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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION- 08/2018 Edition

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HEALTH FACILITIES & SERVICES REVIEW BOARD

# PILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

ORIGINAL

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

### Facility/Project Identification

| | |
|---|---|
| Facility Name: | **Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center – Discontinuance of Pediatric Service Category** |
| Street Address: | **836 W. Wellington Avenue** |
| City and Zip Code: | **Chicago, IL 60657-5147** |
| County: **Cook** | Health Service Area **6** Health Planning Area: **A-01** |

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

| | |
|---|---|
| **Exact Legal Name: Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center** | |
| Street Address: | 836 W. Wellington Avenue |
| City and Zip Code: | Chicago, IL 60657-5147 |
| 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: | Susan Nordstrom-Lopez |
| President Street Address: | 836 W. Wellington Avenue |
| President City and Zip Code: | Chicago, IL 60657-5147 |
| President Telephone Number: (773) 975-1600 | |

### 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: | Susan Nordstrom-Lopez |
| Title: | President, Advocate Illinois Masonic Medical Center |
| Company Name: | Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center |
| Address: | 836 W. Wellington Avenue, Chicago, IL 60657-5147 |
| Telephone Number: | (773) 296-7081 |
| E-mail Address: | susan.nordstrom.lopez@advocatehealth.com |
| Fax Number: | (773) 296-5251 |

**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: **Cook** | Health Service Area: **6** Health Planning Area: **A-01** |

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

| |
|---|
| Exact Legal Name: Advocate Health and Hospitals Corporation |
| 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, Suite 600 |
| 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
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| County: **Chicago** | Health Service Area **6** Health Planning Area: **A-01** |

### 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 |
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| City and Zip Code: | **Chicago, IL 60657-5147** |
| County: **Cook** | Health Service Area **6** Health Planning Area: **A-01** |

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

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

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|---|---|
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|---|---|
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| 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 |

**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: | Susan Nordstrom-Lopez |
| Title | President, Advocate Illinois Masonic Medical Center |
| Company Name: | Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center |
| Address: | 836 W. Wellington Avenue, Chicago, IL 60657-5147 |
| Telephone Number: | (773) 296-7081 |
| E-mail Address: | susan.nordstrom.lopez@advocatehealth.com |
| Fax Number: | (773) 296-5251 |

**Site Ownership**

[Provide this information for each applicable site]

| | |
|---|---|
| Exact Legal Name of Site Owner: | **Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center** |
| Address of Site Owner: | **836 W. Wellington Avenue, Chicago, IL 60657-5147** |
| Street Address or Legal Description of the Site: **836 W. Wellington Avenue, Chicago, IL 60657-5147** | |
| **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 North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center** |
| Address | **3075 Highland Parkway, Suite 600 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.

## 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 North Side Health Network - d/b/a Advocate Illinois Masonic Medical Center, Advocate Health and Hospitals Corporation, Advocate Health Care Network, and Advocate Aurora Health, Inc., the applicants, are proposing to discontinue pediatrics category of service at Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center. The discontinuance will take effect April 26, 2019, pending State Board approval. The hospital is located at 836 West Wellington, Chicago, IL 60657.

There are 14 authorized pediatric beds proposed to be taken out of the hospital inventory. There were 143 pediatric admissions in 2016 and 106 in 2017 demonstrating a declining demand.

The hospital has a total of 397 authorized CON beds. The hospital is requesting to convert those 14 beds to the neonatal category under the "twenty bed rule". Therefore, the total authorized beds would remain 397.

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 **N/A**

**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 North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center 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 |
| Susan Nordstrom-Lopez<br>PRINTED NAME | William Santulli<br>PRINTED NAME |
| President<br>Advocate Illinois Masonic Medical Center<br>PRINTED TITLE | Chief Operating Officer<br>PRINTED TITLE |
| Notarization:<br>Subscribed and sworn to before me<br>this 11TH day of DECEMBER 2018 | Notarization:<br>Subscribed and sworn to before me<br>this _____ day of _____ |
| Signature of Notary | Signature of Notary |
| Seal<br>OFFICIAL SEAL<br>GAIL B. ZATOR<br>NOTARY PUBLIC, STATE OF ILLINOIS<br>My Commission Expires Feb 21, 2019 | Seal |

*Insert EXACT legal name of the applicant

IMMC Beds Discontinuation pg-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);
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| | |
|---|---|
| SIGNATURE | SIGNATURE |
| Susan Nordstrom-Lopez<br>PRINTED NAME | William Santulli<br>PRINTED NAME |
| President<br>Advocate Illinois Masonic Medical Center<br>PRINTED TITLE | Chief Operating Officer<br>PRINTED TITLE |
| Notarization:<br>Subscribed and sworn to before me<br>this _____ day of _____ | Notarization:<br>Subscribed and sworn to before me<br>this 12 day of December 2018 |
| Signature of Notary | Signature of Notary |
| Seal | Seal |

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

*Insert EXACT legal name of the applicant

IMMC Peds Discontinuation page 12

## CERTIFICATION

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

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JA Skogsbergh
SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

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

Cristin G. Foster
Signature of Notary

Seal

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

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

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*Insert EXACT legal name of the applicant

IMMC Beds Discontinuation page 13

Page 14 has intentionally been left blank.

## CERTIFICATION

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PRINTED NAME

President and CEO
PRINTED TITLE

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PRINTED TITLE

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My Commission Expires Mar 4, 2019

*Insert EXACT legal name of the applicant

IMMC Peds Discontinuation page 15

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SIGNATURE

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PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
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Cristin G Foster
Signature of Notary

Seal

OFFICIAL SEAL
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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

Cristin G Foster
Signature of Notary

Seal

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

IMMC Pets Discontinuation page 14

## 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 |
|---|---|---|
| 1 | Applicant Identification including Certificate of Good Standing | 23-34 |
| 2 | Site Ownership | 35-36 |
| 3 | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | 37-41 |
| 4 | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc. | 42-45 |
| 5 | Discontinuation General Information Requirements | 46-47 |
| 6 | Reasons for Discontinuation | 48 |
| 7 | Impact on Access | 49-60 |
| 8 | Background of the Applicant | 61-65- |
| 9 | Safety Net Impact Statement | 66-67 |
| 10 | Charity Care Information | 68-69 |

## 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.**

See Attachment #1, Exhibits 1, 2, 3, and 4.

*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.

***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 .

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

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

***File Number*** 5237-115-5

## *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 NORTH SIDE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

***In Testimony Whereof,*** *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1833001900 verifiable until 11/26/2019
Authenticate at: http://www.cyberdrivellinois.com

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 160.16

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 |

4835-2888-4084.2

7155 8517

**Directors:**

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



4835-2888-4084.2

## Site Ownership

[Provide this information for each applicable site]

| | |
|---|---|
| Exact Legal Name of Site Owner: | **Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center** |
| **Address of Site Owner:** | **936 W. Wellington Avenue, Chicago, IL 60657-5147** |
| Street Address or Legal Description of the Site: **836 W. Wellington Avenue, Chicago, IL 60657-5147** **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 North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center
Discontinuation of Pediatric Category of Service

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center owns the 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



IMNC Peds Discontinuation pg 36

## Operating Identity/Licensee

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

| | |
|---|---|
| Exact Legal Name: | **Advocate North Side Health Network – d/b/a Advocate Illinois Masonic Medical Center** |
| Address: | **836 W. Wellington Avenue, Chicago, IL 60657-5147** |

| | | | | |
|---|---|---|---|---|
| ☒ | 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, Advocate North Side Health Network - d/b/a Advocate Illinois Masonic Medical Center, Advocate Health Care Network and Advocate Aurora Health, Inc. are appended as Attachment #3, Exhibits 1, 2, 3, and 4.

*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.

*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 .

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

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 #: 1812701536 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

***File Number*** 5237-115-5

## *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 NORTH SIDE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1833001900 verifiable until 11/26/2019
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* 26TH *day of* NOVEMBER *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 |

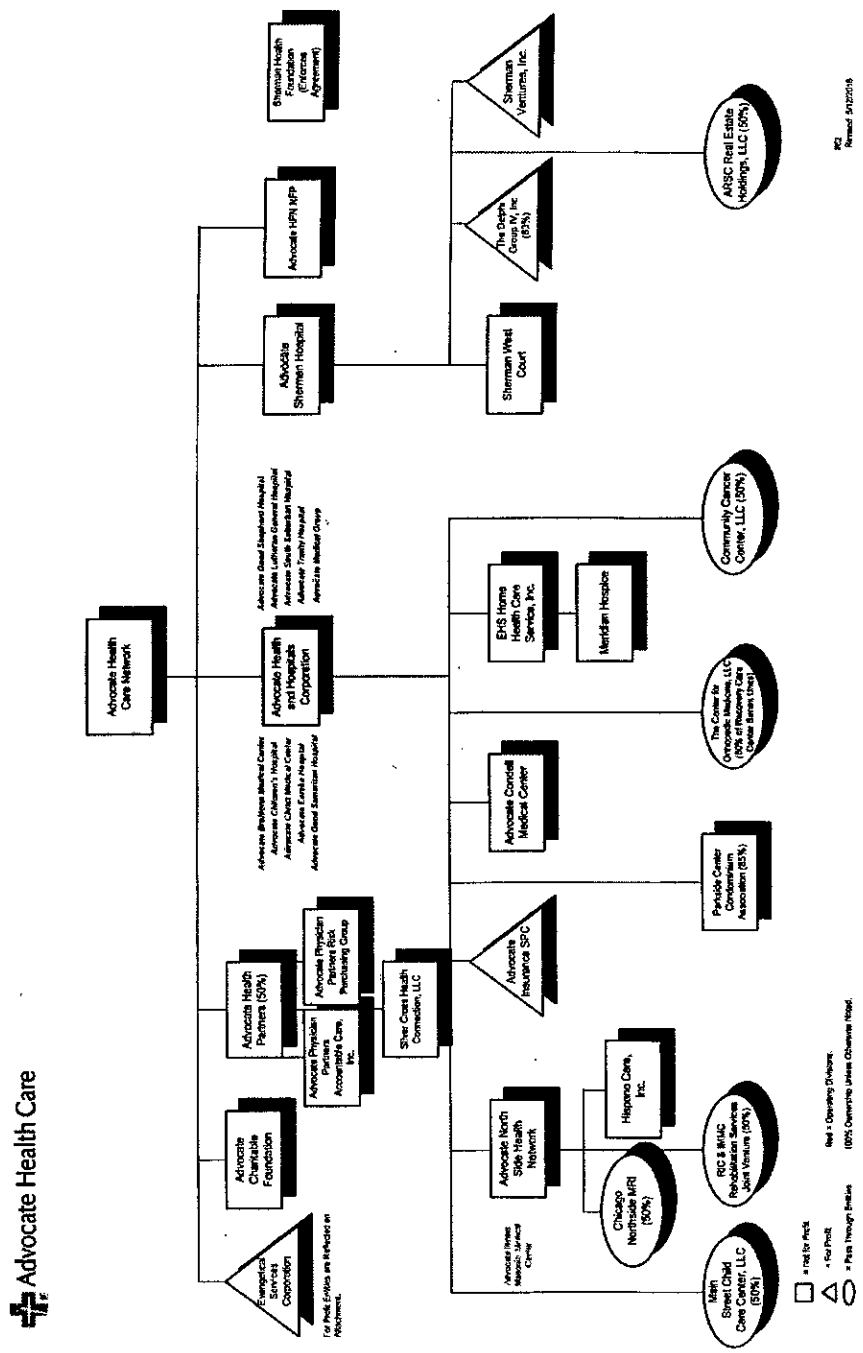
**Registered Agent Information**

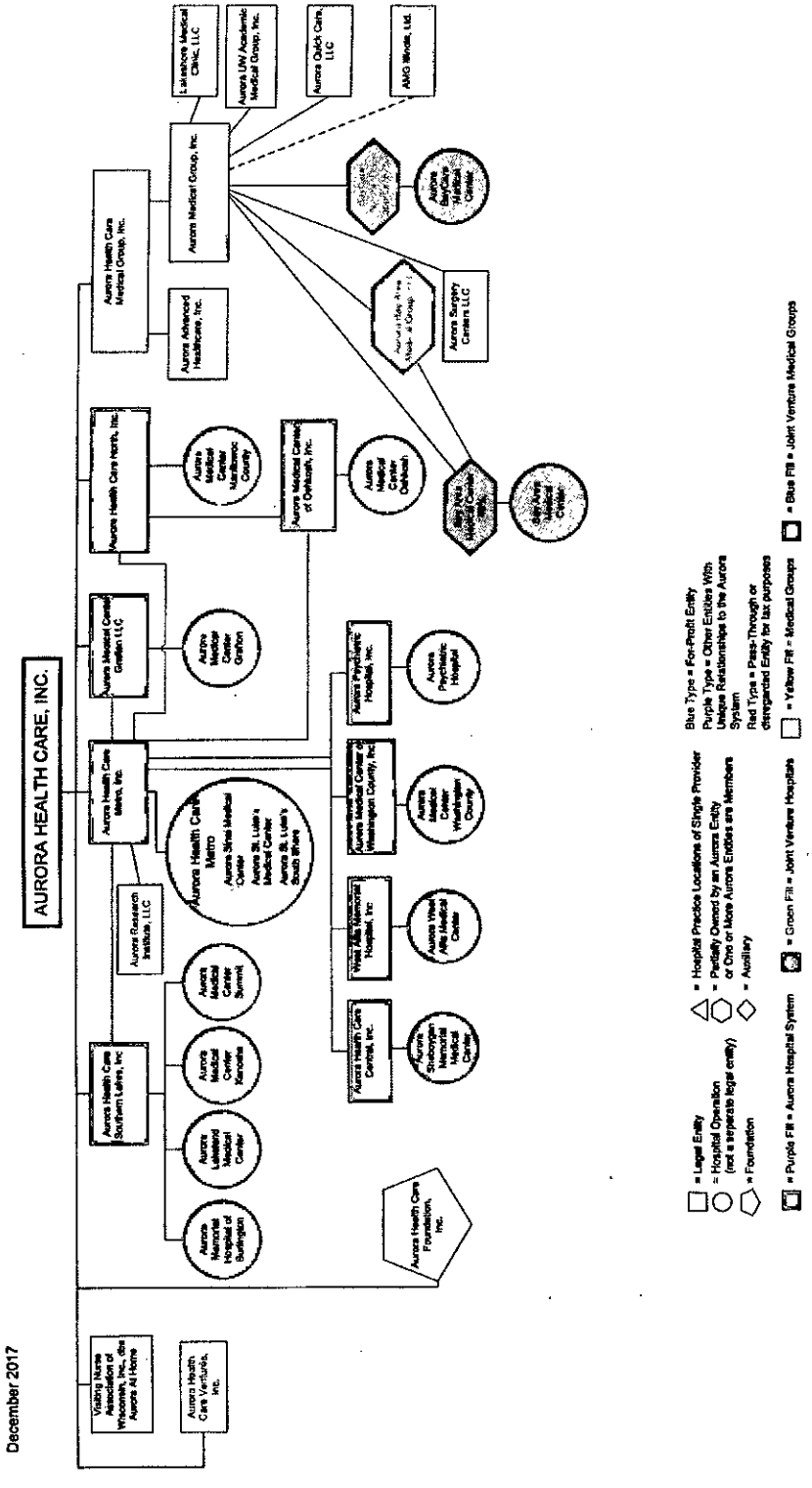
| | | | |
|---|---|---|---|
| Name: | THE CORPORATION TRUST COMPANY | | |
| Address: | CORPORATION TRUST CENTER 1209 ORANGE ST | | |
| City: | WILMINGTON | Country: | |
| State: | DE | Postal Code: | 19801 |
| Phone: | 302-658-7581 | | |

## Organizational Relationships

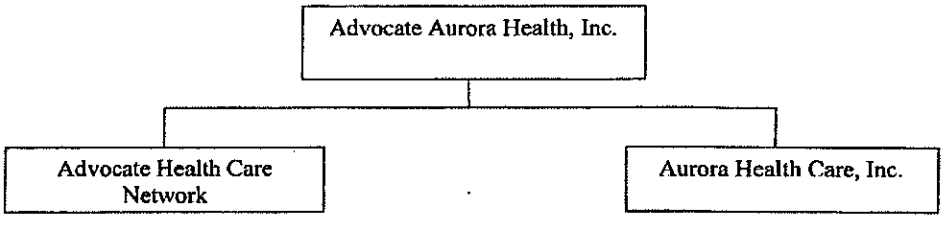
| |
|---|
| Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount 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
Advocate Health Care Network
Advocate Health and Hospitals Corporation
Advocate Health Partners (50%)
Advocate Physician Partners Accountable Care, Inc.
Advocate Physician Partners Risk Purchasing Group
Silver Cross Health Connection, LLC
Advocate Charitable Foundation
Evangelical Services Corporation
Advocate Insurance SPC
Advocate North Side Health Network
Hispano Care, Inc.
Chicago Northside MRI (50%)
RIC & MAC Rehabilitation Services Joint Venture (50%)
Main Street Child Care Center, LLC (50%)
Advocate Condell Medical Center
Pontiac Center Condominium Association (85%)
BHS Home Health Care Service, Inc.
Meridian Hospice
Community Cancer Center, LLC (50%)
The Center for Advanced Pain Medicine, LLC (50% of Rockford Pain Center Assets Only)
Advocate Sherman Hospital
Sherman West Court
The Depre Group IV, Inc (83%)
Sherman Ventures, Inc.
ARSC Real Estate Holdings, LLC (50%)
Sherman Health Foundation (Enforce Agreement)
Advocate HPN NFP
= Not for Profit
= For Profit
= Pass Through Entities
Red = Operating Divisions
(50% Ownership Unless Otherwise Noted)


AURORA HEALTH CARE, INC.
December 2017
Aurora Health Care Foundation, Inc.
Aurora Health Care Ventures, Inc.
Visiting Nurse Association of Wisconsin, Inc., dba Aurora At Home
Aurora Health Care Medical Group, Inc.
Aurora Health Care Metro, Inc.
Aurora Health Care Southern Lakes, Inc.
Aurora Health Care North, Inc.
Aurora Medical Center Grafton LLC
Aurora Medical Center of Oshkosh, Inc.
Aurora Research Institute, LLC
Aurora Advanced Healthcare, Inc.
Aurora Medical Group, Inc.
Lakeshore Medical Clinic, LLC
Aurora UW Academic Medical Group, Inc.
Aurora Quick Care, LLC
AMG Illinois, Ltd.
Aurora Surgery Centers LLC
Aurora Health Care Central, Inc.
Aurora Psychiatric Hospital, Inc.
Aurora Psychiatric Hospital
Aurora Medical Center Washington County, Inc.
Aurora Medical Center Washington County
West Allis Memorial Hospital, Inc.
Aurora West Allis Medical Center
Aurora Memorial Hospital of Burlington
Aurora Medical Center Summit
Aurora Medical Center Kenosha
Aurora Medical Center
Aurora Medical Center Grafton
Aurora Medical Center Oshkosh
Aurora Sinai Medical Center
Aurora St. Luke's Medical Center
Aurora St. Luke's South Shore
Aurora Health Care Metro
Aurora Sheboygan Memorial Medical Center
= 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 Relationships 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.

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.**

1. The Pediatric category of service with 14 beds is 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 available for 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 Chicago Sun-Times.

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
Discontinue Authorized Bed

ADORDERNUMBER: 0001074803-01
PO NUMBER: Discontinue Authorized Be
AMOUNT: 312.00
NO OF AFFIDAVITS: 1

Advocate Illinois Masonic Medical Center, 836 West Wellington Avenue, Chicago, IL 60657 intends to discontinue the authorized bed category of service for its fourteen (14) 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 application to the HFSRB to be considered by March 5, 2019. A copy of the application will be posted on the HFSRB website at http://www.illinois.gov/sites/hfsrb/Projects/Pages/CompApps.aspx. For additional information, contact Barb Perino, (708) 684 4507. 11/20, 11/27, 11/28/18 #1074803

# Chicago Sun-Times
# Certificate of Publication

State of Illinois - County of Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisements in the following secular newspapers. All newspapers meet Illinois Compiled Statute requirements for publication of Notices per Chapter 715 ILCS 5/0.01 et seq. R.S. 1874, P728 Sec 1, EFF. July 1, 1874. Amended by Laws 1959, P1494, EFF. July 17, 1959. Formerly Ill. Rev. Stat. 1991, CH100, PI.
Note: Notice appeared in the following checked positions.
PUBLICATION DATE(S): 11/20/2018, 11/27/2018, 11/28/2018

Chicago Sun-Times

IN WITNESS WHEREOF, the undersigned, being duly authorized, has caused this Certificate to be signed

by

Mary Lou Davis
Account Manager - Public Legal Notices

This 28th Day of November 2018 A.D.

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
836 W WELLINGTON AVE
CHICAGO, IL 60657

**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.**

The Applicant's main reason is the low occupancy of the 14-bed 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 | 106 | 13.8 |
| 2016 | 143 | 16.2 |
| 2015 | 200 | 16.3 |
| 2014 | 185 | 17.5 |

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 closing. They are as follows:

| HOSPITAL NAME | STREET | CITY |
|---|---|---|
| Advocate Lutheran General Hospital | 1775 Dempster St. | Park Ridge |
| Ann & Robert Lurie Children's Hospital of Chicago | 225 E. Chicago Ave. | Chicago |
| Jackson Park Hospital & Medical Center | 7531 Stony Island Ave. | Chicago |
| John H. Stroger Hospital of Cook County | 1901 West Harrison St. | Chicago |
| LaRabida Children's Hospital | 6501 S. Promontory Drive | Chicago |
| Loyola University Medical Center/Foster G. McGaw | 2160 South 1st Avenue | Maywood |
| NorthShore Evanston Hospital | 2650 Ridge Avenue | Evanston |
| Presence Resurrection Medical Center | 7435 West Talcott Avenue | Chicago |
| Presence Saint Joseph Hospital | 2900 North Lake Shore Dr. | Chicago |
| Presence St. Mary's Hospital | 2233 West Division Street | Chicago |
| Rush University Medical Center | 1653 West Congress Parkway | Chicago |
| Shriner's Hospital for Children | 2211 North Oak Park Ave. | Chicago |
| St. Anthony Hospital | 2875 West 19th Street | Chicago |
| St. Bernard Hospital | 326 West 64th Street | Chicago |
| Swedish Covenant Hospital | 5145 N. California Avenue | Chicago |
| University of Chicago Medical Center | 5841 South Maryland | Chicago |
| University of Illinois Hospital | 1740 West Taylor St., Ste. 1400, M/C 693 | Chicago |
| West Suburban Medical Center | 3 Erie Court | Oak Park |

Source: IHFSRB

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

Advocate Christ Medical Center and Advocate Lutheran General Hospital have extensive pediatric specialty services where patients from across the country routinely come for care. In addition, one letter was received from the University of Chicago Medical Center indicating it has the capacity to accommodate the pediatric patients that would have come to Advocate Illinois Masonic Medical Center.

Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773 975.1600 || advocatehealth.com

November 21, 2018

Via Certified Mail

Office of the President / Administration
Advocate Lutheran General Hospital
1775 Dempster St.
Park Ridge, Illinois 60068-1143

Subject: Request for Impact Statement

Dear Administrator:

This letter is to inform you that Advocate Illinois Masonic Medical Center is seeking a Certificate of Exemption from the Illinois Health Facilities and Services Review Board to discontinue its Pediatric category of service with its 14 pediatric beds. The date of discontinuance is April 26, 2019.

In 2016, Advocate Illinois Masonic Medical Center had 143 pediatric patients admitted. In 2017, the hospital admitted 106 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 Illinois Masonic Medical Center's market area.

Thank you for your consideration of this request.

Sincerely,

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
Presence Saint Joseph Hospital
2900 North Lake Shore Dr.
Chicago, IL 60657-6275

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature: X — ☐ Agent ☐ Addressee

B. Received by (Printed Name) — 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
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6640

PS Form 3811, July 2013 Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
University of Illinois Hospital
740 W Taylor St. Ste. 1400 M/C 693
Chicago, IL 60612-7236

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature: X — ☐ Agent ☐ Addressee

B. Received by (Printed Name) — 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
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6725

PS Form 3811, July 2013 Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
Presence St. Mary's Hospital
2233 West Division Street
Chicago, IL 60622-3087

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature: X — ☒ Agent ☐ Addressee

B. Received by (Printed Name) — 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
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6657

PS Form 3811, July 2013 Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
Advocate Lutheran General Hospital
1775 Dempster St.
Park Ridge, IL 60068-1143

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature: X — ☐ Agent ☐ Addressee

B. Received by (Printed Name) — 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
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6565

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

**ENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

ffice of the President/Administration

niversity of Chicago Medical Center
5841 South Maryland
Chicago, IL 60637-1470

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 11/27/18

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

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express®
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6718

S Form 3811, July 2013 Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration

West Suburban Medical Center
3 Erie Court
Oak Park, IL 60302-2599

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
X [signature] ☐ 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
☒ Certified Mail® ☐ Priority Mail Express®
☐ Registered ☒ Return Receipt for M
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6732

PS Form 3811, July 2013 Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

ffice of the President/Administration

Jackson Park Hospital & Medical Center
7531 Stoney Island Ave.
Chicago, IL 60649-3393

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
[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

7531 Stoney Island Ave.

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6589

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration

Rush University Medical Center
1653 West Congress Parkway
Chicago, IL 60612-3864

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
[signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) 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
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Number (Transfer from service label) 7014 1200 0000 1985 6664

11, February 2004 Domestic Return Receipt 102595-02-M-15

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:
Office of the President/Administration
Ann & Robert Lurie Children's Hospital of Chicago
225 E. Chicago, IL 60611-2991

**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
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6578

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:
Office of the President/Administration
Shriner's Hospital for Children
2211 North Oak Park Ave.
Chicago, IL 60707-3392

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Deliver
[illegible] 2018

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No
60707-USPS

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6671

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-15

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:
Office of the President/Administration
Presence Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631-3707

**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
29 2018

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6633

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:
Office of the President/Administration
John H. Stroger Hospital of Cook County
1901 West Harrison St.
Chicago, IL 60612

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

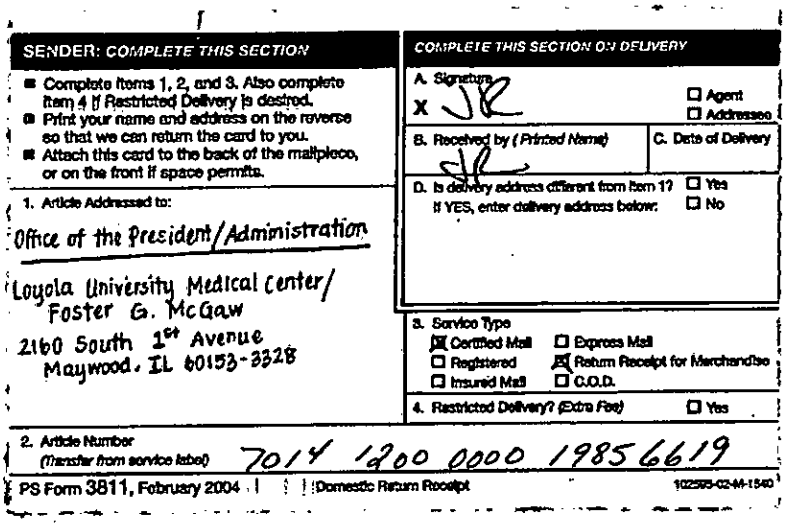
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6596

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154



SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Office of the President/Administration
Loyola University Medical Center/
Foster G. McGaw
2160 South 1st Avenue
Maywood, IL 60153-3328

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X JR
☐ Agent
☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7014 1200 0000 1985 6619

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL™

7014 1200 0000 1985 6626

7014 1200 0000 1985 6626

**CERTIFIED MAIL™ RECEIPT**
*(Domestic Mail Only; No Insurance Coverage Provided)*

For delivery information visit our website at www.usps.com®

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

Postmark Here

Sent To President's Office/Administration
NorthShore Evanston Hospital
Street, Apt. No.; or PO Box No. 2650 Ridge Avenue
City, State, ZIP+4
Evanston, IL 60201

PS Form 3800, August 2006 — See Reverse for Instructions

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
NorthShore Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature
X ☐ Agent ☐ Addressee

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

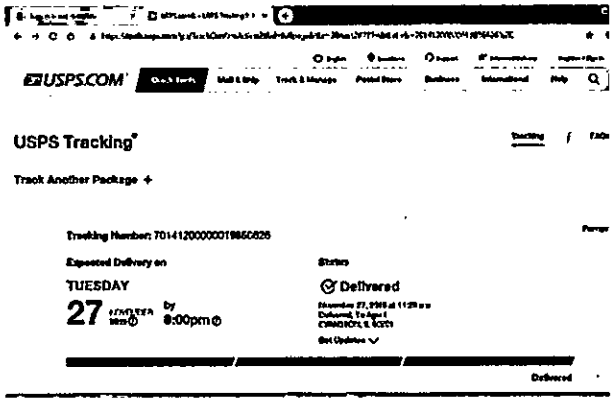
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label)

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



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Sent to President's Office/Administration
St. Anthony Hospital
Street, Apt. No., or PO Box No. 2875 West 19th Street
City, State, ZIP+4 Chicago, IL 60623-3501

PS Form 3800, August 2006 See Reverse for Instructions

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Office of the President/Administration
St. Anthony Hospital
2875 West 19th Street
Chicago, IL 60623-3501

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A. Signature
X ☐ Agent ☐ Addressee

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

D. Is delivery address different from item 1? ☐ Yes
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3. Service Type
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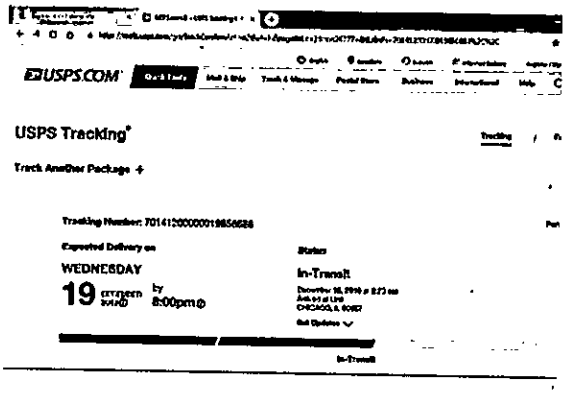

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Sent To President's Office/Administration
St. Bernard Hospital
Street, Apt. No.; or PO Box No. 326 West 64th Street
City, State, ZIP+4 Chicago, IL 60621-3196

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

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1. Article Addressed to:

Office of the President/Administration
St. Bernard Hospital
326 West 64th Street
Chicago, IL 60621-3196

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

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☐ Certified Mail® ☐ Priority Mail Express™
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4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label)

PS Form 3811, July 2013 Domestic Return Receipt

USPS.COM

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Tracking Number: 70141200000019856695

Expected Delivery on
MONDAY
26 by 8:00pm

Status
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7014 1200 0000 1985 6701

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Sent To President's Office /Administration
Swedish Covenant Hospital
Street, Apt. No.; or PO Box No. 6145 N. California Avenue
City, State, ZIP+4 Chicago, IL 60625-3642

PS Form 3800, August 2006

SENDER: COMPLETE THIS SECTION

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1. Article Addressed to:

Office of the President/Administration
Swedish Covenant Hospital
5145 N. California Avenue
Chicago, IL 60625-3642

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
☐ Certified Mail® ☐ Priority Mail Express™
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☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label)

PS Form 3811, July 2013 Domestic Return Receipt

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Tracking Number: 70141200000019856701

Expected Delivery on
MONDAY
26 NOVEMBER 2018 by 8:00pm

Status
Delivered

CERTIFIED MAIL

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

Postmark Here

Sent To President's Office/Administration
LaRabida Children's Hospital
Street, Apt. No.; or PO Box No. 6501 S. Promontory Drive
City, State, ZIP+4 Chicago, IL 60649-1003

PS Form 3800, August 2006 See Reverse for Instructions

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

Office of the President/Administration
LaRabida Children's Hospital
6501 S. Promontory Drive
Chicago, IL 60649-1003

**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
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label)

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

USPS.COM

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Track Another Package +

Tracking Number: 70141200000019856602

Expected Delivery on
TUESDAY
27 NOVEMBER 2018 by 8:00pm

Status
Delivered
November 27, 2018 at 9:21 am
Delivered, Individual Picked Up at Postal Facility
CHICAGO, IL 60649

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AT THE FOREFRONT
UChicago Medicine

Sharon O'Keefe
*President*

MC 1000, S-115
5841 South Maryland Avenue
Chicago, Illinois 60637-1470
*phone* (773) 702-8908
*fax* (773) 702-1897



November 29, 2018

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center
836 West Wellington Avenue
Chicago, IL 60657

Re: Proposed Discontinuation of Pediatric Inpatient Service at Advocate Illinois Masonic Medical Center

Dear Ms. Lopez:

Thank you for your letter dated November 21, 2018, informing us of Advocate Illinois Masonic Medical Center's) ("Illinois Masonic") intention to file a Certificate of Exemption to discontinue its Pediatric Inpatient Service. You indicated that Illinois Masonic admitted approximately 143 pediatric patients in 2016 and 106 pediatric patients in 2017.

Please accept this letter as timely confirmation that the University of Chicago Medical Center's Comer Children's Hospital ("Comer") has the capacity to accommodate all of Illinois Masonic's experienced case load. We can provide services to residents of Illinois Masonic's service area without restriction or limitation consistent with our other inpatient admissions. Comer also has the capability to provide inpatient services for both general and specialty pediatric patients and maintains its designation as a Level I Pediatric Trauma Center.

Sincerely,

The University of Chicago Medical Center

Sharon O'Keefe
President

cc: Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

AT THE FOREFRONT OF MEDICINE®

## 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 North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center. 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, Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center, or 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, Advocate North Side Health Network, d/b/a Advocate Illinois Masonic Medical Center, 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 exemptions filed by Advocate Health Network in 2018.

| Facility | Location | License No. | DNV Accreditation No. |
|---|---|---|---|
| Advocate Northside Health Network – d/b/a Illinois Masonic Medical Center | 836 W. Wellington Chicago, IL | 0005165 | 192082-2015-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 Samaritan Hospital | 3815 Highland Ave. Downers Grove, IL | 0003384 | 176404-2018-AHC-USA-NIAHO |
| Advocate Good Shepherd Hospital | 450 W. Highway, #22 Barrington, IL | 0003475 | 261250-2018-AHC-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-AHC-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.

# Illinois Department of PUBLIC HEALTH

HF116734

## LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

| EXPIRATION DATE | CATEGORY | I.D. NUMBER |
|---|---|---|
| 11/4/2019 | | 0005165 |

**General Hospital**

Effective: 11/05/2018

Advocate Northside Health Network
dba Illinois Masonic Medical Center Campus
836 W Wellington Avenue

Chicago, IL 60657

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: |
|---|---|---|
| 192082-2015-AHC-USA-NIAHO | 12/15/2015 | 12/15/2018 |

This is to certify that:

## Advocate Illinois Masonic Medical Center

836 West Wellington Avenue, Chicago, IL 60657

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 | 187 | 141 | 226 |
| Outpatient | 3,401 | 3,430 | 1,320 |
| **Total** | 3,588 | 3,571 | 1,546 |
| **Charity (cost In dollars)** | | | |
| Inpatient | $4,634,000 | $3,194,000 | $4,624,000 |
| Outpatient | $3,388,000 | $2,453,000 | $2,623,000 |
| **Total** | $8,022,000 | $5,647,000 | $7,247,000 |
| **MEDICAID** | | | |
| **Medicaid (# of patients)** | **2015** | **2016** | **2017** |
| Inpatient | 4,230 | 4,061 | 3,330 |
| Outpatient | 40,509 | 37,679 | 37,061 |
| **Total** | 44,739 | 41,740 | 40,391 |
| **Medicaid (revenue)** | | | |
| Inpatient | $50,299,837 | $44,242,454 | $34,605,594 |
| Outpatient | $16,850,125 | $11,354,922 | $11,611,164 |
| **Total** | $67,149,962 | $55,597,376 | $46,216,758 |

Source: Hospital Profile

Other community services provided by Advocate Illinois Masonic Medical Center in 2017 that are relevant to safety net services include the following:

| | **Advocate IMMC** |
|---|---|
| Language Assistant Services | $ 1,239,796 |
| | |
| Donations | $ 684,159 |
| | |
| Volunteer Services | $ 751,303 |
| | |
| Education | $ 26,153,193 |
| | |
| Government -sponsored program services | $ 51,673 |
| | |
| Subsidized health services | $ 2,802,822 |

Source: State 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.**

| Advocate Illinois Masonic Medical Center CHARITY CARE | | | |
|---|---|---|---|
| | **2015** | **2016** | **2017** |
| **Net Patient Revenue** | $417,997,172 | $436,677,329 | $450,137,813 |
| Amount of Charity Care (charges) | $ 37,115,490 | $ 26,187,580 | $ 31,932,425 |
| Cost of Charity Care | $ 8,022,000 | $ 5,647,000 | $ 7,247,000 |

Source: Hospital Profile