

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

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

AUG 13 2019

Facility/Project Identification

Facility Name:	Presence Chicago Hospitals Network d/b/a AMITA Health Saint Francis Hospital Evanston		
Street Address:	355 Ridge Avenue		
City and Zip Code:	Evanston IL 60202		
County:	Cook	Health Service Area	VII Health Planning Area: A-08

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

Exact Legal Name	Presence Chicago Hospitals Network d/b/a AMITA Health Saint Francis Hospital-Evanston		
Street Address:	200 S. Wacker Drive, 11 th 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

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

☐ 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:	

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DISCONTINUATION APPLICATION FOR EXEMPTION**

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Facility/Project Identification

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City and Zip Code:	Evanston IL 60202		
County:	Cook	Health Service Area	VI I Health Planning Area: A-08

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

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
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Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msri.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

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Street Address:	355 Ridge Avenue		
City and Zip Code:	Evanston IL 60202		
County:	Cook	Health Service Area	VII Health Planning Area: A-08

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:	Joseph R. Impiccicchio
CEO Street Address:	4600 Edmunson Road
CEO City and Zip Code:	St. Louis, MO 63134
CEO Telephone Number:	314/733-8000

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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:	Kenneth Preston Jones
Title:	CEO
Company Name:	AMITA Health Saint Francis Hospital Evanston
Address:	355 Ridge Avenue Evanston, IL 60202
Telephone Number:	847/316-4000
E-mail Address:	Kenneth.Jones@amitahealth.org
Fax Number:	

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, 11 th Fl. Chicago, IL 60606
Street Address or Legal Description of the Site:	355 Ridge Avenue Evanston, IL 60202
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/Licensees

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

Exact Legal Name:	Presence Chicago Hospitals Network d/b/a AMITA Health Saint Francis Hospital Evanston		
Address:	200 South Wacker Drive, 11 th Fl. Chicago, IL 60606		
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership		
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental		
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other	
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensees 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 18-bed obstetrics category of service and associated support areas ("the service") at AMITA Health Saint Francis Hospital Evanston, within thirty days following approval of this Certificate of Exemption application.

While deliveries will no longer occur at the hospital following the formal discontinuation, the OB/gyn service is not closing. Outpatient OB/gyn care, including prenatal care, will continue to be provided, as will subspecialty gynecological programs, including oncology, urogynecology and gynecologic surgery. In addition, the hospital will continue to support an outpatient OB residency program, with residents' inpatient rotations taking place at AMITA Health Resurrection Medical Center Chicago.

Inpatient gynecologic services will continue to be provided, with those patients occupying medical/surgical beds.

A full range of obstetrics services are available at a number of area hospitals, including The Family Birthplace at AMITA Health Saint Joseph Hospital Chicago (which includes a Level III neonatal intensive care unit) and The Family Birthplace AMITA Health Resurrection Medical Center Chicago.

This is a "substantive" project, because it addresses the discontinuation of a HFSRB-designated 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 ☒ 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): October 31, 2019

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

X All 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 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

Secretary
PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 6 day of August 2019
Melissa Kulik

Signature of Notary

Seal



Notarization:

Subscribed and sworn to before me
this ____ day of _____

Signature of Notary

Seal

PA

CERTIFICATION

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- ❑ 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 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.

Pat Eddy
SIGNATURE

Patricia Eddy
PRINTED NAME

Sister VP Financial Planning Reporting
PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 8 day of August, 2019

Nancy R. Wilson-Lister
Signature of Notary

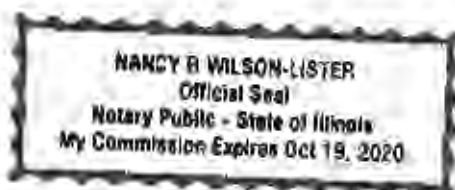
Seal

Notarization:

Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal



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- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Alexian Brothers-AHS Midwest Region Health Co. dba 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.

Mark A. Frey
SIGNATURE

Mark Frey
PRINTED NAME

President & CEO
PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of August, 2019

Nancy R. Wilson-Lister
Signature of Notary

Seal

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

Signature of Notary

Seal



CERTIFICATION

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This Application is filed on the behalf of **Alexian Brothers-AHS Midwest Region Health Co. dba 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.

Eddie Soter
SIGNATURE

Eddie Soter
PRINTED NAME

VVP of Finance / CFO multistate Division
PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7 day of August, 2019

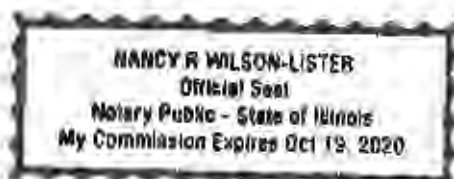
Nancy R Wilson-Lister
Signature of Notary

Seal

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

Signature of Notary

Seal



CERTIFICATION

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- 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.

Christine K. McCoy
SIGNATURE

Christine K. McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

SIGNATURE

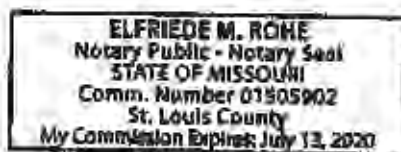
Rhonda C. Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5th day of August, 2019

Elfriede M. Rohe
Signature of Notary

Seal



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

Signature of Notary

Seal

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- in the case of a sole proprietor, the individual that is the proprietor.

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

[Signature]
SIGNATURE

Rhonda C. Anderson
PRINTED NAME

Sr VA Finance
PRINTED TITLE

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12 day of October 2019

[Signature]
Signature of Notary

Seal

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

Signature of Notary

Seal



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 3980/5.4]**:

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 98-0031			
CHARITY CARE			
Charity (# of patients)	2016	2017	2018*
Inpatient	528	71	184
Outpatient	8,885	1,212	1,833
Total	7,513	1,283	1,817
Charity (cost in dollars)			
Inpatient	1,852,766	540,876	912,745
Outpatient	2,380,180	801,814	1,068,894
Total	4,042,846	1,442,490	1,982,739
MEDICAID			
Medicaid (# of patients)	2016	2017	2018*
Inpatient	621	530	960
Outpatient	7,080	19,865	7,814
Total	7,701	20,595	8,774
Medicaid (revenue)			
Inpatient	12,338,025	31,418,703	16,870,955
Outpatient	7,584,814	25,782,125	3,290,891
Total	19,922,939	57,200,828	20,161,846

*six months

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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			
	2016	2017	2018
Net Patient Revenue	167,195,901	174,967,222	162,236,422
Amount of Charity Care (charges)	22,691,367	16,229,097	16,420,426
Cost of Charity Care	4,042,946	1,442,490	3,214,230

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

File Number

6783-860-2



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

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 .

Jesse White

SECRETARY OF STATE ATTACHMENT 1

Authentication #: 1830801614 verifiable until 11/05/2019

Authenticate at: <http://www.cyberdriveillinois.com>

File Number

6964-462-7



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

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 .



Authentication #: 1830801492 verifiable until 11/05/2019

Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE ATTACHMENT 1



March 11, 2019

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site of Presence Saint Francis Hospital, that being 355 Ridge Avenue in Evanston Illinois, is owned by Presence Chicago Hospitals Network.

Sincerely,

Kenneth Preston Jones
President

Notarized:

Notary Public - State of Illinois
My Commission Expires Sep 1, 2022



AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847.318.4000
ATTACHMENT 2
AMITAhealth.org

140

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 .

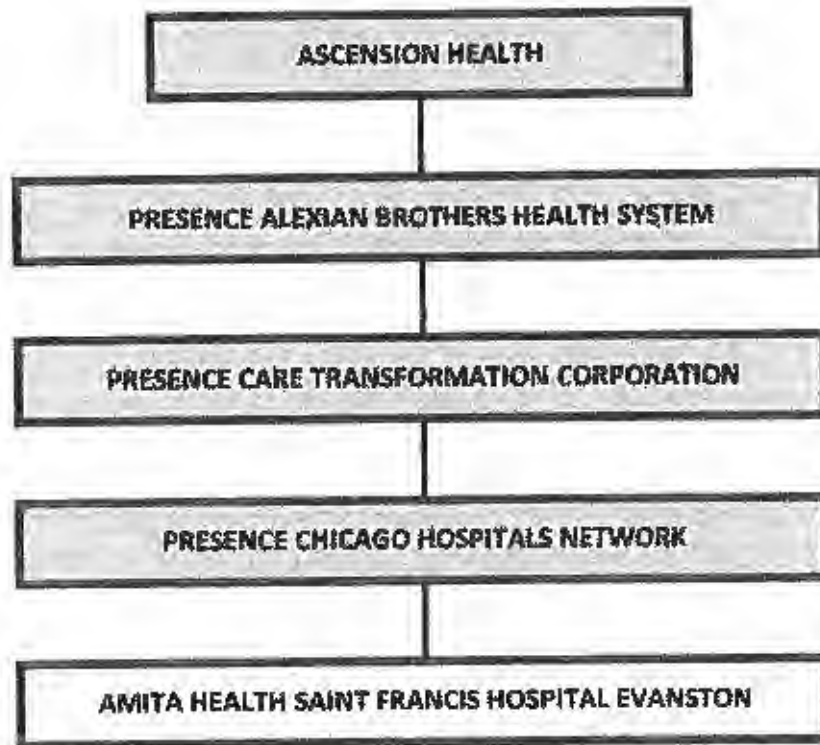


Authentication #: 1830901492 verifiable until 11/05/2019

Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE ATTACHMENT 3



DISCONTINUATION

1. This Certificate of Exemption (“COE”) application addresses the discontinuation of the applicant hospital’s obstetrics category of service, which includes 18 authorized beds. Outpatient obstetrics services as well as inpatient and outpatient gynecologic services will continue to be provided at the hospital.
2. The following clinical areas/services, each of which is associated with obstetrics care, will also be discontinued:
 - twelve labor-delivery-recovery-postpartum rooms (“LDRPs”)
 - two traditional semi-private postpartum rooms
 - two C-Section rooms
 - a Level I/II/II+ nursery
3. All of the clinical services identified in items 1 and 2, above, will be discontinued within 30 days following receipt of the request COE Permit. Discontinuation will occur via formal notification to the HFSRB, IDPH and the perinatal network.
4. The applicants intend to re-designate the twelve LDRPs and six traditional postpartum rooms as fifteen private Medical/Surgical rooms. The eighteen obstetrics beds are currently located in fifteen rooms, identified as: LD01-LD12, each of which is a private LDRP, PD-01 and PD-02, which are semi-private rooms and RR-01 and RR-02, both of which are private.

The future uses of the C-Section rooms and the nursery have not been determined, as of the filing of this COE application. Equipment will be used in other areas of the hospital, as applicable, sold, or discarded.

5. The medical records of past patients will be retained by the hospital, consistent with licensure and accreditation requirements, as well as contemporary medical records retention practices.
6. This COE application is limited to the discontinuation of a category of service.
7. The required legal notice was published in the Chicago Sun-Times on July 25, 2019. Proof of publication is attached.

AMITA HEALTH

LEGAL NOTICE AMITA Health Saint Francis Hospital-Evanston II

ADORDERNUMBER: 0001089945-01

PO NUMBER: St Francis Hosp/Evanston

AMOUNT: 188.00

NO OF AFFIDAVITS: 1

Chicago Sun-Times Certificate of Publication

State of Illinois - County of Cook

LEGAL NOTICE

AMITA Health Saint Francis Hospital-Evanston intends to cease the operations of its obstetrics 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 December 31, 2019. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by August 10, 2019, after which time additional information relating to its proposed discontinuation can be found on the IHFSRB website at hsr.ilinois.gov.
7/25/19 #1089945

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, PL.

Note: Notice appeared in the following checked positions:

PUBLICATION DATE(S): 07/25/2019

Chicago Sun-Times

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

by



Pamela D. Henson
Account Manager - Public Legal Notices

This 25th Day of July 2019 A.D.

AMITA HEALTH
2601 NAVISTAR DRIVE
ATTN: MARYELLEN LARSON
Lisle, IL 60532

ATTACHMENT 5

REASONS FOR DISCONTINUATION

The inpatient obstetrics category of service (beds) at AMITA Health Saint Francis Hospital Evanston is proposed to be discontinued primarily as the result of low utilization. During calendar 2018, the hospital's obstetrics average daily census was 4.05 patients, down from 4.88 patients the previous year. While, with the exception of emergency situations, deliveries will no longer be performed at the hospital, patient care will be enhanced because clinical studies have shown that hospitals that perform higher volumes of deliveries have better results and lower complication rates.

With eight other providers of obstetrical services within ten miles, including AMITA Health Resurrection Medical Center Chicago, AMITA Health Saint Joseph Hospital Chicago, and Evanston Hospital, the applicants do not believe that the proposed discontinuation will result in an unreasonable diminishment of accessibility to the service.

IMPACT ON ACCESS

The proposed discontinuation of obstetrical services at AMITA Health Saint Francis Hospital Evanston ("the hospital") will have minimal impact on access to that service for residents in the communities and neighborhoods surrounding the hospital, because of the volume of obstetrical programs in the area.

The following eight providers of obstetrical services are located within ten miles of the hospital:

- Highland Park Hospital, Highland Park
- Evanston Hospital, Evanston
- Lutheran General Hospital, Park Ridge
- Advocate Illinois Masonic Medical Center, Chicago
- Northwestern Memorial Hospital, Chicago
- AMITA Health Resurrection Medical Center, Chicago
- AMITA Health Saints Mary and Elizabeth Medical Center, Chicago
- Swedish Covenant Hospital, Chicago

Notifications of the proposed discontinuation and requests for impact statements have been sent to each of the hospitals listed above. Copies of any responses received will be forwarded to HFSRB Staff.

Attached are the letters used to notify the above-listed hospitals of the proposed discontinuation and request an impact statement, as well as proof of delivery.

ATTACHMENT 7



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

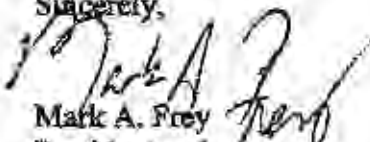
Dear Ms. Avery:

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.

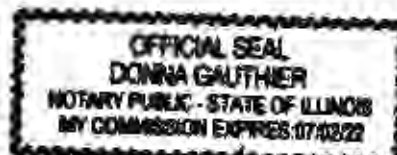
If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,


 Mark A. Frey
 President and
 Chief Executive Officer

Date: 4/3, 2019

Notarized:



Donna Gauthier 4-3-19

AMITA Health System Office
 2801 Navistar Dr.
 Lisle, IL 60532

CONFIDENTIAL

ATTACHMENT 8



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Doug Silverstein:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,


Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
365 Ridge Ave
Evanston, IL 60202

847.316.4600
ATTACHMENT 7

AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Terika Richardson:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,

A handwritten signature in black ink, appearing to read "K. Jones".

Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847.316.4000
ATTACHMENT 7
AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Susan Nordstrom Lopez:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,


Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847.316.4000
ATTACHMENT 7
AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Jose R. Sanchez:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,

A handwritten signature in black ink, appearing to read "K. Jones", written over the printed name.

Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847-315-4000

ATTACHMENT 7

AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Robert Dahl:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,

A handwritten signature in black ink, appearing to read "K. Jones", written over the printed name.

Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847-515-8000
ATTACHMENT 7

AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Martin Judd:


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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,232 obstetrical patients were admitted to the hospital's hospital, and 3,260 patient days of care were provided to those patients. 1,088 babies were born at HRMC during that period.

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 obstetrical 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,


Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

847.316.4000

ATTACHMENT 7

AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear John Baird:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

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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 obstetrical 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,


Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

ATTACHMENT 7

AMITAhealth.org



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: AMITA Health Saint Francis Hospital Evanston
Proposed Discontinuation of Obstetrics
Category of Service**

Dear Anthony Guaccio:

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.

AMITA Health Saint Francis Hospital Evanston ("AMITA Saint Francis") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB) to discontinue AMITA Saint Francis' 18-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

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Sincerely,


Kenneth Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave.
Evanston, IL 60202

343151669
ATTACHMENT 7

AMITAhealth.org

34



July 25, 2019

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Ms. Shannon Lightner
Deputy Director
Illinois Department of Public Health
Office of Women's Health and Family Services
525 West Jefferson
Springfield, IL 62761

RE: AMITA Health Saint Francis Hospital-Evanston
Proposed Discontinuation of Obstetrics
Category of Service

Dear Ms. Lightner:

Please be advised that AMITA Health Saint Francis Hospital-Evanston intends to file a Certificate of Exemption application with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of the hospital's obstetrics program. It is anticipated that the application will be filed next month, and be placed on the IHFSRB's October 22, 2019 agenda. Assuming approval on October 22nd, obstetrical admissions will cease before the end of the year.

Should you have any questions relating to these plans, please don't hesitate to contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "K. Jones", written over the printed name and title.

Kenneth Preston Jones
President

AMITA Health
Saint Francis Hospital
Evanston
355 Ridge Ave
Evanston, IL 60202

847.315.4000
ATTACHMENT 7

AMITAhealth.org

SENDER COMPLETES 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:

AMITA HEALTH RESURRECTION
MEDICAL CENTER
7435 W. TALCOTT AVE.
CHICAGO, IL 60631
ROBERT DAHL

2. Article Number

(Transfer from service label)

7009 0960 0000 1182 2830

PS Form 3811, February 2004

Domestic Return Receipt

108905-02-M-1040

RECEIVED BY ADDRESSEE

A. Signature

X

☐ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1?

If YES, enter delivery address below:

☐ Yes☐ No

3. Service Type

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

4. Restricted Delivery? (Extra Fee)

☐ Yes

SENDER COMPLETES 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:

AMITA HEALTH ST.
JOSEPH HOSPITAL-CHGO
2900 N. LAKE SHORE DR
CHICAGO, IL 60657
JOHN BAIRD

2. Article Number

(Transfer from service label)

7009 0960 0000 1182 2878

PS Form 3811, February 2004

Domestic Return Receipt

108905-02-M-1040

RECEIVED BY ADDRESSEE

A. Signature

X

☐ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1?

If YES, enter delivery address below:

☐ Yes☐ No

3. Service Type

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

4. Restricted Delivery? (Extra Fee)

☐ Yes

SENDER COMPLETES 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:

ADVOCATE ILLINOIS
MASONIC MEDICAL CENTER
836 W. WELLINGTON AVE
CHICAGO, IL 60657
SUSAN NORDSTROM LOPEZ

2. Article Number

(Transfer from service label)

7009 0960 0000 1182 2793

PS Form 3811, February 2004

Domestic Return Receipt

ATTACHMENT 7

RECEIVED BY ADDRESSEE

A. Signature

X

☐ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1?

If YES, enter delivery address below:

☐ Yes☐ No

3. Service Type

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

4. Restricted Delivery? (Extra Fee)

☐ Yes

<p>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</p> <p>Print your name and address on the reverse so that we can return the card to you.</p> <p>Attach this card to the back of the mailpiece, or on the front if space permits.</p>		<p>A. Signature X <i>Brian M. Hill</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
<p>1. Article Addressed to:</p> <p>ADVOCATE LUTHERN GENERAL HOSPITAL 1775 DEMPSTER ST. PARK RIDGE, IL 60068 TERIKA RICHARDSON</p>		<p>B. Received by (Printed Name) <i>Brian M. Hill</i></p>	<p>C. Date of Delivery 8/1</p>
<p>2. Article Number (Transfer from service label) 7009 0960 0000 1182 2786</p>		<p>D. Is delivery address different from item 1? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If YES, enter delivery address below:</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt (2004-02-01-1040)</p>		<p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	

<p>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</p> <p>Print your name and address on the reverse so that we can return the card to you.</p> <p>Attach this card to the back of the mailpiece, or on the front if space permits.</p>		<p>A. Signature X <i>John J. Judd</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
<p>1. Article Addressed to:</p> <p>AMITA HEALTH ST. MARY OF NAZARETH HOSPITAL 2233 W. DIVISION ST. CHICAGO, IL 60622 MARTIN JUDD</p>		<p>B. Received by (Printed Name) <i>Martin Judd</i></p>	<p>C. Date of Delivery 8/1/11</p>
<p>2. Article Number (Transfer from service label) 7009 0960 0000 1182 2861</p>		<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below:</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt (2004-02-01-1040)</p>		<p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	

<p>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</p> <p>Print your name and address on the reverse so that we can return the card to you.</p> <p>Attach this card to the back of the mailpiece, or on the front if space permits.</p>		<p>A. Signature X <i>Shannon Lightner</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
<p>1. Article Addressed to:</p> <p>ILLINOIS DEPT OF PUBLIC HEALTH - OFFICE OF WOMEN HEALTH & FAMILY SERVICES 535 W. JEFFERSON SPRINGFIELD, IL 62761 SHANNON LIGHTNER</p>		<p>B. Received by (Printed Name) <i>Shannon Lightner</i></p>	<p>C. Date of Delivery 8/2/11</p>
<p>2. Article Number (Transfer from service label) 7009 0960 0000 1182 2892</p>		<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below:</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt (2004-02-01-1040)</p>		<p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	

ATTACHMENT 7

SENDER: COMPLETE THIS SECTION		ADDRESSEE: COMPLETE THIS SECTION	
<p>■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</p> <p>■ Print your name and address on the reverse so that we can return this card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p>		<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p><i>Laura Weiss</i></p>	
<p>1. Article Addressed to:</p> <p>SWEDESH COVENANT HOSPITAL 6145 N. CALIFORNIA AVE CHICAGO, IL 60625 ANTHONY GUACCIO</p>		<p>B. Received by (Printed Name) C. Date of Delivery</p> <p>LAURA WEISS 8-1-19</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7009 0960 0000 1182 2885</p>		<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If YES, enter delivery address below</p>	
<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	

PS Form 3811, February 2004

Domestic Return Receipt

102896-02-00-10-00

ATTACHMENT 7

BACKGROUND

Applicant 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 Glen Oaks
Glendale Heights, IL IDPH #3814

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

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

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

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

AMITA Health Alexian Brothers Behavioral Health Hospital
Hoffman Estates, IL

AMITA Health Holy Family Medical Center Des Plaines
Des Plaines, IL

AMITA Health Resurrection Medical Center Chicago
Chicago, IL IDPH #6031

AMITA Health Saint Francis Hospital Evanston
Evanston, IL IDPH #5991

AMITA Health Saint Joseph Hospital Chicago
Chicago, IL IDPH #5983

ATTACHMENT 8

AMITA Health Mercy Medical Center Aurora
Aurora, IL IDPH #4903

AMITA Health Saint Joseph Hospital Elgin
Elgin, IL IDPH #4887

AMITA Health Saint Joseph Medical Center Joliet
Joliet, IL IDPH #4838

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

AMITA Health Saints Mary and Elizabeth Medical Center Chicago
Chicago, IL IDPH #6007

Lakeshore Gastroenterology
Des Plaines, IL

Belmont/Harlem Surgery Center
Chicago, IL IDPH #7003131

SAFETY NET STATEMENT

AMITA Health Saint Francis Hospital Evanston is and will continue to be a safety net provider, serving primarily Evanston and the northeastern neighborhoods of Chicago. Because of the nature of obstetrical services, the discontinuation of the service will have no substantial impact on the hospital's commitment to or provision of safety net services.

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

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