

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

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

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name:	AMITA Health Mercy Medical Center Aurora Modernization Project		
Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County:	Kane	Health Service Area:	VIII Health Planning Area: A-12

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

Exact Legal Name:	Presence Central and Suburban Hospitals Network
Street Address:	200 S. Wacker Drive, 11 <sup>th</sup> Floor
City and Zip Code:	Chicago, 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:	Dana Gilbert
CEO Street Address:	2601 Navistar Drive
CEO City and Zip Code:	Lisle, IL 60532
CEO Telephone Number:	224/273-3388

**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:	847/776-7004

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
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Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County:	Kane	Health Service Area:	VIII Health Planning Area: A-12

**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 Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Joseph R. Impicliche
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:	847/776-7004

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

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

**Post Permit Contact**

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

Name:	Julie Roknich
Title:	Vice President, Senior Associate General Counsel
Company Name:	AMITA Health
Address:	2601 Navistar Drive Building 2, 2 <sup>nd</sup> Floor Lisle, IL 60532
Telephone Number:	224/273-2320
E-mail Address:	Julie.Roknich@amitahealth.org
Fax Number:	

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Presence Central and Suburban Hospitals Network
Address of Site Owner:	2601 Navistar Drive Lisle, IL 60532
Street Address or Legal Description of the Site:	1325 North Highland Avenue Aurora, IL 60506
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 Central and Suburban Hospitals Network		
Address:	2601 Navistar Drive Lisle, IL 60532		
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership		
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental		
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/>	
Other			
<ul style="list-style-type: none"> <li>Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li> <li>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</li> </ul>			
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.

**Flood Plain Requirements**

[Refer to application instructions.]

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

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

**Historic Resources Preservation Act Requirements**

[Refer to application instructions.]

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

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

**DESCRIPTION OF PROJECT****1. Project Classification**

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☐ Substantive

☒ Non-substantive

## 2. Narrative Description

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

The focus of the proposed project is the replacement and reduction in the number of treatment stations provided through the hospital's Emergency Department ("ED"), the development of a Critical Stabilization Unit ("CSU"), and the development of a small (6-station) observation unit, to be located adjacent to the ED:

- the ED will be reduced from 26 stations to 20 stations, including designated trauma, isolation, behavioral health, and sexual abuse stations
- the observation unit will be used by stable ED patients awaiting lab work and/or disposition decisions
- the CSU will serve as a voluntary short-term (typically 5-7 hours) setting for non-acute individuals suffering from mental illness.

From a facility perspective, a two-story lobby atrium will be reconfigured to retain the lobby/public area on the lower level, and to house a portion of the re-designed ED on the upper level (the first floor of the hospital), adjacent to the existing ED. A portion of the existing ED will then be reconfigured to house the 6-station observation unit. The hospital's current outpatient cardiopulmonary rehabilitation department, located on the first floor of the hospital will be vacated, to house the CSU. Last, the outpatient cardiopulmonary rehabilitation department will be relocated to the first floor of the medical office building, located adjacent to the hospital. The project will be completed through three phases, to allow for the continued operation of the ED.

The project does not address any HFSRB-designated categories of service, nor will the areas addressed in the project serve inpatients; and as such, the project is designated as being non-substantive.

## PROJECT COST AND SOURCES OF FUNDS

	Reviewable	Non-Reviewable	Total
<b>Project Cost:</b>			
Preplanning Costs	\$ 250,525	\$ 24,475	\$ 275,000
Site Survey and Soil Investigation			
Site Preparation	\$ 77,435	\$ 7,565	\$ 85,000
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$ 9,066,060	\$ 1,902,510	\$ 10,968,570
Contingencies	\$ 398,790	\$ 88,920	\$ 487,710
Architectural/Engineering Fees	\$ 832,900	\$ 175,200	\$ 1,008,100
Consulting and Other Fees	\$ 1,047,650	\$ 102,350	\$ 1,150,000
Movable and Other Equipment (not in construction contracts)	\$ 6,007,250	\$ 225,000	\$ 6,232,250
Net Interest Expense During Construction Period			
Fair Market Value of Leased Space			
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized	\$ 950,000	\$ 2,095,000	\$ 3,045,000
Acquisition of Building or Other Property			
<b>TOTAL USES OF FUNDS</b>	<b>\$ 18,630,610</b>	<b>\$ 4,621,020</b>	<b>\$ 23,251,630</b>
<b>Sources of Funds:</b>			
Cash and Securities	\$ 18,630,610	\$ 4,621,020	\$ 23,251,630
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$ 18,630,610</b>	<b>\$ 4,621,020</b>	<b>\$ 23,251,630</b>

**Related Project Costs**

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

<p>Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Purchase Price: \$ _____</p> <p>Fair Market Value: \$ _____</p>
<p>The project involves the establishment of a new facility or a new category of service  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.</p> <p>Estimated start-up costs and operating deficit cost is \$ _____.</p>

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>
<p>Indicate the stage of the project's architectural drawings:</p> <p style="text-align: center;"> <input type="checkbox"/> None or not applicable <span style="margin-left: 100px;"><input type="checkbox"/> Preliminary</span>  <input checked="" type="checkbox"/> Schematics <span style="margin-left: 100px;"><input type="checkbox"/> Final Working</span> </p>
<p>Anticipated project completion date (refer to Part 1130.140): <u>November 30, 2023</u></p>
<p>Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):</p> <p><input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.</p> <p><input type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies</p> <p><input checked="" type="checkbox"/> Financial Commitment will occur after permit issuance.</p>
<p><b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>

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

Are the following submittals up to date as applicable:

- ☒ Cancer Registry
  - ☒ APORS
  - ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
  - ☒ All reports regarding outstanding permits
- Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.**

## Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							

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

**Facility Bed Capacity and Utilization**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed incomplete.

<b>FACILITY NAME:</b> Amita Health Mercy Medical Center-Aurora		<b>CITY:</b> Aurora			
<b>REPORTING PERIOD DATES:</b> From: January 1, 2019 to: December 31, 2019					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	149	4,095	17,455	None	149
Obstetrics	16	277	607	None	16
Pediatrics	16	75	153	None	16
Intensive Care	16	891	3,335	None	16
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	95	2,109	11,924	None	95
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
<b>TOTALS:</b>	292	7,447	33,474	None	292

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

Julie P. Roknich  
SIGNATURE  
Julie P. Roknich  
PRINTED NAME  
Secretary  
PRINTED TITLE

DANA GILBERT  
SIGNATURE  
DANA GILBERT  
PRINTED NAME  
PRESIDENT  
PRINTED TITLE

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

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

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

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

Seal

Seal

\*Insert the EXACT legal name of the applicant

**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.



SIGNATURE

Matthew A. Jagger

PRINTED NAME

Treasurer of Ascension

PRINTED TITLE

SIGNATURE

PRINTED NAME

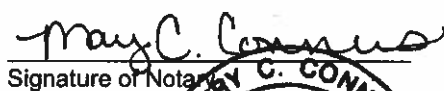
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 23 day of November 2020

Notarization:

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



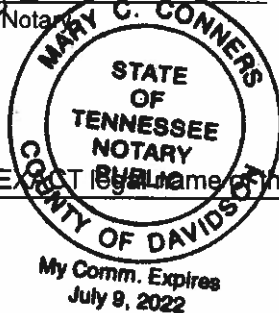
Signature of Notary

Signature of Notary

Seal

Seal

\*Insert the EXACT legal name of the applicant



**CERTIFICATION**

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 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

PRINTED NAME

PRINTED NAME

PRINTED TITLE

PRINTED TITLE

Notarization:

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

Notarization:

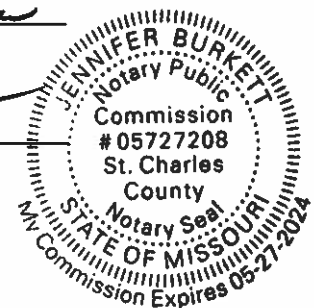
Subscribed and sworn to before me  
 this 24~~th~~ day of November

Signature of Notary

Signature of Notary

Seal

Seal



\*Insert the EXACT legal name of the applicant

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

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

#### 1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
  - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
  - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.
  - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
  - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
  - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. 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.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

**Criterion 1110.110(b) & (d)****PURPOSE OF PROJECT**

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

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

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

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

**ALTERNATIVES**

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

Alternative options must include:

- A) Proposing a project of greater or lesser scope and cost;
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

**SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE****Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
  - c. The project involves the conversion of existing space that results in excess square footage.
  - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

**Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.**

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

**APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**PROJECT SERVICES UTILIZATION:**

**This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.**

**Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110. Appendix B. A narrative of the rationale that supports the projections must be provided.**

**A table must be provided in the following format with Attachment 15.**

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

**APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**UNFINISHED OR SHELL SPACE:****none included in project**

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
  - a. Requirements of governmental or certification agencies; or
  - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
  - a. Historical utilization for the area for the latest five-year period for which data is available; and
  - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**ASSURANCES:**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

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

**M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service**

- Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:
- Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
<input type="checkbox"/> <b>Emergency Department</b>	<b>26</b>	<b>20</b>
<input type="checkbox"/> <b>General Radiology</b>	<b>4</b>	<b>3</b>
<input type="checkbox"/>		

- READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
<b>APPEND DOCUMENTATION AS <u>ATTACHMENT 30</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

## proof of bond rating provided as ATTACHMENT 33

### VI. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

<div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px;"></div>	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and</li> <li>2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;</li> </ol> <p>b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.</p> <p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p> <p>d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:</p> <ol style="list-style-type: none"> <li>1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;</li> <li>4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>
--	---

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	<b>TOTAL FUNDS AVAILABLE</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

**SECTION VII. 1120.130 - FINANCIAL VIABILITY**

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

**Financial Viability Waiver**

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

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

See Section 1120.130 Financial Waiver for information to be provided

**APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**proof of bond rating provided as ATTACHMENT 33**

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

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

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

**Variance**

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

**APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**SECTION VIII.1120.140 - ECONOMIC FEASIBILITY**

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

**A. Reasonableness of Financing Arrangements****proof of bond rating provided as ATTACHMENT 33**

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

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

**B. Conditions of Debt Financing****project does not involve debt financing**

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

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

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

Read the criterion and provide the following:

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

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

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

#### D. Projected Operating Costs

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

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

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

**APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**SECTION IX. SAFETY NET IMPACT STATEMENT**

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

**not applicable, non-substantive project**

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 37.**

### Amita Health Mercy Medical Center-Aurora

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2017	2018	2019
Inpatient	147	337	321
Outpatient	2077	4213	3586
<b>Total</b>	<b>2224</b>	<b>4550</b>	<b>3907</b>
Charity (cost in dollars)			
Inpatient	\$1,240,933	\$2,746,750	\$2,374,479
Outpatient	\$2,125,573	\$4,135,515	\$3,142,198
<b>Total</b>	<b>\$3,366,506</b>	<b>\$6,882,265</b>	<b>\$5,516,677</b>
MEDICAID			
Medicaid (# of patients)	2017	2018	2019
Inpatient	2477	2521	2313
Outpatient	64057	27141	24430
<b>Total</b>	<b>66534</b>	<b>29662</b>	<b>26743</b>
Medicaid (revenue)			
Inpatient	\$14,378,748	\$19,754,988	\$36,385,707
Outpatient	\$17,501,748	\$5,701,175	\$41,356,844
<b>Total</b>	<b>\$31,880,496</b>	<b>\$25,456,163</b>	<b>\$77,742,551</b>

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**SECTION X. CHARITY CARE INFORMATION**

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

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

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

A table in the following format must be provided for all facilities as part of Attachment 39.

**Amita Health Mercy Medical Center-Aurora**

CHARITY CARE			
	2017	2018	2019
Net Patient Revenue	\$187,529,429	\$140,060,305	\$203,698,036
Amount of Charity Care (charges)	\$38,791,796	\$45,058,579	\$34,876,556
Cost of Charity Care	\$3,366,506	\$6,882,265	\$5,516,677

APPEND DOCUMENTATION AS **ATTACHMENT 38**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number

5968-176-1



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

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

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



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 6TH day of OCTOBER A.D. 2020 .***

*Jesse White*  
26

SECRETARY OF STATE ATTACHMENT 1

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 26TH*  
*day of AUGUST A.D. 2020 .*

*Jesse White*  
27

SECRETARY OF STATE ATTACHMENT 1

Authentication #: 2023902944 verifiable until 08/26/2021

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



November 5, 2020

Illinois Health Facilities and  
Services Review Board  
Springfield, Illinois

To Whom It May Concern:

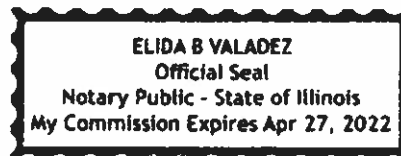
This letter is being provided as confirmation that the AMITA Health Mercy Medical Center-Aurora site is owned by Presence Central and Suburban Hospitals Network.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard C. Roehr".

Richard C. Roehr  
Chief Executive Officer

Notarized:



A handwritten signature in black ink, appearing to read "Elida B Valadez".

File Number

5968-176-1



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

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

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



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 6TH day of OCTOBER A.D. 2020 .***

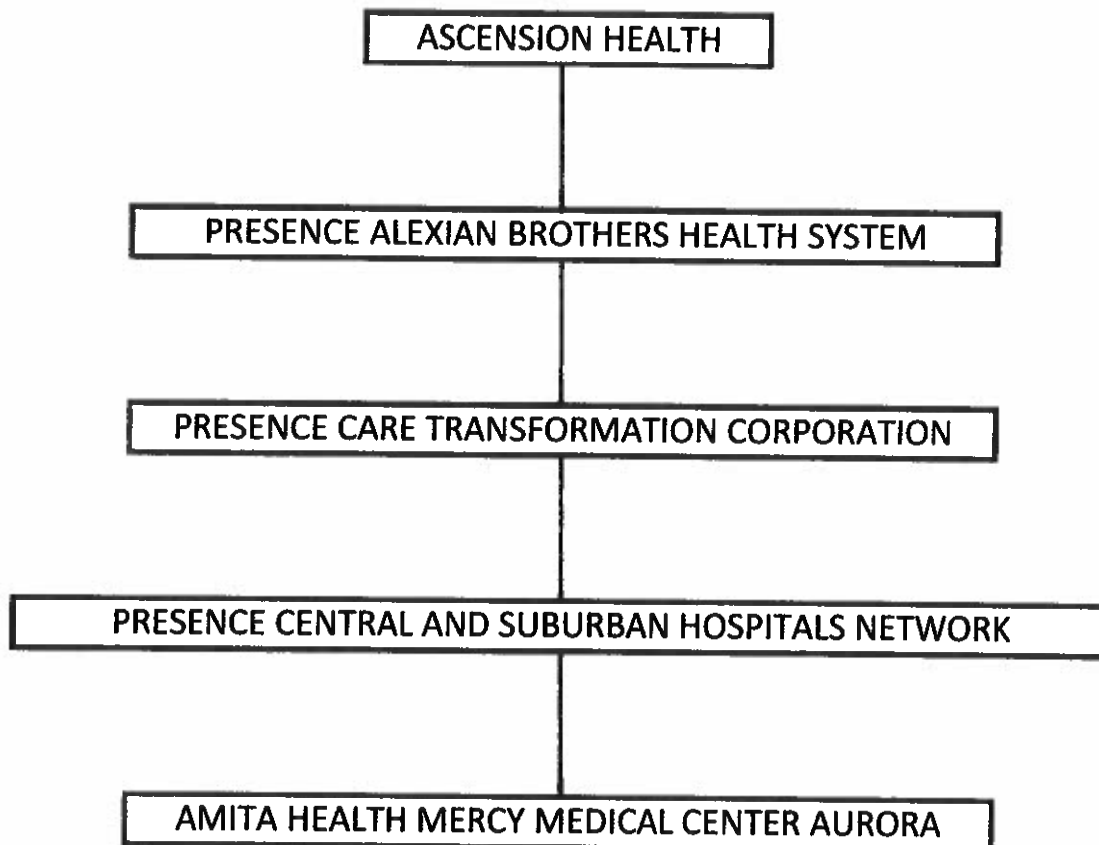
*Jesse White*  
29

SECRETARY OF STATE ATTACHMENT 3

Authentication #: 2028001932 verifiable until 10/06/2021

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

## ORGANIZATIONAL CHART





Illinois Health Facilities and  
Services review Board  
Springfield, Illinois

To Whom It May Concern:

I hereby confirm that the project proposed in this Certificate of Need application, that being the renovation of selected areas within AMITA Health Mercy Medical Center-Aurora and its adjacent medical office building, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA, is attached.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard C. Roehr", written over a horizontal line.

Richard C. Roehr  
Chief Executive Officer

10 11 12

AMITA Health  
Mercy Medical Center  
Aurora  
1325 N. Highland Ave.  
Aurora, IL 60506

630.859.2222

# National Flood Hazard Layer FIRMette



88°19'49"W 41°47'30"N

## Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS	Without Base Flood Elevation (BFE) Zone A, V, A99
	With BFE or Depth Zone AE, AO, AH, VE, AR Regulatory Floodway
OTHER AREAS OF FLOOD HAZARD	0.2% Annual Chance Flood Hazard. Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
	Future Conditions 1% Annual Chance Flood Hazard Zone X Area with Reduced Flood Risk due to Levee. See Notes. Zone X Area with Flood Risk due to Levee Zone D
OTHER AREAS	NO SCREEN Area of Minimal Flood Hazard Zone X
	Effective LOMRs
GENERAL STRUCTURES	Area of Undetermined Flood Hazard Zone I
	Channel, Culvert, or Storm Sewer Levee, Dike, or Floodwall
OTHER FEATURES	Cross Sections with 1% Annual Chance Water Surface Elevation Coastal Transect Base Flood Elevation Line (BFE) Limit of Study Jurisdiction Boundary Coastal Transect Baseline Profile Baseline Hydrographic Feature
	Digital Data Available No Digital Data Available Unmapped
MAP PANELS	

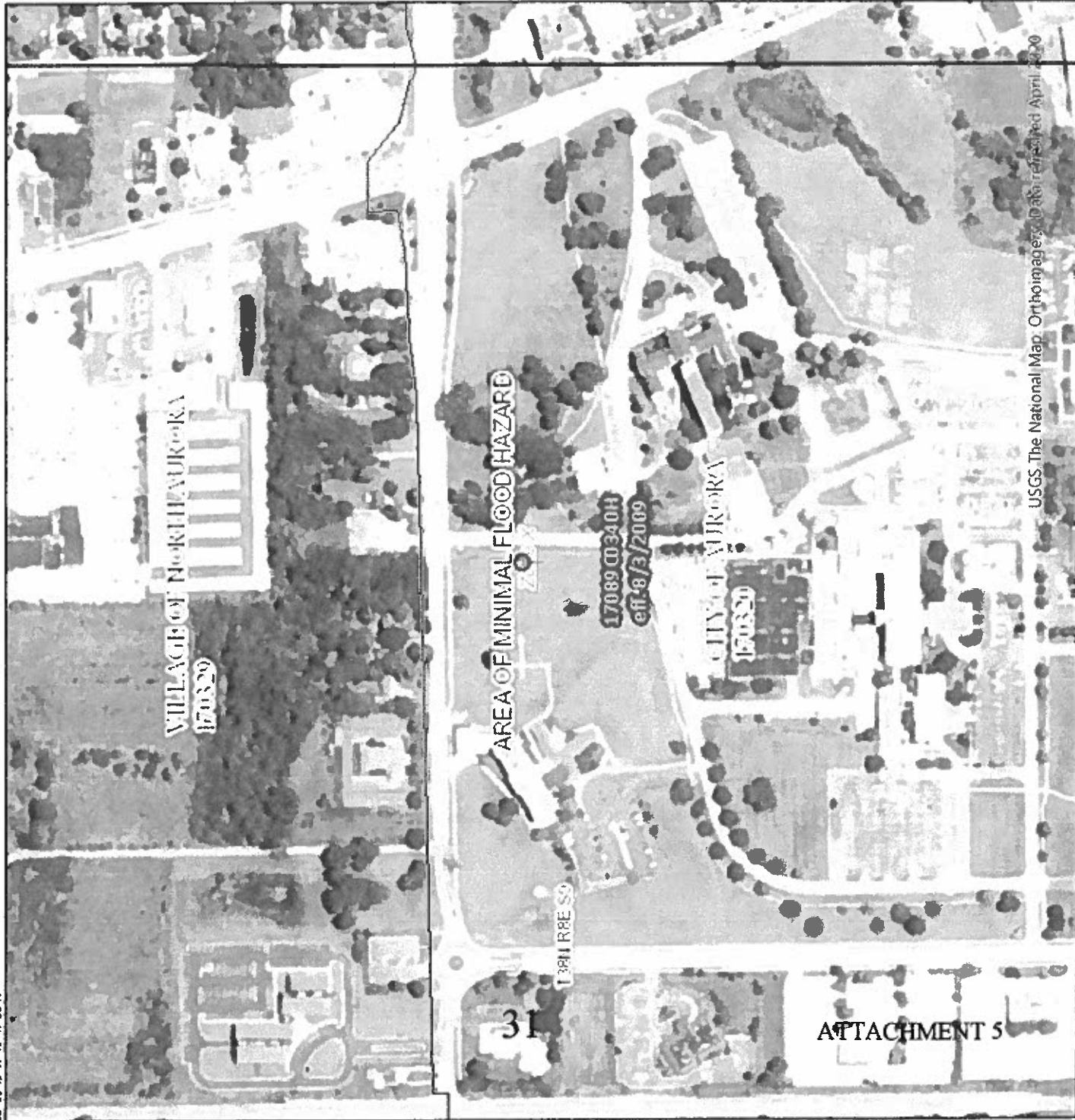
The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

#20-043

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards.

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 10/17/2020 at 12:54 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for



USGS The National Map. Orthoimagery. Data refreshed April 2020

Feet

1:6,000

88°19'12"W 41°47'4"N

**Axel & Associates, Inc.**

MANAGEMENT CONSULTANTS

October 5, 2020

Illinois Dept. of Natural Resources  
Illinois State Historic Preservation Office  
**ATTN: Review and Compliance/Old State Capitol**  
1 Natural Resources Way  
Springfield, IL 62702-1271

RE: Proposed Renovation to AMITA Health  
Mercy Medical Center-Aurora

To Whom It May Concern:

I am in the process of developing a Certificate of Need application, to be filed with the Illinois Health Facilities Services and Review Board, and I am in need of a determination of applicability from your agency.

The project involves the renovation of approximately 28,000 square feet on the first floor of the above-referenced hospital, and approximately 4,400 square feet on the first floor of an adjacent medical office building ("MOB"). The address of the hospital is 1325 North Highland Avenue. The portion of the hospital to be renovated was built in the late 1970s, and the MOB was built in the late 1980s. There do not appear to be any structures of historical significance near the site, the exterior of the buildings will not be altered, and the project will have no impact on surrounding buildings.

I have enclosed a map of the site and pictures of the hospital and the MOB, as well as surrounding buildings.

A letter from your office, confirming that the Preservation Act is not applicable to this project would be greatly appreciated.

Should you have any questions, I may be reached at the phone number below.

Sincerely,



Jacob M. Axel  
President

enclosures

## PROJECT COSTS AND SOURCES OF FUNDS

**Project Costs:**

Preplanning Costs		\$	275,000	
arch. & consultant selection	\$	22,000		
evaluation of location alternatives	\$	85,000		
project scope assessment	\$	52,500		
feasibility assessment	\$	44,000		
misc./other	\$	71,500		
Site Preparation		\$	85,000	
exterior signage & lighting	\$	65,000		
curb cuts & walkways	\$	20,000		
Moderization contracts		\$	10,968,570	
see ATTACHMENT 39C				
Contingencies		\$	487,710	
see ATTACHMENT 39C				
Architectural & Engineering Fees		\$	1,008,100	
assessment of alternatives	\$	39,400		
design services	\$	819,895		
specification prep	\$	29,500		
governmental agency interaction	\$	50,405		
inspections & supervision	\$	39,400		
reimbursables	\$	29,500		
misc/other				
Consulting and Other Fees		\$	1,150,000	
CON and permit-related	\$	84,000		\$ 1,150,000
project management	\$	373,750		
permitting & governmental dealings	\$	138,000		
interior design/furniture selection	\$	86,250		
equipment planning	\$	57,500		
IT-related	\$	100,000		
legal services	\$	34,500		
insurance	\$	86,250		
systems testing	\$	57,500		
commissioning	\$	46,000		
misc./other	\$	86,250		
Movable and Other Equipment		\$	6,232,250	
Emergency Department	\$	4,367,250		
Observation Unit	\$	320,000		
Crisis Stabilization Program	\$	455,000		
Outpt. Cardiopulmonary Rehab.	\$	865,000		
Lobby/Public	\$	225,000		

PROJECT COSTS AND SOURCES OF FUNDS

Other Costs to be Capitalized		\$ 3,045,000
demolition	\$ 45,000	
atrium infill	\$ 650,000	
phasing-related	\$ 950,000	
hospital-wide mechanicals	\$ 850,000	
elevators	\$ 550,000	
<b>TOTAL PROJECT COSTS</b>		<b>\$ 23,251,630</b>
<b>Sources of Funds</b>		
Cash		\$ 23,251,630
Cash from Ascension Health	\$ 23,251,630	

## Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>Reviewable-Hospital</b>							
Emergency Dept.	\$ 13,041,427	17,434	16,218		16,218		2,970
Observation	\$ 1,620,863	0	2,970		2,970		
Crisis Stabilization	\$ 2,366,087	0	4,398		4,398		
<b>Reviewable-MOB</b>							
Cardiopulmonary Rehab.	\$ 1,602,232	4,398			3,000		4,398
<b>Non-Reviewable-Hosp.</b>							
ED Transition Space	\$ 2,957,453				4,137		
Lobby/Public	\$ 1,663,567				1,791		
<b>Total</b>	<b>\$ 23,251,630</b>				<b>32,514</b>		

## 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 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

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

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 Saint Elizabeth Hospital  
Chicago, IL IDPH #6015

AMITA Health Saint Mary Hospital Chicago  
Chicago, IL IDPH #6007

Lakeshore Gastroenterology  
Des Plaines, IL

Belmont/Harlem Surgery Center  
Chicago, IL IDPH #7003131

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

**Illinois Department of  
PUBLIC HEALTH**



**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**Ngozi O. Ezike, M.D.**

**Director**

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	LD. NUMBER
3 12/31/2020		0004903
<b>General Hospital</b>		
<b>Effective: 01/01/2020</b>		

**Presence Central and Suburban Hospitals Network  
dba Presence Mercy Medical Center  
1325 N Highland Avenue**

**Aurora, IL 60506**

**Presence Central and Suburban Hospi  
dba Presence Mercy Medical Center  
1325 N Highland Avenue  
Aurora, IL 60506**

**Exp. Date 12/31/2020**

**Lic Number 0004903**

**Date Printed 11/15/2019**

**FEE RECEIPT NO.**

**ATTACHMENT**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/18



March 6, 2020

Rich Roehr  
CEO  
Presence Central and Suburban Hospitals Network  
1325 North Highland Avenue  
Aurora , IL 60506

Joint Commission ID #: 7240  
Program: Hospital Accreditation  
Accreditation Activity: 60-day Evidence of Standards  
Compliance  
Accreditation Activity Completed : 3/6/2020

Dear Mr. Roehr:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospital**

This accreditation cycle is effective beginning December 14, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS  
Chief Operating Officer and Chief Nurse Executive  
Division of Accreditation and Certification Operations



December 13, 2019

Rich Roehr  
CEO  
Presence Central and Suburban Hospitals Network  
1325 North Highland Avenue  
Aurora , IL 60506

Joint Commission ID #: 7240  
Program: Behavioral Health Care Accreditation  
Accreditation Activity: Unannounced Full Event  
Accreditation Activity Completed : 12/13/2019

Dear Mr. Roehr:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Behavioral Health Care**

This accreditation cycle is effective beginning December 10, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS  
Chief Operating Officer and Chief Nurse Executive  
Division of Accreditation and Certification Operations

## PURPOSE OF PROJECT

The proposed project will vastly improve the manner in which AMITA Health Mercy Medical Center-Aurora (“hospital”) is able to provide Emergency Department (“ED”) and mental illness services, and as such, the proposed project will provide health care services that will improve the health care and well-being of the area’s residents.

Specifically, through the proposed project, the hospital’s out-dated ED will be replaced, a small observation unit will be developed, and voluntary short-term setting will be developed for non-acute individuals suffering from mental illness, and in need of stabilization rather than acute care services.

Paramount among the issues relating to the existing ED that will be addressed through the proposed project is the improvement and enhancement of both audio and visual privacy within the ED to ensure that each patient has the utmost privacy in the unit, including ensuring that conversations between staff and patients/family are not able to be overheard; separation of patients by acuity level or type (i.e. trauma, routine, psychiatric, sexual abuse, observation); allowing for sufficient space in treatment stations; and improving on a currently inefficient design.

The stabilization area noted above will expand the scope of the hospital’s mental health programming. Mercy is one of three hospitals located in Planning Area A-12, and is the only A-12 hospital providing acute mental illness (“AMI”) services, admitting over 2,100 patients to its AMI unit during 2019. Planning Area A-12 consists of southern Kane County and Kendall County.

The project's service area, consistent with the HFSRB's definition of a geographic service area (GSA") for a provider in Kane County, is a ten-mile radius from the hospital. The ZIP Code areas located within the GSA, are identified below.

<u>ZIP</u>	<u>Community</u>		<u>County</u>
<u>60506</u>	AURORA	IL	KANE
<u>60542</u>	NORTH AURORA	IL	KANE
<u>60568</u>	AURORA	IL	KANE
<u>60507</u>	AURORA	IL	KANE
<u>60538</u>	MONTGOMERY	IL	KENDALL
<u>60505</u>	AURORA	IL	KANE
<u>60554</u>	SUGAR GROVE	IL	KANE
<u>60539</u>	MOOSEHEART	IL	KANE
<u>60510</u>	BATAVIA	IL	KANE
<u>60512</u>	BRISTOL	IL	KENDALL
<u>60502</u>	AURORA	IL	DUPAGE
<u>60504</u>	AURORA	IL	DUPAGE
<u>60519</u>	EOLA	IL	DUPAGE
<u>60503</u>	AURORA	IL	WILL
<u>60572</u>	AURORA	IL	DUPAGE
<u>60134</u>	GENEVA	IL	KANE
<u>60543</u>	OSWEGO	IL	KENDALL
<u>60598</u>	AURORA	IL	DUPAGE
<u>60147</u>	LAFOX	IL	KANE
<u>60144</u>	KANEVILLE	IL	KANE
<u>60569</u>	AURORA	IL	DUPAGE
<u>60511</u>	BIG ROCK	IL	KANE
<u>60119</u>	ELBURN	IL	KANE
<u>60555</u>	WARRENVILLE	IL	DUPAGE

The project's goals are to have the services identified above available to the community consistent with the project completion date identified in this application, and to improve the ED patient satisfaction, which will be measurable through post-discharge surveys.

## ALTERNATIVES

The impetus for the proposed project, which includes four clinical areas, was the perceived need to improve the patient experience in the hospital's Emergency Department ("ED"). The critical stabilization unit ("CSU") component of the proposed project has minimal relationship to the ED component. As such, a number of alternatives to the proposed project were evaluated.

### Alternative 1: Construct New Emergency Department

The applicants could have elected to simply construct a replacement ED, rather than to renovate the existing ED. From an operations perspective, this alternative is very attractive, because it could be completed approximately six months sooner than the proposed project, which requires phasing, to ensure that the ED remains functional during the duration of the project. The primary, and significant drawback to this alternative, however, is the associated construction cost of new construction, which would have added approximately \$2.5M in capital costs to the project. Had this alternative been selected, the associated operating costs, accessibility, and quality of care would have been very similar to those of the proposed project.

### Alternative 2: Eliminate the Critical Stabilization Unit Component of the Project

The concept of a CSU is somewhat inconsistent with the role of an acute care hospital, and conceivably, the CSU could have been developed elsewhere in the community. As discussed in ATTACHMENT 30, the concept of a CSU was developed by a team that expanded beyond the hospital, to include community mental illness advocates, first responders, and others. AMITA Health Mercy Medical Center-Aurora is the sole provider of inpatient acute mental illness services in the Health Planning Area, and is the "go to" provider for area first responders, who will be transporting a significant percentage of the of CSU's patients; and given the ability to provide

appropriate space in the hospital, and the proximity to other services such as a laboratory and clinical pharmacy, an alternative location was viewed as being inferior. The capital costs associated with an alternate location are unknown, however the capital costs associated with the proposed project's CSU component are relatively modest. It is anticipated that operating costs, primarily staffing-related, would be similar to those of the proposed project. Accessibility would be dependent on the location selected. Last, with the clinical expertise available at the hospital, the potential exists for an off-campus location's quality of care to be inferior to that of the proposed project.

## SIZE

The HFSRB maintains a space standard for only one functional area included in the proposed project. That area is the Emergency Department (“ED”).

The proposed ED will consist of a total of twenty treatment stations, consisting of seven general examination/treatment stations, four trauma stations, four isolation stations, four behavioral health stations and one sexual abuse station.

The ED, including all functional areas required by IDPH licensure, will consist of 14,500 DGSF. The planned space, as documented in the table below, is consistent with the HFSRB standard, is necessary, and is not excessive.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Emergency Department	16,218	<18,000	1,782	YES

## PROJECT SERVICES UTILIZATION

The proposed project includes only two components having HFSRB-adopted utilization standards: Emergency Department (“ED”) stations and general radiology. Upon the completion of the proposed project, the hospital’s number of ED stations will be reduced from 26 to 20, and the number of general radiology units will be reduced from four to three, with one of three remaining units to be located in the ED, therein requiring that general radiology be addressed in this ATTACHMENT.

### Emergency Department Stations

The HFSRB utilization standard for ED stations is 2,000 patient encounters, annually.

Between 2016 and 2019, utilization of the ED remained relatively constant, ranging from 36,428 to 38,418 annual patients. The use of 2020 utilization as a basis for forecasting future utilization, is not reasonable due to drastic decreases in ED utilization nation-wide, as a result of the COVID-19 pandemic. CDC data from June 2020 documents a year-to-year decline of 26% as recent as the last week of May 2020.

Unable to reasonably use 2020 utilization data due to the impact of the pandemic on ED utilization, and anticipating utilization to return to pre-pandemic levels, the applicants used 2018-2019 mean utilization (37,298 annual visits) as the basis for projecting future utilization. While utilization is anticipated to increase over recent historical levels due to an improved patient experience resulting from the project, in order to be conservative, utilization is projected to increase by only 0.5-1.0% annually, through the second year following the project’s completion. Those projections are displayed in the table below.

2018-19 mean:	37,298	@0.5%	@1.0%	"justified" stations
2020		37,484	37,671	19
2021		37,672	38,048	20
2022		37,860	38,428	20
2023		38,050	38,812	20
2024		38,240	39,201	20
2025		38,431	39,593	20

### General Radiology

The HFSRB utilization standard for general radiology procedures is 8,000 examinations, annually.

The proposed project is not anticipated to have an appreciable impact on general radiology procedures performed at the hospital. As such, utilization of this service is projected to remain constant at the 2018-2019 mean utilization level of 25,430 annual examinations, through the second year following the completion of the proposed project, supporting the "need" for the three general radiology units to be provided at the hospital.

	PROJECTED UTILIZATION		STATE STANDARD	MET STANDARD?
	YEAR 1	YEAR 2		
ED Stations	38,720	39,012	38,001	YES
Gen'l Radiology	25,430	25,430	24,001	YES

## CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project is limited in scope, and contains only four clinical care areas, and none of those areas are IHFSRB-designated “categories of service”.

### Emergency Department

The hospital’s Emergency Department (“ED”), which holds a “comprehensive” designation, was opened in its current location in the early 1970s, and has not had any significant physical improvements or updating for over fifteen years. The proposed replacement will reduce the number of treatment stations from 26 to 20 treatment stations, eliminate the visual and audio privacy issues currently existing, and provide the following designated treatment stations: 4 trauma stations, 4 behavioral health stations, 4 medical isolation stations, 7 general stations, and 1 sexual abuse/assault station.

As with most EDs, the vast majority of patients reside near the hospital, and the department’s patient origin is not anticipated to change significantly as a result of the proposed project. During 2019, 43% of the ED’s patients resided in ZIP Code 60506, the location of the hospital, with an additional 27.5% residing in adjacent Aurora ZIP Code 60505, and 6.6% residing in North Aurora ZIP Code 60542. During 2019, approximately one of every four patients treated in the hospital’s ED was a Medicaid recipient, and that ratio is anticipated to remain relatively constant following the completion of the proposed project.

During 2019, 86% of the non-obstetrics patients admitted to the hospital were initially seen in the ED.

Between 2016 and 2019, utilization of the ED remained relatively constant, ranging from 36,428 to 38,418 annual patients. The use of 2020 utilization as a basis for forecasting future utilization, is not reasonable due to drastic decreases in ED utilization nation-wide, as a result of the COVID-19 pandemic. (CDC data from June 2020 documents a year-to-year decline of 26% as recent as the last week of May 2020.)

Unable to reasonably use 2020 utilization data due to the impact of the pandemic on ED utilization, and anticipating utilization to return to pre-pandemic levels, the applicants used 2018-2019 mean utilization (37,298 annual visits) as the basis for projecting future utilization. While utilization is anticipated to increase over recent historical levels due to an improved patient experience resulting from the project, in order to be conservative, utilization is projected to increase by only 0.5-1.0% annually, through the second year following the project's completion.

Those projections are displayed in the table below.

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2020		37,484	37,671	19
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2022		37,860	38,428	20
2023		38,050	38,812	20
2024		38,240	39,201	20
2025		38,431	39,593	20

As is common with virtually all contemporary EDs, the proposed ED will have an imaging component, with the imaging modalities being limited to a single digital x-ray unit. Currently, ED patients are transported to the hospital's central imaging department for all imaging procedures.

Upon the completion of the proposed project, the hospital's number of general radiology units will be reduced from four to three, including the aforementioned unit in the ED.

#### Observation Unit

The observation unit will consist of six stations, and be located adjacent to the ED. The primary purposes of this unit are to: 1) provide a short-term location for patients having been treated in the ED, and awaiting a decision (typically pending lab results) on whether or not to be admitted, or 2) provide a location for patients having been treated in the ED, but requiring a short-term stabilization period, or awaiting transportation prior to discharge. The hospital does not currently have this setting, resulting in patients occupying ED stations significantly longer than necessary, which, in turn, results in unnecessary waits for patients seeking care through the ED.

Discussions with hospital representatives suggest that approximately one out of every five patients treated in the ED would use the proposed observation unit, and the average length of stay would range from 4-6 hours, with patients very rarely staying beyond eight hours. Given the small size of the unit, an 80% target occupancy rate was used to identify the number of stations needed. Based on the projection of approximately 39,000 ED patient visits by 2025 (see discussion above), and an average length of stay of five hours, the need for 5.57 observation stations (rounded to six) was calculated.

#### Critical Stabilization Unit ("CSU")

The CSU will be the first hospital-based program of its kind in the area, and is being developed as a collaboration between community organizations, philanthropists, the AMITA foundation, first responders and the hospital's behavioral health professionals. The program is designed for adults requiring immediate intervention to address a mental health emergency, to stabilize an emotional crisis, or to address a psychiatric issue in a safe environment, less restrictive

than a hospital's inpatient unit. The goal of the unit is to stabilize the patient, and to connect individuals to community resources, in order to manage current and future crises.

The unit is being designed to accommodate eight patients, simultaneously, will operate on a "24/7" basis, and be staffed with therapists, nurses, and case managers, with a psychiatrist being on call at all times. Patients will be evaluated, stabilized, medicated if appropriate, and a follow-up plan will be developed, typically within 5-7 hours, with patients staying in the unit, with rare exception, less than 24 hours. It is anticipated that no more than 30% of the patients treated through the CSU will require a referral to an inpatient acute mental illness ("AMI") unit. The applicants estimate that 1,800-1,850 patient encounters will occur during the unit's second year of operation.

#### Cardiopulmonary Rehabilitation

The hospital's cardiopulmonary rehabilitation gym, which serves outpatients exclusively, will relocate from the first floor of the hospital (with that space to be occupied by the critical stabilization unit) to the first floor of a medical office building located adjacent to the hospital. Utilization of the service ranged from 6,374 to 7,295 patient visits between 2016 and 2019. For planning purposes, and acknowledging that only a tremendous increase in utilization would require additional capacity, utilization is projected to remain constant at approximately 6,900 patient visits, annually.

# MOODY'S

## INVESTORS SERVICE

**Rating Action:** Moody's assigns Aa2 to Ascension's Ser. 2019A,B,C bonds; stable outlook

25 Sep 2019

New York, September 25, 2019 -- Moody's Investors Service has assigned Aa2 ratings to Ascension Health Alliance's (Ascension) Revenue Bonds (Ascension Senior Credit Group), Series 2019A (\$146 million), Ascension's Taxable Bonds, Series 2019B (\$304 million) and Ascension's Taxable Bonds, Series 2019C (up to \$500 million). The proposed Series 2019A will be tax-exempt fixed rate bonds and will be issued through the Wisconsin Health and Educational Facilities Authority. The outlook is stable. We affirmed senior debt ratings of Aa2 and Aa2/VMIG 1, subordinated debt ratings of Aa3 and Aa3/VMIG 1, and the commercial paper rating of P-1. We have also affirmed the senior debt ratings of Aa2 for Presence Health, IL's Series 2016C and Hospital de la Concepcion's Series 2017A and the Aa2/VMIG 1 rating for St. Vincent de Paul Center's Series 2000A bonds. These actions affect approximately \$7.5 billion of outstanding debt, including debt by Presence Health and secured under Ascension's master trust indenture.

### RATINGS RATIONALE

The Aa2 long-term senior rating is based on significant strengths Ascension will continue to derive from its status as one of the largest not-for-profit healthcare systems in the US, including a large diversified portfolio of sizable hospitals and further growth in non-acute care business lines from commercialization opportunities. The system's centralized governance and operating model, as well as recent management restructuring, will provide a strong platform for further efficiencies and accelerated growth strategies. Before considering investment performance, near-term liquidity growth will slow because of increasing capital spending. However, liquidity will remain strong since cashflow will largely support capital spending; additionally, Ascension has \$1 billion in undrawn committed bank facilities. Leverage metrics will improve from cashflow improvement and no material incremental debt is expected. Reflecting industry-wide trends, the system's margins will remain modest and revenue growth will be constrained because of increased reliance on governmental payers and volume pressure. Most hospitals will face increasing competition as providers consolidate and become larger and more formidable. The Aa3 long-term subordinated rating reflects the structural subordination of the related bonds.

The VMIG 1 and P-1 short-term ratings are based on the system's ability to provide liquidity for unremarketed tenders or maturing commercial paper. This ability is supported by a strong treasury management function, large portfolio of diversified investments, strong daily liquidity, availability of a backup bank facility, and other factors that suggest manageable liquidity needs.

### RATING OUTLOOK

The stable outlook reflects expected improvement in margins in FY 2020, excluding the effect of a pension accounting change, given continued cost reductions and accelerated growth strategies, which will compensate for higher governmental payers and volume pressures. Increasing capital spending will likely slow further liquidity growth, but we expect cashflow will largely cover capital spending and liquidity will remain strong. We expect commercialization strategies of non-acute care businesses will provide revenue and balance sheet opportunities. The stable outlook anticipates no new material debt outside of acquisitions and that any acquisitions or mergers will not be significantly dilutive to key credit measures nor present high execution risk.

### FACTORS THAT COULD LEAD TO AN UPGRADE

- Significant and sustained improvement in operating margins
- Reduction in leverage and improved debt metrics
- Continued diversification of non-acute care revenues

### FACTORS THAT COULD LEAD TO A DOWNGRADE

- Sustained decline in margins
- Significant increase in leverage
- Materially dilutive merger or acquisition
- Notable sustained decline in liquidity
- For short-term ratings, significant decline in liquidity

## LEGAL SECURITY

Security for the senior bondholders is a revenue pledge of the senior credit group. Security for the subordinated bondholders is an unsecured general obligation of Ascension and the bonds are subordinate to all outstanding senior bonds. No debt service reserve funds are in place. Covenants include minimal debt service coverage test and no additional indebtedness tests. Replacement of the master indenture is allowed without bondholder consent if certain conditions are met, including rating agency confirmations of no rating impact. Members of the subordinate credit group are identical to those in the senior credit group.

## USE OF PROCEEDS

Proceeds from the Series 2019 bonds will be used to refinance existing bonds.

## PROFILE

Ascension is one of the largest not-for-profit healthcare systems in the U.S. with \$25 billion in revenue, operating 119 general acute care hospitals, two long-term care acute care hospitals, eight behavioral health hospitals and five rehabilitation hospitals. The system operates in 21 states and D.C.

## METHODOLOGY

The principal methodology used in the long-term ratings was Not-For-Profit Healthcare published in December 2018. The principal methodology used in the short-term ratings was Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in March 2018. The principal methodology used in the Series 2000A and 2017A long-term ratings was Rating Transactions Based on the Credit Substitution Approach: Letter of Credit-backed, Insured and Guaranteed Debts published in May 2017. Please see the Rating Methodologies page on [www.moodys.com](http://www.moodys.com) for a copy of these methodologies.

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**MOODY'S**  
 INVESTORS SERVICE

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## COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Cost/Sq. Ft.		DGSF		DGSF		New Const. \$		Modernization \$		Costs	
	New	Mod.	New	Circ.	Mod.	Circ.	(A x C)	(B x E)	(G + H)			
<b>Reviewable-Hospital</b>												
Emergency Dept.		\$ 370.00			16,218			\$ 6,000,660	\$ 6,000,660	\$ 6,000,660		
Observation		\$ 300.00			2,970			\$ 891,000	\$ 891,000	\$ 891,000		
Crisis Stabilization		\$ 300.00			4,398			\$ 1,319,400	\$ 1,319,400	\$ 1,319,400		
Contingency		\$ 15.00						\$ 353,790	\$ 353,790	\$ 353,790		
		\$ 363.13			23,586			\$ 8,564,850	\$ 8,564,850	\$ 8,564,850		
<b>Non-Reviewable-Hosp.</b>												
ED Transitional Space		\$ 330.00			4,137			\$ 1,365,210	\$ 1,365,210	\$ 1,365,210		
Lobby/Public		\$ 300.00			1,791			\$ 537,300	\$ 537,300	\$ 537,300		
Contingency		\$ 15.00						\$ 88,920	\$ 88,920	\$ 88,920		
		\$ 335.94			5,928			\$ 1,991,430	\$ 1,991,430	\$ 1,991,430		
<b>Reviewable-MOB</b>												
Cardiopulmonary Rehab		\$ 285.00			3,000			\$ 855,000	\$ 855,000	\$ 855,000		
Contingency		\$ 15.00						\$ 45,000	\$ 45,000	\$ 45,000		
		\$ 300.00						\$ 900,000	\$ 900,000	\$ 900,000		
<b>TOTAL</b>		\$ 352.35			32,514			\$ 11,456,280	\$ 11,456,280	\$ 11,456,280		

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PROJECTED OPERATING COSTS  
and  
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

**AMITA Health Mercy Medical Center-Aurora**

Projected Adj. Pt. Days:	<u>141,512,000</u>	
	2,819	50,194

**Year 2 OPERATING COST per ADJUSTED PATIENT DAY**

Salaries & Benefits	\$65,951,000
Medical Supplies	<u>\$54,818,000</u>
	\$120,769,000
per Adjusted Patient Day:	\$ 2,406.03

**YEAR 2 CAPITAL COST per ADJUSTED PATIENT DAY**

Interest, Dep. & Amort	\$ 8,103,000
per Patient Day:	\$ 161.43

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
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2	Site Ownership	28
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	29
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	30
5	Flood Plain Requirements	31
6	Historic Preservation Act Requirements	32
7	Project and Sources of Funds Itemization	33
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13	Alternatives to the Project	43
14	Size of the Project	45
15	Project Service Utilization	46
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
	<b>Service Specific:</b>	
18	Medical Surgical Pediatrics, Obstetrics, ICU	
19	Comprehensive Physical Rehabilitation	
20	Acute Mental Illness	
21	Open Heart Surgery	
22	Cardiac Catheterization	
23	In-Center Hemodialysis	
24	Non-Hospital Based Ambulatory Surgery	
25	Selected Organ Transplantation	
26	Kidney Transplantation	
27	Subacute Care Hospital Model	
28	Community-Based Residential Rehabilitation Center	
29	Long Term Acute Care Hospital	
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31	Freestanding Emergency Center Medical Services	
32	Birth Center	
	<b>Financial and Economic Feasibility:</b>	
33	Availability of Funds	52
34	Financial Waiver	
35	Financial Viability	
36	Economic Feasibility	57
37	Safety Net Impact Statement	
38	Charity Care Information	25

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## Axel & Associates, Inc.

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MANAGEMENT CONSULTANTS

**by FedEx**

December 5, 2020

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

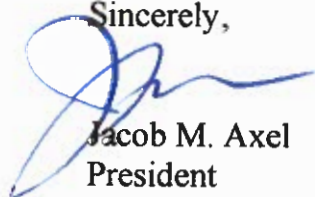
Dear Courtney:

Enclosed please find two copies of a Certificate of Need application, primarily addressing the replacement of the emergency department at AMITA Health Mercy Medical Center Aurora. The application is classified as "non-substantive".

The application is accompanied with 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

cc J. Roknich