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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	**Advocate Good Samaritan Hospital – Discontinuance of Pediatric Service Category**
Street Address:	**3815 Highland Avenue**
City and Zip Code:	**Downers Grove, IL 60515-1590**
County: **DuPage**	Health Service Area: **7** Health Planning Area: **A-05**

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

Exact Legal Name:	**Advocate Health and Hospitals Corporation - d/b/a Advocate Good Samaritan Hospital**
Street Address:	3815 Highland Avenue
City and Zip Code:	Downers Grove, IL 60515-1590
Name of Registered Agent: Michael Kerns	
Registered Agent Street Address: 3075 Highland Parkway, Suite 600	
Registered Agent City and Zip Code: Downers Grove, IL 60515	
Name of President:	Nancy Tinsley
President Street Address:	3815 Highland Avenue
President City and Zip Code:	Downers Grove, IL 60515-1590
President Telephone Number: (630) 275-1121	

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Nancy Tinsley
Title	President
Company Name:	Advocate Good Samaritan Hospital
Address:	3815 Highland Avenue, Downers Grove, IL 60515
Telephone Number:	(630) 275-1121
E-mail Address:	Nancy.Tinsley@advocatehealth.com
Fax Number:	(630) 963-8605

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

Additional Contact [Person who is also authorized to discuss the application for permit]	
Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Aurora Health, Inc.
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

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County:	**DuPage**	Health Service Area: **7**	Health Planning Area: **A-05**

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

Exact Legal Name: Advocate Health Care Network
Street Address: 3075 Highland Parkway, Suite 600
City and Zip Code: Downers Grove, IL 60515
Name of Registered Agent: Michael Kerns
Registered Agent Street Address: 3075 Highland Parkway
Registered Agent City and Zip Code: Downers Grove, IL 60515
Name of Chief Executive Officer: James H. Skogsbergh
Chief Executive Officer Street Address: 3075 Highland Parkway, Suite 600
Chief Executive Officer City and Zip Code: Downers Grove, IL 60515
Chief Executive Officer Telephone Number: (630) 572-9393

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
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Title	President
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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

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Street Address:	**3815 Highland Avenue**
City and Zip Code:	**Downers Grove, IL 60515-1590**
County: **DuPage**	Health Service Area: **7** Health Planning Area: **A-05**

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

Exact Legal Name:	Advocate Aurora Health, Inc.
Street Address:	750 W. Virginia
City and Zip Code:	Milwaukee, WI 53204
Name of Registered Agent:	The Corporation Trust Company
Registered Agent Street Address:	Wilmington, DE 19801
Name of Chief Executive Officer:	James H. Skogsbergh
Chief Executive Officer Street Address:	3075 Highland Parkway, Suite 600
Chief Executive Officer City and Zip Code:	Downers Grove, IL 60515
Chief Executive Officer Telephone Number:	(630) 572-9393
Name of Chief Executive Officer:	Nick Turkal, MD
Chief Executive Officer Street Address:	750 W. Virginia
Chief Executive Officer City and Zip Code:	Milwaukee, WI 53204
Chief Executive Officer Telephone Number:	(414) 299-1763

Type of Ownership of Applicants

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

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Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Post Exemption Contact

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

Name:	Nancy Tinsley
Title	President
Company Name:	Advocate Good Samaritan Hospital
Address:	3815 Highland Avenue, Downers Grove, IL 60515
Telephone Number:	(630) 275-1121
E-mail Address:	Nancy.Tinsley@advocatehealth.com
Fax Number:	(630) 963-8605

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	**Advocate Health and Hospitals Corporation – d/b/a Advocate Good Samaritan Hospital**
Address of Site Owner:	**3075 Highland Parkway, Suite 600 Downers Grove, IL 60515-1590**
Street Address or Legal Description of the Site:	**3815 Highland Avenue, Downers Grove, IL 60515**

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

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

Operating Identity/Licensee

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

Exact Legal Name:	**Advocate Health and Hospitals Corporation – d/b/a Advocate Good Samaritan Hospital**
Address	**3815 Highland Parkway, Downers Grove, IL 60515-1590**

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

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

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

Organizational Relationships

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

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

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.

Advocate Health and Hospitals Corporation, d/b/a/ Advocate Good Samaritan Hospital, Advocate Health Care Network, and Advocate Aurora Health, Inc., the applicants, are proposing to discontinue a pediatrics category of service at Advocate Good Samaritan Hospital. The discontinuance will take effect April 26, 2019, pending State Board approval. The hospital is located at 3815 Highland Avenue, Downers Grove, IL 60515-1590.

There are 7 pediatric beds proposed to be taken out of the hospital inventory. There were no pediatric admissions in 2016 due to the unit being temporarily closed. The closure was reported to the Illinois Department of Public Health (IDPH), Division of Health Care Facilities and Programs, due to the inability to provide pediatric credentialed nurses. By 2017, staffing was secured through an Advocate-wide pediatric resource pool and the reopening was acknowledged to the IDPH. However, admissions have continued to be low with only 114 pediatric admissions in 2017.

The hospital has a total of 284 authorized CON beds. The hospital is requesting to convert those 7 pediatric beds to medical surgical category under the "twenty bed rule". Therefore, the total authorized beds will remain 284.

Letters were sent asking for an impact statement from hospitals in the geographic service area regarding the proposed closure of pediatric beds. No expectation of any adverse impact was reported.

Pursuant to Section 1110.40 of the Illinois Administrative Code, this project is classified as substantive because it is discontinuing a category of service.

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No _X_. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): _____

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 **None.**

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

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Advocate Health Care 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 for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 12 day of December 2018

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

"Insert EXACT legal name of the applicant

SIGNATURE

William Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 12 day of December 2018

Signature of Notary

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

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

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

SIGNATURE Nancy Tinsley

Nancy Tinsley
PRINTED NAME

President
Advocate Good Samaritan Hospital
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6th day of DECEMBER 2018

Anna Zaborowski
Signature of Notary

Seal

ANNA ZABOROWSKI
Official Seal
Notary Public – State of Illinois
My Commission Expires Apr 21, 2021

SIGNATURE _____

William Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

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

_____
Signature of Notary

Seal

*Insert EXACT legal name of the applican

GSAM Reds Discontinuation page 10

CERTIFICATION

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

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- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- 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 for Permit is filed on the behalf of Advocate Health and Hospitals Corporation - d/b/a Advocate Good Samaritan Hospital in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Nancy Tinsley
PRINTED NAME

President
Advocate Good Samaritan Hospital
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this_____day of _____

Signature of Notary

Seal

SIGNATURE

William Santulli
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 12 day of December 2018

Cristin G. Foster

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

GSAM Replacement Facility page 11

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Advocate Aurora Health, Inc. in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
James H. Skogsbergh PRINTED NAME	William Santulli PRINTED NAME
President and CEO PRINTED TITLE	Chief Operating Officer PRINTED TITLE
Notarization: Subscribed and sworn to before me this 12 day of December 2018	Notarization: Subscribed and sworn to before me this 12 day of December 2018
Signature of Notary	Signature of Notary
Seal OFFICIAL SEAL CRISTIN G FOSTER NOTARY PUBLIC, STATE OF ILLINOIS My Commission Expires Mar 4, 2019	Seal OFFICIAL SEAL CRISTIN G FOSTER NOTARY PUBLIC, STATE OF ILLINOIS My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

GSAM Beds Discontinuation page 12

SECTION II. DISCONTINUATION

Type of Discontinuation

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

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

REASONS FOR DISCONTINUATION

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

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

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.
2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. 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 or exemption, 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 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A HEALTH CARE FACILITY OR CATEGORY OF SERVICE [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 9.

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

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

SECTION V. CHARITY CARE INFORMATION

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 10.

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

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

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
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3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	31-34
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Type of Ownership of Applicants

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

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

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

Attachment #1, Exhibits, 1, 2, and 3.

File Number 1707-692-2

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1814100660 verifiable until 05/21/2019
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* MAY *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1812701538 verifiable until 05/07/2019
Authenticate at: http://www.cyberdriveillinois.com

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

Jesse White

SECRETARY OF STATE

State Of Delaware

Entity Details

7/31/2018 6:24:28PM

File Number:	6645600	Incorporation Date / Formation Date:	12/4/2017
Entity Name:	ADVOCATE AURORA HEALTH, INC.		
Entity Kind:	Corporation	Entity Type:	Exempt
Residency:	Domestic	State:	DELAWARE
Status:	Good Standing	Status Date:	12/4/2017

Registered Agent Information

Name:	THE CORPORATION TRUST COMPANY		
Address:	CORPORATION TRUST CENTER 1209 ORANGE ST		
City:	WILMINGTON	Country:	
State:	DE	Postal Code:	19801
Phone:	302-658-7581		

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

APRIL 3, 2018 7155-851-7

CT CORPORATION SYSTEM
118 W EDWARDS #200
SPRINGFIELD IL 62704

RE ADVOCATE AURORA HEALTH, INC.

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE AUTHORITY OF THE ABOVE NAMED CORPORATION TO CONDUCT AFFAIRS IN THIS STATE.

PAYMENT OF THE FILING FEE IS HEREBY ACKNOWLEDGED.

CERTAIN NOT FOR PROFIT CORPORATIONS ORGANIZED AS A CHARITABLE CORPORATION ARE REQUIRED TO REGISTER WITH THE OFFICE OF THE ATTORNEY GENERAL. UPON RECEIPT OF THE ENCLOSED AUTHORITY, YOU MUST CONTACT THE CHARITABLE TRUST DIVISION, OFFICE OF THE ATTORNEY GENERAL, 100 W. RANDOLPH, 3RD FLOOR, CHICAGO, ILLINOIS 60601, TELEPHONE (312) 814-2595.

SINCERELY,

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

FORM **NFP 113.15** (rev. Dec. 2003)
APPLICATION FOR AUTHORITY TO CONDUCT AFFAIRS IN ILLINOIS (Foreign Corporations)
General Not For Profit Corporation Act

Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1834
www.cyberdriveillinois.com

Remit payment in the form of a cashier's check, certified check, money order or an Illinois attorney's or CPA's check payable to Secretary of State.

FILED

APR 03 2018

JESSE WHITE
SECRETARY OF STATE

File # 7155-8517 Filing Fee: $50 Approved: BC

----- Submit in duplicate ----- Type or Print clearly in black ink ----- Do not write above this line -----

1. a. Corporate Name: Advocate Aurora Health, Inc.

   b. Assumed Corporate Name (Complete only if the new corporate name is not available in this state.):

   By electing this assumed name, the Corporation hereby agrees NOT to use its corporate name in the transaction of business in Illinois. Form NFP 104.15 is attached.

2. a. State or Country of Incorporation: Delaware

   b. Date of Incorporation: December 4, 2017

   c. Period of Duration: Permanent

3. a. Address of Principal Office, wherever located: 3075 Highland Pkwy.,
   Downers Grove, IL 60515-1206

   b. Address of Principal Office in Illinois: 3075 Highland Pkwy.,
   Downers Grove, IL 60515-1206

4. Name and Address of Registered Agent and Registered Office in Illinois:

   Registered Agent: Earl J. Barnes II
   (First Name / Middle Name / Last Name)

   Registered Office: 3075 Highland Pkwy Suite 600
   (Number / Street / Suite # (P.O. Box alone is unacceptable))

   Downers Grove 60515 DuPage County
   (City / ZIP Code / County)

5. States and Countries in which Corporation is admitted or qualified to conduct affairs: Wisconsin (application pending)

6. Names and respective addresses of Corporation's officers and directors:

	Street Address	City State ZIP
President See attached		
Secretary		
Director		
Director		
Director		

If there are additional officers or more than three directors, please attach list.

Printed by authority of the State of Illinois. January 2015 - 1 - C 150.15

7. Purpose(s) for which the Corporation is organized and proposes to pursue in the conduct of affairs in this State:
For more space, attach additional sheets of this size.

See attached.

8. This application must be accompanied by an originally certified copy of the Articles of Incorporation and any amendments or mergers, duly authenticated within the last 90 days by the proper officer of the state or country wherein the corporation is incorporated.

9. The undersigned Corporation has caused this statement to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct. All signatures must be in **BLACK INK.**

Dated April 1, 2018 (Month, Day) , 2018 (Year)

Advocate Aurora Health, Inc.
Exact Name of Corporation

Any Authorized Officer's Signature

Michael Lappin, Secretary
Name and Title (type or print)

Legal

A Corporation that is to function as a club, as defined in Section 1-3.24 of the Liquor Control Act of 1934, must insert in its purpose clause a statement that it will comply with the State and local laws and ordinances relating to alcoholic liquors.

7155-8517

ATTACHMENT TO APPLICATION FOR AUTHORITY TO CONDUCT BUSINESS IN ILLINOIS (FORM NFP 113.15) FOR ADVOCATE AURORA HEALTH, INC.

Section 6: NAMES AND ADDRESSES OF DIRECTORS AND OFFICERS

Officers:

Office/Name	Address
Co-CEO - James H. Skogsbergh	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Co-CEO - Nick W. Turkal, M.D.	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Treasurer – Dominic Nakis	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Secretary – Michael Lappin	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Chair – Joanna Disch	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Chair Elect – Michele Baker Richardson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515

4835-2888-4064.2

7155 8517

Directors:

Name	Address
Michele Baker Richardson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
John F. Timmer	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Lynn Y. Crump-Caine	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
K. Richard Jaklc	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Mark M. Harris	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
David B. Anderson	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
James H. Skogsbergh	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Joanne Disch	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
John W. Daniels, Jr.	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Joanne B. Bauer	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Charles Harvey	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Rick Weiss	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Thomas Bolger	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515
Nick W. Turkal	c/o Aurora Advocate Health, Inc. 3075 Highland Pkwy Suite 600, Downers Grove, IL 60515

7155-8517

Section 7: PURPOSE(S) FOR WHICH THE CORPORATION IS ORGANIZED AND PROPOSES TO PURSUE IN THE CONDUCT OF AFFAIRS IN THIS STATE:

The Corporation is organized and shall be operated exclusively for charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provisions of any future United States Internal Revenue Law) (hereinafter the "Code"); and limited as further provided in its Certificate of Incorporation. Specifically, the Corporation is organized and shall be operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of its supported organizations, as listed below (the "**Supported Organizations**"). The Corporation is organized and operated as a Type III functionally integrated supporting organization as defined in section 509(a)(3) of the Code and Treas. Reg. Section 1.509(a)-4(i). The Corporation is organized for the purpose of serving as the parent organization of the Supported Organizations and shall exercise direction over the policies, programs and activities of the Supported Organizations. The Corporation shall engage in activities relating to the purposes described above, and invest in, receive, hold, use, and dispose of all property, real or personal, as may be necessary or desirable to carry into effect such purposes. The Corporation is formed as a result of the affiliation of Advocate Health Care Network, an Illinois nonprofit corporation ("**Advocate**") and Aurora Health Care, Inc., a Wisconsin nonstock corporation ("**Aurora**"), in accordance with the terms and conditions of that certain Affiliation Agreement between Advocate and Aurora dated December 4, 2017 (the "**Affiliation Agreement**").

The Corporation's Supported Organizations, which are described in Section 509(a)(1) or Section 509(a)(2) of the Code, are as follows:

- Advocate Health and Hospitals Corporation
- EHS Home Health Care Services, Inc.
- Advocate Charitable Foundation
- Advocate North Side Health Network
- Meridian Hospice
- Advocate Condell Medical Center
- Advocate Sherman Hospital
- Sherman West Court
- Visiting Nurse Association of Wisconsin, Inc.
- Aurora UW Academic Medical Group
- Aurora Health Care Central, Inc.
- Aurora Psychiatric Hospital, Inc.
- Aurora Medical Center of Washington County, Inc.
- Aurora Health Care North, Inc.
- West Allis Memorial Hospital, Inc.
- Aurora Family Service, Inc.
- Aurora Medical Center of Oshkosh, Inc.
- Aurora Medical Group, Inc.
- Kradwell School, Inc.
- Aurora Advanced Healthcare, Inc.

7155-8517

- Aurora Health Care Metro, Inc.
- Aurora Health Care Southern Lakes, Inc.
- AMG Illinois, Ltd.
- Aurora Medical Center Grafton

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	**Advocate Health and Hospitals Corporation – d/b/a Advocate Good Samaritan Hospital**
Address of Site Owner:	**3075 Highland Parkway, Suite 600, Downers Grove, IL 60515**
Street Address or Legal Description of the Site:	**3815 Highland Avenue, Downers Grove, IL 60515-1590**

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

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

Attachment #2, Exhibit 1.

Advocate Health Care
3075 Highland Parkway, Suite 600 || Downers Grove, Illinois 60515 || T 630.572.9393|| advocatehealth.com

November 26, 2018

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

RE: Advocate Good Samaritan Hospital
Discontinuation of Pediatric Category of Service

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate Health and Hospitals Corporation owns the Advocate Good Samaritan Hospital site.

We trust this attestation complies with the State Agency Proof of Ownership requirement indicated in the Permit application – August 2018 edition.

Respectfully,

William Santulli
Chief Operating Officer
Advocate Aurora Health

Notarization:

Subscribed and sworn to before me
This 12 day of December, 2018.

(Seal of Notary)

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

Cristin G. Foster
Signature of Notary

GSAM Peds Discontinuation page 30

Operating Identity/Licensee

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

Exact Legal Name:	**Advocate Health and Hospitals Corporation – d/b/a Advocate Good Samaritan Hospital**
Address:	**3815 Highland Avenue, Downers Grove, IL 60515-1590**

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

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

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

Certificates of Good Standing for Advocate Health and Hospital Corporation d/b/a Advocate Good Samaritan Hospital, Advocate Health Care Network and Advocate Aurora Health, Inc. are appended as Attachment #3, Exhibits 1, 2, and 3.

File Number 1707-692-2

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1814100660 verifiable until 05/21/2019
Authenticate at: http://www.cyberdrivelllinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* MAY *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1812701538 verifiable until 05/07/2019
Authenticate at: http://www.cyberdrivelllinois.com

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

State Of Delaware

Entity Details

7/31/2018 6:24:28PM

File Number: 6645600
Incorporation Date / Formation Date: 12/4/2017
Entity Name: ADVOCATE AURORA HEALTH, INC.
Entity Kind: Corporation
Entity Type: Exempt
Residency: Domestic
State: DELAWARE
Status: Good Standing
Status Date: 12/4/2017

Registered Agent Information

Name: THE CORPORATION TRUST COMPANY
Address: CORPORATION TRUST CENTER 1209 ORANGE ST
City: WILMINGTON
Country:
State: DE
Postal Code: 19801
Phone: 302-658-7581

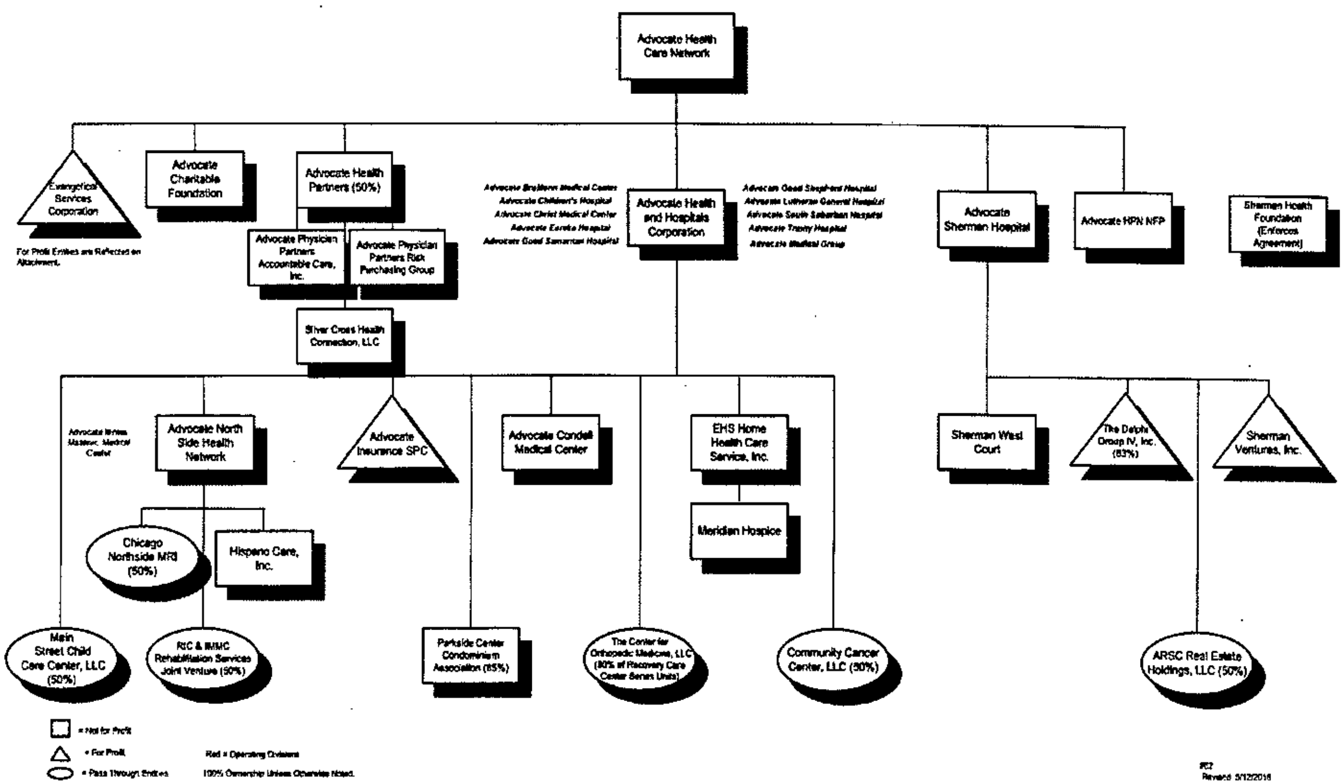
Organizational Relationships

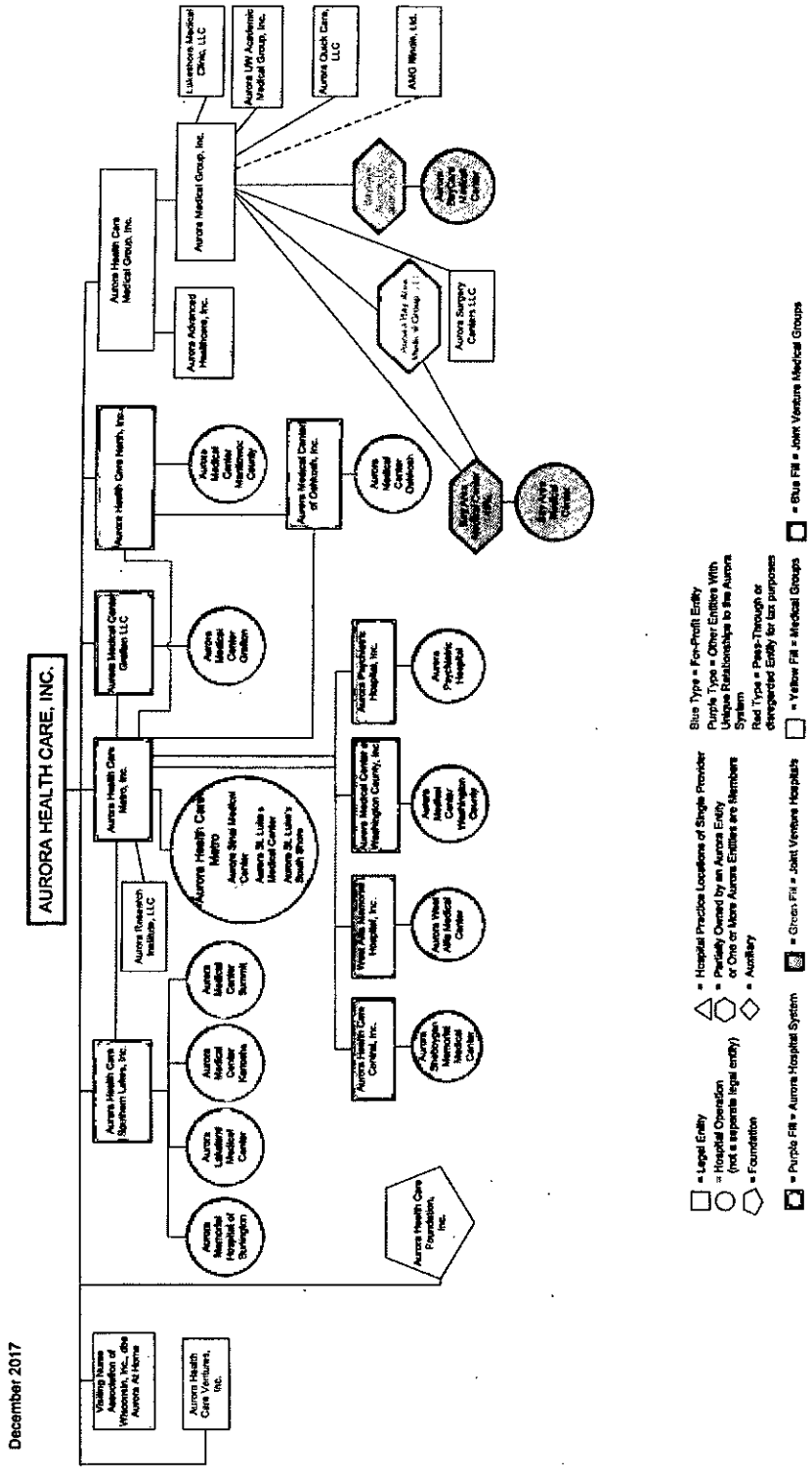
Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type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

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

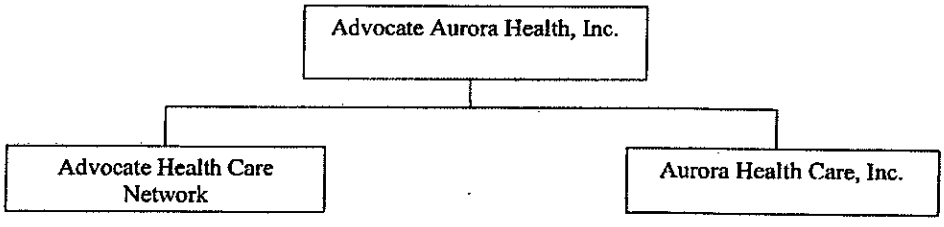
Attachment # 4, Exhibits 1, 2, and 3 show the legacy organizations Advocate Health Care Network and Aurora Health Care, Inc. that came together as Advocate Aurora Health, Inc.

Advocate Health Care




AURORA HEALTH CARE, INC.
December 2017
Visiting Nurse Association of Wisconsin, Inc., dba Aurora At Home
Aurora Health Care Ventures, Inc.
Aurora Health Care Foundation, Inc.
Aurora Health Care Southern Lakes, Inc.
Aurora Kenosha Medical Center
Aurora Medical Center Summit
Aurora Lakeland Medical Center
Aurora Memorial Hospital of Burlington
Aurora Research Institute, LLC
Aurora Health Care Metro, Inc.
Aurora Health Care Metro
Aurora West Allis Medical Center
Aurora St. Luke's Medical Center
Aurora St. Luke's South Shore
Aurora Health Care Central, Inc.
Aurora Sheboygan Memorial Medical Center
West Allis Memorial Hospital, Inc.
Aurora Medical Center of Washington County, Inc.
Aurora Medical Center Washington County
Aurora Psychiatric Hospital, Inc.
Aurora Psychiatric Hospital
Aurora Medical Center Grafton LLC
Aurora Medical Center Grafton
Aurora Health Care North, Inc.
Aurora Medical Center Manitowoc County
Aurora Medical Center of Oshkosh, Inc.
Aurora Medical Center Oshkosh
Aurora Health Care Medical Group, Inc.
Aurora Advanced Healthcare, Inc.
Aurora Medical Group, Inc.
Lakeshore Medical Clinic, LLC
Aurora UW Academic Medical Group, Inc.
Aurora Quick Care, LLC
AMG Rhode, Ltd.
Aurora Surgery Centers LLC
= Legal Entity
= Hospital Operation (not a separate legal entity)
= Foundation
= Hospital Practice Locations of Single Provider
= Partially Owned by an Aurora Entity or One or More Aurora Entities are Members
= Auxiliary
Blue Type = For-Profit Entity
Purple Type = Other Entities With Unique Relationship to the Aurora System
Red Type = Pass-Through or Disregarded Entity for tax purposes
= Purple Fill = Aurora Hospital System
= Green Fill = Joint Venture Hospitals
= Yellow Fill = Medical Groups
= Blue Fill = Joint Venture Medical Groups

POST-CLOSING ORGANIZATIONAL CHART



All of the Advocate Health Care Network ("Advocate") entities will remain under the Advocate corporate structure and all of the Aurora Health Care, Inc. ("Aurora") entities will remain under the Aurora corporate structure, shown on the previously included organizational charts for each of Advocate and Aurora.

FREAD THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

1. The Pediatric category of service with 7 beds to be discontinued.
2. There are no other clinical services discontinued.
3. The Pediatric category of service is anticipated to be discontinued April 26, 2019.
4. The physical plant and equipment will be used for patient support service.
5. The medical records will remain with the hospital along with all the other services' records.
6. This discontinuance is not for the entire facility
7. See Attachment 5, Exhibit 1 for the attestation about the required notice that was published in the local newspaper, the *Daily Herald.*

Advocate Good Samaritan Hospital, 3815 Highland Avenue, Downers Grove, Il 60515, intends to discontinue the authorized bed category of service for its seven (7) bed pediatric inpatient services pending approval by the Illinois Health Facilities and Services Review Board (HFSRB). The Hospital plans to submit the required Certificate of Exemption applications to the HFSRB to be considered by March 5, 2019. Copies of the application will be posted on the HFSRB website at https://www.illinois.gov/sites/hfsrb/Projects/Pages/CompApps.aspx. For additional information, contact Barb Perino, (708) 684 4507.
Published in Daily Herald December 3, 4, 5, 2018 (4513911)

Source: Daily Herald Newspaper

REASONS FOR DISCONTINUATION

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

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

Source: Hospital Profile

The Applicant's main reason is the low occupancy of the pediatric service. The volume of inpatients admissions and CON occupancy rate for the past four years are as follows:

Year	Admissions	CON Occupancy Rate %
2017	114	18.1
2016	0	0
2015	92	12.8
2014	108	24.8

Source: Hospital Profile

Pediatric hospital admissions across the nation have been declining for several years. In Illinois alone, there has been an almost 29% drop since 2013. Fortunately, it's in part, because healthcare has become proficient at treating conditions in the outpatient setting that once required hospitalization. Also, children who require inpatient admission are usually more acutely ill and require pediatric critical and subspecialty care. With less children requiring a hospital admission, Advocate proposes to close the pediatric service at this hospital.

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.

2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

It is not expected that the discontinuance will have an adverse effect on access to care in this hospital's market area. There are 18 other hospitals nearby that offer pediatrics inpatient care and they have been made aware of this pending closure. They are as follows:

Gottlieb Memorial Hospital	701 West North Avenue	Melrose Park
VHS Westlake Hospital	1225 W Lake St	Melrose Park
VHS West Suburban Medical Center	3 Erie Ct.	Oak Park
Elmhurst Memorial Hospital	155 East Brush Hill Road	Elmhurst
Edward Hospital	801 South Washington	Naperville
Silver Cross Hospital	1900 Silver Cross Boulevard	New Lenox
MacNeal Memorial Hospital	3249 South Oak Park Avenue	Berwyn
Saint Mary Of Nazareth Hospital	2233 West Division Street	Chicago
Presence Mercy Medical Center	1325 North Highland Avenue	Aurora
Northwest Community Hospital	800 West Central Road	Arlington Heights
Presence Resurrection Medical Center	7435 West Talcott Avenue	Chicago
Adventist Hinsdale Hospital	120 North Oak Street	Hinsdale
Rush University Medical Center	1653 West Congress Parkway	Chicago
Central DuPage Hospital	25 North Winfield Road	Winfield
University of Illinois Hospital	1740 West Taylor Avenue	Chicago
Loyola University Medical Center/Foster G. McGaw	2160 South 1st Avenue	Maywood
Shriner's Hospitals for Children	2211 North Oak Park	Chicago
Advocate Lutheran General Hospital	1775 Dempster St.	Park Ridge

Source: IHFSRB

See Attachment 7, Exhibits 1 and 2 for a copy of the notification letter and evidence that the letters were received.

It should be noted that both Advocate Christ Medical Center and Advocate Lutheran General Hospital have extensive pediatric specialty services where patients from across the country routinely come for care.

Insert sample of closing letter to hospitals.

Advocate Good Samaritan Hospital
3815 Highland Avenue || Downers Grove, IL 60515 || T 630.275.5900 || advocatehealth.com

November XX, 2018

Certified Mail

(Name
Address
Address)

Request for Impact Statement

Dear Administrator;

This letter is to inform you that Advocate Good Samaritan Hospital is seeking a Certificate of Exemption from the Illinois Health Facilities and Services Review Board to discontinue its Pediatric category of service with its 7 pediatric beds. The date of discontinuance is April 26, 2019.

In 2016 Advocate Good Samaritan Hospital had no pediatric patients admitted as the service was temporarily closed. In 2017 the hospital admitted 114 pediatric patients.

The purpose of this letter is to inquire whether your hospital has or will have available capacity to accommodate a portion or all the experienced caseload. In addition, please indicate whether any restrictions or limitations preclude providing service to the residents of Advocate Good Samaritan Hospital's market area.

Thank you for your consideration of this request.

Sincerely,

Nancy Tinsley
President

Northwestern Medicine®

Central DuPage Hospital
25 North Winfield Road
Winfield, Illinois 60190
.org

November 29, 2018

Ms. Nancy M. Tinsley, RN, MBA, FACHE
President
Advocate Good Samaritan Hospital
3815 Highland Avenue
Downers Grove, IL 60515

RE: Response to Request for Impact Statement
Discontinuation of Pediatric Category of Service

Dear Ms. Tinsley:

We received your correspondence from November 21, 2018 regarding the discontinuation of seven (7) pediatric beds at Advocate Good Samaritan Hospital. Northwestern Medicine Central DuPage Hospital, located 15 miles from Advocate Good Samaritan Hospital, has capacity to accommodate the pediatric patients that would be affected by this discontinuation.

Northwestern Medicine Central DuPage Hospital has 22 licensed pediatric beds and also offers Neonatal and Pediatric ICU services. Our board-certified pediatricians and nurse practitioners, working with their partners at the Ann & Robert H. Lurie Children's Hospital of Chicago, provide exceptional and comprehensive pediatric health and wellness care. If you have any further questions about our hospital, please feel free to contact me at 630.933.5501.

Sincerely,

Brian Lemon
President, Northwestern Medicine Central DuPage Hospital

c: Bridget Orth, Director, Regulatory Planning

DEC 03 2018

LOYOLA MEDICINE

Shawn P. Vincent
President and Chief Executive Officer

Tel: 708-216-3215
Fax: 708-216-4275
Shawn.Vincent@luhs.org

December 5, 2018

Nancy M. Tinsley
President
Advocate Good Samaritan Hospital
3815 Highland Ave.
Downers Grove, IL 60515

Dear Ms. Tinsley,

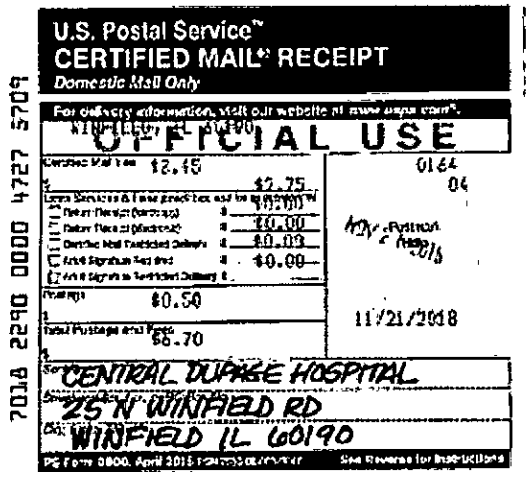
Thank you for your correspondence dated November 21, 2018 requesting an Impact Statement as Advocate Good Samaritan Hospital seeks a Certificate of Exemption with the Illinois Health Facilities and Services Review Board to discontinue its Pediatric category of service.

Loyola Medicine supports your request for the Certificate of Exemption. We offer inpatient Pediatric services at both our MacNeal Hospital and Loyola University Medical Center campuses and have capacity to accommodate some or all of your patients. We are not aware of any restrictions or limitations that would preclude us from providing pediatrics services to the patients in your service area.

Sincerely,

Shawn P. Vincent
President and CEO
Trinity Health Illinois
Loyola Medicine

Proof that notification letters were received.



U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

OFFICIAL USE

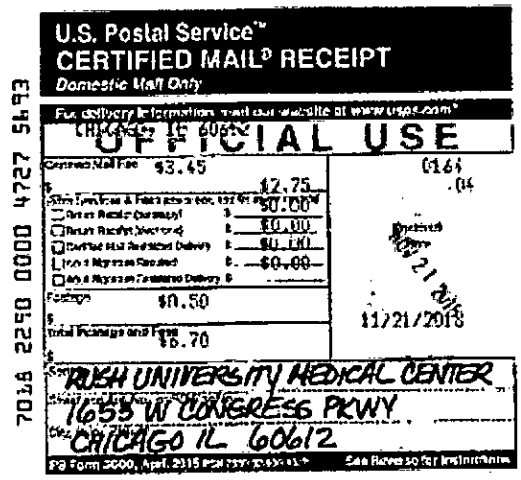
7018 2290 0000 4727 5709

$2.45 $2.75 $0.00 $0.00 $0.00 $0.00 $0.50 $5.70

0164 04

11/21/2018

CENTRAL DUPAGE HOSPITAL
25 N WINFIELD RD
WINFIELD IL 60190



U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

OFFICIAL USE

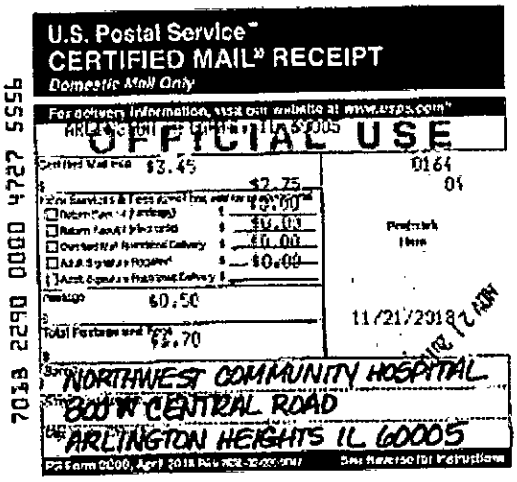
7018 2290 0000 4727 5493

$3.45 $2.75 $0.00 $0.00 $0.00 $0.00 $0.50 $6.70

0164 04

11/21/2018

RUSH UNIVERSITY MEDICAL CENTER
1655 W CONGRESS PKWY
CHICAGO IL 60612



U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

OFFICIAL USE

7018 2290 0000 4727 5556

$3.45 $2.75 $0.00 $0.00 $0.00 $0.00 $0.50 $6.70

0164 04

11/21/2018

NORTHWEST COMMUNITY HOSPITAL
800 W CENTRAL ROAD
ARLINGTON HEIGHTS IL 60005

SENDER: COMPLETE THIS SECTION

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

ADVOCATE LUTHERAN GENERAL HOSP
ATTN: ADMINISTRATOR
1775 DEMPSTER ST
PARK RIDGE IL 60068

9590 9402 4458 8248 4275 03

2. Article Number *(Transfer from service label)*
7018 2290 0000 4727 5747

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* [illegible] C. Date of Delivery 11-25-18

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

PRESENCE MERCY MEDICAL CENTER
ATTN: ADMINISTRATOR
1325 NORTH HIGHLAND AVE
AURORA IL 60506-1449

9590 9402 4458 8248 4274 11

2. Article Number *(Transfer from service label)*
7018 2290 0000 4727 5952

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Maria Lopez C. Date of Delivery 11-28-18

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricte Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

UNIVERSITY OF ILLINOIS HOSPITAL
ATTN: ADMINISTRATOR
1740 WEST TAYLOR AVE
CHICAGO IL 60612

9590 9402 4458 8248 4274 73

2. Article Number *(Transfer from service label)*
7018 2290 0000 4727 5716

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Simmons C. Date of Delivery 11/30/18

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

VHS WESTLAKE HOSPITAL
ATTN: ADMINISTRATOR
1225 W LAKE ST
MELROSE PARK IL 60160

9590 9402 4458 8248 4273 43

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8694

PS Form 3811, July 2015 PSN 7530-02-000-9053 — Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Maricela C. Date of Delivery 11-26

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

MACNEAL MEMORIAL HOSPITAL
ATTN: ADMINISTRATOR
3249 SOUTH OAK PARK AVE
BERWYN IL 60402

9590 9402 4458 8248 4273 98

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5938

PS Form 3811, July 2015 PSN 7530-02-000-9053 — Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

LOYOLA UNIVERSITY MEDICAL
CENTER/FOSTER G. MCGAW
ATTN: ADMINISTRATOR
2160 SOUTH 1ST AVE
MAYWOOD IL 60153

9590 9402 4458 8248 4274 80

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5723

PS Form 3811, July 2015 PSN 7530-02-000-9053 — Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

EDWARD HOSPITAL
ATTN: ADMINISTRATOR
801 SOUTH WASHINGTON
NAPERVILLE IL ~~60566~~ 60540

9590 9402 4458 8248 4273 74

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8724

PS Form 3811, July 2015 PSN 7530-02-000-9053 — Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

PRESENCE RESURRECTION MEDICAL CENTER
ATTN: ADMINISTRATOR
7435 WEST TALCOTT AVE
CHICAGO IL 60631

9590 9402 4458 8248 4274 35

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5679

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

ADVENTIST HINSDALE HOSPITAL
ATTN: ADMINISTRATOR
120 NORTH OAK ST
HINSDALE IL 60521

9590 9402 4458 8248 4274 42

Article Number (Transfer from service label)
9018 2290 0000 4727 5686

Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restric Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

ELMHURST MEMORIAL HOSPITAL
ATTN: ADMINISTRATOR
155 EAST BRUSH HILL RD
ELMHURST IL 60126

9590 9402 4458 8248 4273 67

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8917

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

GOTTLIEB MEMORIAL HOSPITAL
ATTN: ADMINISTRATOR
701 WEST NORTH AVE
MELROSE PARK IL 60160

9590 9402 4458 8248 4273 36

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8687

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delive
Joseph Tadelle 11-26

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restri Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmatio
☐ Signature Confirmatio Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

SHRINER'S HOSPITALS FOR CHILDREN
ATTN: ADMINISTRATOR
2211 NORTH OAK PARK
CHICAGO IL 60707

9590 9402 4458 8248 4274 97

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5130

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) V. [illegible] C. Date of Delivery

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

NOV 24 2018

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

VHS WEST SUBURBAN MEDICAL CENTER
ATTN: ADMINISTRATOR
3 ERIE CT
OAK PARK IL 60302

9590 9402 4458 8248 4273 50

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8700

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 11-2

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

SILVER CROSS HOSPITAL
ATTN: ADMINISTRATOR
1900 SILVER CROSS BOULEVARD
NEW LENOX IL 60451

9590 9402 4458 8248 4273 81

2. Article Number (Transfer from service label)
7018 2290 0000 4727 8731

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

SAINT MARY OF NAZARETH HOSPITAL
ATTN: ADMINISTRATOR
2233 WEST DIVISON ST
CHICAGO IL 60622

9590 9402 4458 8248 4274 04

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5945

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

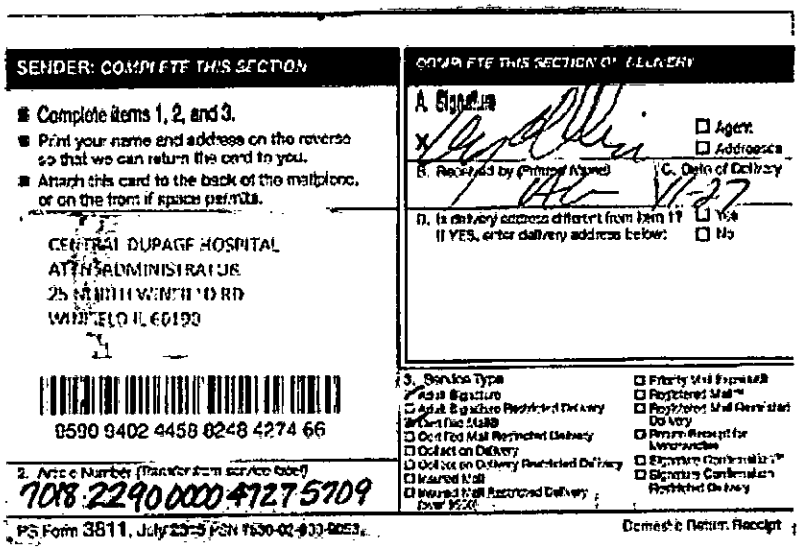
COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Deliver 11-26

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery



SENDER: COMPLETE THIS SECTION

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

CENTRAL DUPAGE HOSPITAL
ATTN ADMINISTRATOR
25 WINFIELD RD
WINFIELD IL 60190

9590 9402 4458 8248 4274 66

2. Article Number (Transfer from service label)
7018 2290 0000 4727 5709

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

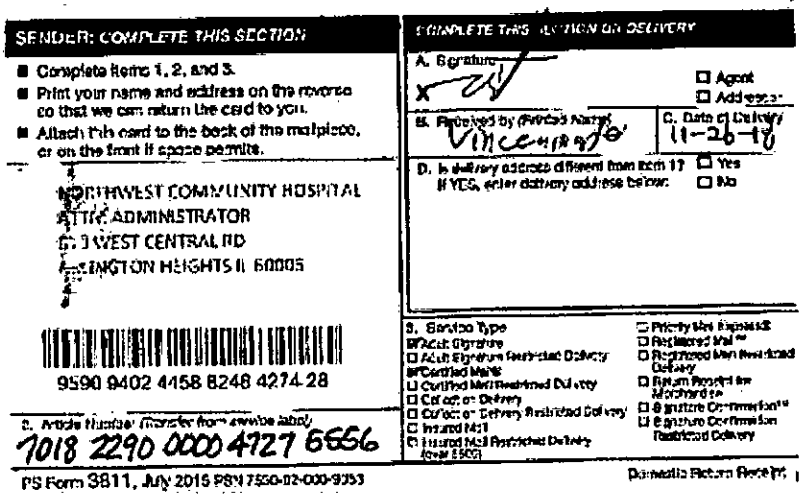
A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
11-27

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt



SENDER: COMPLETE THIS SECTION

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

NORTHWEST COMMUNITY HOSPITAL
ATTN ADMINISTRATOR
800 WEST CENTRAL RD
ARLINGTON HEIGHTS IL 60005

9590 9402 4458 8248 4274 28

2. Article Number (Transfer from service label)
7018 2290 0000 4727 6656

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name) Vincent Pyle C. Date of Delivery 11-26-18

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

3. Service Type
☑ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

SECTION III. 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 or exemption, 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.

1. Health Care Facilities Owned and Operated by Advocate Health and Hospitals Corporation.

Attachment 8, Exhibit 1 is the listing of all the facilities owned by Advocate Health Care Network. Exhibit 2 is the current state hospital license for Advocate Health and Hospitals, d/b/a Advocate Good Samaritan Hospital. There are no other Illinois hospitals owned by Advocate Aurora Health, Inc. The most recent DNV accreditation certificate for the Hospital is included as Attachment 8, Exhibit 3.

2.Certified Listing of Any Adverse Action Against Any Facility Owned or Operated by the Applicant

By the signatures on the Certification pages, the applicants attest there have been no adverse actions against any facility owned and/or operated by Advocate Health Care Network, Advocate Health and Hospitals Corporation, and Advocate Aurora Health, Inc. as demonstrated by compliance with the CMS Conditions of Participation with Medicare and Medicaid, during the three years prior to the filing of this application.

3.Authorization Permitting HFPB and DPH to Access Necessary Documentation

Advocate Health and Hospitals Corporation, Advocate Health Care Network, and Advocate Aurora Health, Inc. hereby authorize the Health Facilities and Services Review Board and the Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

4. **for Filing Multiple Certificates of Exemption in One Year attestation 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.**

Not applicable. This is one of three certificates of exemption filed by Advocate Health Care Network in 2018.

Facility	Location	License No.	DNV Accreditation No.
Advocate Good Samaritan Hospital	3815 Highland Ave. Downers Grove, IL	0003384	176404-2018-AHC-USA-NIAHO

Additional hospitals owned and operated as a part of Advocate Health Care Network.

Facility	Location	License No.	DNV Accreditation No.
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	0005645	189504-2018-AHC-USA-NIAHO
Advocate Christ Medical Center	4440 W. 95th St. Oak Lawn, IL	0000315	197946-2016-AHC-USA-NIAHO
Advocate Condell Medical Center	801 S. Milwaukee Ave. Libertyville, IL	0005579	211487-2016-AHC-USA-NIAHO
Advocate Eureka Hospital	101 S. Major Eureka, IL	0005652	195598-2016-AQ-USA-RvA
Advocate Good Shepherd Hospital	450 W. Highway, #22 Barrington, IL	0003475	186883-2015-AQ-USA-RvA
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	0005165	192082-2015-ACH-USA-NIAHO
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	004796	178979-2018-AHC-USA-NIAHO
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	0004697	195597- 2016- AQ-USA-RvA
Advocate Sherman Hospital	1425 N. Randall Rd Elgin, IL	0005884	246588-2017-AHC-USA-NIAHO
Advocate Trinity Hospital	2320 E. 93rd St. Chicago, IL	0004176	193041-2015-ACH-USA-NIAHO

Additionally, AHHC has an ownership interest of fifty percent (50%) or more in the following licensed healthcare facilities:

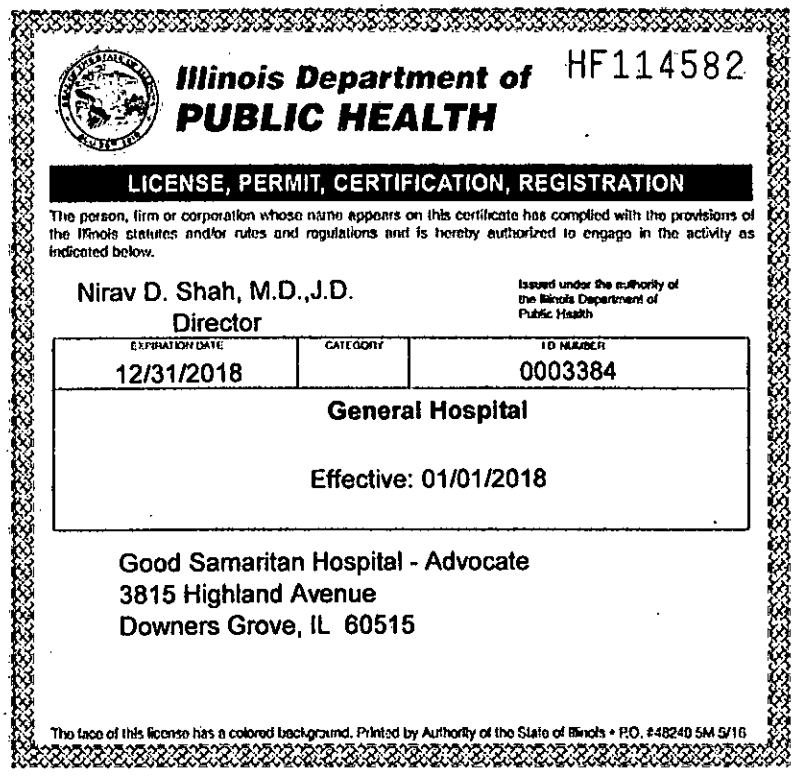
Facility	Location	License No.	Joint Commission Accreditation No./ Accreditation Association for Ambulatory Health Care, Inc.
BroMenn Comfort & Care Suites	2502-B East Empire Bloomington, IL	4000025	AAAHC
Dreyer Ambulatory Surgery Center	1221 N. Highland Ave Aurora, IL	7001779	AAAHC
RML Specialty Hospital Chicago	3435 W. Van Buren St. Chicago, IL	0005678	JCAHO
RML Specialty Hospital Hinsdale	5601 S. County Line Rd Hinsdale, IL	0004804	JCAHO

*Licensed under the Nursing Home Act.

Advocate
Good Samaritan Hospital

2018 Hospital License

Contact: Anna Zaborowski
630.275.1121 | 31.1121



Illinois Department of PUBLIC HEALTH

HF114582

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/2018		0003384

General Hospital

Effective: 01/01/2018

Good Samaritan Hospital - Advocate
3815 Highland Avenue
Downers Grove, IL 60515

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

DNV·GL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
176404-2018-AHC-USA-NIAHO	4/5/2018	4/5/2021

This is to certify that:

Advocate Good Samaritan Hospital
3815 Highland Avenue, Downers Grove, IL 60515

has been found to comply with the requirements of the:
NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

DNV GL - Healthcare, 400 Techne Center Drive, Suite 100, Milford OH, 45150. Tel: 513-947-8343 www.dnvglhealthcare.com

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A HEALTH CARE FACILITY OR CATEGORY OF SERVICE [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 9.

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

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

See Attachment #9, Exhibit 1.

No other providers reported any expected material impact on essential safety net services.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2015**	**2016**	**2017**
Inpatient	170	281	189
Outpatient	2,620	3,076	789
Total	2,790	3,357	978
Charity (cost In dollars)			
Inpatient	$2,321,000	$2,295,000	$2,629,000
Outpatient	$2,441,000	$1,978,000	$1,967,000
Total	$4,762,000	$4,273,000	$4,596,000
MEDICAID			
Medicaid (# of patients)	**2015**	**2016**	**2017**
Inpatient	953	2,054	2,023
Outpatient	7,709	18,767	16,789
Total	8,662	20,821	18,812
Medicaid (revenue)			
Inpatient	$22,314,469	$30,521,712	$28,580,699
Outpatient	$ 1,649,068	$ 5,095,842	$ 6,079,191
Total	$23,963,537	$35,617,554	$34,659,890

Source: Hospital Profiles

Other community services provided by Advocate Good Samaritan Hospital in 2017 that are relevant to safety net services include the following:

	Advocate Good Samaritan Hospital
Language Assistant Services	$ 1,108,084
Donations	$ 589,164
Volunteer Services	$ 828,405
Education	$ 2,545,670
Government -sponsored program services	$ 43,904
Subsidized health services	$ 570,082

Source: Community Benefits Report

SECTION V. CHARITY CARE INFORMATION

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 10.

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

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

See Attachment #10, Exhibit #1.

Advocate Good Samaritan Hospital CHARITY CARE			
	2015	2016	2017
Net Patient Revenue	$371,814,320	$391,182,171	$407,474,572
Amount of Charity Care (charges)	$ 20,313,733	$ 18,565,739	$ 19,085,651
Cost of Charity Care	$ 4,762,000	$ 4,273,000	$ 4,596,000

Source: Hospital data