

E-029-18

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR EXEMPTION PERMIT

ORIGINAL

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

**Facility/Project Identification**

|                    |                                                                |                     |                              |
|--------------------|----------------------------------------------------------------|---------------------|------------------------------|
| Facility Name:     | Kankakee Valley Dialysis Network d/b/a Manteno Dialysis Centre |                     |                              |
| Street Address:    | 1 East Division Street                                         |                     |                              |
| City and Zip Code: | Manteno, IL 60950                                              |                     |                              |
| County:            | Kankakee                                                       | Health Service Area | IX Health Planning Area: N/A |

RECEIVED

MAY 21 2018

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

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

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

**Type of Ownership of Applicants**

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

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

**Primary Contact** [Person to receive ALL correspondence or inquiries]

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

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

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

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

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

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

**Type of Ownership of Applicants**

|                                                                                                                                                                                                                                                                                                                                                      |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <input checked="" type="checkbox"/> Non-profit Corporation                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Partnership         |
| <input type="checkbox"/> For-profit Corporation                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Governmental        |
| <input type="checkbox"/> Limited Liability Company                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Sole Proprietorship |
| <input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                                       |                                              |
| <ul style="list-style-type: none"><li>o Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li><li>o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.</li></ul> |                                              |

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**Primary Contact** [Person to receive ALL correspondence or inquiries]

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

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

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

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

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

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

**Type of Ownership of Applicants**

- |                                                                   |                                                                             |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input checked="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 |

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

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

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

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

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

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

|                                     |                                          |
|-------------------------------------|------------------------------------------|
| Exact Legal Name:                   | Kankakee Valley Dialysis Network, L.L.C. |
| Street Address:                     | 500 West Court Street                    |
| City and Zip Code:                  | Kankakee, IL 60901                       |
| Name of Registered Agent:           | Christopher Shride                       |
| Registered Agent Street Address:    | 500 West Court Street                    |
| Registered Agent City and Zip Code: | Kankakee, IL 60901                       |
| Name of Chief Executive Officer:    | Christopher Shride                       |
| CEO Street Address:                 | 500 West Court Street                    |
| CEO City and Zip Code:              | Kankakee, IL 60901                       |
| CEO Telephone Number:               | 815/937-2400                             |

**Type of Ownership of Applicants**

- |                                                                 |                                                                                                                      |
|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Non-profit Corporation                 | <input type="checkbox"/> Partnership                                                                                 |
| <input type="checkbox"/> For-profit Corporation                 | <input type="checkbox"/> Governmental                                                                                |
| X <input checked="" type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship <span style="margin-left: 100px;"><input type="checkbox"/> Other</span> |

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

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

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
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**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

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

|                                     |                                                           |
|-------------------------------------|-----------------------------------------------------------|
| Exact Legal Name:                   | Presence Legacy Association f/k/a Presence Health Network |
| Street Address:                     | 200 S. Wacker Drive, 11 <sup>th</sup> Floor               |
| City and Zip Code:                  | Chicago, Illinois 60606                                   |
| Name of Registered Agent:           | Kathleen Cronin                                           |
| Registered Agent Street Address:    | 18927 Hickory Creek Drive                                 |
| Registered Agent City and Zip Code: | Mokena, IL 60448                                          |
| Name of Chief Executive Officer:    | Vacant                                                    |
| CEO Street Address:                 | 200 S. Wacker Drive, 11 <sup>th</sup> Floor               |
| CEO City and Zip Code:              | Chicago, Illinois 60606                                   |
| CEO Telephone Number:               | 312/308-3291                                              |

**Type of Ownership of Applicants**

- |                                                    |                                              |   |       |
|----------------------------------------------------|----------------------------------------------|---|-------|
| <input 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 | X | 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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

**Primary Contact** [Person to receive ALL correspondence or inquiries]

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

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

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

### Post Exemption Permit Contact

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

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

### Site Ownership

[Provide this information for each applicable site]

|                                                                                                                                                                                                                                                                                                                 |                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| Exact Legal Name of Site Owner:                                                                                                                                                                                                                                                                                 | Jerry Curwick                            |
| Address of Site Owner:                                                                                                                                                                                                                                                                                          | 600 N. Main Street Manteno, IL 60950     |
| Street Address or Legal Description of the Site:                                                                                                                                                                                                                                                                | 1 East Division Street Manteno, IL 60950 |
| <b>Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.</b> |                                          |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                           |                                          |

### Operating Identity/Licensee

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                |                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------|--|
| Exact Legal Name:                                                                                                                                                                                                                                                                                                                                                                                                                                      | Kankakee Valley Dialysis Network d/b/a Manteno Dialysis Centre |                                |  |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 East Division Street Manteno, IL 60950                       |                                |  |
| <input checked="" type="checkbox"/> Non-profit Corporation                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Partnership                           |                                |  |
| <input type="checkbox"/> For-profit Corporation                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Governmental                          |                                |  |
| <input type="checkbox"/> Limited Liability Company                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Sole Proprietorship                   | <input type="checkbox"/> Other |  |
| <ul style="list-style-type: none"><li>Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>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.</li><li><b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li></ul> |                                                                |                                |  |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                                                                                                                                                                  |                                                                |                                |  |

### Organizational Relationships

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

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

## Flood Plain Requirements

[Refer to application instructions.]

**NOT APPLICABLE**

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

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

## Historic Resources Preservation Act Requirements

[Refer to application instructions.]

**NOT APPLICABLE**

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

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

## DESCRIPTION OF PROJECT

### 1. Project Classification

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

Part 1110 Classification:

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

## 2. Narrative Description

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

Through a Definitive Agreement enacted on March 2, 2018 ("the Agreement"), Ascension Health assumed ownership and control of the acute care and long term care facilities, ambulatory surgical treatment centers ("ASTC's"), end stage renal disease facilities and other entities owned and controlled by Presence Legacy Association ("Presence") f/k/a Presence Health Network. The ten Presence hospitals, three end stage renal disease ("ESRD") facilities, and the two ASTCs that Presence controlled and that are included in the Agreement operate as components of AMITA Health ("AMITA").

This Certificate of Exemption ("COE") application addresses the change of ownership and control of Manteno Dialysis Centre, located at 1 East Division Street in Manteno, Illinois.

It is the intent of the applicants to file COE applications addressing subsequent changes of ownership of the three ESRD facilities during 2018.

Key points of the Agreement include:

1. The transaction addresses the following types of facilities and services requiring a HFSRB approval through the Certificate of Exemption process: acute care hospitals, ESRD facilities, and ambulatory surgery facilities; and the following types of facilities and services not requiring HFSRB approval: physician groups, home health, hospice, educational institutions and programs, and skilled nursing and senior care or residence facilities.
2. The change of control transaction occurred through a membership substitution for Presence, the system parent of the Presence hospitals, ESRD facilities, and ASTCs, through which (i) Ascension Health became the sole corporate member of Presence and (ii) Ascension Living, a subsidiary of Ascension Health, became the sole corporate member of the Presence entities providing long-term care or senior-related services.
3. The membership substitutions described in paragraph 2 above have been accomplished through amendments to existing governing documents.
4. Presence acute care inpatient facilities and services, ambulatory care facilities and services, ESRD facilities, and physician groups are operated as a part of AMITA.
5. Ascension Health will assure capital investments are made for routine needs, conversion of EHR and ERP systems, and strategic initiatives.
6. The transaction strengthens the ministry of Catholic health care in the Chicagoland region.

8. The transaction enhanced and assured the ability of Presence facilities and services to continue to serve the health care and related needs of their communities through the provision of high quality, affordable, and accessible health care services.
9. The transaction acts to further the respective charitable and educational purposes of the parties.
10. A plan relating to employees' credit for prior service to Presence entities has been implemented.

The transaction addressed in this application is limited to the change of ownership and control of a Medicare-certified ESRD facility under the jurisdiction of the Illinois Health Facilities and Services Review Board, and as such, qualifies for review as a Certificate of Exemption.

### Related Project Costs

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

|                                                                                                                                                                                                                                                                                                                              |                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| <p>Land acquisition is related to project <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Purchase Price: \$ _____</p> <p>Fair Market Value: \$ _____</p>                                                                                                                                                    | <p><b>NOT<br/>APPLICABLE</b></p> |
| <p>The project involves the establishment of a new facility or a new category of service</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>                                                                                                                          |                                  |
| <p>If yes, provide the dollar amount of all <b>non-capitalized</b> 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.</p> <p>Estimated start-up costs and operating deficit cost is \$ _____.</p> |                                  |

### Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

☒ None or not applicable

☐ Preliminary

☐ Schematics

☐ Final Working

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

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

**NOT APPLICABLE**

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

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

### State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☒ Cancer Registry

☒ APORS

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

☒ All reports regarding outstanding permits

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

## CERTIFICATION

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



SIGNATURE

Christine McCoy

PRINTED NAME

Assistant Secretary

PRINTED TITLE



SIGNATURE

Rhonda Anderson

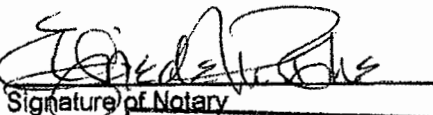
PRINTED NAME

Assistant Treasurer

PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 10<sup>th</sup> day of November, 2017



Signature of Notary

Seal

ELFRIEDE M. ROHE  
Notary Public - Notary Seal  
STATE OF MISSOURI  
Comm. Number 01505902  
St. Louis County

\*Insert the Exact legal name of the applicant

Notarization:

Subscribed and sworn to before me  
this 10<sup>th</sup> day of NOVEMBER, 2017



Signature of Notary

Seal

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

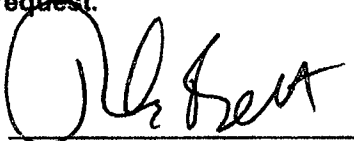
## CERTIFICATION

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

  
SIGNATURE  
Mark A. Frey  
PRINTED NAME  
President/CEO  
PRINTED TITLE

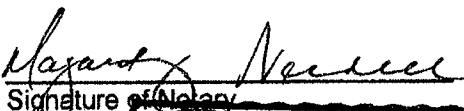
  
SIGNATURE  
PAUL E BELTER  
PRINTED NAME  
SVP/CEO  
PRINTED TITLE

### Notarization:

Subscribed and sworn to before me  
this 7<sup>th</sup> day of November 2017

### Notarization:

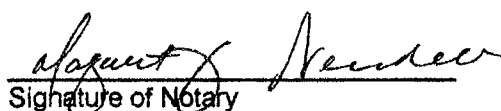
Subscribed and sworn to before me  
this 7<sup>th</sup> day of November 2017

  
Signature of Notary

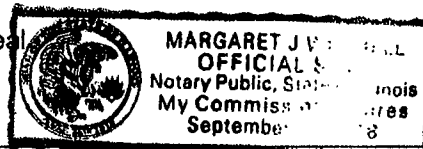
Seal



\*Insert the EXACT legal name of the applicant

  
Signature of Notary

Seal



## CERTIFICATION

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

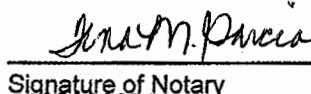
  
SIGNATURE

Julie P. Roknich  
PRINTED NAME

Assistant Secretary  
PRINTED TITLE

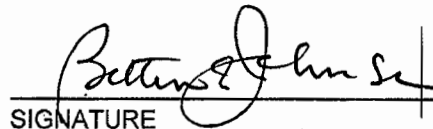
Notarization:

Subscribed and sworn to before me  
this 16 day of May 2018

  
Signature of Notary



\*Insert the EXACT legal name of the applicant

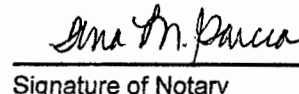
  
SIGNATURE

Bethina Johnson  
PRINTED NAME

Assistant Treasurer  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 16 day of May 2018

  
Signature of Notary

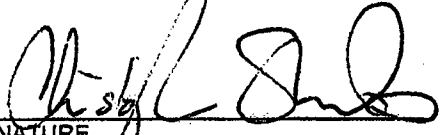


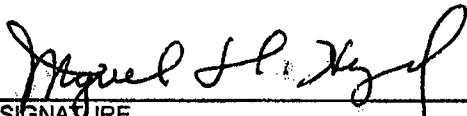
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- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do 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.

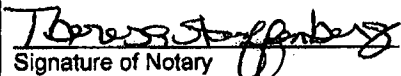
This Application is filed on the behalf of Kankakee Valley Dialysis Network, L.L.C. \*  
In accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the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

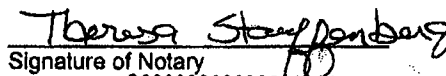
  
SIGNATURE  
Christopher Shride  
PRINTED NAME  
President, Mary's Hospital  
PRINTED TITLE

  
SIGNATURE  
Miguel Hizon  
PRINTED NAME  
Physician  
PRINTED TITLE

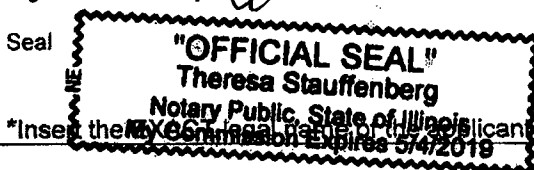
Notarization:  
Subscribed and sworn to before me  
this 16 day of May, 2018

Notarization:  
Subscribed and sworn to before me  
this 16 day of May, 2018

  
Signature of Notary

  
Signature of Notary

Seal



Seal



## CERTIFICATION

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

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

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

PLEASE SEE NOTE  
ON FOLLOWING PAGE

  
SIGNATURE

Patricia L. Smith  
PRINTED NAME

Board Member  
PRINTED TITLE

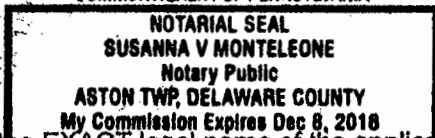
Notarization:

Subscribed and sworn to before me  
this 16th day of MAY 2018

  
Signature of Notary

COMMONWEALTH OF PENNSYLVANIA

Seal



\*Insert the EXACT legal name of the applicant

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary

Seal

NOTE ON CERTIFICATION PAGE

As of the filing of this Certificate of Need application, Presence Legacy Association has only one authorized signatory, Sr. Patricia L. Smith.

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

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

#### **Background**

READ THE REVIEW CRITERION and provide the following required information:

##### **BACKGROUND OF APPLICANT**

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

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

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

**NOT APPLICABLE**

##### **PURPOSE OF PROJECT**

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

achieving the stated goals **as appropriate**.

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

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

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

## **ALTERNATIVES**

**NOT APPLICABLE**

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
  - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
  - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
  - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
  - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

**SECTION V. CHANGE OF OWNERSHIP (CHOW)****1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility**

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.
3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

| <b>APPLICABLE REVIEW CRITERIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>CHOW</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 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 VII. 1120.130 - FINANCIAL VIABILITY**

**NOT APPLICABLE**

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

### **Financial Viability Waiver**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

### **2. Variance**

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

obligations should the applicant default.

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

**SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY**

**NOT APPLICABLE**

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

**A. Reasonableness of Financing Arrangements**

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

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

**B. Conditions of Debt Financing**

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

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

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

Read the criterion and provide the following:

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

**NOT APPLICABLE**

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

\* Include the percentage (%) of space for circulation

**D. Projected Operating Costs**

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

**E. Total Effect of the Project on Capital Costs**

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

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

**SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)**

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

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

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

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

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

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

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

**NOT APPLICABLE**

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

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

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

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

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

### Presence Resurrection Medical Center

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

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

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

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

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

### Presence Saint Francis Hospital

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

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

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

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

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

### Presence Holy Family Hospital

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

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

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

### Presence Mercy Medical Center

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

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## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

### Presence Saint Joseph Hospital Elgin

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

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

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

### Presence Saint Joseph Hospital- Chicago

| CHARITY CARE                     |               |               |               |
|----------------------------------|---------------|---------------|---------------|
|                                  | 2014          | 2015          | 2016          |
| Net Patient Revenue              | \$194,424,001 | \$203,367,193 | \$203,939,322 |
| Amount of Charity Care (charges) | \$13,524,341  | \$10,750,603  | \$9,569,562   |
| Cost of Charity Care             | \$2,679,172   | \$3,128,453   | \$2,145,618   |

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## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

### Presence Saints Mary and Elizabeth Medical Center

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

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

### Presence Saint Joseph Medical Center

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

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## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

### Presence St. Mary's Hospital

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

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## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

### Belmont/Harlem Surgery Center, LLC

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

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## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

**NOT APPLICABLE, FACILITY WAS NOT OPERATIONAL**

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

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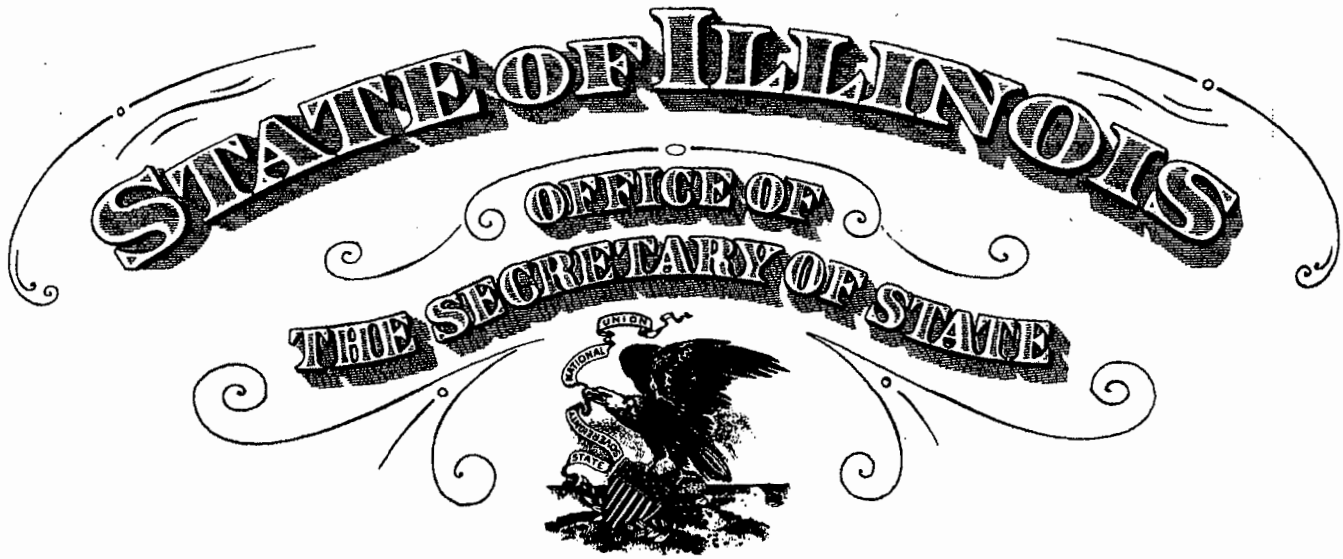
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

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

### Presence Lakeshore Gastroenterology, LLC

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

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



**To all to whom these Presents Shall Come, Greeting:**

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

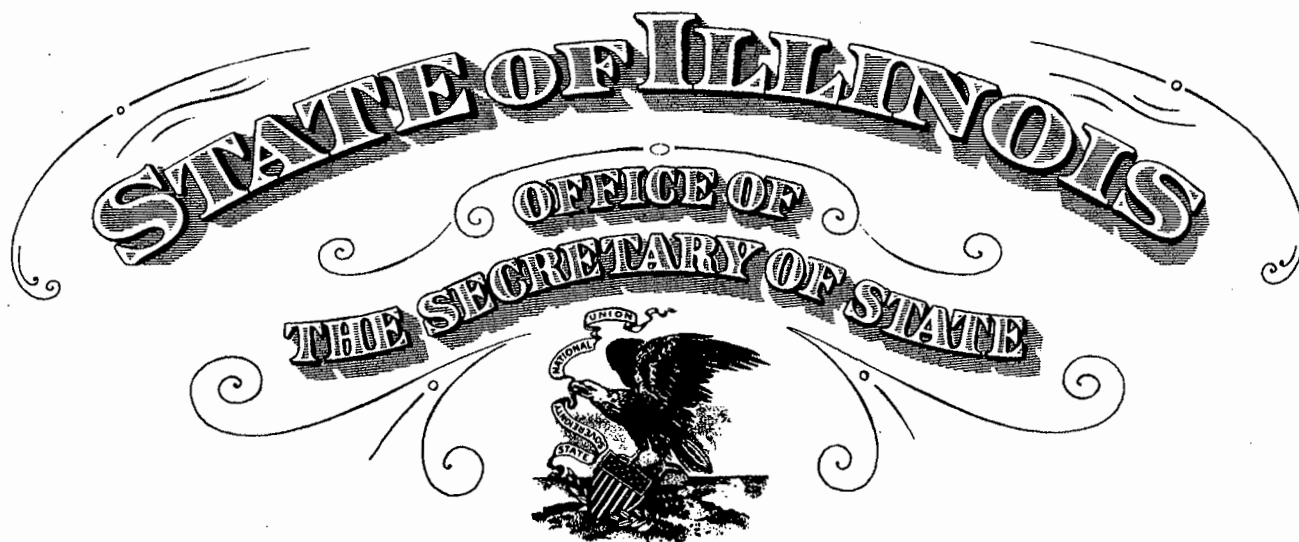
ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT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



**In Testimony Whereof,** I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 7TH  
day of MAY A.D. 2018 .

*Jesse White*

SECRETARY OF STATE ATTACHMENT 1



***To all to whom these Presents Shall Come, Greeting:***

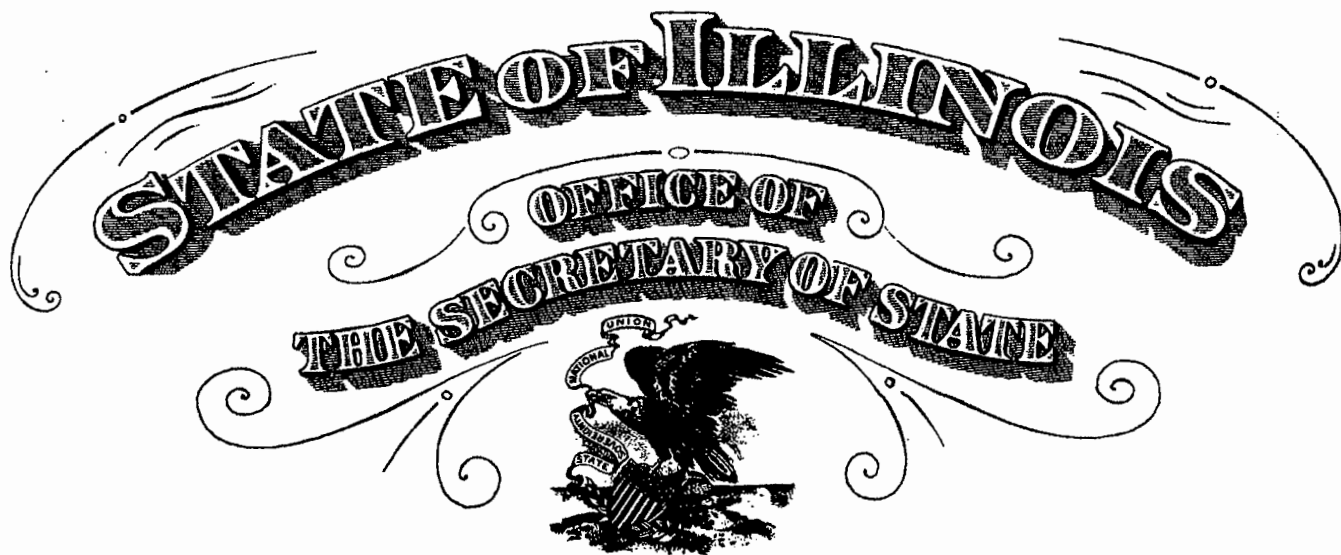
***I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that***

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



***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 14TH  
day of MAY A.D. 2018 .***

*Jesse White*



***To all to whom these Presents Shall Come, Greeting:***

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

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, 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.

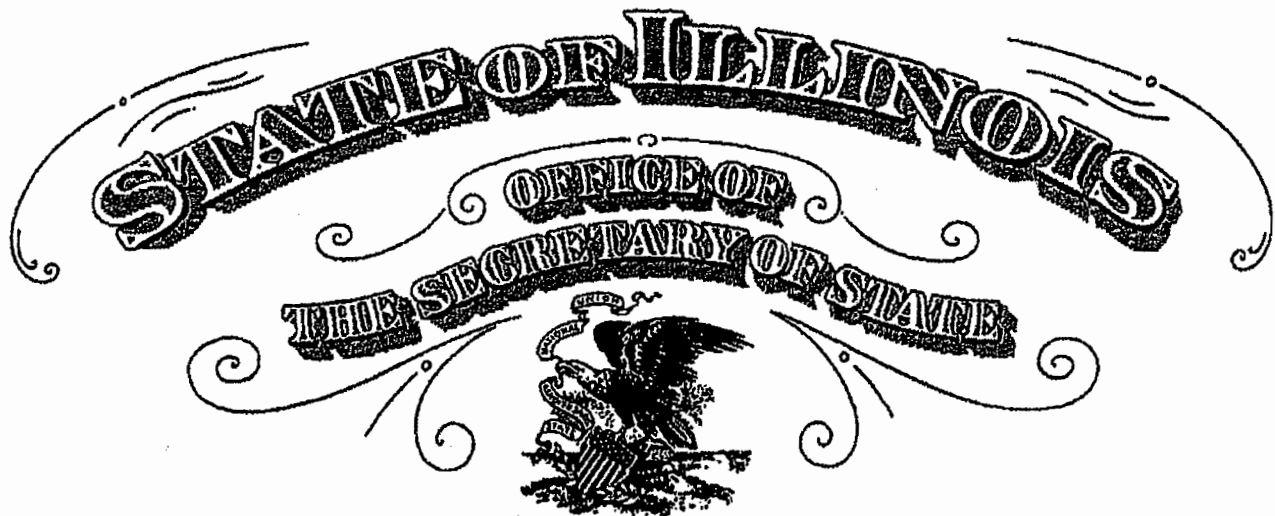


***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 7TH  
day of MAY A.D. 2018 .***

*Jesse White*

File Number

5968-176-1



**To all to whom these Presents Shall Come, Greeting:**

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

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

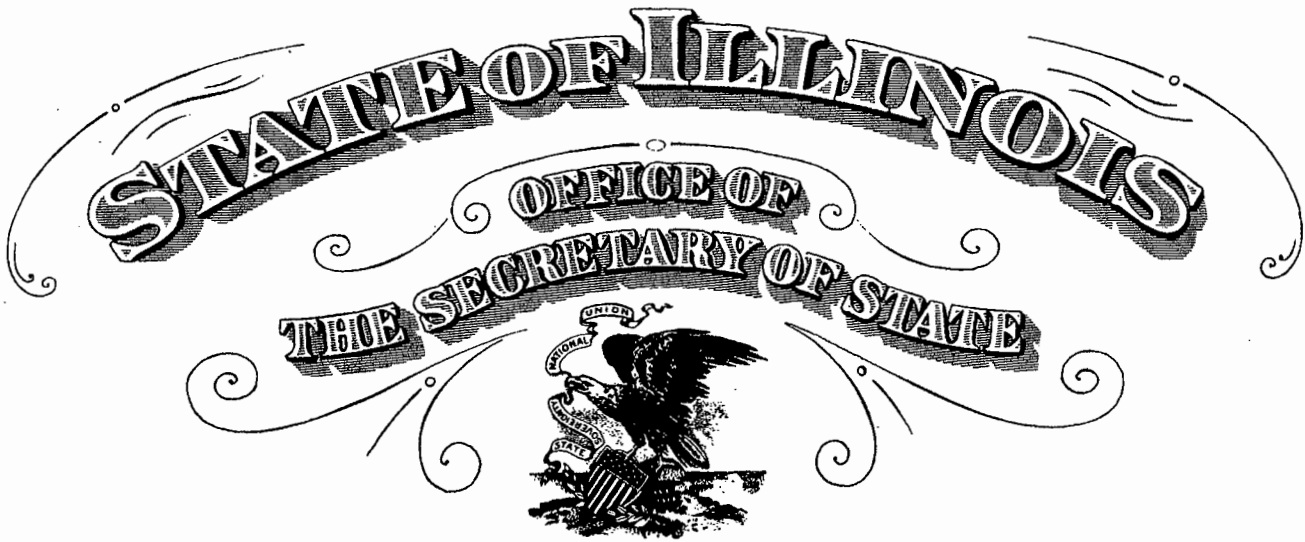


***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 23RD  
day of JUNE A.D. 2017 .***

*Jesse White*

SECRETARY OF STATE

ATTACHMENT 1



***To all to whom these Presents Shall Come, Greeting:***

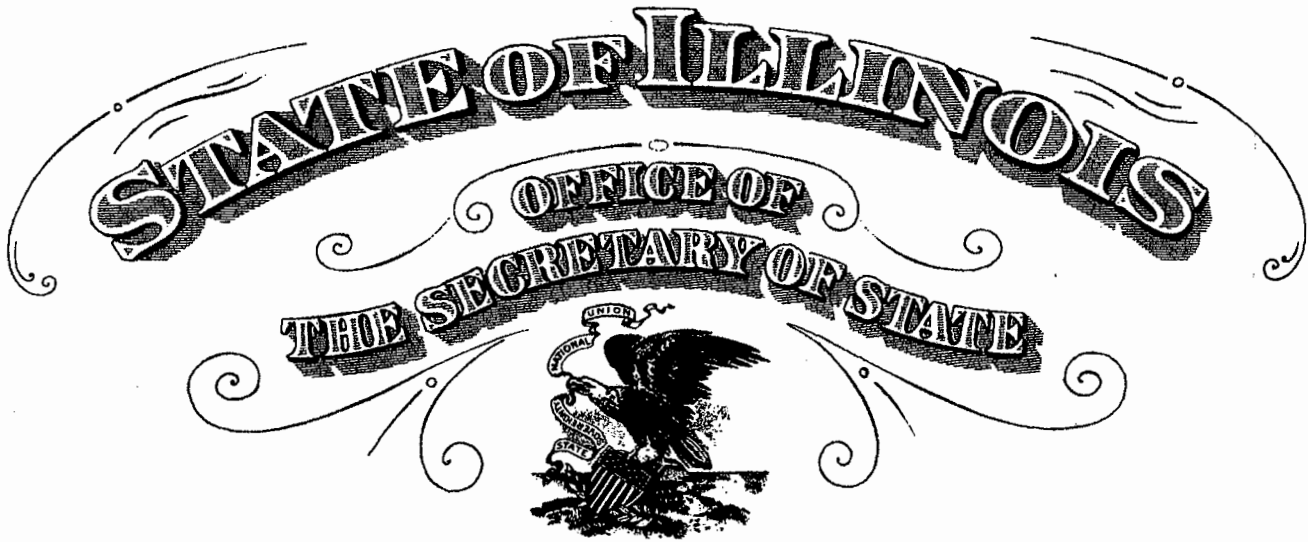
***I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that***

KANKAKEE VALLEY DIALYSIS NETWORK, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JULY 01, 2003, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 7TH  
day of MAY A.D. 2018 .***

*Jesse White*



***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*

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my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 7TH  
day of MAY A.D. 2018 .***

*Jesse White*

OPERATING IDENTITY/LICENSEE

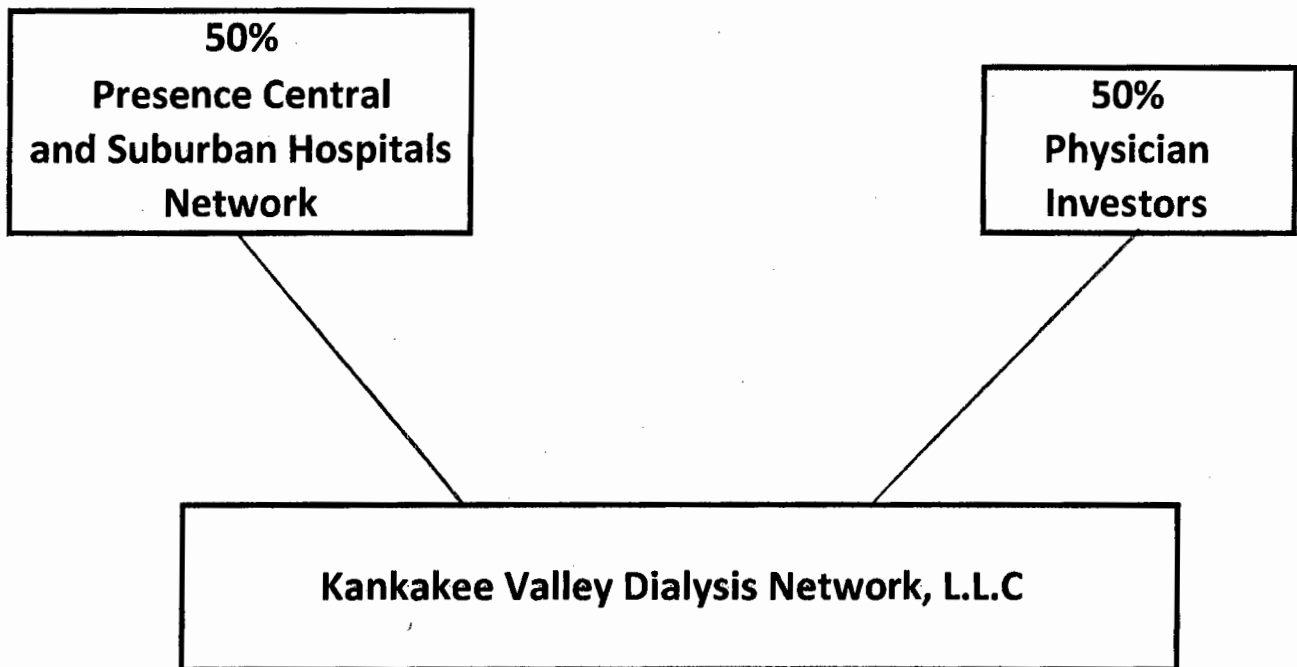
Kankakee Valley Dialysis Network L.L.C.'s ownership is as follows:

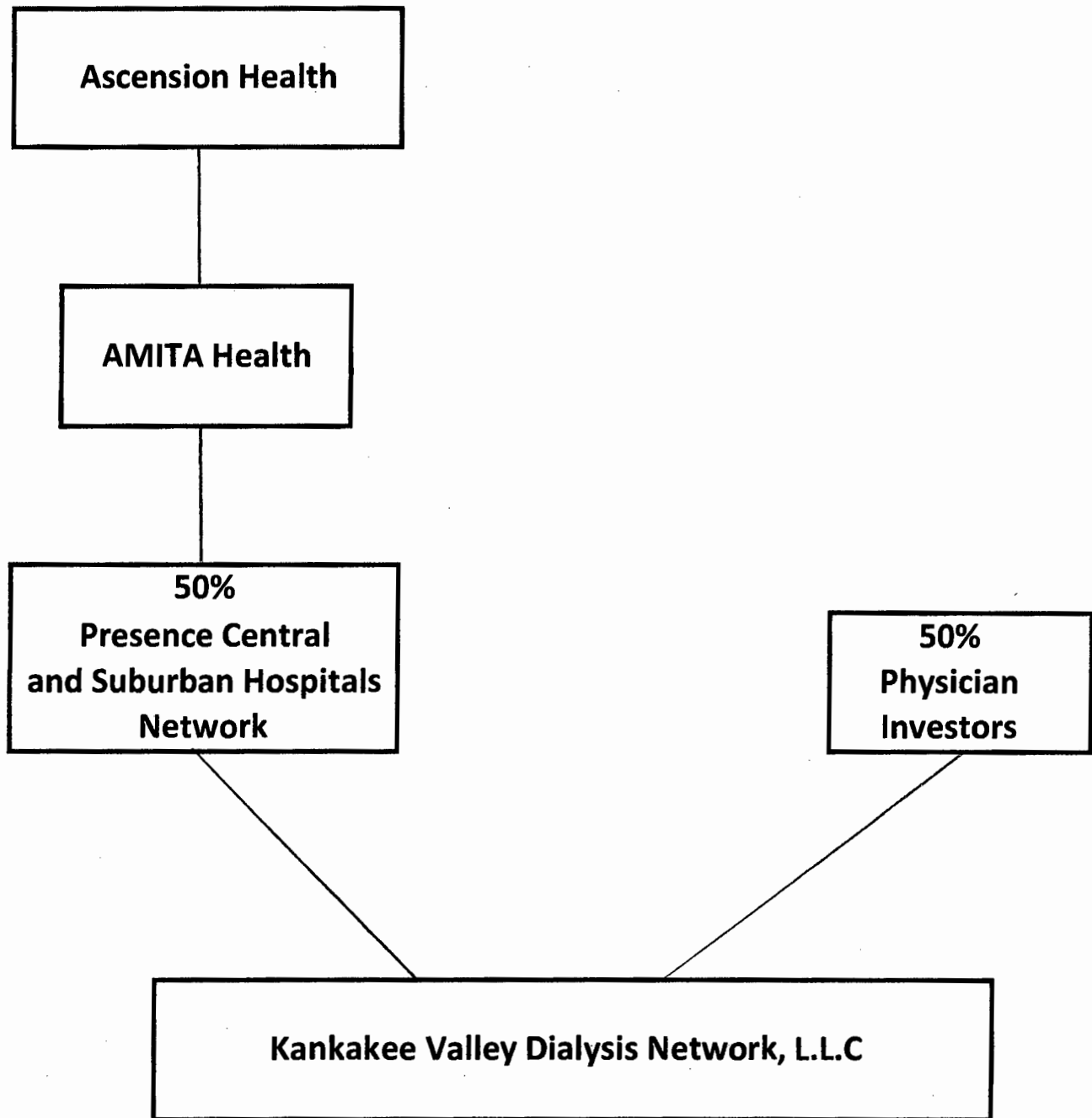
50% is owned by Presence Central and Suburban Hospital Network d/b/a Presence  
St. Mary's Hospital  
500 West Court Street  
Kankakee, IL 60901

25% is owned by Paritosh Tiwari, MD  
260 Barrington Drive  
Bourbonnais, IL 60914

25% is owned by Miguel Hizon, MD  
350 Barrington Drive  
Bourbonnais, IL 60914

Pre-CHOW Organizational Chart





## BACKGROUND

Ascension Health owns, operates and/or controls\* the following Illinois licensed health care facilities AND Medicare-certified end stage renal disease facilities:

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

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

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

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

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

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

AMITA Health Alexian Brothers Behavioral Health Hospital  
Hoffman Estates, IL

Presence Holy Family Medical Center  
Des Plaines, IL

Presence Resurrection Medical Center  
Chicago, IL IDPH #6031

Presence Saint Francis Hospital  
Evanston, IL IDPH #5991

Presence Covenant Medical Center  
Urbana, IL IDPH #4861

Presence United Samaritans Medical Center

Danville, IL IDPH #4853

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

Presence Mercy Medical Center  
Aurora, IL IDPH #4903

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

Presence Saint Joseph Medical Center  
Joliet, IL IDPH #4838

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

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

Presence Saint Elizabeth Hospital  
Chicago, IL IDPH #6007

Presence Lakeshore Gastroenterology  
Des Plaines, IL

Belmont/Harlem Surgery Center  
Chicago, IL IDPH #7003131

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

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

Presence Villa Franciscan  
Joliet, IL IDPH# 42861

Presence Saint Joseph Center  
Freeport, IL IDPH # 41871

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

Presence Saint Anne Center

Rockford, IL IDPH #41731

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

Presence Resurrection Life Center  
Chicago, IL IDPH #44354

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

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

Presence Nazarethville  
Des Plaines, IL IDPH #54072

Presence McCauley Manor  
Aurora, IL IDPH #42879

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

Presence Heritage Village  
Kankakee, IL IDPH #42457

Presence Cor Mariae Center  
Rockford, IL IDPH #41046

Presence Resurrection Medical Center Dialysis  
Chicago, IL Medicare ID #14-2335

Presence St. Mary's Hospital  
Kankakee, IL Medicare ID #14-2318

Manteno Dialysis Centre  
Manteno, IL Medicare ID #14-2671

\*per HFSRB definition

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

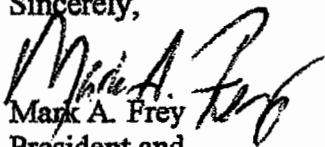
Dear Ms. Avery:

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

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

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

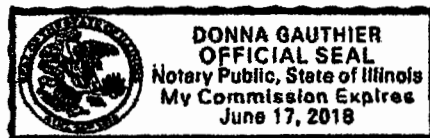
Sincerely,

  
Mark A. Frey  
President and  
Chief Executive Officer

Date: April 11, 2017



Notarized:



ATTACHMENT 11

**SECTION V**  
**CHANGE OF OWNERSHIP (CHOW)**  
**Kankakee Valley Dialysis Network d/b/a Manteno Dialysis Centre**

**Applicable Review Criteria**

**Criterion 1130.520(b)(1)(A) Names of the parties**

The parties named as an applicant are:

1. Kankakee Valley Dialysis Network, L.L.C, the entity that is and will continue to hold Manteno Dialysis Centre's ("the facility") Medicare certification
2. Alexian Brothers-AHS Midwest Region Health Co. (d/b/a AMITA Health) which meets the IDPH definition of control found in Section 1130.140, through its power to approve the use of the facility's funds, among other qualifications of having "control"
3. Presence Legacy Association ("Presence") f/k/a Presence Health Network, the entity having "final control" over Presence Chicago Hospitals Network prior to the change of ownership
4. Ascension Health, the entity that assumed "final control" over the facility following the change of ownership, and which owns a 50% interest in AMITA Health
5. Presence Central and Suburban Hospitals Network (d/b/a Presence saint Mary's Hospital), an entity holding a 50% interest in the Medicare certification holder.

**Criterion 1130.520(b)(1)(B) Background of the parties**

Provided in ATTACHMENT 1 are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 11 are:

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

**Criterion 1130.520(b)(1)(C) Structure of transaction**

The transaction is structured as a series of membership substitutions.

**Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction**

The holder of the Medicare certification, as identified in Section I of this Certificate of Exemption application will not change following the transaction.

**Criterion 1130.520(b)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.**

Current and post-closing organizational charts are provided in ATTACHMENT 4, identifying all applicable Illinois facilities.

**Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred**

The facility's value, per its January 1, 2018 balance sheet is \$885,136. This amount is identified as the facility's fair market value for purposes of this Certificate of Exemption application, exclusively.

**Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets**

Money did not change hands as a result of the change of ownership and control. However, Ascension Health assures that capital investments are made for routine needs, conversion of EHR and ERP systems, and strategic initiatives.

**Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.**

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

- CON Permit 17-020, AMITA Health Bartlett Medical Clinics Building (Bartlett), establishment of a medical clinics building, scheduled for completion January 31, 2019
- CON Permit 17-021, AMITA Health Woodridge Medical Clinics Building (Woodridge), establishment of a medical clinics building, scheduled for completion January 31, 2019
- CON Application 17-028, AMITA Health Adventist Medical Center La Grange, modernization program, scheduled for completion on September 30, 2020
- CON Application 17-046, AMITA Health St. Alexius Medical Center (Hoffman Estates), modernization program, scheduled for completion on November 1, 2020

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

This Certificate of Exemption ("COE") application addresses the change of ownership of an ESRD facility, and as such, this review criterion is not applicable. However, Ascension Health and AMITA Health (and as was the case with Presence Health Network n/k/a Presence Legacy Association), in the tradition of Catholic health care and the shared culture of providing services to the poor, operate with liberal charity care policies. A recent review by *Modern Healthcare* identified Ascension Health and Presence Health as the largest and second largest providers, respectively, of charity care among Catholic health care systems in the U.S. in terms of percentage of net revenue (*Modern Healthcare* 8/28/17 pg. 7).

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

The communities of northeastern Illinois, and particularly persons living in poverty within the service area, will benefit from the efficiencies to be realized through the consolidation of two like-minded partners with similar values and a common desire to increase access to quality health care while reducing the cost of that care. In addition to the facilities addressed in the COE

applications filed with the HFSRB, the transaction integrates networks of outpatient facilities and programs, well-established and extensive physician networks, and highly-successful Accountable Care Organizations, while facilitating the sharing best practices; all targeting better outcomes and better value.

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

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

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

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

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

Members in place on the Community Leadership Board will continue to serve on the Community Leadership Board.

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

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

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

None are currently anticipated