Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

August 4, 2021

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

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Need ("CON") application filed on behalf of Presence Central and Suburban Hospital Network and Ascension Health, addressing the establishment of an infusion therapy center in Romeoville.

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

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

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101

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 Romeoville Infusion Therapy Center				
Street Address:	500 South Weber Road				
City and Zip Code:	Romeoville, IL 60446				
County:	Will	Health Service Area:	IX	Health Planning Area:	N/A

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

Exact Legal Name:	Presence Central and Suburban Hospital Network
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:	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

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	AMITA Health Romeoville Infusion Therapy Center				
Street Address:	500 South Weber Road				
City and Zip Code:	Romeoville, IL 60446				
County:	Will	Health Service Area:	IX	Health Planning Area:	N/A

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
☐ 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.

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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
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 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: Remedy Medical Properties, Ltd.

Address of Site Owner: 800 West Madison Street Suite 400 Chicago, IL 60607

Street Address or Legal Description of the Site: 500 South Weber Road Romeoville, IL 60446

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 (operator)

Address: 2601 Navistar Drive Lisle, IL 60532

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

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

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

Organizational Relationships

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

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

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

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.

Through the proposed project, the applicants will modernize a portion of an existing medical clinics building ("MCB"), in order to provide space for the provision of infusion therapy services and for the development of a pharmacy to support the infusion therapy program. The MCB is currently leased by a subsidiary of applicant Ascension Health. Selected support functions, such as patient registration and utility functions often found in MCBs, are already present on site, and will not be duplicated.

The infusion therapy program will be operated under Presence Central and Suburban Hospitals Network, d/b/a AMITA Health Mercy Medical Center ("MMC"), and consistent with AMITA Health's policies relating to charity care and adjusted payment practices. Both Medicare and Medicaid recipients will be accepted for treatment.

AMITA Health, in the past, provided infusion therapy services in the southwestern suburbs through a contractual arrangement between MMC and a Joliet-based oncology practice at two locations; one in Joliet, Illinois and one in Morris, Illinois. That arrangement was terminated on December 31, 2020. MMC has engaged a new large regional oncology group, and has relocated the MMC infusion services to an interim location on the campus of MMC's sister hospital, AMITA Health Saint Joseph Medical Center, Joliet. The proposed Romeoville infusion center, which is located 6.1 miles from the current Joliet location, will replace the interim center as AMITA Health's primary site for the provision of outpatient infusion therapy services in the region.

While the majority of the infusion therapy treatments to be provided in the proposed center will be oncology-related, infusion therapy associated with other specialties will also be available through the center.

The proposed project is classified as "non-substantive" because it does not address any HFSRB-designated "categories of service"; and a Certificate of Need Permit is being sought because the anticipated project cost exceeds the applicable capital threshold.

PROJECT COST AND SOURCES OF FUNDS

	Reviewable	Non-Reviewable	Total
Project Cost:			
Preplanning Costs	$ 79,800		$ 79,800
Site Survey and Soil Investigation			
Site Preparation	$ 125,500		$ 125,500
Off Site Work			
New Construction Contracts	$ 2,939,085		$ 2,939,085
Modernization Contracts			
Contingencies	$ 199,260		$ 199,260
Architectural/Engineering Fees	$ 259,000		$ 259,000
Consulting and Other Fees	$ 846,750		$ 846,750
Movable and Other Equipment (not in construction contracts)	$ 1,558,500		$ 1,558,500
Net Interest Expense During Construction Period			
Fair Market Value of Leased Space	$ 324,733		$ 324,733
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized			
Acquisition of Building or Other Property			
TOTAL USES OF FUNDS	**$ 6,332,628**		**$ 6,332,628**
Sources of Funds:			
Cash and Securities	$ 6,007,895		$ 6,007,895
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$ 324,733		$ 324,733
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 6,332,628**		**$ 6,332,628**

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): __December 31, 2022_____

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**.

not applicable

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

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 Hospital 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.

SIGNATURE	SIGNATURE
DANA GILBERT	Julie P. Roknich
PRINTED NAME	PRINTED NAME
PRESIDENT	Secretary
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

CERTIFICATION

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

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

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

Christine McCoy
SIGNATURE

Christine McCoy
PRINTED NAME

Secretary
PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

Matthew Jagger
PRINTED NAME

Treasurer
PRINTED TITLE

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

Signature of Notary

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:

no unfinished or shell space 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:

no unfinished or shell space 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.

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
☐ **Infusion Therapy**	**0**	**21**
☐		
☐		

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.

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.

NOTE: 2019 represents the only full calendar year following Presence Health's joining of AMITA, and for which data is currently available.

CHARITY CARE			
			2019
Net Patient Revenue			**$2,770,845,150**
Amount of Charity Care (charges)			$327,033,617
Cost of Charity Care			$60,167,665

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

FLOOD PLAIN HAZARD AREA AND 500-YEAR FLOOD PLAIN DETERMINATION

With the signatures provided on the Certification pages of this Certificate of Need application, the applicants confirm that the AMITA Health Romeoville Medical Clinics Building is not located in a flood plain hazard area, nor is it located in a 500-year flood plain.

File Number 5968-176-1

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 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* 25TH *day of* NOVEMBER *A.D.* 2020 .

Authentication #: 2033002024 verifiable until 11/25/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6783-860-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

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

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

Jesse White

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's Romeoville Medical Clinics Building, located at 500 South Weber Road in Romeoville, is owned by Remedy Medical Properties, Ltd., which is incorporated in Delaware and is licensed to transact business in Illinois.

ATTACHMENT 2

File Number 7208-515-9

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

REMEDY MEDICAL PROPERTIES, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON JANUARY 06, 2020, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS 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* 25TH *day of* MAY ***A.D.*** 2021 .

Authentication #: 2114502204 verifiable until 05/25/2022
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 2

File Number 5968-176-1

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 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* 25TH *day of* NOVEMBER *A.D.* 2020 .

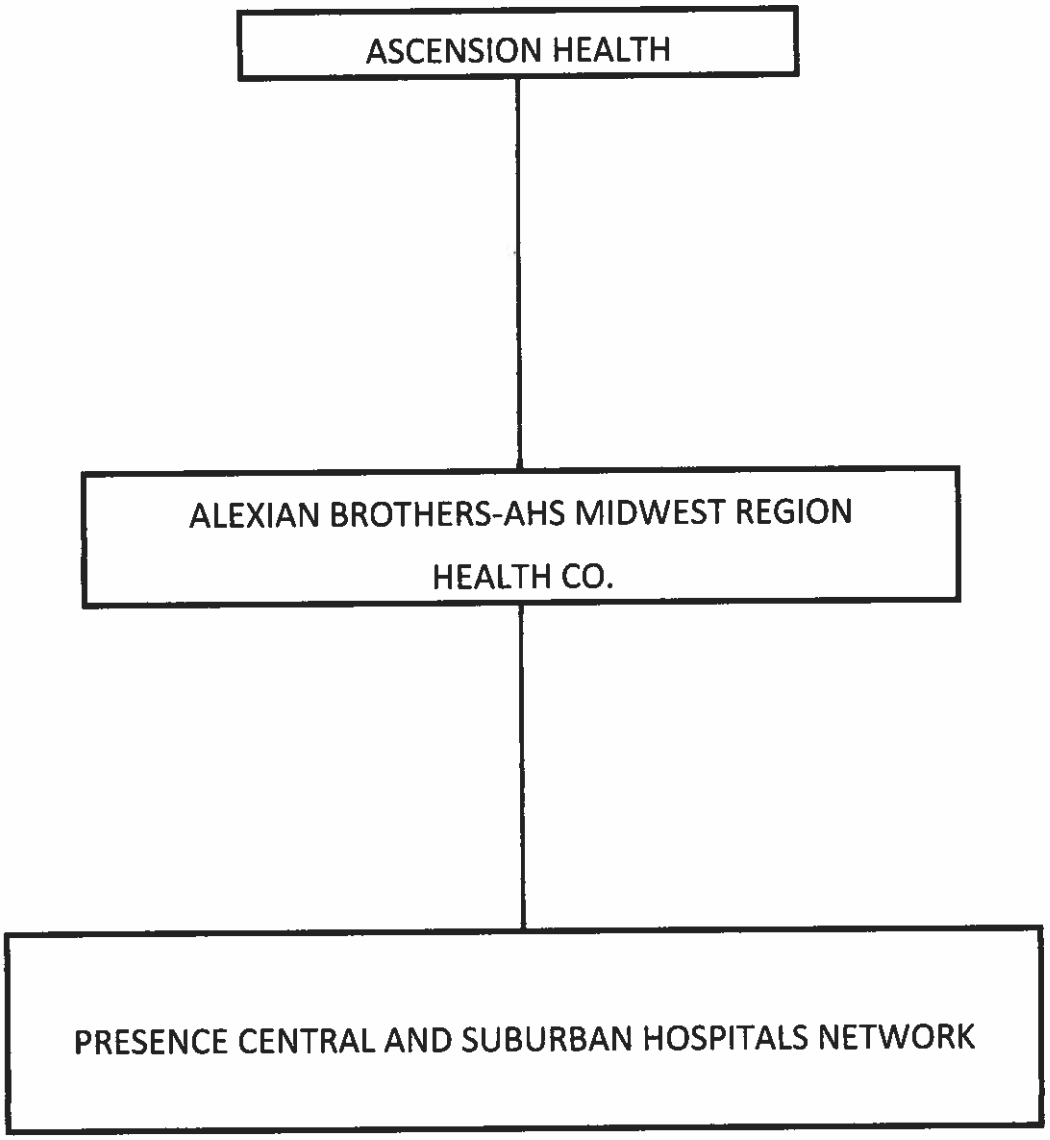
Authentication #: 2033002024 verifiable until 11/25/2021
Authenticate at: http://www.cyberdrivelllinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

ORGRANIZATIONAL 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 establishment of an infusion therapy center in a portion of an existing medical clinics building located at 500 South Weber Road in Romeoville, Illinois, 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

88°7'45"W 41°36'31"N

88°7'7"W 41°36'4"N

0 250 500 1,000 1,500 2,000 Feet 1:6,000

Basemap: USGS National Map: Orthoimagery: Data refreshed October 2020

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
- Area of Undetermined Flood Hazard Zone D

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 represen 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 3/29/2021 at 3:12 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 regulatory purposes.

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

Will County
Romeoville
CON - Rehabilitation of a Medical Office Building
500 S. Weber Road
SHPO Log #009040121

April 12, 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 projec 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 and
SOURCES OF FUNDS

PROJECT COSTS

Preplanning Costs				
Evaluation of Alternatives	$	39,800		
Arch./Consult. Selection	$	15,000		
Internal Approval Process	$	10,000		
Misc./Other	$	15,000		
			$	79,800
Site Preparation				
Driveways and Walkways	$	20,000		
Exterior Signage	$	30,500		
Misc./Other	$	75,000		
			$	125,500
New Construction Contracts				
Per ATTACHMENT 36C			$	2,939,085
Contingencies				
New Construction			$	199,260
Architectural and Engineering				
Design	$	180,000		
Document Preparation	$	10,000		
Interface with Agencies	$	10,000		
Project Monitoring	$	20,000		
Misc./Other	$	39,000		
			$	259,000
Consulting and Other Fees				
Project Management	$	300,000		
Zoning & Local Approvals	$	125,000		
CON-Related	$	75,000		
Interior Design	$	30,000		
Equipment Planning	$	46,750		
Insurance	$	25,000		
IT Planning	$	40,000		
Misc. Regulatory/Pharmacy	$	25,000		
Commissioning	$	50,000		
Legal	$	30,000		
Misc./Other	$	100,000		
			$	846,750
Movable Equipment				
Infusion Therapy Center	$	935,100		
Pharmacy	$	623,400		
			$	1,558,500

ATTACHMENT 7

PROJECT COSTS and
SOURCES OF FUNDS

FMV of Leased Space*	$	324,733
TOTAL SOURCES OF FUNDS	$	6,332,628

* The fair market value of the leased space is based on a pro-rated portion of an existing lease, the term of which expires in 2034.

ATTACHMENT 7

Cost Space Requirements

				Amount of Proposed Total Square Feet			
		Gross Square Feet			That is:		
Dept./Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
Infusion Therapy	$ 5,059,770	-	9,018	9,018			
Pharmacy	$ 1,272,858	-	945	945			
	$ 6,332,628	-	9,963	9,963			
Project Total	$ 6,332,628	-	9,963	9,963			

ATTACHMENT 9

BACKGROUND

Medical clinics buildings, and more specifically, infusion centers located in medical clinics buildings, are not licensed by the Illinois Department of Public Health. Applicant Ascension Health, however, owns, operates and/or ultimately controls the following Illinois 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

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

ATTACHMENT 11

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 ("CON") 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.

ATTACHMENT 11

PURPOSE OF PROJECT

The primary purpose of the proposed project is to provide infusion therapy services for area residents, including Medicare and Medicaid recipients, in an easily-accessible and calm setting; and by doing so, the applicants will be improving the health care and well-being of the market area population to be served.

The proposed site is easily-accessible to the patient populations traditionally looking to AMITA Health's Romeoville medical clinics building, AMITA Health Mercy Medical Center, Joliet, and its sister hospital, AMITA Health Saint Joseph Medical Center, Joliet sites of care.

The infusion center will be located in an existing medical clinics building ("MCB"), and consistent with the entire building, services will be provided in a "non-institutional" setting.

The proposed site is located in Will County, and per the HFSRB definition, the MCB's geographic service area consists of those ZIP Code areas located within ten miles of the site. A listing of those ZIP Code areas is provided below:

ZIP	City
60446	ROMEOVILLE
60441	LOCKPORT
60490	BOLINGBROOK
60440	BOLINGBROOK
60403	CREST HILL
60435	JOLIET

ATTACHMENT 12

60585	PLAINFIELD
60565	NAPERVILLE
60544	PLAINFIELD
60439	LEMONT
60564	NAPERVILLE
60432	JOLIET
60491	HOMER GLEN
60517	WOODRIDGE
60434	JOLIET
60586	PLAINFIELD
60516	DOWNERS GR.
60561	DARIEN
60540	NAPERVILLE
60431	JOLIET
60433	JOLIET

The cumulative population of the 21 ZIP Code areas identified as the geographic service area is approximately 660,000.

AMITA Health currently offers a variety of outpatient services in its Romeoville MCB, including x-ray, mammography, and immediate care, as well as AMITA Medical Group offices providing women's health, GI, and primary care services. Provided on the following page is a patient origin analysis of the services currently provided in the MCB; and it is believed that within two years of the infusion therapy center's opening, the origin of patients availing themselves of that service will be very similar to that of the patients currently receiving services in the MCB.

ATTACHMENT 12

ZIP Code	Community	2019-2020 Pt. Encounters	%	Cumulative %
60446	Romeoville	1,511	27.8%	27.8%
60403	Crest Hill	803	14.8%	42.6%
60435	Joliet	706	13.0%	55.6%
60441	Lockport	533	9.8%	65.4%
60544	Plainfield	373	6.9%	72.2%
60436	Joliet	172	3.2%	75.4%
60431	Joliet	148	2.7%	78.1%
60432	Joliet	135	2.5%	80.6%
60586	Plainfield	127	2.3%	82.9%
60404	Shorewood	123	2.3%	85.2%
60440	Bolingbrook	93	1.7%	86.9%
60433	Joliet	87	1.6%	88.5%
60439	Lemont	57	1.0%	89.6%
	all other, < 1.0%	568	10.4%	100.0%
		5,436		

Comparing the two tables above, it can be seen that the thirteen ZIP Code areas/communities accounting for the highest number of patient encounters, 82.9% of the total encounters, are located within the HFSRB-designated geographic service area.

The goal of the proposed project is to initiate the provision of infusion therapy services at the proposed center within thirty days of the project completion date identified in this Certificate of Need application.

ATTACHMENT 12

ALTERNATIVES

Given the identified need for additional infusion therapy capacity in the area, two alternatives were evaluated by the applicants.

The first alternative considered was the construction of a freestanding building in the general vicinity of the proposed site, to house the infusion therapy program. This alternative was dismissed due to the unnecessary capital costs that would be incurred. In addition to the acquisition cost associated with the purchase of a suitable site, the actual square footage that would need to be constructed would increase by approximately 30% (2,000 sf) to accommodate needed non-clinical areas, the cost of new construction would exceed that of the proposed project, and the cost of providing parking would be incurred. In total, approximately $2M in construction-related costs would be added to the project. Had this alternative been selected, the quality of care, operating costs, and patient accessibility would be identical that of the proposed project.

The second alternative considered was the conversion of space within AMITA Health Saint Joseph Medical Center Joliet into a "non-institutional" appearing infusion therapy center. Because the center would have been located in a hospital, conceptually, and from a regulatory perspective, this alternative would be difficult to fully accomplish. However, had this alternative been undertaken, patient accessibility from the east would have been compromised, the capital costs would have exceeded those of the proposed project by approximately $1M, and the quality of care would be identical to that of the proposed project.

SIZE

The proposed project includes two clinical areas: a 21-station infusion therapy center and a pharmacy, providing support to the infusion therapy center, exclusively.

The infusion therapy center will consist of 9,018 dgsf, and include fifteen private therapy stations, a six-station communal therapy area, and a variety of support areas, including a control station, consultation rooms, supply and equipment storage areas, a physician work area, and staff areas.

The pharmacy will occupy 945 dgsf, and include a compounding area, pharmacists' work stations, storage, and an office.

The HFSRB does not have adopted space standards for either of the proposed clinical areas.

UTILIZATION

Infusion therapy utilization projections are based, in major part, on AMITA Health's experience in the provision of infusion therapy services in the western and southwestern suburbs, both in the cancer center and hospital settings.

Utilization, in terms of administrations, assume patients to receive an average of 14.89 administrations, occupying an infusion station for, on average, 3 hours per administration, both of which are consistent with AMITA Health's experience. The center is projected to operate 255 days a year (Monday-Friday) from 8AM to 8PM, with a target utilization/occupancy rate of 75%.

As discussed in the Narrative Description section of this application, AMITA Health's oncology relationship in the southwestern suburbs is currently transitioning from one with a Joliet-based oncology group to one with a regional oncology group, in association with its relocation of its infusion services from sites in Joliet and Morris, to an interim site at AMITA Health Saint Joseph Medical Center, Joliet, to ultimately the Romeoville location. Conservatively, and in part as a result of AMITA Health's commitment to the treatment of Medicare and Medicaid recipients, by 2024, the applicants anticipate that the proposed infusion therapy center in Romeoville will "recapture" approximately 40% of the historical caseload from the Joliet center and 15% of the historical caseload from the Morris center, a total of approximately 1,075 patients. Using the variables identified in the paragraph above, and as demonstrated below, the need for the proposed twenty-one stations is supported.

Joliet center patients @ 40%	955
Morris center patients @ 15%	120
projected Year 2 patients	1,075
treatments per patient	14.89
Year 2 treatments	16,007
hours per treatment	3
Year 2 treatment hours	48,021
annual treatment days	255
Year 2 hrs. of treatment per day	188.3
hrs. of operation per day	12
concurrent patients	15.69
targeted utilization/occupancy	75%
stations needed	20.9>>21

ATTACHMENT 15

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project does not include any clinical services areas for which the HFSRB has adopted utilization standards. Please refer to ATTACHMENT 15 for a discussion of the projected utilization of the infusion therapy service.

ATTACHMENT 30

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:

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

ATTACHMENT 33

- 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.

For ratings issued on a program, series, category/class of debt or security this announcement provides certain regulatory disclosures in relation to each rating of a subsequently issued bond or note of the same series, category/class of debt, security or pursuant to a program for which the ratings are derived exclusively from existing ratings in accordance with Moody's rating practices. For ratings issued on a support provider, this announcement provides certain regulatory disclosures in relation to the credit rating action on the support provider and in relation to each particular credit rating action for securities that derive their credit ratings from the support provider's credit rating. For provisional ratings, this announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating. For further information please see the ratings tab on the issuer/entity page for the respective issuer on www.moodys.com.

Regulatory disclosures contained in this press release apply to the credit rating and, if applicable, the related rating outlook or rating review.

Moody's general principles for assessing environmental, social and governance (ESG) risks in our credit analysis can be found at https://www.moodys.com/researchdocumentcontentpage.aspx?docid=PBC_1133569.

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.

Please see the ratings tab on the issuer/entity page on www.moodys.com for additional regulatory disclosures for each credit rating.

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MOODY'S
INVESTORS SERVICE

ATTACHMENT 33

ATTACHMENT 33

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									
Infusion Therapy	$ 295.00		9,018				$ 2,660,310		$ 2,660,310
Pharmacy	$ 295.00		945				$ 278,775		$ 278,775
Contingency	$ 20.00						$ 180,360		$ 180,360
	$ 313.10		9,963				$ 3,119,445		$ 3,119,445
Project Total	**$ 313.10**		**9,963**				**$ 3,119,445**		**$ 3,119,445**

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ATTACHMENT 36C

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

AMITA Health Romeoville Medical Clinics Building
Infusion Therapy Related Services

Projected Year 2 Infusion Therapy Administrations: 16,007

Year 2 Operating Cost per Adminsitration

Salaries and Benefits:	$	1,818,038
Infusion-Related Supplies:	$	7,782,200
	$	9,600,238
per Administration:	$	599.75

Year 2 Capital Cost per Administration

Interest, Depreciation, and Amortization:	$	467,957
per Administration:	$	29.23

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

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