E-070-18

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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

ORIGINAL

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago
Street Address:	2900 North Lake Shore Drive
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area VI Health Planning Area: A-01

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

Exact Legal Name:	Presence Chicago Hospitals Network d/b/a Presence Saint Joseph Hospital-Chicago
Street Address:	200 S. Wacker Drive, 11th Floor
City and Zip Code:	Chicago, IL 60606
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Mark A. Frey
CEO Street Address:	2601 Navistar Drive
CEO City and Zip Code:	Lisle, IL 60532
CEO Telephone Number:	224/273-4121

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago
Street Address:	2900 North Lake Shore Drive
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area VI Health Planning Area: A-01

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

Exact Legal Name:	Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health
Street Address:	2601 Navistar Drive Lisle
City and Zip Code:	IL 60532
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Mark A. Frey
CEO Street Address:	2601 Navistar Drive
CEO City and Zip Code:	Lisle, IL 60532
CEO Telephone Number:	224/273-4121

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago
Street Address:	2900 North Lake Shore Drive
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area VI Health Planning Area: A-01

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

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

Type of Ownership of Applicants

X Non-profit Corporation ☐ 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.

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

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:	Peg Wendell, Esq.
Title:	Executive Vice President, Chief Legal Officer
Company Name:	AMITA Health
Address:	2601 Navistar Drive Lisle, IL 60532
Telephone Number:	224/273-2333
E-mail Address:	peg.wendell@amitahealth.org
Fax Number:	224/273-4121

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Presence Chicago Hospitals Network
Address of Site Owner:	200 South Wacker Drive, 11th Fl. Chicago, IL 60606

Street Address or Legal Description of the Site: 2900 North Lake Shore Drive Chicago, IL 60657

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: Presence Chicago Hospitals Network d/b/a Presence saint Joseph Hospital-Chicago

Address: 2900 North Lake Shore Drive Chicago, IL 60657

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which 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.

The proposed project is limited to the discontinuation of the open heart surgery category of service ("the service") at Presence Saint Joseph Hospital-Chicago, within thirty days following approval of this Certificate of exemption application.

The service was suspended via a letter dated November 6, 2018, and sent to the Administrator of the Illinois Health Facilities and Services Review Board and the Division Chief of IDPH's Division of Health Care Facilities and Programs.

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:

X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
XAll reports regarding outstanding permits
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 representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of **Presence Chicago Hospitals Network d/b/a Saint Joseph Hospital-Chicago** *

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

Julie P. Roknich
SIGNATURE

Julie P. Roknich
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of Dec, 2018

Elizabeth D Neary
Signature of Notary

Seal

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

Bettina Johnson
SIGNATURE

Bettina Johnson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of Dec 2018

Elizabeth D Neary
Signature of Notary

Seal

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Mark A. Finn
PRINTED NAME

President/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of Dec, 2018

Elizabeth D Neary
Signature of Notary

Seal

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

SIGNATURE

PAUL E BERK
PRINTED NAME

EVP/CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of Dec, 2018

Elizabeth D Neary
Signature of Notary

Seal

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

Christ K. McCoy
SIGNATURE

Christine K. McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of December

Signature of Notary

Seal

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

Signature

Rhonda Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11 day of DECEMBER

Signature of Notary

Seal

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

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

☐	Discontinuation of an Existing Health Care Facility
X	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.

File Number 3128-198-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, 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* 5TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1830901492 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

17

File Number 6964-462-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1831202022 verifiable until 11/08/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6783-860-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1830901614 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

Presence
Saint Joseph Hospital

James L. Robinson III, PsyD.
President

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site of Presence Saint Joseph Hospital-Chicago, that being 2900 North Lake Shore Drive, is owned by Presence Chicago Hospitals Network.

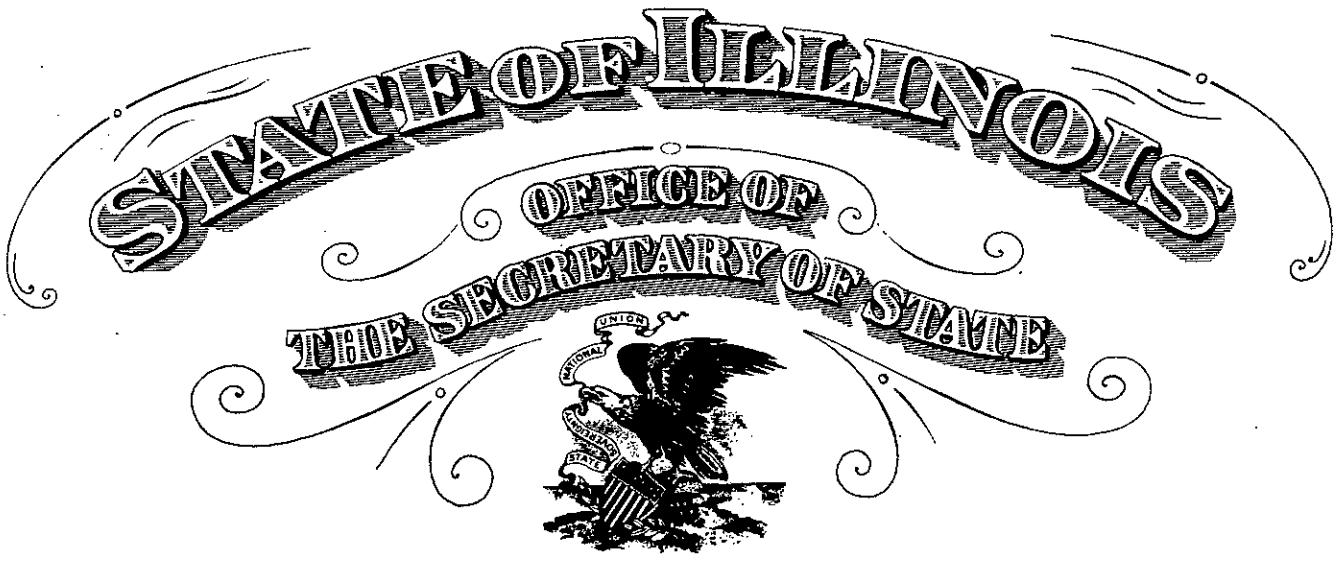
Sincerely,

James L. Robinson III, PsyD
President

Notarized:

GERALDINE ESCAMILLA
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 11, 2019

File Number 3128-198-9



To all to whom these Presents Shall Come, Greeting:

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, 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.

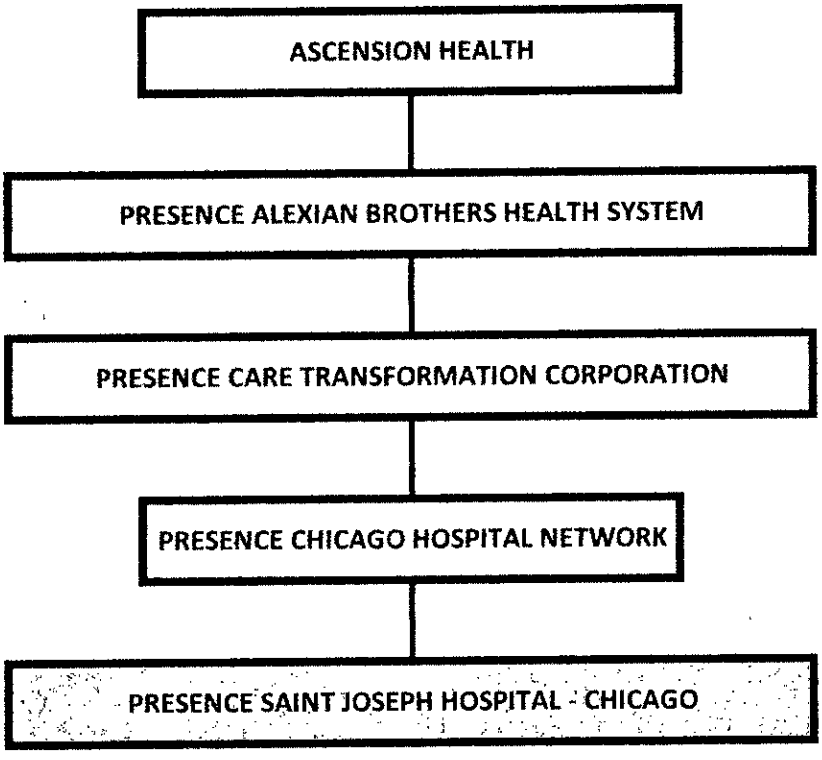
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* NOVEMBER *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

Authentication #: 1830901492 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 3



ATTACHMENT 4

DISCONTINUATION

1. Only the hospital's open heart surgery category of service is proposed to be discontinued through this Certificate of Exemption ("COE") application. No beds will be discontinued through this COE application.

2. No non-category of service clinical services are proposed to be discontinued as a result of the approval of this COE application.

3. The open heart surgery category of service will be discontinued within thirty days following the approval of the COE application addressing the discontinuation.

4. Presence Saint Joseph Hospital-Chicago designates one of its operating rooms for cardiovascular procedures. Following discontinuation, that OR will be used as a "general" OR, to be used by a number of specialties. A minimal amount of the hospital's equipment is used exclusively in conjunction with its open heart surgery program, and as appropriate, that equipment will be distributed to other AMITA Health hospitals.

5. Medical records will be retained by the hospital, consistent with all licensure and accreditation standards and requirements.

6. Not applicable, applies only to the discontinuation of an entire facility.

7. With the signatures on the Certification pages of this COE application, the applicants attest that notice of the category of service was published in the *Chicago Sun Times* on November 15, 2018. As of the filing of this COE application, the applicants are not aware of any responses to that notice. A copy of the notice is attached.

ATTACHMENT 5

AMITA HEALTH PRESENCE HEALTH
Presence St Joseph Hosp

ADORDERNUMBER: 0001074006-01
PO NUMBER: Presence St Joseph Hosp
AMOUNT: 168.00
NO OF AFFIDAVITS: 1

LEGAL NOTICE

Presence Saint Joseph Hospital-Chicago intends to cease the operations of its open heart surgery program following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur before March 31, 2019. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by December 15, 2018; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hfsrb.illinois.gov.
11/15/18 #1074006

Chicago Sun-Times
Certificate of Publication

State of Illinois - County of Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisments in the following secular newspapers. All newspapers meet Illinois Compiled Statue 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, Pl.
Note: Notice appeared in the following checked positions.

PUBLICATION DATE(S): 11/15/2018

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 15th Day of November 2018 A.D.

AMITA HEALTH PRESENCE HEALTH
200 S WACKER DR
ATTN: OLGA SOLARES
CHICAGO, IL 60606

ATTACHMENT 5

REASONS FOR DISCONTINUATION

The primary reason for proposing the discontinuation of the hospital's open heart surgery program is low utilization. During both 2016 and 2017, only 46 cases were performed each year. And, with the advent of less-invasive procedures, volumes cannot reasonably be anticipated to increase.

ATTACHMENT 6

November 14, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

name
title
hospital
street address
city/state/ZIP code

RE: Proposed Discontinuation of Open Heart Surgery
Category of Service

Dear :

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

Presence Saint Joseph Hospital has suspended its open heart surgery category of service, and anticipates the formal discontinuation of that service to occur within thirty days following the Illinois Health Facilities and Services Review Board's ("IHFSRB's") approval of the hospital's Certificate of Exemption application to discontinue the category of service. That application will be filed prior to the end of this month.

During the 24-month period ending September 30, 2018, a total of 101 patients received open heart surgery at the hospital.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing open heart surgery services to residents from our service area. Any impact statement received will be forwarded to the IHFSRB. If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

James L. Robinson III, PsyD
President

ATTACHMENT 7

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:

Robert Barish, MD, MBA, Interim CEO
University of Illinois Hospital & Health Sciences System
1740 West Taylor Street, Ste. 1400, M/C 693
Chicago, Illinois 60625-3642

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Address

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

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5333

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

Robert Dahl, President and CEO
Presence Resurrection Medical Center
7435 West Talcott
Chicago, Illinois 60631-3707

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Address

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5265

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Richard Helm, President
Advocate Christ Medical Center
4440 West 95th Street
Oak Lawn, Illinois 60453-2699

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☑ Agent ☐ Address

B. Received by (Printed Name) JOHN CHRISTIE C. Date of Deliv 11-19-18

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5111

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

John Baird · hief Executive Officer
MetroSou· · Medical Center
12935 South Gregory Street
Blue Island, Illinois. 60406-2428

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5227

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

M.E. Cleary, Chief Executive Officer
MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, Illinois. 60402-0715

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

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

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

2

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5203

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:

Pamela Dunley, MBA, MS, RN, CENP
President & CEO
Elmhurst Hospital
155 East Brush Hill Road
Elmhurst, Illinois 60126

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addres

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

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5166

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

ATTACHMENT 7

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:

Michael Murrill, Chief Executive Officer
AMITA Health Adventist Medical Center
La Grange
5101 South Willow Springs Road
La Grange, Illinois 60525-2600

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Address

B. Received by (Printed Name) Donald Cox C. Date of Delive 11/20/18

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

11763C

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5159

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

Steven Province, Chief Executive Officer
AMITA Health Adventist Medical Center
Hinsdale
120 North Oak Street
Hinsdale, Illinois 60521-3829

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Address

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

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

NOV 20 2018

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5135

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Larry Goluberg, Chief Executive Officer
Loyola University Medical Center
2160 South First Avenue
Maywood, Illinois. 60153-3328

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) 7017 2680 0000 6944 5173

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:

Douglas Silverstein, President
Northshore University HealthSystem
Evanston Hospital
2650 Ridge Avenue
Evanston, Illinois 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) 7017 2680 0000 6944 5241

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

ATTACHMENT 7

ER: COMPLETE THIS SECTION

omplete items 1, 2, and 3. Also complete
m 4 if Restricted Delivery is desired.
rint 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:

Sharon O'Keefe, President
UChicago Medicine
5841 South Maryland, M/C 1000
Chicago, Illinois 60637-1470

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X (Ellen Pundy) ☐ Agent ☐ Address

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7017 2680 0000 6944 5319

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ER: COMPLETE THIS SECTION

mplete items 1, 2, and 3. Also complete
m 4 if Restricted Delivery is desired.
rint 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:

Anthony Guaccio, President & CEO
Swedish Covenant Hospital
5145 North California Avenue
Chicago, Illinois 60625-3642

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

B. Received by (Printed Name) C. Date of Delive 11/19

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7017 2680 0000 6944 5302

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Mary Shehan, DNP, RN, NEA-BC, Interim CEO
Weiss Memorial Hospital
4646 North Marine Drive
Chicago, Illinois 60640-5759

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X G. Floyd ☐ Agent ☐ Address

B. Received by (Printed Name) G. Floyd C. Date of Delive 9-21-

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label) 7017 2680 0000 6944 5326

Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

John Shannon, MD, CEO
John H. Stroger, Jr. Hospital of Cook County, CCHHS
1901 West Harrison Street
Chicago, Illinois 60612

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

B. Received by (Printed Name) C. Date of Delive 9/21

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5197

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Larry Goldberg, Chief Executive Officer
Gottlieb Memorial Hospital
701 West North Avenue
Melrose Park, Illinois 60160-1612

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Rocko ☐ Agent ☐ Address

B. Received by (Printed Name) Rocko C. Date of Deliv 11/20/18

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 Merchan
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5180

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

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:

Kenneth Jones, President
Presence Saint Frances Hospital
355 Ridge Avenue
Evanston, Illinois. 60202-3399

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X B. Hunter ☐ Agent ☐ Address

B. Received by (Printed Name) B. Hunter C. Date of Delive 11/20/18

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5272

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Patrick Magoon, President & CEO
Ann & Robert H. Lurie Children's
Hospital of Chicago
225 East Chicago Avenue
Chicago, Illinois 60611-2991

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

Article Number
(Transfer from service label) 7017 2680 0000 6944 5142

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

ATTACHMENT 7

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:

Loren [illegible]dler, President
Mount Sinai Hospital Medical Center
California Avenue at 15th Street
Chicago, Illinois 60608-1797

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Address

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

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

1 2018

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5234

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

Larry Goodman, Chief Executive Officer
Rush University Medical Center
1653 West Congress Parkway
Chicago, Illinois 60612-33864

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addres

B. Received by (Printed Name) C. Date of Delive
7/25

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 Merchandi
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5289

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

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:

Julie Creamer, MS, RN, President
Northwestern Memorial Hospital
251 Huron Street
Chicago, Illinois 60611

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5258

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

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:

Susan Nordstrom Lopez, President
Advocate Illinois Masonic Medical Center
836 W. Wellington Avenue
Chicago, Illinois 60657

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☑ Agent ☐ Addressee

B. Received by (Printed Name) CHICAGO 606 C. Date of Delive 11/19/18

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

NOV 19 2018

USPS

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5128

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

ATTACHMENT 7

BACKGROUND

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

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

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

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

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

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

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

AMITA Health Alexian Brothers Behavioral Health Hospital
Hoffman Estates, IL

Presence Holy Family Medical Center
Des Plaines, IL

Presence Resurrection Medical Center
Chicago, IL IDPH #6031

Presence Saint Francis Hospital
Evanston, IL IDPH #5991

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

Presence Mercy Medical Center
Aurora, IL IDPH #4903

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

Presence Saint Joseph Medical Center
Joliet, IL IDPH #4838

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

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

Presence Saint Elizabeth Hospital
Chicago, IL IDPH #6007

Presence Lakeshore Gastroenterology
Des Plaines, IL

Belmont/Harlem Surgery Center
Chicago, IL IDPH #700313

*per HFSRB definition

ATTACHMENT 8

AMITA HEALTH

Mark A. Frey
President & Chief Executive Officer

AMITA Health System Office
2601 Navistar Dr.
Lisle, IL 60532

224.273.2347
mark.frey@amitahealth.org

AMITAhealth.org

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

Dear Ms. Avery:

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

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

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

Sincerely,

Mark A. Frey
President and
Chief Executive Officer

Date: November 8, 2018

Notarized:

OFFICIAL SEAL
MELISSA KULIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/13/22

Melissa Kulik
11-8-18

ATTACHMENT 8

SAFETY NET IMPACT STATEMENT

Presence Saint Joseph Hospital-Chicago has a long history of being a safety net provider, both in terms of services provided directly at or by the hospital, as well as its role in the community. The proposed discontinuation of open heart surgery services will have no impact on that commitment, nor will it have any impact on any other providers of safety net services.

ATTACHMENT 9

Adventist Hinsdale Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	75	73	146
Outpatient	513	421	1,610
Total	588	494	1,756

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	909,758	941,159	513,833
Outpatient	822,738	770,058	561,760
Total	1,732,496	1,711,217	1,075,593

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,365	1,204	1,404
Outpatient	44,634	25,405	30,905
Total	45,999	26,609	32,309

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	27,417,603	14,175,204	13,190,650
Outpatient	7,843,260	10,385,734	9,624,655
Total	35,260,863	24,560,938	22,815,305

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	283,527,840	301,668,355	311,985,334
Amount of Charity (charges)	6,828,478	6,248,091	3,968,482
Cost of Charity Care	1,732,496	1,711,217	1,075,593

Adventist La Grange Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	81	82	89
Outpatient	422	388	1,160
Total	503	470	1,249

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	639,886	643,676	664,624
Outpatient	1,244,364	940,188	942,448
Total	1,884,250	1,583,864	1,607,072

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	824	741	885
Outpatient	12,578	12,005	16,073
Total	13,402	12,746	16,958

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	9,456,596	9,643,426	6,888,007
Outpatient	4,306,103	4,122,811	6,323,812
Total	13,762,699	13,766,237	13,211,819

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	159,802,351	160,571,704	158,971,897
Amount of Charity (charges)	7,637,693	6,375,572	6,565,635
Cost of Charity Care	1,884,250	1,583,864	1,607,072

Adventist Bolingbrook Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	105	111	176
Outpatient	798	853	2,329
Total	903	964	2,505

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	737,726	640,020	564,434
Outpatient	1,506,569	1,126,392	1,000,180
Total	2,244,295	1,766,412	1,564,614

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,437	1,439	1,503
Outpatient	23,443	27,265	29,138
Total	24,880	28,704	30,641

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	6,521,510	6,632,741	8,884,199
Outpatient	9,527,298	9,361,396	9,271,291
Total	16,048,808	15,994,137	18,155,490

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	119,827,083	121,154,941	129,089,238
Amount of Charity (charges)	9,756,066	7,309,134	6,689,129
Cost of Charity Care	2,244,295	1,766,412	1,564,614

ATTACHMENTS 9 & 10

Adventist Glen Oaks Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	112	110	102
Outpatient	715	803	1,328
Total	827	913	1,430

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	765,891	675,725	718,114
Outpatient	1,592,189	1,362,203	1,099,263
Total	2,358,080	2,037,928	1,817,377

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	2,286	1,981	2,085
Outpatient	14,631	17,301	17,632
Total	16,917	19,282	19,717

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	18,178,083	16,324,722	11,839,293
Outpatient	16,087,927	14,249,071	8,911,320
Total	34,266,010	30,573,793	20,750,613

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	83,016,363	80,487,930	85,268,778
Amount of Charity (charges)	7,743,127	6,613,992	6,157,479
Cost of Charity Care	2,358,080	2,037,928	1,817,377

Alexian Brothers Behavioral Health Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	690	414	687
Outpatient	405	209	428
Total	1,095	623	1,115

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	418,356	461,258	543,631
Outpatient	296,690	185,059	200,688
Total	715,046	646,317	744,319

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	329	416	322
Outpatient	3,423	818	40,847
Total	3,752	1,234	41,169

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	649,000	707,674	723,609
Outpatient	1,679,000	1,831,801	1,872,017
Total	2,328,000	2,539,475	2,595,626

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	74,048,702	76,916,399	78,615,801
Amount of Charity (charges)	1,993,961	2,098,548	1,919,198
Cost of Charity Care	715,046	646,317	744,319

ATTACHMENTS 9 & 10

Alexian Brothers Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	311	125	399
Outpatient	3,008	1,477	2,232
Total	3,319	1,602	2,631

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	2,307,325	2,756,581	2,331,830
Outpatient	2,349,008	2,409,470	2,134,299
Total	4,656,333	5,166,051	4,466,129

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,074	3,806	2,410
Outpatient	41,044	49,428	45,946
Total	42,118	53,234	48,356

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	13,668,000	24,917,316	14,688,808
Outpatient	8,288,000	14,100,420	12,104,570
Total	21,956,000	39,017,736	26,793,378

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	449,261,000	457,943,000	472,013,000
Amount of Charity (charges)	23,820,931	26,603,784	23,058,353
Cost of Charity Care	4,656,333	5,166,051	4,461,129

St. Alexius Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	586	111	352
Outpatient	5,110	2,322	1,568
Total	7,659	7,136	6,105

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	2,214,865	2,574,992	1,876,626
Outpatient	3,053,373	2,994,694	2,201,842
Total	5,268,239	5,569,686	4,078,468

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	3,190	5,233	3,870
Outpatient	40,829	57,423	56,410
Total	50,178	51,762	51,803

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	24,916,000	24,335,000	26,698,588
Outpatient	15,813,000	18,494,000	19,870,057
Total	40,729,000	42,829,000	46,568,645

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	345,017,000	353,092,000	353,952,000
Amount of Charity (charges)	27,143,649	30,717,841	21,730,913
Cost of Charity Care	5,268,239	5,569,686	4,078,468

Presence St. Mary's Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	683	1,016	25
Outpatient	3,404	5,061	1,099
Total	4,087	6,077	1,124

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,178,589	1,143,754	263,568
Outpatient	2,058,972	1,063,567	647,661
Total	3,237,561	2,207,321	911,229

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,170	1,195	1,363
Outpatient	44,038	34,629	20,489
Total	45,208	35,824	21,852

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	17,053,694	9,251,698	8,946,439
Outpatient	30,980,047	8,603,075	10,260,434
Total	48,033,741	17,854,773	19,206,873

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	109,622,889	120,646,101	121,698,113
Amount of Charity (charges)	17,119,961	13,900,377	15,606,551
Cost of Charity Care	3,237,561	2,207,321	911,229

Presence St. Joseph Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	148	3,053	2,104
Outpatient	2,067	10,612	7,314
Total	2,215	13,665	9,418

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,223,021	4,528,712	3,763,727
Outpatient	2,127,121	2,780,350	4,085,625
Total	3,350,142	7,309,062	7,849,352

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	4,418	4,151	4,014
Outpatient	48,591	106,220	96,420
Total	53,009	110,371	100,434

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	22,317,603	20,626,384	21,495,441
Outpatient	12,872,225	12,663,326	31,224,865
Total	35,189,828	33,289,710	52,720,306

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	349,215,843	386,006,011	374,114,333
Amount of Charity (charges)	41,754,548	42,334,283	45,193,272
Cost of Charity Care	3,350,142	7,309,062	7,849,352

Presence St. Joseph Hospital-Elgin

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	683	1,199	63
Outpatient	2,857	5,017	1,323
Total	3,540	6,216	1,386

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,659,661	2,150,613	678,071
Outpatient	2,522,152	1,239,628	1,919,060
Total	4,181,813	3,390,241	2,597,131

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	915	846	1,165
Outpatient	22,401	28,782	33,195
Total	23,316	29,628	34,360

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	11,609,548	8,499,358	9,376,281
Outpatient	19,114,352	4,899,091	5,259,631
Total	30,723,900	13,398,449	14,635,912

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	132,597,966	148,323,931	143,143,526
Amount of Charity (charges)	21,617,399	20,728,074	23,593,393
Cost of Charity Care	4,181,813	3,390,241	2,597,131

Presence Mercy Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,204	1,988	147
Outpatient	4,078	6,732	2,077
Total	5,282	8,720	2,224

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	2,293,444	2,853,889	1,240,933
Outpatient	3,128,539	3,166,129	2,125,573
Total	5,421,983	6,050,491	3,366,506

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	2,273	1,826	2,477
Outpatient	55,196	45,825	64,057
Total	57,469	47,651	66,534

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	16,138,639	13,345,368	14,378,748
Outpatient	41,136,666	14,805,466	17,501,748
Total	57,275,305	28,150,834	31,880,496

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	173,471,950	185,662,250	191,487,648
Amount of Charity (charges)	29,885,457	36,903,020	38,791,796
Cost of Charity Care	5,421,983	6,050,491	3,366,506

Presence Resurrection Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	765	768	66
Outpatient	3,845	6,081	890
Total	4,610	6,849	956

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	2,563,124	1,173,755	686,843
Outpatient	1,929,857	2,189,381	825,415
Total	4,492,981	3,363,136	1,512,258

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	601	387	378
Outpatient	13,200	6,737	21,852
Total	13,801	7,124	22,230

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	(2,406,200)	6,232,260	67,975,604
Outpatient	3,702,310	3,629,433	37,801,109
Total	1,296,110	9,861,693	105,776,713

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	257,729,252	264,576,914	270,126,791
Amount of Charity (charges)	22,922,240	18,571,646	15,804,220
Cost of Charity Care	4,492,981	3,363,136	1,512,258

ATTACHMENTS 9 & 10

Presence Holy Family Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	30	133	5
Outpatient	1,369	552	52
Total	1,399	685	57

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	316,123	350,291	555,325
Outpatient	144,232	82,536	49,475
Total	460,355	432,827	604,800

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	123	45	52
Outpatient	304	815	4,371
Total	427	860	4,423

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	(2,347,748)	5,554,348	27,387,711
Outpatient	627,226	1,033,372	4,330,314
Total	(1,720,522)	6,587,720	31,718,025

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	69,586,245	66,443,334	70,564,615
Amount of Charity (charges)	1,561,868	2,255,868	4,544,910
Cost of Charity Care	460,355	432,827	604,800

ATTACHMENTS 9 & 10

Presence St. Francis Hospital

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	611	628	71
Outpatient	3,898	6,885	1,212
Total	4,509	7,513	1,283

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,824,721	1,652,766	540,676
Outpatient	2,807,049	2,390,180	901,814
Total	4,631,770	4,042,946	1,442,490

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,068	621	630
Outpatient	13,374	7,080	19,965
Total	14,442	7,701	20,595

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	8,028,798	12,338,025	31,418,703
Outpatient	12,825,638	7,584,914	25,782,125
Total	20,854,436	19,922,939	57,200,828

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	164,750,924	167,195,901	174,967,222
Amount of Charity (charges)	21,880,375	22,691,367	18,229,097
Cost of Charity Care	4,631,770	4,042,946	1,442,490

ATTACHMENTS 9 & 10

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	794	723	42
Outpatient	2,531	4,445	452
Total	3,325	5,168	494

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,437,204	727,799	354,365
Outpatient	1,691,249	1,520,340	454,772
Total	3,128,453	2,248,139	809,137

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	786	464	427
Outpatient	6,397	3,000	10,536
Total	7,183	3,464	10,963

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	9,300,603	20,516,947	33,379,547
Outpatient	9,517,719	7,584,914	18,530,768
Total	18,818,322	28,101,861	51,910,315

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	203,357,193	207,300,397	218,077,373
Amount of Charity (charges)	10,750,603	9,569,562	4,321,924
Cost of Charity Care	3,128,453	2,248,139	809,137

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,213	985	173
Outpatient	6,969	12,243	2,531
Total	8,182	13,228	2,704

Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	4,380,283	2,542,044	1,389,711
Outpatient	4,421,583	4,423,868	1,951,885
Total	8,801,866	6,965,912	3,341,596

Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	3,639	1,918	1,926
Outpatient	27,255	12,046	73,984
Total	30,894	13,964	75,910

Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	40,340,734	47,951,568	45,807,382
Outpatient	45,164,598	24,498,704	24,334,912
Total	85,505,332	72,450,272	70,142,294

Section V

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	303,495,761	304,924,151	331,806,223
Amount of Charity (charges)	39,232,810	36,373,058	28,512,920
Cost of Charity Care	8,801,866	6,965,912	3,341,596

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

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Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

E-070-18

by FedEX

December 19, 2018

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

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Exemption ("COE") application addressing the discontinuation of the open heart surgery category of service at Presence saint Joseph Hospital-Chicago.

The application is accompanied by a check, in the amount of $2,500.00, as a filing fee.

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

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

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