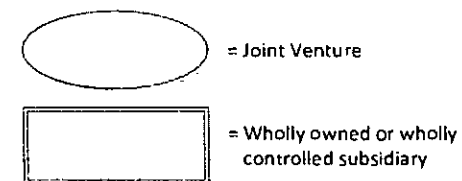
Section I
Attachment 4
Organizational Relationships

The organizational charts for the Applicants are attached at ATTACHMENT 4.

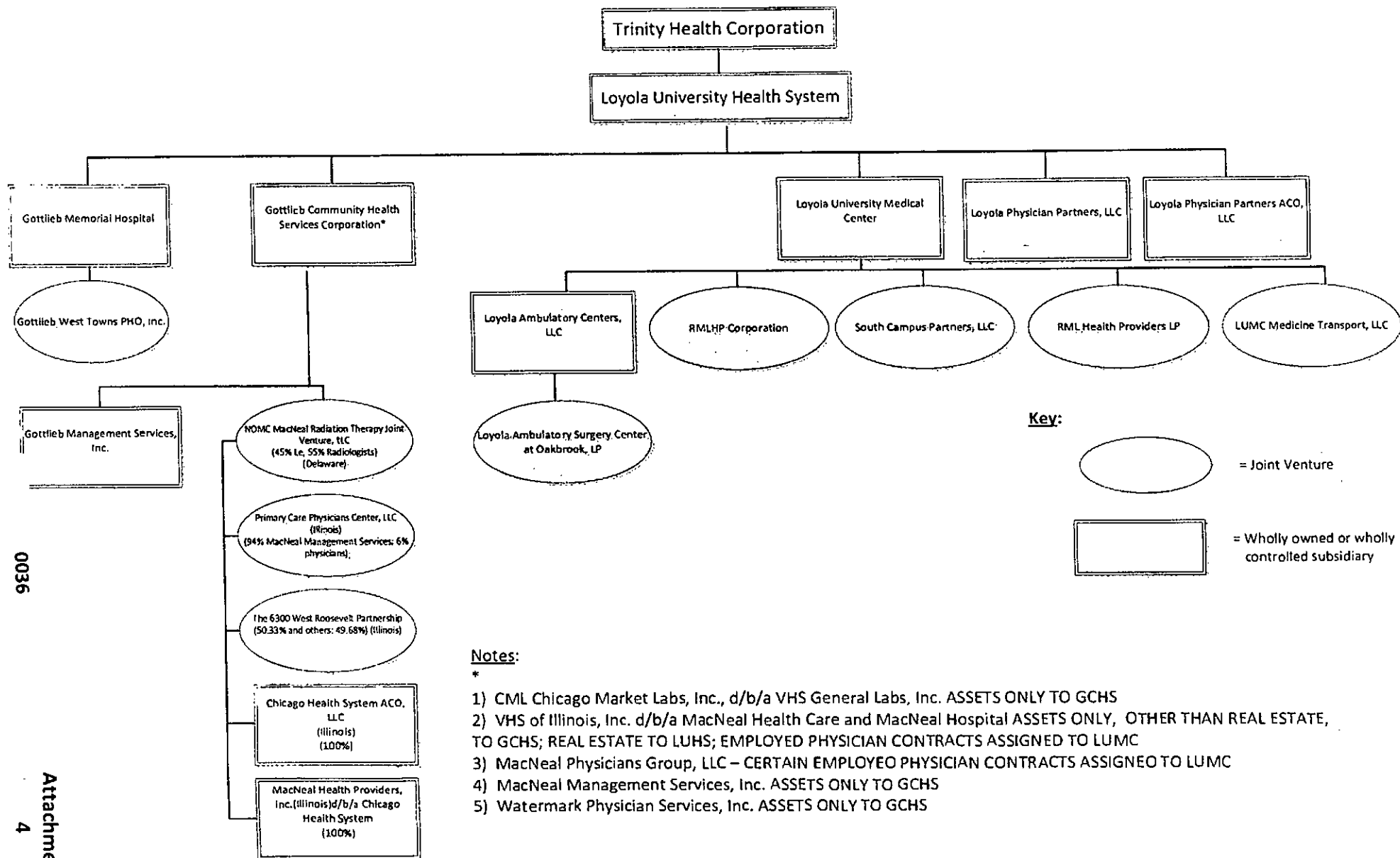
Current Structure



Key:



Post-Transaction Structure



Section I
Attachment 5
Flood Plain Requirements

This Project involves a change of ownership. This Project does not involve any construction or modernization. Accordingly, this criterion is not applicable.

Section I
Attachment 6
Historic Resources Preservation Act Requirements

This Project involves a change of ownership. This Project does not involve any construction or modernization. Accordingly, this criterion is not applicable.

Section III
Attachment 11
Criterion 1110.230(a), Background of The Applicants

GCHS

1. GCHS is an Illinois not for profit corporation. GCHS will be the licensee and operator of MacNeal Hospital following the Transaction.
2. There have been no adverse actions taken against any facility owned or operated by GCHS during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.
3. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about GCHS is attached at ATTACHMENT 11.

LUHS

4. LUHS is an Illinois not for profit corporation. Following the Transaction, LUHS will own the land, buildings, and other real estate comprising the campus of MacNeal Hospital.
5. LUHS is the sole corporate member of GCHS.
6. LUHS is a leading Catholic academic medical center with a multidisciplinary focus on delivering outstanding patient care, leading-edge research and rigorous medical, nursing and graduate education. LUHS operates Foster G. McGaw Hospital-Loyola University Medical Center in Maywood, Illinois, and Gottlieb Memorial Hospital in Melrose Park, Illinois.
7. There have been no adverse actions taken against any facility owned or operated by LUHS during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.
8. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about LUHS is attached at ATTACHMENT 11.

Trinity

9. Trinity is an Illinois not for profit corporation. Trinity has guaranteed the financial obligations of GCHS under the Asset Purchase Agreement for this Transaction.
10. Trinity is the sole corporate member of LUHS. Trinity is also the sole corporate member of Mercy Health System, which operates Mercy Hospital and Medical Center in Chicago.
11. Trinity is one of the largest Catholic health care system in the country. Based in Livonia, Michigan, Trinity operates 93 acute-care hospitals and 109 continuing care locations in twenty two states. Employing more than 131,000 colleagues (including 7,500 employed physicians and clinicians), Trinity reported \$17.6 billion in operating revenues in fiscal year 2017. As a not-for-profit health system, Trinity, through its ministry and operations, invests in its communities through programs which serve the poor and uninsured, manage chronic conditions such as diabetes, help educate residents on health care and health related issues, and provide outreach for the elderly. In fiscal year 2017, this included nearly \$1.1 billion in such community benefits.

12. There have been no adverse actions taken against any facility owned or operated in Illinois by Trinity during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.

13. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about Trinity is attached at ATTACHMENT 11.

VHS

14. VHS is a Delaware corporation. VHS is currently the licensee and operator of MacNeal Hospital. VHS currently owns the land, buildings, and other real estate comprising the campus of MacNeal Hospital.

15. In addition to MacNeal Hospital, VHS owns three other hospitals in the Chicagoland area (i.e., Louis A. Weiss Memorial Hospital, Westlake Hospital, and West Suburban Medical Center). Only MacNeal Hospital is being acquired by GCHS.

16. VHS is a wholly owned subsidiary of Tenet.

17. There have been no adverse actions taken against any facility owned or operated by VHS during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.

18. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about VHS is attached at ATTACHMENT 11.

Tenet

19. Tenet is a Nevada corporation.

20. Tenet is a diversified healthcare services company with nearly 130,000 employees united around a common mission: to help people live happier, healthier lives. Through its subsidiaries, partnerships and joint ventures, including United Surgical Partners International, Tenet operates general acute care and specialty hospitals, ambulatory surgery centers, urgent care centers and other outpatient facilities in the United States and the United Kingdom.

21. There have been no adverse actions taken against any facility owned or operated in Illinois by Tenet during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at ATTACHMENT 11.

22. An authorization letter granting access to the Review Board and the Illinois Department of Public Health ("IDPH") to verify information about Tenet is attached at ATTACHMENT 11.



LOYOLA
UNIVERSITY
HEALTH SYSTEM

January 2, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

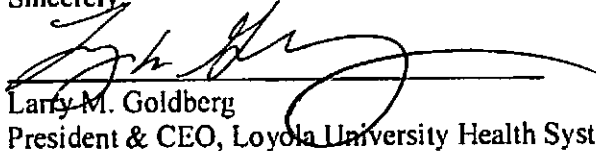
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (MacNeal Hospital Certificate of Exemption)

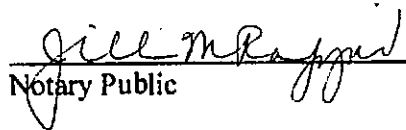
Dear Ms. Avery and Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code §§ 1110.230 and 1130.520(b)(1)(B), that there have been no adverse actions taken against any Illinois facility owned or operated by Loyola University Health System or Gottlieb Community Health Services Corporation during the three (3) years prior to the filing of this Certificate of Exemption.

Sincerely,



Larry M. Goldberg
President & CEO, Loyola University Health System
CEO, Gottlieb Community Health Services Corporation

SUBSCRIBED AND SWORN
to before me this 5th day
of January, 2018.


Notary Public

OFFICIAL SEAL
JILL M RAPPIS
Notary Public - State of Illinois
My Commission Expires Aug 25, 2018

We also treat the human spirit.

A PART OF  TRINITY HEALTH

Loyola University Medical Center | 2160 S. First Ave. Maywood, IL 60153 | (888) 584-7888 | LoyolaMedicine.org



LOYOLA
UNIVERSITY
HEALTH SYSTEM

January 2, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

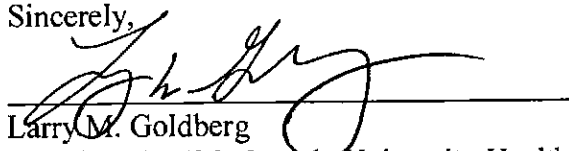
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (MacNeal Hospital Certificate of Exemption)

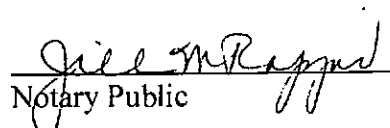
Dear Ms. Avery and Mr. Constantino:

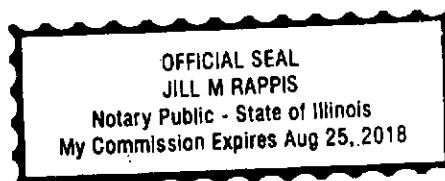
Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Loyola University Health System and Gottlieb Community Health Services Corporation with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,


Larry M. Goldberg
President & CEO, Loyola University Health System
CEO, Gottlieb Community Health Services Corporation

SUBSCRIBED AND SWORN
to before me this 5th day
of January, 2018.


Notary Public




We also treat the human spirit.

Loyola University Medical Center | 2160

0042

L 60153 | (888) 584-788

A PART OF  TRINITY HEALTH
Loyola, IL

Attachment



January 3, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

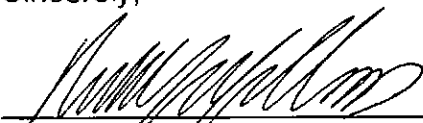
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (MacNeal Hospital Certificate of Exemption)

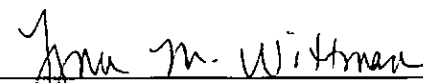
Dear Ms. Avery and Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code §§ 1110.230 and 1130.520(b)(1)(B), that there have been no adverse actions taken against any Illinois facility owned or operated by Trinity Health Corporation during the three (3) years prior to the filing of this Certificate of Exemption.

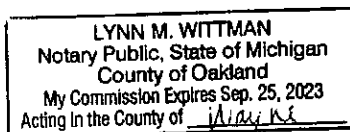
Sincerely,


Richard J. Giffillan, M.D.
Chief Executive Officer
Trinity Health Corporation

SUBSCRIBED AND SWORN
to before me this 3rd day
of January, 2018.



Notary Public





January 3, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

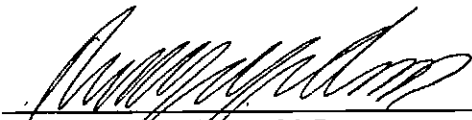
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (MacNeal Hospital Certificate of Exemption)

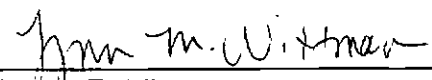
Dear Ms. Avery and Mr. Constantino:

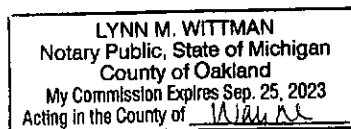
Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Trinity Health Corporation with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,


Richard J. Gilman, M.D.
Chief Executive Officer
Trinity Health Corporation

SUBSCRIBED AND SWORN
to before me this 3rd day
of January, 2018.


Notary Public



MacNealHospital

VHS of Illinois, Inc. d/b/a MacNeal Hospital
3249 S. Oak Park Ave.
Berwyn, IL 60402

January 9, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

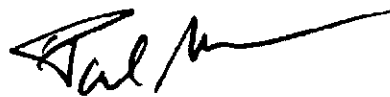
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (MacNeal Hospital Certificate of Exemption)

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code §§ 1110.230 and 1130.520(b)(1)(B), that there have been no adverse actions taken against any Illinois facility owned or operated by VHS of Illinois, Inc. d/b/a MacNeal Hospital during the three (3) years prior to the filing of this Certificate of Exemption.

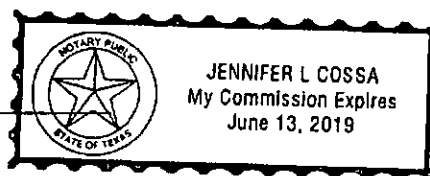
Sincerely,



Its: Assistant Secretary

SUBSCRIBED AND SWORN
to before me this 9th day
of January, 2018.

L. L. Goss
Notary Public



MacNealHospital

VHS of Illinois, Inc. d/b/a MacNeal Hospital
3249 S. Oak Park Ave.
Berwyn, IL 60402

January 9, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

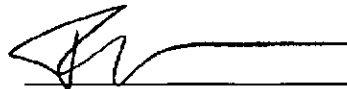
Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (MacNeal Hospital Certificate of Exemption)

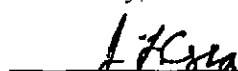
Dear Ms. Avery and Mr. Constantino:

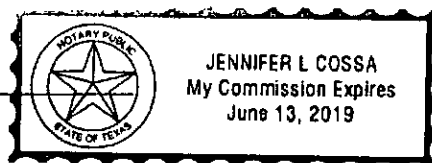
Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by VHS of Illinois, Inc. d/b/a MacNeal Hospital with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,


Its: Assistant Secretary

SUBSCRIBED AND SWORN
to before me this 9th day
of January, 2018.


Notary Public





January 9, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: No Adverse Actions Certification (MacNeal Hospital Certificate of Exemption)

Dear Ms. Avery and Mr. Constantino:

I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code §§ 1110.230 and 1130.520(b)(1)(B), as follows:

1. In or about September of 2016, Tenet Healthcare Corporation ("Tenet"), and certain of Tenet's affiliates located in South Carolina and Georgia, executed that certain Settlement Agreement with the United States Department of Justice (the "DOJ") and the Office of the Inspector General of the Department of Health and Human Services, pursuant to which Tenet, and certain of Tenet's affiliates located in South Carolina and Georgia, resolved certain civil and criminal allegations arising from certain operations at Atlanta Medical Center and North Fulton Medical Center in Georgia. A copy of the DOJ Press Release is attached.

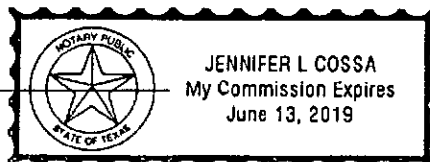
2. There have been no adverse actions taken against any Illinois facility owned or operated by Tenet during the three (3) years prior to the filing of this Certificate of Exemption.

Sincerely,

Its: Vice President

SUBSCRIBED AND SWORN
to before me this 9th day
of January, 2018.

Notary Public



Tenet Healthcare
1445 Ross Avenue, Suite 1400, Dallas, Texas 75202-2703 T 469-893-2000 W tenethealth.com

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FDR IMMEDIATE RELEASE

Monday, October 3, 2016

Hospital Chain Will Pay over \$513 Million for Defrauding the United States and Making Illegal Payments in Exchange for Patient Referrals; Two Subsidiaries Agree to Plead Guilty

A major U.S. hospital chain, Tenet Healthcare Corporation, and two of its Atlanta-area subsidiaries will pay over \$513 million to resolve criminal charges and civil claims relating to a scheme to defraud the United States and to pay kickbacks in exchange for patient referrals.

Principal Deputy Assistant Attorney General David Bitkower of the Justice Department's Criminal Division; U.S. Attorney John Horn of the Northern District of Georgia; Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division; U.S. Attorney G.F. Peterman III of the Middle District of Georgia; Georgia Attorney General Samuel S. Dens; Acting Special Agent in Charge George Crouch of the FBI's Atlanta Field Office; and Special Agent in Charge Derrick L. Jackson of the U.S. Department of Health and Human Services-Office of Inspector General (HHS-DIG) in Atlanta made the announcement.

In addition, two Tenet subsidiaries, Atlanta Medical Center Inc. and North Fulton Medical Center Inc., have agreed to plead guilty to conspiracy to defraud the United States and to pay health care kickbacks and bribes in violation of the Anti-Kickback Statute (AKS). The plea agreements remain subject to acceptance by the court. Up until April 2016, Atlanta Medical Center Inc. and North Fulton Medical Center Inc. owned and operated acute-care hospitals located in the greater Atlanta metropolitan area.

Atlanta Medical Center Inc. and North Fulton Medical Center Inc. were charged in a criminal information filed today in federal court in Atlanta with conspiracy to defraud the United States by obstructing the lawful government functions of HHS and to violate the AKS, which, among other things, prohibits payments to induce the referral of patients for services paid for by federal health care programs. The two Tenet subsidiaries have agreed to plead guilty to the charges alleged in the criminal information and will forfeit over \$145 million to the United States – which represents the amount paid to Atlanta Medical Center Inc. and North Fulton Medical Center Inc. by the Medicare and Georgia Medicaid programs for services provided to patients referred as part of the scheme.

Tenet HealthSystem Medical Inc. and its subsidiaries (collectively THSM) entered into a non-prosecution agreement (NPA) with the Criminal Division's Fraud Section and the U.S. Attorney's Office of the Northern District of Georgia related to the charges in the criminal information. THSM is the parent company of Atlanta Medical Center Inc., North Fulton Medical Center Inc., Spalding Regional Medical Center Inc. and Hilton Head Hospital, and employed their executives. THSM is a subsidiary of Tenet Healthcare Corporation. Under the terms of the NPA, THSM and Tenet will avoid prosecution if they, among other requirements, cooperate with the government's ongoing investigation and enhance their compliance and

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Attachment

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ethics program and internal controls. Tenet has also agreed to retain an independent compliance monitor to address and reduce the risk of any recurrence of violations of the AKS by any entity owned in whole, or in part, by Tenet. The term of THSM's and Tenet's obligations under the NPA is three years, but the NPA may be extended for up to one year.

In the civil settlement, Tenet agreed to pay \$368 million to the federal government, the state of Georgia and the state of South Carolina to resolve claims asserted in *United States ex rel. Williams v. Health Mgmt. Assocs., Tenet Healthcare, et al.*, a lawsuit filed by Ralph D. Williams, a Georgia resident, in the Middle District of Georgia, under the federal and Georgia False Claims Acts. The acts permit whistleblowers to file suit for false claims against the government entities and to share in any recovery. The federal share of the civil settlement is \$244,227,535.30, the state of Georgia will recover \$122,880,339.70 and the state of South Carolina will recover \$892,125. Mr. Williams' share of the combined civil settlement amount is approximately \$84.43 million.

"When pregnant women seek medical advice, they deserve to receive care untainted by bribes and illegal kickbacks," said Principal Deputy Assistant Attorney General Bitkower. "The Tenet case is the first brought through the assistance of the Criminal Division's corporate health care fraud strike force. This is one of more than a dozen active corporate investigations by the strike force, and we are committed to following evidence of health care fraud wherever it leads – whether it be individual physicians, pharmacy owners or corporate boardrooms."

"Our Medicaid system is premised on a patient's ability to make an informed choice about where to seek care without undue interference from those seeking to make a profit," said U.S. Attorney Horn. "Tenet cheated the Medicaid system by paying bribes and kickbacks to a pre-natal clinic to unlawfully refer over 20,000 Medicaid patients to the hospitals. In so doing, they exploited some of the most vulnerable members of our community and took advantage of a payment system designed to ensure that underprivileged patients have choices in receiving care."

"The Department of Justice continues to devote enormous resources to exposing and pursuing alleged misconduct of improper financial relationships between hospitals and referral sources," said Principal Deputy Assistant Attorney General Mizer. "Such relationships exploit vulnerable populations and threaten to drive up the cost of healthcare for everyone. In addition to yielding a substantial recovery for taxpayers, this settlement reflects the department's lack of tolerance for these types of abusive arrangements, and the negative effects they can have on our health care system."

"The global resolution of this complex and sophisticated fraud scheme exemplifies what can be accomplished through the cooperation of federal and state investigative and prosecutorial authorities," said U.S. Attorney Peterman. "I am particularly proud of the civil attorneys in the U.S. Attorney's Office for the Middle District of Georgia, working hand in hand with investigators of the U.S. Department of Health and Human Services and attorneys in the Civil Division and the Medicaid Fraud Control Unit of the Office of the Attorney General of Georgia, whose combined efforts greatly contributed to this outstanding result on behalf of the American taxpayers."

"Tenet took advantage of vulnerable pregnant women in clear violation of the law by paying kickbacks in order to bring their referrals to Tenet hospitals," said Georgia Attorney General Olsens. "Through this scheme, Tenet defrauded the Georgia Medicaid program, and reaped hundreds of millions of dollars. This is an unprecedented settlement for the state of Georgia, and reflects my office's commitment to protecting Georgia taxpayers by uncovering Medicaid fraud and abuse."

"The FBI continues to play a significant role in ensuring that federal laws related to the healthcare industry, to include the federally funded Medicare and Medicaid programs, are enforced," said Acting Special Agent in Charge Crouch. "The settlement agreements announced today involving Tenet Healthcare Corporation,

as well as related guilty pleas by two of its Atlanta-based hospitals, Atlanta Medical Center Inc., and North Fulton Medical Center Inc., are a clear example of those efforts. In addition, the FBI's Major Provider Response Team (MPRT) assisted the Atlanta Field Office in the civil and criminal investigation of Tenet. The MPRT was created in 2011 in response to numerous healthcare related corporate-level schemes resulting in billions in losses to healthcare plans. The FBI, along with its MPRT, will continue to aggressively address the threat of large-scale corporate healthcare schemes significantly impacting both private and government healthcare benefit plans."

"OIG continues to emphasize investigation of improper financial relationships between health care providers," said Special Agent in Charge Jackson. "Using their positions of trust, health providers – after receiving payments from Tenet – sent expectant women specifically to Tenet hospitals. Patients were often directed to Tenet facilities miles and miles from their homes and on their journeys passed other hospitals that could have provided needed care. These women were thereby placed at increased risk during one of the most vulnerable points in their lives. HHS-OIG will continue to protect patients by exposing such illegal arrangements."

As alleged in the criminal information as well as civil complaints filed by the department and the state of Georgia in 2014 and 2013, Atlanta Medical Center Inc., North Fulton Medical Center Inc., Spalding Regional Medical Center Inc. and Hilton Head Hospital paid bribes and kickbacks to the owners and operators of prenatal care clinics serving primarily undocumented Hispanic women in return for the referral of those patients for labor and delivery medical services at Tenet hospitals. These kickbacks and bribes allegedly helped Tenet obtain more than \$145 million in Medicaid and Medicare funds based on the resulting patient referrals.

According to the criminal information, as part of the scheme, expectant mothers were in some cases told at the prenatal care clinics that Medicaid would cover the costs associated with their childbirth and the care of their newborn only if they delivered at one of the Tenet hospitals, and in other cases were simply told that they were required to deliver at one of the Tenet hospitals, leaving them with the false belief that they could not select the hospital of their choice. The criminal information alleges that as a result of these false and misleading statements and representations, many expectant mothers traveled long distances from their homes to deliver at the Tenet hospitals, placing their health and safety, and that of their newborn babies, at risk.

The criminal information also charges Atlanta Medical Center Inc. and North Fulton Medical Center Inc. with conspiring to defraud HHS in its administration and oversight of the Medicare and Medicaid Programs, including HHS-OIG's enforcement of Tenet's September 2006 corporate integrity agreement (the CIA). The criminal information and the civil complaint allege that many of the unlawful payments happened while Tenet was under the CIA. The criminal information further alleges that certain executives of Atlanta Medical Center Inc., North Fulton Medical Center Inc. and others concealed these unlawful payments from HHS-OIG during the pendency of the CIA by, among other things, falsely certifying compliance with the requirements of the CIA and failing to disclose reportable events relating to the unlawful relationship under the CIA.

* * *

Deputy Chief Joseph S. Beemsterboer, Assistant Chief Robert A. Zink and Trial Attorneys Sally B. Molloy, Antonio M. Pozos and A. Brendan Stewart of the Criminal Division's Fraud Section and Chief Randy S. Chartash and Deputy Chief Stephen McClain of the Northern District of Georgia's Economic Crime Section represented the government in the criminal prosecution. The U.S. Attorney's Office of the Middle District of Georgia and the Civil Division's Commercial Litigation Branch represented the federal government in the

civil case. The HHS Office of Counsel to the Inspector General, the FBI and the Georgia and South Carolina Medicaid Fraud Control Units provided assistance in this matter.

The FBI's Atlanta Field Office, HHS-OIG and the FBI Healthcare Fraud Unit MPRT investigated the case.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by the Attorney General and the Secretary of HHS. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than \$30.9 billion through False Claims Act cases, with more than \$18.6 billion of that amount recovered in cases involving fraud against federal health care programs.

If you believe you are a victim of this offense, please visit this [website](#) or call (888) 549-3945.

Attachment(s):

[Download Tenet Civil Settlement Agreement](#)

[Download Tenet NPA and Attachments](#)

[Download Criminal Information for Atlanta Medical Center Inc. and North Fulton Medical Center Inc.](#)

Topic(s):

False Claims Act

Health Care Fraud

Component(s):

[Civil Division](#)

[Criminal Division](#)

[Criminal - Criminal Fraud Section](#)

[USAO - Georgia, Middle](#)

[USAO - Georgia, Southern](#)

Press Release Number:

16-1144

Updated April 27, 2017



January 9, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Authorization to Access Information (MacNeal Hospital Certificate of Exemption)

Dear Ms. Avery and Mr. Constantino:

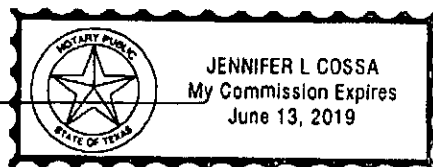
Pursuant to 77 Ill. Admin. Code § 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Tenet Healthcare Corporation with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

Sincerely,

Its: Deputy General Counsel

SUBSCRIBED AND SWORN
to before me this 9th day
of January, 2018.

J L Costa
Notary Public



Section V

Attachment 15

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

Criterion 1130.520(b)(1)(A), Name of the Parties

1. See Criterion 1110.230(a), Background of The Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(B), Background of the Applicants

1. See Criterion 1110.230(a), Background of The Applicants, in support of this Criterion.

Criterion 1130.520(b)(1)(C), Structure of the Transaction

1. GCHS is acquiring MacNeal Hospital pursuant to that certain Asset Sale Agreement, dated October 10, 2017 (the "Asset Sale Agreement").
2. Under the terms of the Asset Sale Agreement, GCHS will be acquiring MacNeal Hospital, and certain other affiliated entities (e.g., the membership interests in MacNeal Health Providers Inc. d/b/a Chicago Health System), from VHS for Two Hundred Seventy Million Dollars (\$270,000,000), subject to adjustments for working capital, assumed indebtedness, and prorations (the "Purchase Price").
3. The Purchase Price paid to Tenet will be funded with cash. A copy of Trinity's financial statements are attached as ATTACHMENT 15.

Criterion 1130.520(b)(1)(D), Licensed Party

1. GCHS will be the licensee and operator of MacNeal Hospital following the Transaction.

Criterion 1130.520(b)(1)(E), List of Ownership Interests in the Licensed Party

1. VHS is currently the owner, licensee and operator of MacNeal Hospital. VHS currently owns the land, buildings, and other real estate comprising the campus of MacNeal Hospital.
2. GCHS will be the licensee and operator of MacNeal Hospital following the Transaction.
3. Following the Transaction, LUHS will own the land, buildings, and other real estate comprising the campus of MacNeal Hospital. LUHS and GCHS will enter into a multi-year lease pursuant to which GCHS will pay fair market value rent and will be responsible for all of the costs and expenses associated with the land, buildings, and other real estate comprising the campus of MacNeal Hospital.

Criterion 1130.520(b)(1)(F), Fair Market Value of Equity Being Transferred

1. Under the terms of the Asset Sale Agreement, GCHS will be acquiring MacNeal Hospital, and certain other affiliated entities (e.g., the membership interests in MacNeal Health Providers Inc. d/b/a Chicago Health System), from VHS for Two Hundred Seventy Million

Dollars (\$270,000,000), subject to adjustments for working capital, assumed indebtedness, and prorations (the "Purchase Price").

2. The Purchase Price was negotiated at arms-length and represents fair market value.

Criterion 1130.520(b)(1)(G), Purchase Price of the Equity Being Transferred

1. Under the terms of the Asset Sale Agreement, GCHS will be acquiring MacNeal Hospital, and certain other affiliated entities (e.g., the membership interests in MacNeal Health Providers Inc. d/b/a Chicago Health System), from VHS for Two Hundred Seventy Million Dollars (\$270,000,000), subject to adjustments for working capital, assumed indebtedness, and prorations (the "Purchase Price"). The Purchase Price to Tenet will be funded with cash.

Criterion 1130.520(b)(2), Completion of Pending CONs

1. There are no pending Certificates of Need for GCHS, LUHS, Trinity, VHS or Tenet.

Criterion 1130.520(b)(3), Charity Care Policies

1. The current charity care policies for MacNeal Hospital are attached at ATTACHMENT 15.
2. Following the Transaction, GCHS will be adopting the LUHS Charity Care policies at MacNeal Hospital, copies of which are attached at ATTACHMENT 15.
3. The LUHS Charity Care policies are not more restrictive than the current charity care policies at MacNeal Hospital.
4. The LUHS Charity Care policies will remain in place for no less than two years following the Transaction. See ATTACHMENT 15.

Criterion 1130.520(b)(4), Benefits to the Community

1. Trinity is one of the largest health care systems in the country with more than \$17.6 billion in operating revenues in fiscal year 2017. As a not-for-profit health system, Trinity, through its ministry and operations, invests in its communities through programs which serve the poor and uninsured, manage chronic conditions such as diabetes, help educate residents on health care and health related issues, and provide outreach for the elderly. In fiscal year 2017, this included nearly \$1.1 billion in such community benefits.
2. With the acquisition of MacNeal Hospital, Trinity continues its commitment to strengthening health care in the Chicagoland area and across the Nation.
3. LUHS and MacNeal Hospital have had a strong collaborative relationship for several years and the Transaction will strengthen that relationship even further.
4. Following the Transaction, MacNeal Hospital will continue to operate for the benefit of the residents of Berwyn and the communities surrounding Berwyn, including serving poor and underserved individuals through charitable initiatives and activities.

Criterion 1130.520(b)(5), Cost Savings

1. It is anticipated that the proposed Transaction will result in some cost savings at MacNeal Hospital and the communities served by MacNeal Hospital. That said, at this time, it is not possible to predict with specificity the cost savings that will be realized.

Criterion 1130.520(b)(6), Quality Improvement

1. Both LUHS and MacNeal Hospital have extensive quality improvement programs in place.

2. LUHS is committed to the on-going training and development of the employees and staff at MacNeal Hospital and will continue to invest in state-of-the art facilities and equipment.

Criterion 1130.520(b)(7), Governing Body

1. Following the Transaction, MacNeal Hospital will be governed by the GCHS Board of Directors (subject to the reserve powers of GCHS's member, LUHS). The GCHS Board of Directors is currently a mirror board to the LUHS Board of Directors. Following the Transaction, the current local MacNeal Hospital Board of Directors will be elected to the GCHS Board of Directors (and certain members of the current GCHS Board of Directors will exit from the GCHS Board of Directors).

Criterion 1130.520(b)(8), Section 1110.240 Written Response

1. The review criteria set forth in 77 Ill. Admin. Code § 1110.240 have been addressed, a copy of which is available for public review at LUHS.

Criterion 1130.520(b)(9), Scope of Service Changes or Charity Care Changes

1. The Transaction set forth in this COE will result in no changes to the scope of services offered at MacNeal Hospital.

2. Following the Transaction, GCHS will be adopting the LUHS Charity Care policies at MacNeal Hospital, copies of which are attached at ATTACHMENT 15.

3. The LUHS Charity Care policies are not more restrictive than the current charity care policies at MacNeal Hospital.

Trinity Health

Consolidated Financial Statements as of and for the
years ended June 30, 2017 and 2016,
Supplemental Consolidating Schedules as of and for
the Year Ended June 30, 2017,
and Independent Auditors' Reports

INDEPENDENT AUDITORS' REPORT

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

We have audited the accompanying consolidated financial statements of Trinity Health Corporation and its subsidiaries (the "Corporation") which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the consolidated financial statements of Baycare Health System, the Corporation's investment which is accounted for by the use of the equity method. The accompanying consolidated financial statements of the Corporation include its investment in the net assets of Baycare Health System of \$2.4 billion and \$2.1 billion as of June 30, 2017, and 2016, respectively, and its equity method income from Baycare Health System of \$360.1 million and \$145.0 million for the years ended June 30, 2017 and 2016, respectively. The consolidated financial statements of Baycare Health System for the years ended December 31, 2016 and 2015, were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for Baycare Health System, is based on the reports of the other auditors and the procedures that we considered necessary in the circumstances with respect to the inclusion of the Corporation's equity investment and equity method income in the accompanying consolidated financial statements taking into consideration the differences in fiscal years. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Corporation's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Corporation as of June 30, 2017 and 2016, and the results of its operations and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

September 27, 2017

TRINITY HEALTH

CONSOLIDATED BALANCE SHEETS

JUNE 30, 2017 AND 2016

(In thousands)

ASSETS	2017	2016
CURRENT ASSETS:		
Cash and cash equivalents	\$ 1,008,197	\$ 1,044,683
Investments	3,526,204	3,617,501
Security lending collateral	332,972	262,035
Assets limited or restricted as to use - current portion	328,712	314,706
Patient accounts receivable, net of allowance for doubtful accounts of \$428.9 million and \$385.2 million at June 30, 2017 and 2016, respectively	1,877,860	1,849,736
Estimated receivables from third-party payors	260,856	248,179
Other receivables	360,051	336,705
Inventories	274,830	248,092
Prepaid expenses and other current assets	172,051	212,008
Assets held for sale	-	64,272
Total current assets	8,141,733	8,197,917
ASSETS LIMITED OR RESTRICTED AS TO USE - noncurrent portion:		
Held by trustees under bond indenture agreements	7,139	4,881
Self-insurance, benefit plans and other	823,948	780,102
By Board	3,709,246	2,959,641
By donors	460,491	409,493
Total assets limited or restricted as to use - noncurrent portion	5,000,824	4,154,117
PROPERTY AND EQUIPMENT - Net	7,853,456	7,676,734
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	3,105,173	2,681,778
GOODWILL	301,043	304,845
OTHER ASSETS	336,854	363,480
TOTAL ASSETS	\$ 24,739,083	\$ 23,378,871

LIABILITIES AND NET ASSETS	2017	2016
CURRENT LIABILITIES:		
Commercial paper	\$ 99,861	\$ 145,958
Short-term borrowings	1,039,840	1,067,730
Current portion of long-term debt	192,680	106,345
Accounts payable and accrued expenses	1,404,413	1,361,438
Salaries, wages and related liabilities	820,014	861,757
Payable under security lending agreements	332,972	262,035
Estimated payables to third-party payors	331,585	374,014
Current portion of self-insurance reserves	269,874	255,552
Liabilities held for sale	-	67,453
Total current liabilities	4,491,239	4,502,282
LONG-TERM DEBT - Net of current portion	5,269,862	5,132,377
SELF-INSURANCE RESERVES - Net of current portion	980,624	933,362
ACCRUED PENSION AND RETIREE HEALTH COSTS	1,315,991	1,857,639
OTHER LONG-TERM LIABILITIES	695,940	705,998
Total liabilities	12,753,656	13,131,658
NET ASSETS:		
Unrestricted net assets	11,282,433	9,576,379
Noncontrolling ownership interest in subsidiaries	173,703	186,595
Total unrestricted net assets	11,456,136	9,762,974
Temporarily restricted net assets	345,974	326,651
Permanently restricted net assets	183,317	157,588
Total net assets	11,985,427	10,247,213
TOTAL LIABILITIES AND NET ASSETS	\$ 24,739,083	\$ 23,378,871

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

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

YEARS ENDED JUNE 30, 2017 AND 2016

(In thousands)

	2017	2016
UNRESTRICTED REVENUE:		
Patient service revenue, net of contractual and other allowances	\$ 15,747,094	\$ 14,718,528
Provision for bad debts	(548,965)	(489,558)
Net patient service revenue less provision for bad debts	15,198,129	14,228,970
Premium and capitation revenue	1,039,749	869,030
Net assets released from restrictions	39,826	36,352
Other revenue	1,350,141	1,204,695
Total unrestricted revenue	17,627,845	16,339,047
EXPENSES:		
Salaries and wages	7,594,863	7,056,453
Employee benefits	1,510,144	1,457,253
Contract labor	242,018	205,916
Total labor expenses	9,347,025	8,719,622
Supplies	2,880,802	2,676,637
Purchased services	2,059,267	1,889,460
Depreciation and amortization	870,289	835,213
Occupancy	744,444	698,198
Medical claims	417,054	414,648
Interest	207,152	195,829
Other	835,673	758,103
Total expenses	17,361,706	16,187,710
OPERATING INCOME BEFORE OTHER ITEMS:	266,139	151,337
Asset impairment charges	(248,070)	(39,623)
Restructuring costs	(36,184)	-
Premium revenue adjustment	-	(65,335)
OPERATING (LOSS) INCOME	(18,115)	46,379
NONOPERATING ITEMS:		
Investment earnings (losses)	859,934	(199,326)
Equity in earnings of unconsolidated affiliates	376,642	162,075
Change in market value and cash payments of interest rate swaps	52,955	(94,783)
Gain (loss) from early extinguishment of debt	792	(43,056)
Inherent contributions related to acquisitions	65,103	133,355
Inherent contributions related to acquisitions - unconsolidated organizations	-	87,170
Other, including income taxes	(488)	(2,011)
Total nonoperating items	1,354,938	43,424
EXCESS OF REVENUE OVER EXPENSES	1,336,823	89,803
EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(45,599)	(48,460)
EXCESS OF REVENUE OVER EXPENSES, net of noncontrolling interest	\$ 1,291,224	\$ 41,343

	2017	2016
UNRESTRICTED NET ASSETS:		
Unrestricted net asset attributable to Trinity Health:		
Excess of revenue over expenses	\$ 1,291,224	\$ 41,343
Net assets released from restrictions for capital acquisitions	37,695	28,031
Net change in retirement plan related items - consolidated organizations	372,579	(838,812)
Net change in retirement plan related items - unconsolidated organizations	4,123	8,544
Other	8,165	12,396
Increase (decrease) in unrestricted net assets before discontinued operations	1,713,786	(748,498)
Discontinued operations:		
Gain (loss) from operations	4,919	(56,165)
(Loss) gain on disposals and settlement of debt	(12,651)	106,765
Increase (decrease) in unrestricted net assets attributable to Trinity Health	1,706,054	(697,898)
Unrestricted net asset attributable to noncontrolling interests:		
Excess of revenue over expenses attributable to noncontrolling interests	45,599	48,460
Noncontrolling interests related to acquisitions	2,500	29,272
Dividends	(52,190)	(42,133)
Other	(8,801)	(45)
(Decrease) increase in unrestricted net assets attributable to noncontrolling interests before discontinued operations	(12,892)	35,554
Discontinued operations attributable to noncontrolling interests:		
Income from operations	-	47
(Decrease) increase in unrestricted net assets attributable to noncontrolling interests	(12,892)	35,601
TEMPORARILY RESTRICTED NET ASSETS:		
Contributions	83,378	84,422
Net investment gain (loss)	17,140	(9,165)
Net assets released from restrictions	(77,521)	(64,383)
Acquisitions	2,874	38,669
Other	(6,548)	1,442
Increase in temporarily restricted net assets	19,323	50,985
PERMANENTLY RESTRICTED NET ASSETS:		
Contributions for endowment funds	1,805	3,763
Net investment gain	7,892	1,361
Acquisitions	16,960	56,411
Other	(928)	1,084
Increase in permanently restricted net assets	25,729	62,619
INCREASE (DECREASE) IN NET ASSETS	1,738,214	(548,693)
NET ASSETS - BEGINNING OF YEAR	10,247,213	10,795,906
NET ASSETS - END OF YEAR	\$ 11,985,427	\$ 10,247,213

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

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS

YEARS ENDED JUNE 30, 2017 AND 2016

(In thousands)

	2017	2016
OPERATING ACTIVITIES:		
Increase (decrease) in net assets	\$ 1,738,214	\$ (548,693)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	870,289	835,213
Provision for bad debts	548,965	489,558
Asset impairment charges	248,070	39,623
Restructuring costs, net of payments	23,484	-
Inherent contributions related to acquisitions	(65,103)	(133,355)
Inherent contributions related to acquisitions - unconsolidated organizations	-	(87,170)
(Gain) loss on extinguishment of debt	(792)	43,056
Change in net unrealized and realized gains on investments	(822,835)	267,459
Change in market values of interest rate swaps	(71,236)	72,950
Undistributed equity in earnings of unconsolidated affiliates	(407,057)	(184,225)
Deferred retirement items - consolidated organizations	(372,579)	838,812
Deferred retirement items - unconsolidated organizations	(4,123)	(8,544)
Noncash items, including net losses (gains) on disposal - discontinued operations	10,280	(88,595)
Increase in noncontrolling interests related to acquisitions	(2,500)	(29,272)
Restricted contributions and investment income received	(9,516)	(22,148)
Restricted net assets acquired	(19,834)	(95,080)
Other adjustments	34,412	11,860
Changes in:		
Patient accounts receivable	(536,942)	(525,800)
Other assets	(5,346)	2,430
Accounts payable and accrued expenses	(84,096)	199,364
Estimated receivables from third-party payors	(12,678)	(46,375)
Estimated payables to third-party payors	(48,914)	10,809
Self-insurance reserves and other liabilities	55,325	(5,107)
Accrued pension and retiree health costs	(256,668)	(159,797)
Total adjustments	(929,394)	1,425,666
Net cash provided by operating activities	808,820	876,973

	2017	2016
INVESTING ACTIVITIES:		
Purchases of investments	(3,446,670)	(3,373,316)
Proceeds from sales of investments	3,574,923	3,471,276
Purchases of property and equipment	(1,113,262)	(977,362)
Proceeds from disposal of property and equipment	8,094	19,784
Net cash acquired from acquisitions	5,610	100,807
Proceeds from the sale of divestitures	8,989	37,487
Change in investments in unconsolidated affiliates	(16,410)	(9,659)
Net repayments from (loans to) affiliates	6,108	(34,100)
Decrease in assets limited as to use and other	9,306	8,077
Net cash used in investing activities	(963,312)	(757,006)
FINANCING ACTIVITIES:		
Proceeds from issuance of debt	426,973	982,400
Repayments of debt	(235,460)	(924,445)
Net change in commercial paper	(47,075)	45,968
Dividends paid	(52,190)	(42,133)
Proceeds from grant received	20,000	-
Proceeds from restricted contributions and restricted investment income	9,516	22,148
Increase in financing costs and other	(3,758)	(2,432)
Net cash provided by financing activities	118,006	81,506
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(36,486)	201,473
CASH AND CASH EQUIVALENTS - BEGINNING OF YEAR	1,044,683	843,210
CASH AND CASH EQUIVALENTS - END OF YEAR	<u>\$ 1,008,197</u>	<u>\$ 1,044,683</u>
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for interest (net of amounts capitalized)	\$ 211,260	\$ 198,809
New capital lease obligations for buildings and equipment	1,360	4,459
Accruals for purchases of property and equipment and other long-term assets	124,056	157,984
Unsettled investment trades and purchases	28,622	135,619
Unsettled investment trades and sales	18,043	74,631
Decrease (increase) in security lending collateral	70,937	(4,537)
(Increase) decrease in payable under security lending agreements	(70,937)	4,537

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

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I. SCOPE

This policy applies to (1) Conifer Revenue Cycle Solutions, LLC ("Conifer RCS") and its subsidiaries and affiliates (each, an "Affiliate"); and (2) any other entity or organization in which Conifer RCS or an Affiliate owns a direct or indirect equity interest of 50% or more (collectively, the "Company").

II. PURPOSE

The purpose of this policy is to define charity care and to distinguish charity care from accounts assigned to bad debt. This document also establishes policies and procedures to ensure consistent identification, accountability, and recording of charity at all Conifer RCS entities and client facilities.

III. DEFINITIONS

Aid to Families with Dependent Children (AFDC): A program administered and funded by federal and state governments to provide financial assistance to needy families.

Federal Poverty Guidelines (FPG): The federally-established money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty.

Internal Revenue Service (IRS): The federal administrative entity principally responsible for the interpretation and enforcement of the federal Internal Revenue Code and its implementing regulations.

Medical Eligibility Counseling Services (MECS): The Conifer RCS line of business that helps patients, who may not have the means to pay for needed hospital services, identify government programs, third-party payers, and social service organizations from which they may be eligible to receive financial assistance.

Medically Indigent Adult (MIA): A state-funded program providing assistance to individuals who may meet guidelines for healthcare-related needs. Patients may qualify for MIA if they are ineligible for state-provided medical care, have no insurance, and lack means of support.

Medical Services Initiative (MSI): a government-sponsored and -funded program that provided healthcare to indigent individuals between the ages of 19 and 64.

Supplemental Security Income (SSI): Additional income from the federal Social Security Administration paid to those who are aged (65 or older), blind, or disabled and have limited income, limited resources, and are a U.S. citizen or national.

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Women, Infants, and Children (WIC): provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

IV. POLICY

It is Conifer RCS policy that:

- A. The determination of charity care generally should be made at the time of admission, or shortly thereafter; however, events after discharge could change the patient's ability to pay.
- B. Designation as charity care will only be considered after all payment sources have been exhausted.
- C. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor.
- D. Patient account transactions for charity care must be posted in the month the determination is made.
- E. The flat rate co-pay amount is based on patient type: Emergency department patients and outpatients are required to pay \$100 flat rate, and inpatients are required to pay \$200 per day, with a \$2,000 cap.
- F. If the account has been assigned as bad debt as part of the monthly journal entry, it will reverse the Patient Access recovery that was given on an account determined to be charity care.
- G. Employees of Conifer RCS should never indicate or suggest to the patient that he/she will be relieved of the debt by way of a write-off to charity care until the determination has been made.
- H. Conifer RCS and the client facility reserve the right to limit or deny financial assistance at their sole discretion.

V. PROCEDURE

A. MECS Procedure

1. The MECS patient financial counselor should screen patients for potential linkage to government/county programs. During the screening process, the patient advocate should secure a Financial Assistance Application. Use the application for potential charity care determination only if MECS is unable to obtain eligibility for the patient for government programs reimbursement. For potential linkage to government/county programs, the patient advocate will:

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- a. Change the financial class and assign the account to MECS within five days from date of discharge, thereby netting the account to expected governmental reimbursement.
 - b. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.
 - c. Return the account to the client facility for assignment as Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for charity care will be assigned by the client facility with the appropriate financial class. The co-pay should be collected by the client facility's financial counselor or business office representative.
2. If, during the initial interview with the patient, it is revealed that there is no viable source of payment, and the patient will not qualify for any governmental programs, the patient advocate will:
- a. Offer the patient a Financial Assistance Application.
 - b. Assist the patient in completing a Financial Assistance Application, which will document the patient's financial need.
 - c. Obtain the patient's signature on the Financial Assistance Application and forward the application to the financial counselor, as deemed appropriate.
 - d. Refer the patient to the client facility financial counselor for collection of the co-pay.

B. MECS Processing For Charity Care

1. For those accounts that remain in MECS past 30 days from assignment with no government program linkage, and that meet the financial criteria for charity care, MECS should have gathered all substantial information to enable the client facility to effect its charity care policy. Included in the charity care packet is a Financial Assistance Application. If the MECS representative has exhausted all efforts to secure all necessary verifications, submit the application for charity care to the financial counselor for review and finalization without the verifications.
 - a. MECS is required to notify the client facility of the inability to obtain eligibility, or the potential qualification for charity care classification, and to return the account to the client facility.

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b. The client facility is required to update the plan ID and financial class.

C. Financial Counselor Procedure (client specific):

1. Patients whom a financial counselor finds to have no third-party coverage and/or benefits available will:
 - a. Be offered the client facility flat rate or Prompt Pay Discount Program where allowed by state law/regulation.
 - b. Be assessed for charity care if the patient is unable to pay the client facility flat rate or Prompt Pay Discount Program amount (as applicable to state law/regulation), and meets the income/asset and other guidelines set forth by the client facility's charity care policy.
2. The financial counselor will take the appropriate steps as outlined below:
 - a. For patients who appear to meet the income guidelines set forth in this policy for charity care, the account should be updated with the financial class of charity on the client facility system, at which time a one hundred percent (100%) charity care reserve should be taken, and the co-pay amount should be collected.
 - b. Patients who do not qualify for charity care should be treated as a self-pay, and standard accounts receivable collection procedures will apply.

D. Documentation

1. Financial Assistance Application
 - a. To qualify for charity care, Conifer RCS requests each patient or family to complete the Financial Assistance Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a charity care patient in accordance with the client facility's charity care policy. The patient's account will have the financial class changed to charity care on the client facility's system.
 - b. In cases where the patient is unable to complete the written application, verbal attestation is acceptable if state law/regulation allows it.
 - c. A Financial Assistance Application completed by the patient may not be required for patients who are deemed to be already eligible for other federal, state, and county assistance programs. Such programs include, but are not limited to, Medicaid, county assistance programs, MIA, MSI, AFDC, food stamps, and WIC.

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- i. Family members – Conifer RCS will require patients to provide the number of family members in their household.
 - a. Adults – To calculate the number of family members in an adult patient’s household, include the patient, the patient’s spouse and/or legal guardian, and all of their dependents.
 - b. Minors – To calculate the number of family members in a minor patient’s household, include the patient, the patient’s mother/father and/or legal guardian, and all of their other dependents.
- ii. Income calculation - Conifer RCS requires patients to provide their household’s yearly gross income.
 - a. Adults – The term “yearly income” on the application means the sum of the total yearly gross income of the patient and the patient’s spouse.
 - b. Minors – If the patient is a minor, the term “yearly income” means the income from the patient, the patient’s mother/father and/or legal guardian, and all of their other dependents.
- iii. Expired patients – Expired patients may be deemed to have no income for purposes of the Conifer RCS calculation of income. Although no documentation of income and no Financial Assistance Application are required for expired patients, the patient’s financial status will be reviewed at the time of death by the financial counselor to ensure that a charity care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.
- iv. Homeless patients – Patients may be deemed homeless once the financial counselor has exhausted verification processes. The co-pay will be waived if no other guarantor appears on the patient account.

2. Income Verification

- a. Conifer RCS requests patients to attest to the income set forth in the application. In determining a patient’s total income, Conifer RCS may consider other financial assets and liabilities of the patient, as well as the patient’s family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay the bill, such determination does not preclude a reassessment of the patient’s ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for charity care:
 - i. Income Documentation – Income documentation may include IRS W-2 form, wage and earnings statement, paycheck stub, tax returns, telephone

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verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

- ii. Participation in a Public Benefit Program – Public benefit program documentation showing current participation in programs, such as social security, workers' compensation, unemployment insurance, Medicaid, county assistance programs, AFDC, food stamps, WIC, or other similar indigence-related programs.
- iii. Assets – All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

3. Information Falsification

Information falsification will result in denial of the charity care application. If, after a patient is granted financial assistance, the client facility finds material provision(s) of the application to be untrue, charity care status may be revoked, and the patient's account will follow the normal collection processes.

4. Revenue Classification

Critical changes in account class are defined as:

- a. Any account originally assigned to the financial counselors self-pay that is re-classified as a result of meeting the criteria for charity care; or
- b. Any account originally assigned to the financial counselor as charity that is re-classified to self-pay as a result of denying charity care.

E. Denied Charity Care Recommendations

1. If the client facility chief financial officer (CFO) denies a patient's application for charity care, place documentation in the client facility collection system as to the reason for the rejection of the recommendation.
2. The client facility CFO is also to indicate on the Financial Assistance Application the reason for denial and the date of the denial. The packet is then to be sent to the financial counselor for review.
3. After an initial review and discussion with the client facility CFO, for those patient accounts where disagreement persists, and the accounts that meet Conifer RCS guidelines for charity care as set forth here, a denial summary will be sent to the respective client regional vice president of finance by the financial counselor for resolution.

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- a. For those patient accounts that the client regional vice president of finance has denied to have met the client facility charity care guidelines as set forth here, a denial summary will be sent to the respective client divisional senior vice president of finance for conference and resolution.

F. Reservation of Rights

1. Non-covered services – Conifer RCS and its client facilities reserve the right to designate certain services that are not subject to the client facilities' charity care policies.
2. No Effect on other regions/client facility policies – This policy shall not alter or modify other Conifer RCS policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, state-specific regulations, state-specific requirements for statutory charity care classification, or programs for uncompensated care.

VI. ENFORCEMENT

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

Financial Assistance to Patients

PURPOSE

Loyola University Medical Center (LUMC) is a community of persons serving together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Aligned with our Core Values, in particular that of "Commitment To Those Who Are Poor," we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the health care expenses incurred. LUMC is committed to:

- Providing access to quality health care services with compassion, dignity and respect for those we serve, particularly the poor and the underserved in our communities;
- Caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

This Procedure, which provides guidance on implementing the accompanying Financial Assistance Policy, balances financial assistance with broader fiscal responsibilities and provides the LUMC requirements for financial assistance for physician, acute care and post-acute care services where applicable.

PROCEDURE

LUMC will establish and maintain the Financial Assistance to Patients ("FAP") procedure outlined below. The FAP is designed to address patients' needs for financial assistance and support as they seek services through LUMC. It applies to all eligible services as provided under applicable state or federal law. Eligibility for financial assistance and support from LUMC will be determined on an individual basis using specific criteria and evaluated on an assessment of the patient and/or Family's health care needs, financial resources and obligations.

I. Qualifying Criteria for Financial Assistance

a. Services eligible for Financial Support:

- i. All medically necessary services, including medical and support services provided by LUMC, will be eligible for Financial Support.
- ii. Emergency medical care services will be provided to all patients who present to LUMC's hospital's emergency department, regardless of the patient's ability to pay.

Such medical care will continue until the patient's condition has been stabilized — prior to any determination of payment arrangements.

- iii. Loyola University Medical Center and satellite locations: All physician charges are eligible and are included under this policy.

b. Services not eligible for Financial Support:

- i. Cosmetic services and other elective procedures and services which are not medically necessary.
- ii. Services not provided and billed by LUMC (e.g. independent physician services, private duty nursing, ambulance transport, etc.).
- iii. As provided in Section II, LUMC will proactively help patients apply for public and private programs such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program or any other program for which there is a reasonable basis to believe that the uninsured patient may be eligible including the purchase of commercial insurance on the Health Insurance Exchange under the Affordable Care Act.. LUMC may deny Financial Support to those individuals who do not cooperate in applying for programs that may pay for their health care services.
- iv. LUMC may exclude services that are covered by an insurance program at another provider location but are not covered at LUMC hospitals after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

c. Residency requirements

- i. RHMs will provide Financial Support to patients who reside within their service areas and who qualify under the LUMC's FAP procedure.
- ii. Loyola University Medical Center will provide financial assistance support to patients who qualify for this program and who are Illinois residents. LUMC will provide medically necessary care and treatment to all patients who present with an urgent, emergent or life-threatening condition regardless of residency. However, LUMC has no obligation to provide financial assistance support for patients who require such care and treatment but are not Illinois residents. Patients required to verify Illinois residency by providing valid documentation to LUMC, including:
 - Valid income verification as specified in section IV
 - A valid Illinois identification card or driver's license
 - A recent residential utility bill
 - A lease agreement
 - A vehicle registration card
 - A voter registration card

- Mail address to the uninsured patient at an Illinois address from a government or other credible source
 - A statement from the family member of the uninsured patient who resides at the same address and presents verification of Illinois residency
 - A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.
- iii. LUMC may identify Service Areas in the FAP and include Service Area information in procedure design and training. Service Area residency requirements will start with the list of zip codes provided by System Office Strategic Planning that define LUMC service areas. LUMC will verify service areas in consultation with their local Community Benefit department. Eligibility will be determined by LUMC using the patient's primary residence zip code.
- iv. LUMC will provide Financial Support to patients from outside their Service Areas who qualify under the RHM FAP and who present with an Urgent, Emergent or life-threatening condition.
- v. LUMC will provide Financial Support to patients identified as needing service by physician foreign mission programs conducted by active medical staff for which prior approval has been obtained from LUMC's President or designee.
- d. Documentation for Establishing Income
- i. Information provided to LUMC by the patient and/or Family should include earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and Income from any other source; number of dependents in household; and other information requested on the FAP application.
- ii. LUMC will list the supporting documentation such as payroll stubs, tax returns, and credit history required to apply for financial assistance in the FAP or FAP application. LUMC may not deny Financial Support based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.
- iii. LUMC will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. LUMC may initiate ECAs if the patient does not submit the missing information and/or documentation within the 30 day resubmission period and it is at least 120 days from the date the RHM provided the first post-discharge billing statement for the care. LUMC must process the FAP application if the patient provides the missing information/or documentation during the 240-day application period (or, if later, within the 30-day resubmission period).

- iv. For purposes of ascertaining a patient's family income, verification of one of the following is required for evaluation for charity care or financial assistance review and approval:

- A copy of the previous year W2, 1040, and any other applicable tax forms that were filed.
- Copies for the last 3 most recent paycheck stubs from the employer.
- If patient is paid cash, a letter from the employer stating amount paid weekly.
- Copies of Social security check if they are receiving one.
- Copy of last statement for checking and/or savings account.

If a patient does not provide appropriate documentation, a credit check will be run on the patient. Based on the information provided by Trans Union Services, a charity determination will be made. If it is discovered that a patient or family member provided fraudulent documentation, the application for financial assistance will be voided.

e. Consideration of Patient Assets

- i. LUMC will also establish a threshold level of assets above which the patient/family's assets will be used for payment of medical expenses and liabilities to be considered in assessing the patient's financial resources.

Protection of certain types of assets and protection of certain levels of assets must be provided in the LUMC's FAP.

Protected Assets relevant to this FAP include:

- 50% equity in primary residence up to \$50,000;
- Business use vehicles;
- Tools or equipment used for business; reasonable equipment required to remain in business;
- Personal use property (clothing, household items, furniture);
- IRAs, 401K, cash value retirement plans;
- Financial awards received from non-medical catastrophic emergencies;
- Irrevocable trusts for burial purposes, prepaid funeral plans; and/or
- Federal/State administered college savings plans.

All other assets will be considered available for payment of medical expenses. Available assets above a certain threshold can either be used to pay for medical expenses or, alternatively, LUMC may count the excess available assets as current year Income in establishing the level of discount to be offered to the patient. A minimum amount of \$5,000 of available assets shall be protected.

f. Presumptive Support

- i. LUMC recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted it is classified as "Presumptive Support".
- ii. The predictive model is one of the reasonable efforts that will be used by LUMC to identify patients who may qualify for financial assistance prior to initiating collection actions, *i.e.* write-off of a patient account to bad debt and referral to collection agency. This predictive model enables LUMC to systematically identify financially needy patients.
- iii. Examples of presumptive cases include:
 - Deceased patients with no known estate
 - Homeless patients
 - Unemployed patients
 - Non-covered medically necessary services provided to patients qualifying for public assistance programs
 - Patient bankruptcies
 - Members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order

For patients who are non-responsive to the FAP application process, other sources of information, if available, should be used to make an individual assessment of financial need. This information will enable LUMC to make an informed decision on the financial need of non-responsive patients.

- iv. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record databases. These public records enable LUMC to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.
- v. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within established timelines and be considered under the traditional financial assistance application process.
- vi. Patient accounts granted presumptive support status will be adjusted using *Presumptive Financial Support* transaction codes at such time the account is deemed uncollectable and prior to referral to collection or write-off to bad debt. The discount granted will be classified as Financial Support; the patient's account will not be sent to collection and will not be included in the LUMC's bad debt expense.

- i. LUMC will notify patients determined to be eligible for less than the most generous assistance available under the FAP that he or she may apply for more generous assistance available under the FAP within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, LUMC may initiate or resume ECAs if the patient does not apply for more generous assistance within 30 days of notification if it is at least 120 days from the date LUMC provided the first post-discharge billing statement for the care. LUMC will process any new FAP application that the patient submits by the end of the 240 day application period or, if later, by the end of the 30-day period given to apply for more generous assistance.

g. Timeline for Establishing Financial Eligibility

- i. Every effort should be made to determine a patient's eligibility for Financial Support prior to or at the time of admission or service. FAP Applications must be accepted any time during the application period. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or either:
 - the end of the period of time that a patient that is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or
 - the deadline provided in a written notice after which ECAs may be initiated.
 - LUMC may accept and process an individual's FAP application submitted outside of the application period on a case-by-case basis as authorized by LUMC's established approval levels.
- ii. LUMC (or other authorized party) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refunds of payments is only required for the episodes of care to which the FAP application applies.
- iii. Determinations of Financial Support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted.
- iv. LUMC will make every effort to make a Financial Support determination in a timely fashion. If other avenues of Financial Support are being pursued, LUMC will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

- v. Once qualification for Financial Support has been determined, subsequent reviews for continued eligibility for subsequent services should be made after a reasonable time period as determined by LUMC.

h. Level of Financial Support

- i. LUMC will follow the Income guidelines established below in evaluating a patient's eligibility for Financial Support. A percentage of the Federal Poverty Level (FPL) Guidelines, which are updated on an annual basis, are used for determining a patient's eligibility for Financial Support. However, other factors should also be considered such as the patient's financial status and/or ability to pay as determined through the assessment process.
- ii. It is recognized that local demographics and the financial assistance policies offered by other providers in the community may expose LUMC to large financial risks and a financial burden which could threaten LUMC's long-term ability to provide high quality care. LUMC may request approval to implement thresholds that are less than or greater than the recommended amounts from Trinity Health's Chief Financial Officer.
- iii. Family Income at or below 200% of the Federal Poverty Level Guidelines:
- A 100% discount for all charges will be provided for Uninsured Patients whose Family's Income is at or below 200% of the most recent Federal Poverty Level Guidelines.
- iv. Family Income between 201% and 600% of the Federal Poverty Level Guidelines:
- A discount off of total facility charges equal to LUMC's average acute care contractual adjustment for Medicare will be provided for acute care patients whose Family Income is between 201% and 400% of the Federal Poverty Level Guidelines. Also, LUMC has compared the discounts for 135% of the hospital's Medicare cost to charge ratio to the amounts generally billed (AGB) which can be found in Appendix A; and have applied the more generous discounts for patients.
 - A discount off of total professional charges equal to LUMC's physician contractual adjustment for Medicare will be provided for ambulatory location patients whose Family Income is between 201% and 400% of Federal Poverty Level Guidelines. Also, LUMC has compared the discounts for 135% of the hospital's Medicare cost to charge ratio to the amounts generally billed and have applied the more generous discounts for patients.
 - LUMC's acute and physician contractual adjustment amounts for Medicare will be calculated utilizing the look back methodology of calculating the sum of paid claims divided by the total or "gross" charges

for those claims by the System Office or RHM annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

- Patients between 401% and 600% of the poverty guidelines will receive the Illinois uninsured patient discount adjustment, which is adjusted annually per the State of Illinois formula. Also, LUMC has compared the discounts for 135% of the hospital's Medicare cost to charge ratio to the amounts generally billed and have applied the more generous discounts for patients.
- v. Patients with Family Income up to and including 200% of the Federal Poverty Level Guidelines will be eligible for Financial Support for co-pay, deductible, and co-insurance amounts provided that contractual arrangements with the patient's insurer do not prohibit providing such assistance.
- vi. Medically Indigent Support / Catastrophic: Financial support is also provided for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their Family or household Income (for example, due to catastrophic costs or conditions), regardless of whether they have Income or assets that otherwise exceed the financial eligibility requirements for Free Care or Discounted Care under the LUMC's FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence/catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's Income, expenses and assets. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of a patient's annual Income will qualify the insured patient's co-pays and deductibles for catastrophic charity care assistance. Discounts for medically indigent care for the uninsured will not be less than LUMC's average contractual adjustment amount for Medicare for the services provided or an amount to bring the patients catastrophic medical expense to annual Income ratio back to 20%. Medically indigent and catastrophic financial assistance will be approved by the LUMC CFO and reported to the System Office Chief Financial Officer.
- vii. While Financial Support should be made in accordance with LUMC's established written criteria, it is recognized that occasionally there will be a need for granting additional Financial Support to patients based upon individual considerations. Such individual considerations will be approved by the LUMC CFO and reported to the System Office Chief Financial Officer.
- i. Accounting and Reporting for Financial Support
- i. In accordance with the Generally Accepted Accounting Principles, Financial Support provided by LUMC is recorded systematically and accurately in the financial

statements as a deduction from revenue in the category "Charity Care". For the purposes of Community Benefit reporting, charity care is reported at estimated cost associated with the provision of "Charity Care" services in accordance with the Catholic Health Association.

ii. The following guidelines are provided for the financial statement recording of Financial Support:

- Financial Support provided to patients under the provisions of the "Financial Assistance Program", including the adjustment for amounts generally accepted as payment for patients with insurance, will be recorded under "Charity Care Allowance."
- Write-off of charges for patients who have not qualified for Financial Support under this Procedure and who do not pay for the services received will be recorded as "Bad Debt."
- Prompt pay discounts will be recorded under "Contractual Allowance."
- Accounts initially written-off to bad debt and subsequently returned from collection agencies where the patient is determined to have met the Financial Support criteria based on information obtained by the collection agency will be reclassified from "Bad Debt" to "Charity Care Allowance".

II. Assisting Patients Who May Qualify for Coverage

- a. LUMC will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Premium assistance may also be granted on a discretionary basis according to LUMC's "Payment of QHP Premium and Patient Payables" procedure.
- b. LUMC will have understandable, written procedures to help patients determine if they qualify for public assistance programs or LUMC's FAP.

III. Effective Communications

- a. LUMC will provide financial counseling to patients about their health care bills related to the services they receive from LUMC and will make the availability of such counseling known.
- b. LUMC will respond promptly and courteously to patients' questions about their bills and requests for financial assistance.
- c. LUMC will utilize a billing process that is clear, concise, correct and patient friendly.
- d. LUMC will make available information about charges for services they provide in an understandable format.

- e. LUMC will post signs and display brochures that provide basic information about their FAP in public locations (at a minimum, the emergency room (if any) and admission areas). At a minimum, the sign will read "You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information contact the LUMC Benefit Advocacy Department at 708-216-5014. The sign will be in English and in any other language that is the primary language of at least 5% of the patients served by LUMC annually. Information is available at the Admitting Office, Emergency Room, Financial Counselor Office at the Outpatient Center and Cancer Center.
- f. LUMC will make available a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process. LUMC will not have failed to widely publicize its FAP because an individual declines a plain language summary that was offered on intake or before discharge or indicates that he or she would prefer to receive a plain language summary electronically.
- g. LUMC will make the FAP, a plain language summary of the FAP and the FAP application form available to patients upon request, in public places (at a minimum, the emergency room (if any) and admission areas), by mail and on the LUMC website. Any individual with access to the Internet must be able to view, download and print a hard copy of these documents. LUMC will provide any individual who asks how to access a copy of the FAP, FAP application form, or plain language summary of the FAP online with the direct website address, or URL, where these documents are posted.
- h. LUMC will list the names of individual doctors, practice groups, or any other entities that are providing emergency or medically necessary care in LUMC's facility by the name used either to contract with the hospital or to bill patients for care provided. This list can be found in Appendix B. Alternately, a hospital facility may specify providers by reference to a department or a type of service if the reference makes clear which services and providers are covered under LUMC's FAP.
- i. These documents will be made available in English and in the primary language of any population with limited proficiency in English that constitutes the lesser of the 1,000 individuals or 5 percent of the community served by LUMC.
- j. LUMC will take measures to notify members of the community served by LUMC about the FAP. Such measures may include, for example, the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low income populations.
- k. LUMC will include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under LUMC's FAP and includes the telephone number of LUMC's department that can provide information about the FAP, the FAP application process and the direct Web site address (or URL) where

copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained.

- l. LUMC will refrain from initiating ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient. LUMC will also ensure all vendor contracts for business associates performing collection activity will contain a clause or clauses prohibiting ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient.
- m. LUMC will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECA(s) that LUMC (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided. LUMC will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the LUMC FAP and about how the patient may obtain assistance with the FAP application process.
- n. In the case of deferring or denying, or requiring a payment for providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under LUMC's FAP, LUMC may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, LUMC must satisfy several conditions. LUMC must:
 - i. Provide the patient with an FAP application form (to ensure the patient may apply immediately, if necessary) and notify the patient in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process an FAP application submitted by the patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the patient must be afforded at least 30 days after the notice to submit an FAP application for the previously provided care.
 - ii. Notify the patient about the FAP by providing a plain-language summary of the FAP and by orally notifying the patient about the hospital facility's FAP and about how the patient may obtain assistance with the FAP application process.
 - iii. Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above are not needed in the following cases:

- i. If 120 days have passed since the first post-discharge bill for the previously provided care and LUMC has already notified the patient about intended ECAs.
 - ii. If LUMC had already determined whether the patient was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the patient was FAP-eligible for the previously provided care.
- o. LUMC will provide written notification that nothing is owed if a patient is determined to be eligible for Free Care.
 - p. LUMC will provide patients that are determined to be eligible for assistance other than Free Care, with a billing statement that indicates the amount the patient owes for care as a FAP-eligible patient. The statement will also describe how that amount was determined or how the patient can get information regarding how the amount was determined.

IV. Fair Billing and Collection Practices

- a. LUMC will implement billing and collection practices for patient payment obligations that are fair, consistent and compliant with state and federal regulations.
- b. LUMC will make available to all patients who qualify a short term interest free payment plan with defined payment time frames based on the outstanding account balance. LUMC will also offer a loan program for patients who qualify.
- c. LUMC will have written procedures outlining when and under whose authority a patient debt is advanced for external collection activities that are consistent with this Procedure.
- d. The following collection activities may be pursued by LUMC or by a collection agent on their behalf:
 - i. Communicate with patients (call, written correspondence, fax, text, email, etc.) and their representatives in compliance with the Fair Debt Collections Act, clearly identifying LUMC. The patient communications will also comply with HIPAA privacy regulations.
 - ii. Solicit payment of the estimated patient payment obligation portion at the time of service in compliance with EMTALA regulations and state laws.
 - iii. Provide low-interest loan program for payment of outstanding debts for patients who have the ability to pay but cannot meet the short-term payment requirements.
 - iv. Report outstanding debts to Credit Bureaus only after all aspects of this Procedure have been applied and after reasonable collection efforts have been made in conformance with LUMC's FAP.

- v. Pursue legal action for individuals who have the means to pay, but do not pay, or who are unwilling to pay. Legal action also may be pursued for the portion of the unpaid amount after application of LUMC's FAP. An approval by the Trinity Health or LUMC CEO/CFO, or the functional leader for Patient Financial Services for LUMC, must be obtained prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).
- vi. Place liens on property of individuals who have the means to pay, but do not pay, or who are unwilling to pay. Liens may be placed for the portion of the unpaid amount after application of LUMC's FAP. Placement of a lien requires approval by the Trinity Health or LUMC CEO/CFO, or the functional leader for Patient Financial Services for LUMC. Liens on primary residence can only be exercised upon the sale of property and will protect certain asset value in the property as documented in this Procedure. LUMC recommends protecting 50% of the equity up to \$50,000.
- e. LUMC (or a collection agent on their behalf) shall not pursue action against the debtor's person, such as arrest warrants or "body attachments." LUMC recognizes that a court of law may impose an arrest warrant or other similar action against a defendant for failure to comply with a court's order or for other violations of law related to a collection effort. While in extreme cases of willful avoidance and failure to pay a justly due amount when adequate resources are available to do so, a court order may be issued; in general, LUMC will first use its efforts to convince the public authorities not to take such an action and, if not successful, consider the appropriateness of ceasing the collection effort to avoid an action against the person of the debtor.
- f. LUMC (or a collection agent on their behalf) will take all reasonably available measures to reverse ECAs related to amounts no longer owed by FAP-eligible patients.
- g. LUMC may have a System Office approved arrangement with a collection agency, provided that such agreement meets the following criteria:
 - i. The agreement with a collection agency must be in writing;
 - ii. Neither LUMC nor the collection agency may at any time pursue action against the debtor's person, such as arrest warrants or "body attachments;"
 - iii. The agreement must define the standards and scope of practices to be used by outside collection agents acting on behalf of LUMC, all of which must be in compliance with this Procedure;
 - iv. No legal action may be undertaken by the collection agency without the prior written permission of LUMC;
 - v. Trinity Health Legal Services must approve all terms and conditions of the engagement of attorneys to represent LUMC in collection of patient accounts;

- vi. All decisions as to the manner in which the claim is to be handled by the attorney, whether suit is to be brought, whether the claim is to be compromised or settled, whether the claim is to be returned to LUMC, and any other matters related to resolution of the claim by the attorney shall be made by LUMC in consultation with Trinity Health Legal Services;
- vii. Any request for legal action to collect a judgment (*i.e.*, lien, gamishment, debtor's exam) must be approved in writing and in advance with respect to each account by the appropriate authorized LUMC representative as detailed in section (IV)(d)(v);
- viii. LUMC must reserve the right to discontinue collection actions at any time with respect to any specific account; and
- ix. The collection agency must agree to indemnify LUMC for any violation of the terms of its written agreement with LUMC.

V. Implementation of Accurate and Consistent Policies

- a. Representatives of LUMC's Patient Financial Services and Patient Access departments will educate staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections, physician offices) about billing, financial assistance, collection policies and practices, and treatment of all patients with dignity and respect regardless of their insurance status or their ability to pay for services.
- b. LUMC will honor Financial Support commitments that were approved under previous financial assistance guidelines.

VI. Other Discounts

- a. Prompt Pay Discounts: LUMC may develop a prompt pay discount program which will be limited to balances equal to or greater than \$200.00 and will be no more than 20% of the balance due. The prompt pay discount is to be offered at the time of service and recorded as a contractual adjustment and cannot be recorded as charity care on the financial statements.
- b. Self-Pay Discounts: LUMC will apply a standard self-pay discount off of charges for all registered self-pay patients that do not qualify for financial assistance (e.g., >600% of FPL) based on the highest commercial rate paid.
- c. Additional Discounts: Adjustments in excess of the percentage discounts described in this Procedure may be made on a case-by-case basis upon an evaluation of the collectability of the account and authorized by LUMC's established approval levels.

Should any provision of this FAP conflict with the requirement of the law of the state in which the LUMC operates, state law shall supersede the conflicting provision and LUMC shall act in conformance with applicable state law.

SCOPE/APPLICABILITY

This procedure applies to all LUMC entities that operate licensed tax-exempt hospitals. LUMC organizations that do not operate tax-exempt licensed hospitals may establish their own financial assistance procedures for other health care services they provide and are encouraged to use the criteria established in this FAP procedure as guidance.

DEFINITIONS

Application Period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either --

- i. the end of the 30 day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.
- ii. the deadline provided in a written notice after which ECAs may be initiated.

Amounts Generally Billed ("AGB") means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care. The RHM's acute and physician AGB will be calculated utilizing the look back methodology of calculating the sum of paid Medicare claims divided by the total or "gross" charges for those claims by the System Office or RHM annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

Discounted care means a partial discount off the amount owed for patients that qualify under the FAP.

Emergent medical services are those needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by Emergency Medical Treatment and Active Labor Act (EMTALA).

Executive Leadership Team ("ELT") means the group that is composed of the highest level of management at LUMC.

Extraordinary Collection Actions ("ECA") include the following actions taken by LUMC (or a collection agent on their behalf):

- Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP. If LUMC requires payment before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual's nonpayment of the

outstanding bill(s) unless LUMC can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.

- Reporting outstanding debts to Credit Bureaus.
- Pursuing legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).
- Placing liens on property of individuals.

Family (as defined by the U.S. Census Bureau) is a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility under LUMC's FAP.

Family Income - A person's Family Income includes the Income of all adult Family members in the household. For patients under 18 years of age, Family Income includes that of the parents and/or step-parents, or caretaker relatives' annual Income from the prior 12 month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Financial assistance policy (FAP) means a written policy and procedure that meets the requirements described in §1.501(r)-4(b).

Financial Assistance Policy ("FAP") application means the information and accompanying documentation that a patient submits to apply for financial assistance under LUMC's FAP. LUMC may obtain information from an individual in writing or orally (or a combination of both).

Financial Support means support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by LUMC who meet the eligibility criteria for such assistance.

Free Care means a full discount off the amount owed for patients that qualify under the FAP.

Income includes wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, alimony, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity is defined as documented in LUMC's state's Medicaid Provider Manual.

Policy means a statement of high-level direction on matters of strategic importance to LUMC or a statement that further interprets LUMC's governing documents. System Policies may be either stand alone or Mirror Policies designated by the approving body.

Plain language summary of the FAP means a written statement that notifies a patient that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

- A brief description of the eligibility requirements and assistance offered under the FAP.
- A brief summary of how to apply for assistance under the FAP.
- The direct Web site address (or URL) and physical locations where the patient can obtain copies of the FAP and FAP application form.
- Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail
- The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and provide assistance with the FAP application process
- A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.
- A statement that a FAP-eligible patient may not be charged more than AGB for emergency or other medically necessary care

Procedure means a document designed to implement a Policy or a description of specific required actions or processes.

Regional Health Ministry ("RHM") means a first tier (direct) subsidiary, affiliate or operating division of LUMC that maintains a governing body that has day-to-day management oversight of a designated portion of LUMC System operations. RHMs may be based on a geographic market or dedication to a service line or business.

Service Area is the list of zip codes comprising the LUMC service market area constituting a "community of need" for primary health care services.

Standards or Guidelines mean additional instructions and guidance which assist in implementing Procedures, including those developed by accreditation or professional organizations.

Uninsured Patient means an individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which LUMC is subrogated, but only if payment is actually made by such insurance company.

Urgent (service level) are medical services needed for a condition that is not life threatening, but requiring timely medical services.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Procedure may be obtained from the VP, Patient Financial Services, in the Revenue Excellence Department.

APPENEDIX A: Amounts Generally Billed

Amounts Generally Billed Discount = 76%

Calculation of AGB:

Medicare Contractual Allowances (\$628,471,925)/Medicare Charges (\$828,950,599) = .758*100
= 76%

APPENDIX B: Provider Listing

RELATED PROCEDURES AND OTHER MATERIALS

- LUMC Financial Assistance Policy No. FIN-002: Financial Assistance Policy ("FAP")
- LUMC Revenue Excellence Policy No, FIN-011: Payment of QHP Premiums and Patient Payables"
- Patient Protection and Affordable Care Act: Statutory Section 501(r)
- Internal Revenue Service Schedule H (Form 990)
- Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Final Rule: Volume 79, No. 250, Part II, 26 CFR, Part 1
- LUMC's EMTALA Emergency Medical Treatment and Labor Act Policy No. 11.05.11



LOYOLA
UNIVERSITY
HEALTH SYSTEM

January 2, 2018

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761-0001

Re: Charity Care Certification (MacNeal Hospital Certificate of Exemption)

Dear Ms. Avery and Mr. Constantino:


I hereby certify, under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109, and pursuant to 77 Ill. Admin. Code § 1130.520(b)(3), that: (a) Gottlieb Community Health Services Corporation ("GCHS") intends to adopt the charity care policy currently in force at Loyola University Health System (the "LUHS Charity Care Policy") for MacNeal Hospital following the acquisition of MacNeal Hospital by GCHS; and (b) GCHS shall maintain the LUHS Charity Care Policy at MacNeal Hospital for no less than two years thereafter.

Sincerely,



Larry M. Goldberg
President & CEO, Loyola University Health System
CEO, Gottlieb Community Health Services Corporation

SUBSCRIBED AND SWORN
to before me this 5th day
of January, 2018.




Notary Public

OFFICIAL SEAL
JILL M RAPPIS
Notary Public - State of Illinois
My Commission Expires Aug 25, 2018

We also treat the human spirit.

Loyola University Medical Center | 2160 S. First

0090

A PART OF  TRINITY HEALTH

| (888) 584-7881

Attachment

15

Section X
Attachment 21
Charity Care

Trinity Facilities Located in Illinois:

Loyola

	2014	2015	2016	2017
Total Net Patient Revenue	1,095,327,560	1,104,584,892	1,130,275,215	1,145,582,319
Amount of Charity Care (Charges)	52,204,912	49,544,508	21,031,815	30,561,525
Cost of Charity Care	16,275,351	13,638,188	5,825,581	8,457,963
Cost of Charity Care/Total Net Patient Ratio	1.49%	1.23%	0.52%	0.74%

Gottlieb

	2014	2015	2016	2017
Total Net Patient Revenue	124,893,323	114,448,200	118,281,186	126,094,287
Amount of Charity Care (Charges)	13,772,342	11,449,397	89,574	5,071,456
Cost of Charity Care	3,008,912	2,401,821	19,885	1,038,059
Cost of Charity Care/Total Net Patient Ratio	2.41%	2.10%	0.02%	0.82%

Total LUHS

	2014	2015	2016	2017
Total Net Patient Revenue	1,220,220,883	1,219,033,092	1,248,556,401	1,271,676,606
Amount of Charity Care (Charges)	65,977,254	60,993,905	21,121,389	35,632,981
Cost of Charity Care	19,284,263	16,040,009	5,845,466	9,496,022
Cost of Charity Care/Total Net Patient Ratio	1.58%	1.32%	0.47%	0.75%

Mercy

	2014	2015	2016	2017
Total Net Patient Revenue	232,867,649	242,361,279	242,945,106	234,662,000
Amount of Charity Care (Charges)	13,582,519	8,252,600	12,446,719	12,499,199
Cost of Charity Care	5,067,120	2,771,486	4,430,706	4,408,423
Cost of Charity Care/Total Net Patient Ratio	2.00%	1.05%	1.60%	1.88%

The charity care numbers for MacNeal Hospital for the past three years are set forth below:

MacNeal Hospital

	2014	2015	2016
Total Net Patient Revenue	242,087,011	251,666,712	263,660,730
Cost of Charity Care	2,960,888	2,266,840	2,684,648
Cost of Charity Care/Total Net Patient Ratio	1.22%	0.90%	1.02%

The 2014, 2015 and 2016 Annual Hospital Profiles for MacNeal Hospital are attached as ATTACHMENT 21.

Hospital Profile - CY 2016

MacNeal Hospital

Berwyn

Page 1

Ownership, Management and General Information				Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	M.E. Cleary			White	45.5%	Hispanic or Latino:	38.3%
ADMINISTRATOR PHONE:	708-783-5378			Black	12.7%	Not Hispanic or Latino:	58.8%
OWNERSHIP:	VHS of Illinois DBA MacNeal Hospital			American Indian	0.0%	Unknown:	2.9%
OPERATOR:	VHS of Illinois DBA MacNeal Hospital			Asian	0.5%		
MANAGEMENT:	For Profit Corporation			Hawaiian/ Pacific	0.1%	IDPH Number:	5082
CERTIFICATION:	(Not Answered)			Unknown	41.1%	HPA	A-06
FACILITY DESIGNATION:	(Not Answered)					HSA	7
ADDRESS	3249 South Oak Park Avenue	CITY: Berwyn	COUNTY: Suburban Cook County				

Facility Utilization Data by Category of Service										
Clinical Service	Authorized CON Beds 12/31/2016	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	233	229	222	9,036	39,581	4,017	4.8	119.1	51.1	52.0
0-14 Years				0	0					
15-44 Years				1,620	4,778					
45-64 Years				2,974	11,723					
65-74 Years				1,757	8,414					
75 Years +				2,685	14,686					
Pediatric	10	10	10	171	346	602	5.5	2.6	25.9	25.9
Intensive Care	26	17	17	1,271	4,502	2	3.5	12.3	47.3	72.4
Direct Admission				918	2,962					
Transfers - Not included in Facility Admissions				355	1,540					
Obstetric/Gynecology	25	23	23	1,471	3,414	36	2.3	9.4	37.7	41.0
Maternity				1,447	3,359					
Clean Gynecology				24	55					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Total AMI	68			2,439	17,047	0	7.0	46.6	68.5	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		68	68	2,439	17,047	0	7.0	46.6		68.5
Rehabilitation	12	12	11	233	3,182	0	13.7	8.7	72.4	72.4
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	374			14,266	68,072	4,657	5.1	198.7	53.1	

Inpatients and Outpatients Served by Payor Source							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	27.1%	8.4%	0.0%	61.4%	1.6%	1.5%	
	3871	1205	0	8758	223	209	14,266
Outpatients	13.7%	5.6%	0.0%	75.7%	4.0%	1.0%	
	31736	13019	0	175270	9256	2330	231,811

Financial Year Reported:	1/1/2016 to	12/31/2016	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	35.5%	16.0%	0.0%	48.2%	0.3%	100.0%			
	56,089,978	25,280,374	0	76,124,504	427,723	157,922,579	1,233,453		2,684,648
Outpatient Revenue (\$)	16.6%	2.7%	0.0%	79.4%	1.1%	100.0%			
	17,719,724	2,829,516	0	83,978,994	1,209,917	105,738,151	1,451,195		1.0%

Birthing Data			Newborn Nursery Utilization				Organ Transplantation	
Number of Total Births:	1,520		Level I	Level II	Level II+		Kidney:	
Number of Live Births:	1,509		Beds	25	5	0	Heart:	
Birthing Rooms:	0		Patient Days	1,979	1,520	0	Lung:	
Labor Rooms:	0		Total Newborn Patient Days			3,499	Heart/Lung:	
Delivery Rooms:	0						Pancreas:	
Labor-Delivery-Recovery Rooms:	9		Laboratory Studies				Liver:	
Labor-Delivery-Recovery-Postpartum Rooms:	0		Inpatient Studies			363,302	Total:	
C-Section Rooms:	2		Outpatient Studies			246,018		
CSsections Performed:	432		Studies Performed Under Contract			0		

<u>Surgery and Operating Room Utilization</u>											
<u>Surgical Specialty</u>	<u>Operating Rooms</u>				<u>Surgical Cases</u>		<u>Surgical Hours</u>			<u>Hours per Case</u>	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	1	0	0	1	110	0	886	0	886	8.1	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	979	1112	3022	2700	5722	3.1	2.4
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	1	1	132	193	587	551	1138	4.4	2.9
OB/Gynecology	0	0	1	1	221	817	782	1993	2775	3.5	2.4
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	1	1	4	1261	10	2158	2168	2.5	1.7
Orthopedic	0	0	2	2	679	978	2244	2421	4665	3.3	2.5
Otolaryngology	0	0	1	1	117	331	285	852	1137	2.4	2.6
Plastic Surgery	0	0	1	1	18	285	122	851	973	8.8	3.0
Podiatry	0	0	0	0	85	217	175	500	675	2.1	2.3
Thoracic	0	0	1	1	28	0	137	0	137	4.9	0.0
Urology	0	0	1	1	142	523	286	917	1203	2.0	1.8
Totals	1	0	11	12	2515	5717	8538	12943	21479	3.4	2.3
SURGICAL RECOVERY STATIONS				Stage 1 Recovery Stations		13	Stage 2 Recovery Stations		12		

<u>Dedicated and Non-Dedicated Procedure Room Utilization</u>											
<u>Procedure Type</u>	<u>Procedure Rooms</u>				<u>Surgical Cases</u>		<u>Surgical Hours</u>			<u>Hours per Case</u>	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	6	6	1269	5902	887	3550	4437	0.7	0.6
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
<u>Multipurpose Non-Dedicated Rooms</u>											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1 (Not Answered)
Operating Rooms Dedicated for Trauma Care	2
Number of Trauma Visits:	12,046
Patients Admitted from Trauma	510
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	2
Persons Treated by Emergency Services:	53,756
Patients Admitted from Emergency:	7,377
Total ED Visits (Emergency+Trauma):	65,804

Free-Standing Emergency Center

Beds in Free-Standing Centers	
Patient Visits in Free-Standing Centers	
Hospital Admissions from Free-Standing Center	

Outpatient Service Data

Total Outpatient Visits	231,611
Outpatient Visits at the Hospital/ Campus:	231,611
Outpatient Visits Offsite/off campus	0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated labs):	3
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,770
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	991
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	402
EP Catheterizations (15+)	377

Cardiac Surgery Data

Total Cardiac Surgery Cases:	110
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	110
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	87

<u>Diagnostic/Interventional Equipment</u>	<u>Examinations</u>					<u>Therapeutic Equipment</u>			<u>Therapies/ Treatments</u>
	Owned	Contract	Inpatient	Outpt	Contract	Owned	Contract		
General Radiography/Fluoroscopy	22	0	13,777	47,578	0	Lithotripsy	0	0	0
Nuclear Medicine	3	0	2,661	3,083	0	Linear Accelerator	0	0	0
Mammography	4	0	0	24,872	0	Image Guided Rad Therapy			0
Ultrasound	6	0	4,155	18,832	0	Intensity Modulated Rad Therapy			0
Angiography	3	0				High Dose Brachytherapy	0	0	0
Diagnostic Angiography			194	215	0	Proton Beam Therapy	0	0	0
Interventional Angiography			273	362	0	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	270	Cyber Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,064	28,824	0				
Magnetic Resonance Imaging	3	0	1,235	6,211	0				

Source: 2016 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

<u>Ownership, Management and General Information</u>				<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Scott Steiner			White	47.0%	Hispanic or Latino:	40.0%
ADMINISTRATOR PHONE	708-783-2997			Black	10.1%	Not Hispanic or Latino:	57.8%
OWNERSHIP:	VHS of Illinois DBA MacNeal Hospital			American Indian	0.0%	Unknown:	2.2%
OPERATOR:	VHS of Illinois DBA MacNeal Hospital			Asian	0.6%		
MANAGEMENT:	For Profit Corporation			Hawaiian/ Pacific	0.1%	IDPH Number:	5082
CERTIFICATION:	(Not Answered)			Unknown	42.2%	HPA	A-06
FACILITY DESIGNATION:	(Not Answered)					HSA	7
ADDRESS	3249 South Oak Park Avenue	CITY: Berwyn	COUNTY: Suburban Cook County				

<u>Facility Utilization Data by Category of Service</u>										
<u>Clinical Service</u>	Authorized CON Beds 12/31/2015	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	233	229	222	10,086	46,353	3,082	4.9	135.4	58.1	59.1
0-14 Years				0	0					
15-44 Years				1,683	4,957					
45-64 Years				3,295	13,316					
65-74 Years				1,845	9,316					
75 Years +				3,263	18,764					
Pediatric	10	10	10	244	484	534	4.2	2.8	27.9	27.9
Intensive Care	26	17	17	1,306	4,960	2	3.8	13.6	52.3	80.0
Direct Admission				976	3,390					
Transfers				330	1,570					
Obstetric/Gynecology	25	23	23	1,871	4,196	24	2.3	11.6	46.2	50.3
Maternity				1,818	4,110					
Clean Gynecology				53	86					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	62	62	62	1,578	11,783	0	7.5	32.3	52.1	52.1
Rehabilitation	12	12	10	46	757	0	16.5	2.1	17.3	17.3
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	368			14,801	68,533	3,642	4.9	197.7	53.7	

(Includes ICU Direct Admissions Only)

<u>Inpatients and Outpatients Served by Payer Source</u>							Charity Care	Totals
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay			
Inpatients	28.7%	12.6%	0.0%	56.2%	1.1%		1.5%	
	4241	1861	0	8316	165		218	14,801
Outpatients	12.9%	11.8%	0.0%	70.4%	3.8%		1.2%	
	28282	25760	0	154113	6356		2553	219,064

<u>Financial Year Reported:</u>	1/1/2015 to	12/31/2015	<u>Inpatient and Outpatient Net Revenue by Payer Source</u>					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	35.4%	18.4%	0.0%	45.8%	0.3%	100.0%			2,266,840
	55,446,061	28,875,332	0	71,981,334	488,547	156,791,274	943,841		Total Charity Care as % of Net Revenue
Outpatient Revenue (\$)	14.4%	4.5%	0.0%	79.2%	1.9%	100.0%			
	13,648,849	4,240,824	0	75,174,384	1,813,401	94,675,438	1,322,999		0.9%

<u>Birth Data</u>			<u>Newborn Nursery Utilization</u>			<u>Organ Transplantation</u>	
Number of Total Births:	1,758		Level I	Level II	Level II+	Kidney:	0
Number of Live Births:	1,749		Beds	25	5	Heart:	0
Birth Rooms:	0		Patient Days	2,457	1,509	Lung:	0
Labor Rooms:	0		Total Newborn Patient Days		3,966	Heart/Lung:	0
Delivery Rooms:	0					Pancreas:	0
Labor-Delivery-Recovery Rooms:	9					Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0					Total:	0
C-Section Rooms:	2		Inpatient Studies		406,035		
CS Sections Performed:	527		Outpatient Studies		231,511		
			Studies Performed Under Contract		0		

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	1	0	0	1	116	0	767	0	767	6.6	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	1148	1167	2512	1675	4187	2.2	1.4
Gastroenterology	0	0	6	6	1393	5832	631	2747	3378	0.5	0.5
Neurology	0	0	1	1	179	197	621	364	985	3.5	1.8
OB/Gynecology	0	0	1	1	293	752	786	1041	1827	2.7	1.4
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	1	1	3	1209	4	927	931	1.3	0.8
Orthopedic	0	0	1	1	789	839	1843	1243	3086	2.3	1.5
Otolaryngology	0	0	1	1	113	344	202	538	740	1.8	1.6
Plastic Surgery	0	0	1	1	22	284	106	581	687	4.8	2.0
Podiatry	0	0	1	1	105	236	112	288	400	1.1	1.2
Thoracic	0	0	1	1	47	2	169	3	172	3.6	1.5
Urology	0	0	1	1	230	771	295	693	988	1.3	0.9
Totals	1	0	17	18	4438	11633	8048	10100	18148	1.8	0.9
SURGICAL RECOVERY STATIONS				Stage 1 Recovery Stations		13	Stage 2 Recovery Stations		12		

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	0	0	0	0	0	0	0	0.0	0.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1 (Not Answered)
Operating Rooms Dedicated for Trauma Care	Adult 1
Number of Trauma Visits:	15,800
Patients Admitted from Trauma	4,058
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	2
Persons Treated by Emergency Services:	51,200
Patients Admitted from Emergency:	12,889
Total ED Visits (Emergency+Trauma):	67,000
Free-Standing Emergency Center	
Beds in Free-Standing Centers	0
Patient Visits in Free-Standing Centers	0
Hospital Admissions from Free-Standing Center	0
Outpatient Service Data	
Total Outpatient Visits	219,064
Outpatient Visits at the Hospital/ Campus:	219,064
Outpatient Visits Offsite/off campus	0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated labs):	3
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Lab	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,653
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	922
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	377
EP Catheterizations (15+)	354

Cardiac Surgery Data

Total Cardiac Surgery Cases:	116
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	116
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	89

Diagnostic/Interventional Equipment	Examinations					Therapeutic Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpt	Contract	Owned	Contract		
General Radiography/Fluoroscopy	22	0	13,962	49,318	0	Lithotripsy	0	0	0
Nuclear Medicine	3	0	3,212	3,796	0	Linear Accelerator	0	0	0
Mammography	4	0	0	23,856	0	Image Guided Rad Therapy			0
Ultrasound	6	0	4,693	18,583	0	Intensity Modulated Rad Thpy			0
Angiography	3	0				High Dose Brachytherapy	0	0	0
Diagnostic Angiography			176	254	0	Proton Beam Therapy	0	0	0
Interventional Angiography			252	380	0	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	294	Cyber knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,293	26,499	0				
Magnetic Resonance Imaging	3	0	1,356	6,186	0				

Source: 2015 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information				Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Scott Steiner			White	49.0%	Hispanic or Latino:	36.9%
ADMINISTRATOR PHONE	708-783-2997			Black	12.6%	Not Hispanic or Latino:	62.4%
OWNERSHIP:	VHS of Illinois DBA MacNeal Hospital			American Indian	0.0%	Unknown:	0.7%
OPERATOR:	VHS of Illinois DBA MacNeal Hospital			Asian	0.7%		
MANAGEMENT:	For Profit Corporation			Hawaiian/ Pacific	0.1%	IDPH Number:	5082
CERTIFICATION:	None			Unknown	37.6%	HPA	A-06
FACILITY DESIGNATION:						HSA	7
ADDRESS	3249 South Oak Park Avenue	CITY: Berwyn	COUNTY: Suburban Cook County				

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2014	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	248	229	229	10,056	50,860	2,431	5.3	146.0	58.9	63.8
0-14 Years				204	881					
15-44 Years				1,615	5,115					
45-64 Years				3,057	13,565					
65-74 Years				1,858	10,258					
75 Years +				3,322	21,041					
Pediatric	10	10	10	697	1,565	461	2.9	5.6	55.5	55.5
Intensive Care	26	17	17	1,327	5,090	6	3.8	14.0	53.7	82.1
Direct Admission				940	3,333					
Transfers				387	1,757					
Obstetric/Gynecology	25	23	23	1,971	4,344	9	2.2	11.9	47.7	51.9
Maternity				1,925	4,280					
Clean Gynecology				46	64					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	62	62	62	2,872	19,131	0	6.7	52.4	84.5	84.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	371			16,536	60,990	2,907	5.1	229.9	62.0	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	28.9%	22.8%	0.0%	44.1%	1.8%	1.6%	
	4943	3774	0	7289	261	269	16,536
Outpatients	13.7%	24.0%	0.0%	56.6%	5.2%	0.4%	
	29086	50982	0	120123	11059	942	212,192

Financial Year Reported:	1/1/2014 to	12/31/2014	Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	40.8%	12.5%	0.0%	43.7%	3.0%	100.0%			
	59,690,192	16,304,942	0	64,000,435	4,453,569	146,449,138	1,276,397		2,960,888
Outpatient Revenue (\$)	16.2%	11.0%	0.0%	70.3%	2.5%	100.0%			
	15,477,354	10,479,275	0	67,278,628	2,402,616	95,637,673	1,684,491		1.2%

Birthing Data		Newborn Nursery Utilization				Organ Transplantation	
Number of Total Births:	1,836		Level I	Level II	Level II+	Kidney:	0
Number of Live Births:	1,835	Beds	23	5	0	Heart:	0
Birthing Rooms:	0	Patient Days	2,614	1,541	0	Lung:	0
Labor Rooms:	0	Total Newborn Patient Days			4,155	Heart/Lung:	0
Delivery Rooms:	0					Pancreas:	0
Labor-Delivery-Recovery Rooms:	9					Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	25	Laboratory Studies				Total:	0
C-Section Rooms:	2	Inpatient Studies			435,381		
CSections Performed:	475	Outpatient Studies			228,078		
		Studies Performed Under Contract			0		

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case			
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient		
Cardiovascular	0	0	1	1	294	133	1160	232	1392	3.9	1.7		
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0		
General	0	0	2	2	966	937	2041	1379	3420	2.1	1.5		
Gastroenterology	0	0	8	6	1521	7333	705	2881	3586	0.5	0.4		
Neurology	0	0	1	1	163	202	524	353	877	3.2	1.7		
OB/Gynecology	0	0	1	1	319	815	863	1066	1929	2.7	1.3		
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0		
Ophthalmology	0	0	1	1	16	1302	32	1027	1059	2.0	0.8		
Orthopedic	0	0	1	1	750	904	1662	1247	2909	2.2	1.4		
Otolaryngology	0	0	1	1	125	369	285	558	823	2.1	1.5		
Plastic Surgery	0	0	1	1	25	282	132	524	656	5.3	1.9		
Podiatry	0	0	1	1	102	246	108	316	424	1.1	1.3		
Thoracic	0	0	1	1	48	2	152	2	154	3.2	1.0		
Urology	0	0	1	1	211	757	242	709	951	1.1	0.9		
Totals	0	0	18	18	4540	13282	7886	10294	18180	1.7	0.8		
SURGICAL RECOVERY STATIONS			Stage 1 Recovery Stations			13			Stage 2 Recovery Stations			12	

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	6	6	1521	7333	705	2881	3586	0.5	0.4
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	24504	0	24504	24504	0.0	1.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
Cystoscopy	0	0	1	1	211	757	242	709	951	1.1	0.9
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	1,137
Patients Admitted from Trauma	1,137
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	2
Persons Treated by Emergency Services:	62,025
Patients Admitted from Emergency:	7,868
Total ED Visits (Emergency+Trauma):	63,162

Free-Standing Emergency Center

Beds in Free-Standing Centers	
Patient Visits in Free-Standing Centers	
Hospital Admissions from Free-Standing Center	

Outpatient Service Data

Total Outpatient Visits	212,192
Outpatient Visits at the Hospital/ Campus:	212,192
Outpatient Visits Offsite/off campus	0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated labs):	3
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Lab	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,599
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	918
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	391
EP Catheterizations (15+)	290

Cardiac Surgery Data

Total Cardiac Surgery Cases:	88
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	88
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	73

Diagnostic/Interventional Equipment**Examinations****Therapeutic Equipment****Therapies/ Treatments**

	Owned		Contract		Inpatient		Outpt		Contract		Owned		Contract		
General Radiography/Fluoroscopy	7	0	14,893	45,526	0						0	0	0	0	
Nuclear Medicine	3	0	3,285	3,742	0						0	0	0	0	
Mammography	5	0	0	22,673	0										
Ultrasound	7	0	4,515	17,490	0										
Angiography	3	0													
Diagnostic Angiography				195	280	0					0	0	0	0	
Interventional Angiography				259	373	0					0	0	0	0	
Positron Emission Tomography (PET)	0	1	0	0	265	0					0	0	0	0	
Computerized Axial Tomography (CAT)	2	0	3,802	24,401	0										
Magnetic Resonance Imaging	3	0	1,324	6,497	0										
Lithotripsy															
Linear Accelerator															
Image Guided Rad Therapy															
Intensity Modulated Rad Thrp															
High Dose Brachytherapy											0	0	0	0	
Proton Beam Therapy											0	0	0	0	
Gamma Knife											0	0	0	0	
Cyber knife											0	0	0	0	

Source: 2014 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	22-28
2	Site Ownership	29
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	30-33
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	34-36
5	Flood Plain Requirements	37
6	Historic Preservation Act Requirements	38
7	Project and Sources of Funds Itemization	N/A
8	Financial Commitment Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	N/A
11	Background of the Applicant	39-52
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
	Service Specific:	
14	Neonatal Intensive Care Services	N/A
15	Change of Ownership	53-90
	Financial and Economic Feasibility:	
16	Availability of Funds	N/A
17	Financial Waiver	N/A
18	Financial Viability	N/A
19	Economic Feasibility	N/A
20	Safety Net Impact Statement	N/A
21	Charity Care Information	91-98



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CLIENT/MATTER NUMBER
026141-0144

January 9, 2018

Via FedEx

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761-0001

Re: Certificate of Exemption Application (Change of Ownership)
MacNeal Hospital, 3249 South Oak Park Avenue, Berwyn, IL

Dear Mr. Constantino:

Enclosed please find an original and one copy of the Certificate of Exemption Application (Change of Ownership) regarding MacNeal Hospital, 3249 South Oak Park Avenue, Berwyn, Illinois. Also enclosed is a check in the amount of \$2,500 to cover the application processing fee.

Please feel free to contact me if you have any questions.

Sincerely,

Edward J. Green

EJGR:sc
Encls.

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