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 Saint Mary Hospital Chicago modernization project		
Street Address:	2233 West Division Street		
City and Zip Code:	Chicago, IL 60622		
County: Cook	Health Service Area: V	Health Planning Area: A-02	

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

Exact Legal Name:	Presence Chicago Hospitals Network d/b/a AMITA Health Saints Mary and Elizabeth Medical Center
Street Address:	200 South Wacker Drive, 11th Floor
City and Zip Code:	Chicago, IL 60606
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	G. Thor Thordarson
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

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

Name:	none

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 Saint Mary Hospital Chicago modernization project				
Street Address:	2233 West Division Street				
City and Zip Code:	Chicago, IL 60622				
County:	Cook	Health Service Area:	V	Health Planning Area:	A-02

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

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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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:	

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

Name:	none

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 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: AMITA Health Saint Mary of Nazareth Hospital

Address of Site Owner: 2601 Navistar Drive Lisle, IL 60532

Street Address or Legal Description of the Site: 2233 West Division Street Chicago, IL 60622

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

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

Operating Identity/Licensee

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

Exact Legal Name: Presence Chicago Hospitals Network

Address: 2601 Navistar Drive Lisle, IL 60532

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

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

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

Organizational Relationships

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

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

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 applicants are proposing a phased modernization project at AMITA Health Saint Mary Hospital Chicago f/k/a Presence Saint Mary of Nazareth Hospital, addressing the renovation of approximately 60,000 dgsf, consisting of portions of the hospital's lower level, first, second, third, fifth, and ninth floors, to include:

- medical records and a number of administrative services relocating on the first floor;
- outpatient pre-op and Stage 2 recovery relocating from the eleventh floor to the first-floor vacated areas referenced above;
- the pre-admission testing function moving from the ninth to the first floor;
- eighteen ICU beds relocating from the first to the fifth floor;
- the fifth floor transitioning from a combination of ICU and Med/Surg unit to an 18-bed ICU;
- PACU moving into a portion of the first-floor space vacated by the ICU;
- the inpatient dialysis unit relocating from its current first-floor location to vacant space on the ninth floor;
- a retail pharmacy being developed in first floor space vacated by the inpatient dialysis unit, and
- the balance of the first-floor undergoing major renovation, to include the renovation of the lobby, the relocating of pre-admission testing, patient registration and a variety of administrative functions.

Upon the completion of the project, the hospital's complement of ICU beds will decrease from 32 to 26 beds and its Med/Surg bed complement will be reduced from 186 to 166 beds.

The proposed project is classified as "non-substantive", not meeting the definition of a "substantive" project contained in Section 1110.20.c).

PROJECT COST AND SOURCES OF FUNDS

	Reviewable	Non-Reviewable	Total
Project Cost:			
Preplanning Costs	$ 86,400	$ 73,600	$ 160,000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$ 12,886,860	$ 12,773,472	$ 25,660,332
Contingencies	$ 754,900	$ 750,173	$ 1,505,073
Architectural/Engineering Fees	$ 710,100	$ 604,900	$ 1,315,000
Consulting and Other Fees	$ 1,137,780	$ 969,220	$ 2,107,000
Movable and Other Equipment (not in construction contracts)	$ 4,985,000	$ 975,000	$ 5,960,000
Net Interest Expense During Construction Period			
Fair Market Value of Leased Space			
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized	$ 4,779,000	$ 4,071,000	$ 8,850,000
Acquisition of Building or Other Property			
TOTAL USES OF FUNDS	**$ 25,340,040**	**$ 20,217,365**	**$ 45,557,405**
Sources of Funds:			
Cash and Securities	$ 25,340,040	$ 20,217,365	$ 45,557,405
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 25,340,040**	**$ 20,217,365**	**$ 45,557,405**

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** or **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**). NOTE: A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

X Non-substantive

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:

Land acquisition is related to project ☐ Yes X No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes X No

If yes, provide the dollar amount of all **non-capitalized** 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.

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
X Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___September 30, 2024____

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ 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
X Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 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.**

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

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**.

FACILITY NAME: AMITA Health Saint Mary Hospital Chicago Chicago			**CITY: Chicago**		
REPORTING PERIOD DATES:		**From: January 1, 2019**	**to: December 31, 2019**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	186	7,028	35,076	-20	166
Obstetrics	20	1,111	2,838		20
Pediatrics	14	134	326		14
Intensive Care	32	968	3,700	-6	26
Comprehensive Physical Rehabilitation	15	376	4,194		15
Acute/Chronic Mental Illness	120	4,905	32,352		120
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	387	14,522	78,486	-26	361

Note: a Certificate of Exemption application has been filed to discontinue the hospital's 14-bed Pediatrics category of service, and to add 14 Medical/Surgical beds in its place.

CERTIFICATION

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

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

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

SIGNATURE

Thor Thordarson
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of May, 2021

Signature of Notary

Seal

OFFICIAL SEAL
DEBORAH A WEAVER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/31/23

SIGNATURE

Julie P. Roknich
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of May

Signature of Notary

Seal

OFFICIAL SEAL
DEBORAH A WEAVER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/31/23

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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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	SIGNATURE
Christine K. McCoy	Matthew Jagger
PRINTED NAME	PRINTED NAME
Secretary & General Counsel	Treasurer for Ascension Health
PRINTED TITLE	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

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 can 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** 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	MEET 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:

not applicable, shell space not 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:

not applicable, shell space not included in project

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.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ **Medical/Surgical**		
☐ **Obstetric**		
☐ **Pediatric**		
X **Intensive Care**	**32***	**26***

*authorized beds

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **PACU/Stage 1 Recovery**	**11**	**11**
☐ **Stage 2 Recovery**	**20**	**27**
☐ **ICU**	**32**	**26**

3. 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
APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

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]:**

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		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
		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;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts;
_____	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:
		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;
		2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
		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.;
		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;

	5) For any option to lease, a copy of the option, including all terms and conditions.
_____	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.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 the project's 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
Enter Historical and/or Projected Years:				
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 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

proof of bond rating provided as ATTACHMENT 33

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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. 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.

not applicable, non-substantive project

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

APPEND DOCUMENTATION AS ATTACHMENT 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 Saints Mary and Elizabeth's Medical Center

CHARITY CARE			
	2017	2018	2019
Net Patient Revenue	**$307,420,155**	**$298,946,230**	**$302,513,528**
Amount of Charity Care (charges)	$26,333,501	$38,876,740	$41,489,102
Cost of Charity Care	$4,880,032	$6,942,837	$7,733,045

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

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: PLEASE SEE PAGE 1 OF APPLICATION

2. Project Location: PLEASE SEE PAGE 1 OF APPLICATION

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go To NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA:

Yes____ No _X__

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? no

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:

(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date:

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

#21-018

File Number 3128-198-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* AUGUST *A.D.* 2020 .

Authentication #: 2023902912 verifiable until 08/26/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

28

File Number 6783-860-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* AUGUST *A.D.* 2020 .

Authentication #: 2023902944 verifiable until 08/26/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

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ATTACHMENT 1

SITE OWNERSHIP

With the signatures provided on the Certification pages of this Certificate of Exemption ("COE") application, the applicants attest that the site of AMITA Health Saint Mary Hospital Chicago, located at 2233 West Division Street in Chicago, is owned by AMITA Health Saint Mary of Nazareth Hospital.

ATTACHMENT 2

File Number 3128-198-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* AUGUST *A.D.* 2020 .

Jesse White

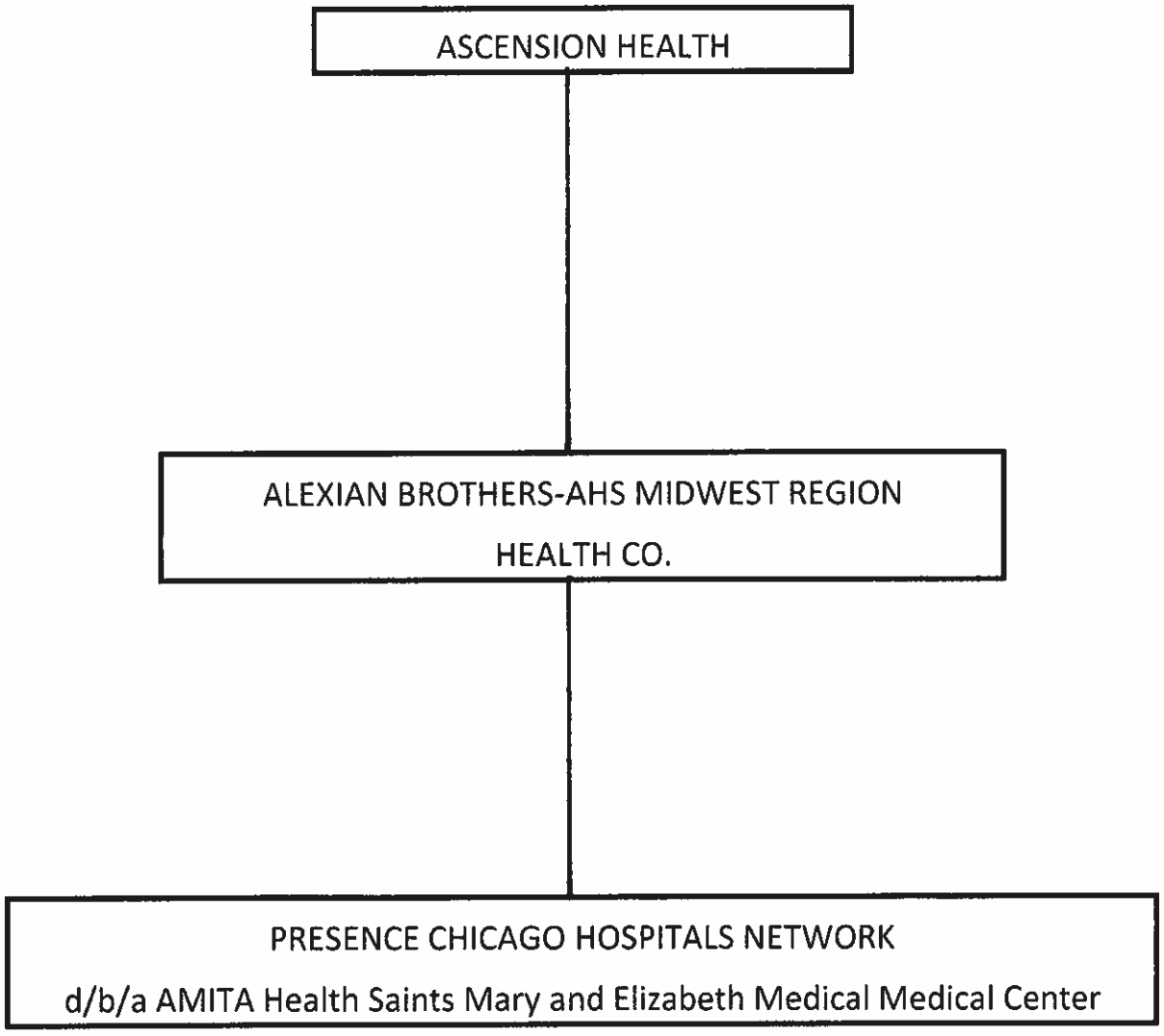
SECRETARY OF STATE

Authentication #: 2023902912 verifiable until 09/26/2021

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

ATTACHMENT 3

ORGABIZATIONAL CHART



ATTACHMENT 4

FLOOD PLAIN REQUIREMENTS

With the signatures provided on the Certification pages of this Certificate of Need application, the applicants confirm that the project addressed thorough this Certificate of Need application, that being the renovation of selected areas within AMITA Health Saint Mary Hospital Chicago, located at 2233 West Division Street, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA is attached.

ATTACHMENT 5

National Flood Hazard Layer FIRMette

FEMA

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, Area 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
- Area of Undetermined Flood Hazard Zone

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 Cross Sections with 1% Annual Chance
- 17.5 Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

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

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 4/1/2021 at 10:37 AM 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 regulatory purposes.

#21-018

#21-018

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of **Natural Resources**

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov Mailing Address: 1 Old State Capitol Plaza, Springfield, IL 62701

JB Pritzker, Governor
Colleen Callahan, Director

FAX (217) 524-7525

Cook County
Chicago
CON - Rehabilitation of First and Fifth Floors, Saint Mary's Hospital - Chicago
2233 W. Division St.
SHPO Log #015032221

April 6, 2021

Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, IL 60067

Dear Mr. Axel:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please call 217/782-4836.

Sincerely,

Robert F. Appleman
Deputy State Historic
Preservation Officer

ATTACHMENT 6

Project Costs:

Preplanning Costs			
Pre-Architectural Planning	$	20,000	
Architect Selection	$	25,000	
Evaluation of Alternatives	$	20,000	
Site Vistits	$	25,000	
Feasibility Analyses	$	45,000	
Misc./Other	$	25,000	
			$ 160,000
Moderization contracts			
see ATTACHMENT 36C			$ 25,660,332
Contingencies			
see ATTACHMENT 36C			$ 1,505,073
Architectural & Engineering Fees			
assessment of alternatives	$	60,000	
design services	$	980,000	
specification prep	$	60,000	
governmental agency interaction	$	40,000	
inspections & supervision	$	50,000	
reimburseables	$	50,000	
misc/other	$	75,000	
			$ 1,315,000
Consulting and Other Fees			
CON and permit-related	$	135,000	
project management	$	600,000	
permitting & govermental dealings	$	175,000	
interior design/furniture selection	$	125,000	
equipment planning	$	50,000	
electrical coordination study	$	302,000	
legal services	$	100,000	
insurance	$	20,000	
systems testing	$	75,000	
commissioning	$	75,000	
IT related	$	150,000	
Misc./Other	$	300,000	
			$ 2,107,000

Movable and Other Equipment		
ICU	$ 2,340,000	
Stage 1 Recovery	$ 720,000	
Stage 2 Recovery	$ 1,350,000	
Pre-Admission Testing	$ 175,000	
Pharmaceutical Services	$ 250,000	
Lobby/Public Areas	$ 300,000	
Staff & Resident's Areas	$ 75,000	
Administrative Areas	$ 250,000	
Medical Staff Areas	$ 75,000	
Patient Registration	$ 125,000	
Other	$ 300,000	
		$ 5,960,000
Other Costs to be Capitalized		
IT Upgrades	$ 1,300,000	
Parking Upgrades	$ 300,000	
Replace Switchboards	$ 1,450,000	
Replace Air Handling Unit	$ 3,300,000	
Replace Paralleling Gear Enclos.	$ 1,250,000	
EM Power Feeders	$ 1,250,000	
		$ 8,850,000
Total Project Cost:		$ 45,557,405
Sources of Funds		
Cash and Securities from Ascension Health	$ 45,557,405	
Total Sources of Funds		$ 45,557,405

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet That is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ICU	$ 14,899,944	3,391	15,899		15,899		
Stage 1 Recovery	$ 734,861	3,000	1,485		1,485		
Stage 2 Recovery	$ 7,500,652	6,800	9,954		9,954		
Inpatient Dialysis	$ 1,520,402	2,128	1,750		1,750		
Pre-Admission Testing	$ 684,181	3,500	1,108		1,108		
	$ 25,340,040		30,196		30,196		
Non-Reviewable							
Residents' On Call/Work	$ 1,496,085	1,500	2,250		2,250		
Public Waiting	$ 1,524,781	2,000	2,047		2,047		
Retail Pharmacy	$ 1,516,302	-	2,128		2,128		
Staff Lockers/Lounges	$ 2,284,562	2,800	3,443		3,443		
Anesthesia Offices	$ 586,304	475	862		862		
Conference Room	$ 343,695	1,800	505		505		
Lobby	$ 2,021,737	1,550	3,030		3,030		
Patient Registration	$ 1,859,998	3,200	2,782		2,782		
Medical Records	$ 242,608	1,500	357		357		
Nursing & Misc. Admin.	$ 3,084,778	2,000	4,795		4,795		
Utilities	$ 181,956	1,000	285		285		
Patient Advocacy	$ 384,130	440	564		564		
Hospitalists' Offices	$ 707,608	1,000	1,038		1,038		
Administrative Suite	$ 1,394,998	3,900	2,064		2,064		
Medical Staff Offices	$ 970,434	1,500	1,445		1,445		
Physicians' Work Room	$ 667,173	1,000	983		983		
DGSF>>>BGSF	$ 950,216		1,429		1,429		
	$ 20,217,365		30,007		30,007		
Project Total	$ 45,557,405		60,203		60,203		

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ATTACHMENT 9

#21-018

BACKGROUND

Attached are a photocopy of AMITA Health Saint Mary Hospital Chicago's (f/k/a Presence saint Mary of Nazareth Hospital) IDPH license and confirmation of the medical center's accreditation.

Applicant Ascension Health owns, operates and/or controls the following Illinois licensed acute 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

ATTACHMENT 11

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

Lincoln Park Gastroenterology Center
Chicago, IL HFSRB Permit # 20-012

Additionally, Ascension Living, an affiliate of Ascension Health, operates and/or controls the following Illinois long term care facilities:

Presence Arthur Merkel and Clara Knipprath Nursing Home
Clifton, IL IDPH #21832

Presence Villa Scalabrini Nursing and Rehabilitation Center
Northlake, IL IDPH #44792

Presence Villa Franciscan
Joliet, IL IDPH# 42861

Presence Saint Joseph Center
Freeport, IL IDPH # 41871

Presence Saint Benedict Nursing and Rehabilitation Center
Niles, IL IDPH #44784

Presence Saint Anne Center
Rockford, IL IDPH #41731

Presence Resurrection Nursing and Rehabilitation Center
Park Ridge, IL IDPH #44362

Presence Resurrection Life Center
Chicago, IL IDPH #44354

Presence Our Lady of Victory Nursing Home
Bourbonnais, IL IDPH # 41723

Presence Nazarethville
Des Plaines, IL IDPH #54072

Presence McCauley Manor
Aurora, IL IDPH #42879

Presence Maryhaven Nursing Home and Rehabilitation Center
Glenview, IL IDPH #44768

Presence Heritage Village
Kankakee, IL IDPH #42457

Presence Cor Mariae Center
Rockford, IL IDPH #41046

With the signatures provided on the Certification pages of this Certificate of Need ("COE") application, each of the applicants attest that, to the best of their knowledge, no adverse action has been taken against any Illinois health care facility owned and/or operated by them, during the three years prior to the filing of this CON application. Further, with the signatures provided on the Certification pages of this CON application, each of the applicants authorize the

Health Facilities and Services Review Board and the Illinois Department of Public Health access to any documents which it finds necessary to verify any information submitted, including, but not limited to official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

#21-018

DISPLAY THIS PART IN A CONSPICUOUS PLACE

HF 121500

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	I.D. NUMBER
12/31/2021		0006007

General Hospital

Effective: 01/01/2021

Presence Chicago Hospitals Network
dba Presence Saint Mary of Nazareth Hospital
2233 W Division Street

Chicago, IL 60622

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

Exp. Date 12/31/2021

Lic Number 0006007

Date Printed 10/14/2020

Presence Chicago Hospitals Network
dba Presence Saint Mary of Nazareth
2233 W Division Street
Chicago, IL 60622

FEE RECEIPT NO.

ATTACHMENT 11

CERTIFICATE OF DISTINCTION

has been awarded to

Presence Saints Mary and Elizabeth Medical Center

Chicago, IL

for Advanced Certification as a

Primary Stroke Center

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

September 26, 2019

Certification is customarily valid for up to 24 months.

David Perrott, MD, DDS, MBA, FACS
Chair, Board of Commissioners

ID #7308

Print Reprint Date: 09/26/2019

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original certification certificate has been issued for use in regulatory payer agency verification of certification by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current certification status and for a listing of the organization's locations of care.

ATTACHMENT 11

PURPOSE OF PROJECT

The purpose of the proposed project will modernize the areas through which certain services are provided at the hospital, and as a result, the health care and well-being of the communities that have traditionally looked to AMITA Health Saint Mary Hospital Chicago for care will be improved.

The hospital's geographic service area ("GSA") as defined by the HFSRB, includes those ZIP Code areas located within ten miles of the hospital. Below are listed the 96 ZIP Code areas located within a 10-mile radius of the hospital, and that area has a population of approximately 2,564,000.

ZIP	City
60622	CHICAGO
60642	CHICAGO
60612	CHICAGO
60647	CHICAGO
60674	CHICAGO
60614	CHICAGO
60610	CHICAGO
60661	CHICAGO
60654	CHICAGO
60607	CHICAGO
60606	CHICAGO
60657	CHICAGO
60602	CHICAGO
60624	CHICAGO

60603	CHICAGO
60601	CHICAGO
60701	CHICAGO
60604	CHICAGO
60611	CHICAGO
60618	CHICAGO
60689	CHICAGO
60651	CHICAGO
60613	CHICAGO
60608	CHICAGO
60664	CHICAGO
60668	CHICAGO
60669	CHICAGO
60670	CHICAGO
60673	CHICAGO
60675	CHICAGO
60677	CHICAGO
60678	CHICAGO
60680	CHICAGO
60681	CHICAGO
60684	CHICAGO
60685	CHICAGO
60686	CHICAGO
60687	CHICAGO
60688	CHICAGO
60690	CHICAGO
60691	CHICAGO
60693	CHICAGO
60694	CHICAGO
60696	CHICAGO
60697	CHICAGO
60699	CHICAGO
60695	CHICAGO

ATTACHMENT 12

60605	CHICAGO
60639	CHICAGO
60623	CHICAGO
60644	CHICAGO
60640	CHICAGO
60641	CHICAGO
60616	CHICAGO
60625	CHICAGO
60303	OAK PARK
60302	OAK PARK
60659	CHICAGO
60660	CHICAGO
60804	CICERO
60304	OAK PARK
60301	OAK PARK
60609	CHICAGO
60630	CHICAGO
60632	CHICAGO
60653	CHICAGO
60707	ELMWOOD PARK
60645	CHICAGO
60626	CHICAGO
60305	RIVER FOREST
60634	CHICAGO
60682	CHICAGO
60712	LINCOLNWOOD
60130	FOREST PARK
60402	BERWYN
60646	CHICAGO
60615	CHICAGO
60706	HARWOOD HEIGHTS
60171	RIVER GROVE
60141	HINES

ATTACHMENT 12

60202	EVANSTON
60153	MAYWOOD
60636	CHICAGO
60656	CHICAGO
60621	CHICAGO
60546	RIVERSIDE
60629	CHICAGO
60161	MELROSE PARK
60637	CHICAGO
60638	CHICAGO
60204	EVANSTON
60160	MELROSE PARK
60076	SKOKIE
60534	LYONS
60155	BROADVIEW
60631	CHICAGO

As is the case with most hospitals located in the metropolitan Chicago area, the hospital's primary service area (i.e., the neighborhoods and communities from which the hospital attracts a major portion of its patients) includes a much smaller geographic area than the HFSRB-identified GSA.

The table below identifies those ZIP Code areas accounting for 1.0%+ of the hospital's patient encounters during the past year. Twenty ZIP Code areas accounted for a minimum of 1.0% patient encounters, with only two ZIP Code areas accounting for 10.0% or more.

ZIP Code	City	Approximate Distance (miles)	Patient Encounters	%	Cumulative %
60647	Chicago	1.8	1,562	11.1%	11.1%
60622	Chicago	0	1,528	10.8%	21.9%
60639	Chicago	4.3	1,279	9.1%	30.9%
60651	Chicago	3.4	1,215	8.6%	39.5%
60624	Chicago	2.9	472	3.3%	42.9%
60641	Chicago	4.7	464	3.3%	46.2%
60618	Chicago	3.3	349	2.5%	48.6%
60634	Chicago	7.5	319	2.3%	50.9%
60612	Chicago	1.6	314	2.2%	53.1%
60626	Chicago	7.4	308	2.2%	55.3%
60642	Chicago	1.8	299	2.1%	57.4%
60644	Chicago	4.5	292	2.1%	59.5%
60202	Evanston	8.7	263	1.9%	61.3%
60623	Chicago	4.4	213	1.5%	62.9%
60629	Chicago	9.1	172	1.2%	64.1%
60608	Chicago	3.8	170	1.2%	65.3%
60645	Chicago	7.3	164	1.2%	66.4%
60640	Chicago	4.7	164	1.2%	67.6%
60804	Cicero	6.1	163	1.2%	68.8%
60625	Chicago	4.9	153	1.1%	68.8%
other ZIP Code areas <1.0%			4,260	31.2%	100.0%
			14,123		

The goal of the project is to improve the hospital's patient experience, as reflected in the post-discharge surveys returned by patients, and improved comments and ratings are anticipated as the various phases of the proposed project are completed.

ALTERNATIVES

The primary goal of the proposed project is to improve the facilities dedicated to the provision of ICU services and pre- and post-operative care, as well as numerous administrative and support functions. Because additional square footage is needed for many of these individual services, renovation without relocation, and particularly for the ICU, will not meet the project's goal. As such, aside from relocating the services to other locations within the hospital, no viable alternatives are available. Additionally, because the proposed project locates the pre-and post-operative (recovery) services adjacent to the surgical suite, from an accessibility perspective, any other locations in the hospital would be inferior.

The use of alternative sites in the hospital would result in a project that would have similar operating costs and an identical quality of care, compared to the proposed project, and the capital costs associated with alternative sites would likely be of a magnitude similar to those addressed in this Certificate of Need application.

The project does not involve any new construction, but rather reallocates existing space within the hospital.

SIZE

The proposed project addresses the renovation of 60,203 DGSF in five clinical and sixteen non-clinical functional areas of the hospital; and the proposed space plan is necessary and not excessive. The project does not involve any new construction.

Included in the proposed project are three functional areas having HFSRB-adopted space standards: ICU, PACU/Stage 1 Recovery and Stage 2 Recovery. The ICU beds, which will be located on the first and fifth floors, will occupy 15,899 DGSF, 1,911 DGSF below the adopted standard of 685 DGSF per bed. The PACU/Stage 1 Recovery areas will occupy 1,485 DGSF, 495 DGSF below the adopted standard of 180 DGSF per station. The Stage 2 Recovery area, which will be located on the first floor, will occupy 9,954 DGSF, 846 DGSF below the adopted standard of 400 DGSF per station.

The functional relationship between the surgical suite, the PACU/Stage 1 recovery area and the Stage 2 Recovery area make close proximity of the functions to one another highly desirous. Through the proposed project, existing space originally designed to accommodate a 20-bed ICU, and connected to the surgical suite by a non-public corridor, will be inexpensively converted into the proposed PACU/Stage 1 recovery area, and continue to house eight ICU beds.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ICU (26)	15,899	17,810	(1,911)	YES
PACU/Stage 1 Recov. (11)	1,485	1,980	(495)	YES
Stage 2 Recovery (27)	9,954	10,800	(846)	YES

ATTACHMENT 14

PROJECT SERVICES UTILIZATION

The proposed project includes one clinical service for which the HFSRB has adopted a utilization standard, ICU beds. And, the project is being developed consistent with the applicable utilization standard of 60%.

The hospital currently is authorized for 32 ICU beds. Through the proposed project, the total number of ICU beds will be reduced from 32 to 26. Eighteen of the beds will be located on the fifth floor, and eight beds will remain in the current ICU space on the first floor. The remainder of the current ICU will house the PACU/Stage 1 Recovery functions.

During the three-year period 2017-2019 (2020 data was not used due to the episodic impact of the Covid-19 pandemic on utilization), 15,342 patient days of care were provided in the hospital's ICU beds, resulting in an average daily census ("ADC") of 14.01 patients. (During that period the ADC of "traditional" ICU patients was 13.14 patients and the ADC of ICU "observation" patients was .87 patients). Future utilization is projected to increase, and primarily due to the rapidly aging population in the communities in the HFSRB-designated planning area, the primary source of patients for the hospital. Specifically, per IDPH projections, between 2017 and 2022, Health Planning Area A-02's 75+ population is projected to increase by 23.6% and the HPA's 65-74 age group is projected to grow by 17.6%, resulting in average annual increases of 4.7% and 3.5% for the two age groups accounting for the vast majority of ICU admissions, respectively. For planning purposes, utilization is projected to increase modestly (1.5-2.0% annually) through the second year following the project's completion, resulting in a 2026 average daily census of 15.32- 15.78 patients. Using the HFSRB-adopted target occupancy rate of 60% for ICUs, the proposed 26 beds are justified.

MEDICAL/SURGICAL, OBSTETRIC, PEDIATRIC, AND INTENSIVE CARE

The only inpatient category of service to be addressed through the proposed project is ICU. As discussed in ATTACHEMNT 15, the number of approved ICU beds will be reduced from 32 to 26, and the beds are anticipated to operate at the HFSRB's target utilization rate.

Twelve of the hospital's existing ICU beds are located on the first floor, and twenty are located on the fifth floor, which was originally designed as a Medical/Surgical unit. Upon the completion of the project, eighteen ICU beds will be located on the hospital's fifth floor, which will require major renovation to become consistent with contemporary ICU design standards, including the patient privacy afforded by a "hard wall" design. The remaining eight ICU beds will continue to be located in their existing location of the first floor, requiring minimal renovation. The balance of the current first floor ICU will be converted to the PACU/Stage 1 Recovery area.

In order to accommodate the relocation of ICU beds as discussed above, twenty Medical/Surgical beds will be removed from the fifth floor.

With the proposed reduction in the number of ICU beds to be provided, the performance requirement of having a minimum of four ICU beds will be reached, and per the discussion of utilization presented in ATTACHMENT 15, the proposed number of beds, twenty-six, are "justified".

The project's renovation, addressing the needs of the entire hospital, will include the replacement of a number of mechanical systems, including three electrical switchboards, two generators, and a primary air handling unit.

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project addresses four functional areas classified as "clinical", but not having HFSRB-adopted utilization standards: PACU/Stage 1 Recovery, Stage 2 Recovery, pre-admission testing, and inpatient dialysis.

The proposed project will, depending of the functional area addressed, improve facility-related challenges, and/or improve patient accessibility/patient flow. None of the clinical functions addressed in this ATTACHMENT have HFSRB-adopted utilization standards.

The PACU/Stage 1 Recovery and Stage 2 Recovery areas are being relocated to improve the patient flow associated with perioperative services, locating both functions in close proximity to the surgical suite. Similarly, the pre-admission testing function is being relocated from the ninth floor to an easily-accessible location on the first floor. Approximately 4,500 patients are projected to utilize the PACU/Stage I Recovery area, approximately 4,300 patients are projected to utilize the Stage 2 Recovery area annually, and approximately 3,200 patients are anticipated to utilize the pre-admission testing area, annually.

The inpatient dialysis unit, which will have four stations, is being provided to eliminate the need to transport inpatients from a Medical/Surgical unit through high-traffic corridors to the current unit, located on the first floor. The planned unit, which is anticipated to provide approximately 2,400 treatments, annually, will be located on the ninth floor.

#21-018

MOODY'S
INVESTORS SERVICE

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Rating Action: Moody's affirms Ascension's Aa2, Aa2/VMIG 1, Aa3, Aa3/VMIG 1 & P-1 ratings; stable outlook

29 Oct 2020

New York, October 29, 2020 -- Moody's Investors Service affirmed Ascension Health Alliance's (d/b/a Ascension) Aa2 and Aa2/VMIG 1 senior debt ratings, Aa3 and Aa3/VMIG 1 subordinated debt ratings, and P-1 commercial paper rating. We also affirmed the Aa2 rating for Presence Health's (IL) Series 2016C bonds, which are secured under Ascension's master trust indenture. We affirmed the Aa2 rating for Hospital de la Concepcion's Series 2017A and the Aa2/VMIG 1 rating for St. Vincent de Paul Center's Series 2000A bonds, both of which are guaranteed by Ascension. These actions affect approximately $7.4 billion of outstanding debt. The outlook is stable.

Please click on this link http://www.moodys.com/viewresearchdoc.aspx?docid=PBM_PBM906816793 for the List of Affected Credit Ratings. This list is an integral part of this Press Release and identifies each affected issuer.

RATINGS RATIONALE

The Aa2 affirmation reflects Moody's view that Ascension's large, diversified portfolio of sizable hospitals as one of the largest not-for-profit healthcare systems in the US, centralized management model, and strong liquidity will allow it to manage pandemic challenges while driving margin improvement. Further, investments in key markets and growth opportunities in non-acute care business lines will position the system to resume its pre-COVID trend of cashflow growth. The system's centralized governance and operating model, along with greater focus on consolidating certain outpatient clinical service lines, will provide a strong platform for further efficiencies and accelerated growth strategies. Liquidity will remain strong even after repaying the Medicare advances. Capital spending will increase to fund strategic initiatives, but we expect the system will align spending with cashflow generation as it has done in the past. Modest near-term margins from the material impact of COVID will elevate the system's operating leverage, but steady cashflow growth will improve this metric. The pace of operating improvement will be challenged by a potentially prolonged volume recovery due to new outbreaks and a likely increase in Medicaid amid the economic downturn. The Aa3 long-term subordinated rating reflects the contractual subordination of the related bonds.

The Aa2 affirmations and stable outlooks for St. Vincent de Paul Center and Hospital De La Conception are based on Ascension's legal guarantee of each entity's bonds. Ascension provides an irrevocable and unconditional guarantee covering full and timely payment of all scheduled payments of principal and interest on related bonds.

The P-1 commercial paper rating and VMIG 1 short-term bond ratings are based on the system's strong debt and treasury management and strong liquidity to pay maturing commercial paper notes or unremarketed bonds.

RATING OUTLOOK

The stable outlook reflects expected improvement in margins in FY 2021, which will be driven by volume recovery, cost management and already received federal relief grants. Accelerated growth strategies will drive further improvement beyond 2021. Strong liquidity will provide sufficient resources to repay Medicare advances. 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 OF THE RATINGS

-Significant and sustained improvement in operating margins

-Reduction in leverage and improved debt metrics

-Continued diversification of non-acute care revenues

-Short-term ratings: not applicable

FACTORS THAT COULD LEAD TO A DOWNGRADE OF THE RATINGS

-Inability to progressively improve margins

-Significant increase in leverage

-Materially dilutive merger or acquisition

-Notable sustained decline in liquidity

-Prolonged recovery from or significant resurgence of COVID

-Short-term ratings: downgrade of long-term rating or material reduction of 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. 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.

PROFILE

Ascension is one of the largest not-for-profit healthcare systems in the U.S. with $25 billion in revenue, operating 150 hospitals in 20 states and D.C.

METHODOLOGY

The principal methodology used in these long term ratings was Not-For-Profit Healthcare published in December 2018 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBM_1154632. The principal methodology used in these short term ratings was Short-term Debt of US States, Municipalities and Nonprofits Methodology published in July 2020 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBM_1210749. The principal methodology used in the long-term term ratings for entities guaranteed by Ascension was Rating Transactions Based on the Credit Substitution Approach: Letter of Credit-backed, Insured and Guaranteed Debts published in May 2017 and available at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_1068154. Alternatively, please see the Rating Methodologies page on www.moodys.com for a copy of these methodologies.

REGULATORY DISCLOSURES

The List of Affected Credit Ratings announced here are all solicited credit ratings. Additionally, the List of Affected Credit Ratings includes additional disclosures that vary with regard to some of the ratings. Please click on this link http://www.moodys.com/viewresearchdoc.aspx?docid=PBM_PBM906816793 for the List of Affected Credit Ratings. This list is an integral part of this Press Release and provides, for each of the credit ratings covered, Moody's disclosures on the following items:

ATTACHMENT 33

Related Issuers

Ascension Health Alliance

Connecticut Health & Educational Fac. Auth.

Hospital De La Concepcion

Illinois Development Finance Authority

Illinois Finance Authority

Related Research

Credit Opinion: Ascension Health Alliance: Update to credit analysis

Credit Opinion: Ascension Health Alliance: Update to credit analysis

Credit Opinion: Ascension Health Alliance: Update to credit analysis

Credit Opinion: CWA Authority, Inc., IN: Update to credit analysis following rating upgrade

Credit Opinion: Hanover College, IN: Update to credit analysis following revision of outlook to negative

#21-018

- Participation: Access to Management

- Participation: Access to Internal Documents

- Disclosure to Rated Entity

- Endorsement

For further specification of Moody's key rating assumptions and sensitivity analysis, see the sections Methodology Assumptions and Sensitivity to Assumptions in the disclosure form. Moody's Rating Symbols and Definitions can be found at: https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_79004.

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Please see www.moodys.com for any updates on changes to the lead rating analyst and to the Moody's legal entity that has issued the rating.

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Global

ATTACHMENT 33

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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)
Reviewable									
ICU		$ 470.00			15,899			$ 7,472,530	$ 7,472,530
Stage 1 Recovery		$ 110.00			1,485			$ 163,350	$ 163,350
Pre-OP/Stage 2 Recovery		$ 420.00			9,954			$ 4,180,680	$ 4,180,680
Inpatient Dialysis		$ 390.00			1,750			$ 682,500	$ 682,500
Pre-Admission Testing		$ 350.00			1,108			$ 387,800	$ 387,800
Contingency		$ 25.00						$ 754,900	$ 754,900
		$ 451.77			30,196			$ 13,641,760	$ 13,641,760
Non-Reviewable									
Residents' On Call/Work		$ 425.00			2,250			$ 956,250	$ 956,250
Public Waiting		$ 425.00			2,047			$ 869,975	$ 869,975
Retail Pharmacy		$ 450.00			2,128			$ 957,600	$ 957,600
Staff Lockers/Lounges		$ 400.00			3,443			$ 1,377,200	$ 1,377,200
Anesthesia Offices		$ 430.00			862			$ 370,660	$ 370,660
Conference Room		$ 425.00			505			$ 214,625	$ 214,625
Lobby		$ 425.00			3,030			$ 1,287,750	$ 1,287,750
Patient Registration		$ 425.00			2,782			$ 1,182,350	$ 1,182,350
Medical Records		$ 430.00			357			$ 153,510	$ 153,510
Nursing & Misc. Admin.		$ 430.00			4,795			$ 2,061,850	$ 2,061,850
Utilities		$ 400.00			285			$ 114,000	$ 114,000
Patient Advocacy		$ 430.00			564			$ 242,520	$ 242,520
Hospitalists' Offices		$ 430.00			1,038			$ 446,340	$ 446,340
Administrative Suite		$ 430.00			2,064			$ 887,520	$ 887,520
Medical Staff Offices		$ 430.00			1,445			$ 621,350	$ 621,350
Physicians' Work Room		$ 430.00			983			$ 422,690	$ 422,690
DGSF>>>BGSF		$ 425.00			1,429			$ 607,283	$ 607,283
Contingency		$ 25.00						$ 750,173	$ 750,173
		$ 450.68			30,007			$ 13,523,645	$ 13,523,645
PROJECT TOTAL		$ 451.23			60,203			$ 27,165,405	$ 27,165,405

ATTACHMENT 36C

#21-018

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

AMITA Health Saint Mary Hospital-Chicago

Projected Adj. Pt. Days:	141,833,174	
	2,047	69,288

Year 2 OPERATING COST per ADJUSTED PATIENT DAY

Salaries & Benefits		$115,761,800
Medical Supplies		$39,739,700
		$155,501,500
per Adjusted Patient Day:	$	2,244.27

YEAR 2 CAPITAL COST per ADJUSTED PATIENT DAY

Interest	$	5,092,500
Depreciation & Amortization	$	9,599,600
	$	14,692,100
per Adjusted Patient Day:	$	212.04

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