ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Midwestern Regional Medical Center---Real Estate a/k/a Cancer Treatment Centers of America, Chicago
Street Address:	2520 Elisha Avenue
City and Zip Code:	Zion, IL 60099
County: Lake	Health Service Area: VIII Health Planning Area: A-09

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	Midwestern Regional Medical Center, LLC
Street Address:	2520 Elisha Avenue
City and Zip Code:	Zion, IL 60099
Name of Registered Agent:	Angela S. Minshall
Registered Agent Street Address:	2610 Sheridan Road
Registered Agent City and Zip Code:	Zion, IL 60099
Name of Chief Executive Officer:	Pete Govorchin
CEO Street Address:	2520 Elisha Avenue
CEO City and Zip Code:	Zion, IL 60099 847/872-6309
CEO Telephone Number:	847/872-6309

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- X 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:	

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County: Lake	Health Service Area: VIII Health Planning Area: A-09

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	Sheridan Trust U/A/D 4/1/12
Street Address:	c/o Dennis P. Lynde, Trustee 20 N. Martingdale Road Ste 180
City and Zip Code:	Schaumburg, IL 60173
Name of Registered Agent:	N/A
Registered Agent Street Address:	N/A
Registered Agent City and Zip Code:	N/A
Name of Chief Executive Officer:	N/A
CEO Street Address:	N/A
CEO City and Zip Code:	N/A
CEO Telephone Number:	N/A

Type of Ownership of Applicants

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

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County: Lake	Health Service Area: VIII Health Planning Area: A-09

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	Northeast Illinois Medical Properties L.P.
Street Address:	2520 Elisha Avenue
City and Zip Code:	Zion, IL 60099
Name of Registered Agent:	Angela S. Minshall
Registered Agent Street Address:	2610 Sheridan Road
Registered Agent City and Zip Code:	Zion, IL 60099
Name of Chief Executive Officer:	Robert Mayo, General Partner
CEO Street Address:	c/o Dennis P. Lynne 201 N. Martingale Road Suite 180
CEO City and Zip Code:	Schaumburg, IL 60173
CEO Telephone Number:	847/342-6881

Type of Ownership of Applicants

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

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	2520 Elisha Avenue
City and Zip Code:	Zion, IL 60099
County: Lake	Health Service Area: VIII Health Planning Area: A-09

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	RJS Capital Investment Company d/b/a International Capital Investment Company
Street Address:	c/o Dennis Lynde 20 N. Martingdale Lane Suite 180
City and Zip Code:	Schaumburg, IL 60173
Name of Registered Agent:	Dennis Lynde
Registered Agent Street Address:	20 N. Martingdale Lane Suite 180
Registered Agent City and Zip Code:	Schaumburg, IL 60173
Name of Chief Executive Officer:	Dennis Lynde, President
CEO Street Address:	20 N. Martingdale Lane, Suite 180
CEO City and Zip Code:	Schaumburg, IL 60173
CEO Telephone Number:	847/342-6881

Type of Ownership of Applicants

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

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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County: Lake	Health Service Area: VIII Health Planning Area: A-09

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	Robert W. Mayo
Street Address:	20 N. Martingale Road Suite 180
City and Zip Code:	Schaumburg, IL 60173
Name of Registered Agent:	N/A
Registered Agent Street Address:	N/A
Registered Agent City and Zip Code:	N/A
Name of Chief Executive Officer:	N/A
CEO Street Address:	201 N. Martingale Road Suite 180
CEO City and Zip Code:	Schaumburg, IL 60173
CEO Telephone Number:	847/342-6881

Type of Ownership of Applicants

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Facility Name:	Midwestern Regional Medical Center---Real Estate a/k/a Cancer Treatment Centers of America, Chicago		
Street Address:	2520 Elisha Avenue		
City and Zip Code:	Zion, IL 60099		
County: Lake	Health Service Area: VIII	Health Planning Area: A-09	

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	COH HoldCo Inc.
Street Address:	1500 East Duarte Road
City and Zip Code:	Duarte, CA 91010
Name of Registered Agent:	The Corporation Trust Company
Registered Agent Street Address:	1209 Orange Street
Registered Agent City and Zip Code:	Wilmington, DE 19801
Name of Chief Executive Officer:	Robert Stone
CEO Street Address:	1500 East Duarte Road
CEO City and Zip Code:	Duarte, CA 91203
CEO Telephone Number:	626/256-4673

Type of Ownership of Applicants

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

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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
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Street Address:	2520 Elisha Avenue		
City and Zip Code:	Zion, IL 60099		
County: Lake	Health Service Area: VIII	Health Planning Area: A-09	

Legislators

State Senator Name:	Melinda Bush
State Representative Name:	Joyce Mason

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

Exact Legal Name:	City of Hope
Street Address:	1500 East Duarte Road
City and Zip Code:	Duarte, CA 91010
Name of Registered Agent:	C T Corporation System
Registered Agent Street Address:	330 N. Brand Blvd. Suite 700
Registered Agent City and Zip Code:	Glendale, CA 91203
Name of Chief Executive Officer:	Robert Stone
CEO Street Address:	1500 East Duarte Road
CEO City and Zip Code:	Duarte, CA 91203
CEO Telephone Number:	626/256-4673

Type of Ownership of Applicants

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

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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]

Name:	Monica Hon
Title:	Vice President & Director of Client Solutions
Company Name:	Advis, Inc.
Address:	7840 Graphics Drive, Ste 100 Tinley Park, IL 60477
Telephone Number:	708/478-7030
E-mail Address:	mhon@advis.com
Fax Number:	708/478-7094

Post Exemption Contact

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

Name:	to be named prior to transaction's closing
Title:	CEO
Company Name:	Midwestern Regional Medical Center
Address:	2520 Elisha Avenue Zion, IL 60099
Telephone Number:	847/872-6309
E-mail Address:	
Fax Number:	

Site Ownership after the Project is Complete

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Northeast Illinois Medical Properties, LLC*
Address of Site Owner: 1500 East Duarte Road Duarte, CA 91010
Street Address or Legal Description of the Site: 2520 Elisha Avenue Zion, IL 60099 **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.

*converted from an L.P. prior to the closing of the proposed transaction

Current Operating Identity/Licensee

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

Exact Legal Name:	Midwestern Regional Medical Center, LLC
Address:	2520 Elisha Avenue Zion, IL 60099

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

Operating Identity/Licensee after the Project is Complete

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

Exact Legal Name:	Midwestern Regional Medical Center, LLC
Address:	2520 Elisha Avenue Zion, IL 60099

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

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

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

Organizational Relationships

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

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

Narrative Description

In the space below, provide a brief narrative description of the change of ownership. 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.

This Certificate of Exemption ("COE") application addresses the change of ownership and control of the real estate associated with Midwestern Regional Medical Center ("MRMC") a/k/a Cancer Treatment Centers of America, Chicago, located in Zion, Illinois.

Upon the completion of the proposed transaction addressed in this application, the real estate will be owned and controlled by a subsidiary of City of Hope ("COH"), Northeast Illinois Medical Properties, LLC (converted from an L.P. prior to the transaction's closing). The changes of ownership addressed in this COE application and the accompanying application addressing MRMC's licensee are part of a larger transaction addressing COH's acquisition of the Cancer Treatment Centers of America's three hospitals in Georgia, Arizona and Illinois.

The applicants are: 1) Midwestern Regional Medical Center, LLC, the current and post-transaction licensee of the hospital; 2) Sheridan Trust U/A/D 4/1/12, which currently controls MRMC by virtue of its 70% Class A Voting interest in MRMC; 3) Northeast Illinois Medical Properties L.P. ("NIMP"), which currently owns the real estate; 4) RJS Capital Investment Company d/b/a International Capital Investment Company, which holds final control over NIMP; 5) Robert W. Mayo, general partner of NIMP, and who has the authority to direct the sale of NIMP assets; 6) COH HoldCo Inc., which will own the real estate in its entirety, following the closing of the proposed transaction; and 7) City of Hope, which will have final control over COH HoldCo Inc.

.

Concurrent to the filing of this COE application, a second COE application is being filed, addressing the change of ownership of the MRMC, the hospital/licensee. The changes of ownership addressed in the two COE applications are intended to occur simultaneously.

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 X Yes ☐ No
Purchase Price: $_____

included in identified acquisition cost identified in response to review criterion 1130.520.(b)(1)(G)

Fair Market Value: $_____

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No _X_. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): _within 60 days of the receipt of the requested Certificate of exemption___

State Agency Submittals

Are the following submittals up to date as applicable:

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

CERTIFICATION

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

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

This Application is filed on the behalf of ___Midwestern Regional Medical Center, LLC_____* 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.

Dennis P. Lynde
SIGNATURE

Dennis P. Lynde
PRINTED NAME

Sole Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of December 2021

Karen E. Schell
Signature of Notary

Seal

KAREN E SCHELL
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 15, 2024

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- 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 ___Sheridan Trust U/A/D 4/1/12_____* 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

Richard J Stephenson
PRINTED NAME

Beneficiary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of December

Signature of Notary

Seal

KAREN E SCHELL
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 15, 2024

SIGNATURE

Ann Stephenson Hostetler
PRINTED NAME

Beneficiary
PRINTED TITLE

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

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of ___Sheridan Trust U/A/D 4/1/12_____* 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
Richard J Stephenson PRINTED NAME	Ann Stephenson Hostetler PRINTED NAME
Beneficiary PRINTED TITLE	Beneficiary PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 2ND day of December 2021
Signature of Notary	Signature of Notary
Seal	Seal

KELLEY JERNIGAN BLACK NOTARY PUBLIC My Comm Expires Aug 15, 2022 DADE COUNTY STATE OF GEORGIA

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist), and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of ___Northeast Illinois Medical Properties L.P.____* 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

Robert W. Mayo
PRINTED NAME

General Partner
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 06 day of December, 2021

Signature of Notary

Seal

AJA SAMMONS
MY COMMISSION # GG330512
EXPIRES: July 16, 2023

SIGNATURE

Dennis P. Lynde
PRINTED NAME

Authorized Signer
PRINTED TITLE

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

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- 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 ___Northeast Illinois Medical Properties L.P.____* 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.

_____	Dennis P. Lynde
SIGNATURE	SIGNATURE
Robert W. Mayo	Dennis P. Lynde
PRINTED NAME	PRINTED NAME
General Partner	Authorized Signer
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me	Subscribed and sworn to before me
this _____ day of _____	this 6th day of December, 2021
_____	Karen E. Schell
Signature of Notary	Signature of Notary
Seal	Seal
	KAREN E SCHELL Official Seal Notary Public - State of Illinois My Commission Expires Sep 15, 2024

*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 _RJS Capital Investment Company d/b/a International Capital Investment Company_* 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.

Dennis P. Lynde
SIGNATURE

Dennis P. Lynde
PRINTED NAME

Global Managing Director
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of December, 2021

Signature of Notary

Seal

KAREN E SCHELL
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 15, 2024

SIGNATURE

STEVEN L KROOL
PRINTED NAME

SECRETARY
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of December

Signature of Notary

Seal

KAREN E SCHELL
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 15, 2024

*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 ___Robert W. Mayo_____* 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

Robert W. Mayo
PRINTED NAME

General Partner
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 06 day of December, 2021

Signature of Notary

Seal

AJA SAMMONS
MY COMMISSION # GG330512
EXPIRES: July 16, 2023

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

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 City of Hope* 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

Jennifer Ann Parkhurst
PRINTED NAME

Treasurer and Chief Financial Officer
PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

Robert William Stone
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization: See attached CA Jurat
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 2 day of December,

20 21 by Jennifer Ann Parkhurst,

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Victoria Taylor-McKinley
Signature (Seal)

VICTORIA TAYLOR-MCKINLEY
Notary Public - California
Los Angeles County
Commission # 2376310
My Comm. Expires Sep 25, 2025

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Certificate of Living Trust
(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages ____ Document Date ____

Additional information

INSTRUCTIONS

The wording of all Jurats completed in California after January 1, 2015 must be in the form as set forth within this Jurat. There are no exceptions. If a Jurat to be completed does not follow this form, the notary must correct the verbiage by using a jurat stamp containing the correct wording or attaching a separate jurat form such as this one with does contain the proper wording. In addition, the notary must require an oath or affirmation from the document signer regarding the truthfulness of the contents of the document. The document must be signed AFTER the oath or affirmation. If the document was previously signed, it must be re-signed in front of the notary public during the jurat process.

- State and county information must be the state and county where the document signer(s) personally appeared before the notary public.
- Date of notarization must be the date the signer(s) personally appeared which must also be the same date the jurat process is completed.
- Print the name(s) of the document signer(s) who personally appear at the time of notarization.
- Signature of the notary public must match the signature on file with the office of the county clerk.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different jurat form.
  - Additional information is not required but could help to ensure this jurat is not misused or attached to a different document.
  - Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

CALIFORNIA JURAT WITH AFFIANT STATEMENT

GOVERNMENT CODE § 8202

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], ~~not~~ Notary)

Signature of Document Signer No. 1

Signature of Document Signer No. 2 (if any)

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me
on this 6th (Date) day of December (Month), 20 21 (Year)
by
(1) Robert William Stone (Name of Signer),
proved to me on the basis of satisfactory evidence
to be the person who appeared ~~before me~~ (.) (,)
(and
(2) _____ (Name of Signer),
proved to me on the basis of satisfactory evidence
to be the person who appeared before me.)

MARTHA VALENZUELA
Notary Public - California
Los Angeles County
Commission # 2360366
My Comm. Expires Jun 8, 2025

Place Notary Seal Above

Signature _____ (Signature of Notary Public)

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

RIGHT THUMBPRINT OF SIGNER #1	RIGHT THUMBPRINT OF SIGNER #2
Top of thumb here	Top of thumb here

Further Description of Any Attached Document

Title or Type of Document: Certification / Notary Hope

Document Date: _____ Number of Pages: ___

Signer(s) Other Than Named Above: _____

Item #5910

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 COH HoldCo Inc. * 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

Jennifer Ann Parkhurst
PRINTED NAME

Treasurer
PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

Robert William Stone
PRINTED NAME

President
PRINTED TITLE

Notarization: See attached CA Jurat
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 2 day of December, 20 21 by Jennifer Ann Parkhurst,

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

VICTORIA TAYLOR-MCKINLEY
Notary Public - California
Los Angeles County
Commission # 2376310
My Comm. Expires Sep 25, 2025

Signature (Seal)

OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

Certificate of Good Standing

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages ____ Document Date ____

Additional information

INSTRUCTIONS

The wording of all Jurats completed in California after January 1, 2015 must be in the form as set forth within this Jurat. There are no exceptions. If a Jurat to be completed does not follow this form, the notary must correct the verbiage by using a jurat stamp containing the correct wording or attaching a separate jurat form such as this one with does contain the proper wording. In addition, the notary must require an oath or affirmation from the document signer regarding the truthfulness of the contents of the document. The document must be signed AFTER the oath or affirmation. If the document was previously signed, it must be re-signed in front of the notary public during the jurat process.

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  - Additional information is not required but could help to ensure this jurat is not misused or attached to a different document.
  - Indicate title or type of attached document, number of pages and date.
- Securely attach this document to the signed document with a staple.

CALIFORNIA JURAT WITH AFFIANT STATEMENT

GOVERNMENT CODE § 8202

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

1
2
3
4
5
6

Signature of Document Signer No. 1

Signature of Document Signer No. 2 (if any)

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 6th (Date) day of December (Month), 2021 (Year)
by
(1) Robert William Stone (Name of Signer)
proved to me on the basis of satisfactory evidence to be the person who appeared before me.) (.) (.)
(and
(2) _____ (Name of Signer)
proved to me on the basis of satisfactory evidence to be the person who appeared before me.)

MARTHA VALENZUELA
Notary Public - California
Los Angeles County
Commission # 2360366
My Comm. Expires Jun 8, 2025

Place Notary Seal Above

Signature _____
Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

RIGHT THUMBPRINT OF SIGNER #1	RIGHT THUMBPRINT OF SIGNER #2
Top of thumb here	Top of thumb here

Further Description of Any Attached Document

Title or Type of Document: Certification / COA Gold Co Inc.

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

Item #5910

SECTION II. BACKGROUND.

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. 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. 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.

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, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 5.

SECTION III. CHANGE OF OWNERSHIP (CHOW)

Transaction Type. Check the Following that Applies to the Transaction:

- ☐ Purchase resulting in the issuance of a license to an entity different from current licensee.
- ☐ Lease resulting in the issuance of a license to an entity different from current licensee.
- ☐ Stock transfer resulting in the issuance of a license to a different entity from current licensee.
- ☐ Stock transfer resulting in no change from current licensee.
- ☐ Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee.
- ☐ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee.
- ☐ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity.
- ☐ Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets.
- ☐ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility.
- X Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee.
- ☐ Change of ownership among related persons resulting in a license being issued to an entity different from the current licensee
- ☐ Change of ownership among related persons that does not result in a license being issued to an entity different from the current licensee.
- ☐ Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets and explain in "Narrative Description."

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(3) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(4) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(5) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X

1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

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

SECTION IV.CHARITY CARE INFORMATION

NOT APPLICABLE, APPLICATION IS LIMITED TO REAL ESTATE

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 7.

CHARITY CARE			
	2018	**2019**	**2020**
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0948484-1

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

MIDWESTERN REGIONAL MEDICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 31, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 14TH *day of* OCTOBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

Authentication #: 2128702072 verifiable until 10/14/2022
Authenticate at: http://www.ilsos.gov

ATTACHMENT 1

Secretary of State
Certificate of Status

I, SHIRLEY N. WEBER, Ph.D., Secretary of State of the State of California, hereby certify:

Entity Name:	CITY OF HOPE
File Number:	C0948790
Registration Date:	01/01/1980
Entity Type:	DOMESTIC NONPROFIT CORPORATION
Jurisdiction:	CALIFORNIA
Status:	ACTIVE (GOOD STANDING)

As of November 10, 2021 (Certification Date), the entity is authorized to exercise all of its powers, rights and privileges in California.

This certificate relates to the status of the entity on the Secretary of State's records as of the Certification Date and does not reflect documents that are pending review or other events that may affect status.

No information is available from this office regarding the financial condition, status of licenses, if any, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of November 11, 2021.

SHIRLEY N. WEBER, Ph.D.
Secretary of State

Certificate Verification Number: RG6V3GZ

To verify the issuance of this Certificate, use the Certificate Verification Number above with the Secretary of State Certification Verification Search available at bebizfile.sos.ca.gov/certification/index.

File Number 5756-626-4

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

RJS CAPITAL INVESTMENT COMPANY, INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON NOVEMBER 24, 1993, AND MUST CONDUCT ALL BUSINESS IN THIS STATE UNDER THE ASSUMED NAME OF INTERNATIONAL CAPITAL INVESTMENT COMPANY, 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* 1ST *day of* DECEMBER *A.D.* 2021 .

Authentication #: 2133503512 verifiable until 12/01/2022
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number C006090

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

NORTHEAST ILLINOIS MEDICAL PROPERTIES L.P., HAVING REGISTERED IN THE STATE OF ILLINOIS ON APRIL 03, 1991, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE UNIFORM LIMITED PARTNERSHIP ACT (2001) OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LP/LLLP IN THE STATE OF ILLINOIS, HAVING FULFILLED ALL REQUIREMENTS OF SAID ACT WITH REGARD TO PAYMENT OF FEES, THE FILING OF ANNUAL REPORTS (IF APPLICABLE) AND NEITHER HAVING BEEN ADMINISTRATIVELY DISSOLVED BY THE SECRETARY OF STATE NOR HAVING VOLUNTARILY FILED A STATEMENT OF TERMINATION.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 12TH *day of* NOVEMBER *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

Authentication #: 2131602990

Authenticate at: https://www.ilsos.gov

ATTACHMENT 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "COH HOLDCO INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE NINETEENTH DAY OF NOVEMBER, A.D. 2021.

AND I DO HEREBY FURTHER CERTIFY THAT THE AFORESAID CORPORATION IS AN EXEMPT CORPORATION.

6373565 8300C

SR# 20213858663

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 204751088

Date: 11-19-21

ATTACHMENT 1

SITE OWNERSHIP

With the signatures on the Certification pages of this Certificate of Exemption application, the applicants attest to the fact that the site of Midwestern Regional Medical Center ("MRMC"), that being 2520 Elisha Avenue in Zion, Illinois, is currently owned by Northeast Illinois Medical Properties L.P.; and, prior to the proposed transaction's closing, Northeast Illinois Medical Properties L.P. will be converted to an LLC, Northeast Illinois Medical Properties, LLC. Northeast Illinois Medical Properties, LLC will be owned by COH HoldCo Inc. upon the closing of the transaction addressed in the Certificate of Exemption and the accompanying application, addressing MRMC's licensee.

POST-TRANSACTION OPERATING IDENTITY/LICENSEE

The hospital's current licensee, Midwestern Regional Medical Center, LLC, will remain as the licensee following the closing of the proposed transaction.

File Number 0948484-1

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

MIDWESTERN REGIONAL MEDICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 31, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 14TH *day of* OCTOBER *A.D.* 2021 .

Jesse White

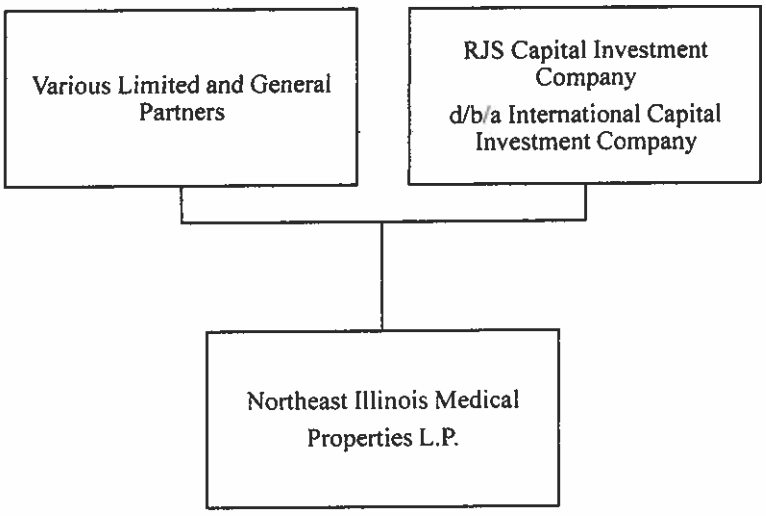
SECRETARY OF STATE

Authentication #: 2128702072 verifiable until 10/14/2022

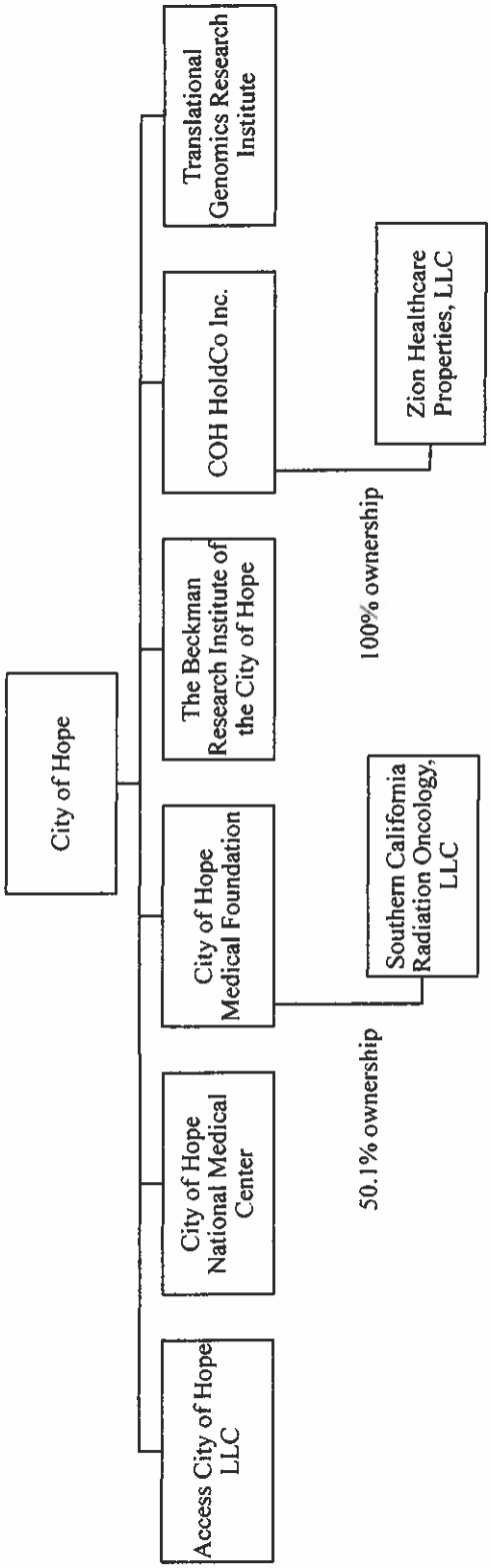
Authenticate at: http://www.ilsos.gov

ATTACHMENT 3

Pre-Closing Organizational Chart
Real Estate



Post-Closing Organizational Chart



BACKGROUND OF APPLICANTS

With the exception of Midwestern Regional Medical Center, LLC, no applicant owns and/or operates any hospitals, skilled care nursing facilities, ambulatory surgical treatment centers, or end stage renal dialysis facilities in Illinois.

Applicant RJS Capital Investment Company d/b/a International Capital Investment Company, holds a 50.194% ownership interest in Northeast Illinois Medical Properties L.P. ("NIMP L.P."). Richard J. Stephenson Revocable Trust U/A/D 9/14/93 holds a 45.926% interest in NIMP L.P., and two trusts and one individual each own less than a 2% share.

Entities related to an applicant own and operate Cancer Treatment Center of America hospitals in Atlanta and Phoenix, and City of Hope owns and operates City of Hope National Medical Center in Duarte, California.

BACKGROUND OF THE APPLICANTS

With the signatures provided on the Certification pages of this Certificate of Exemption ("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 COE application. Further, with the signatures provided on the Certification pages of this COE 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.

#E-061-21

DISPLAY THIS PART IN A CONSPICUOUS PLACE

HF 122927

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	LO NUMBER
06/30/2022		0002956

General Hospital

Effective: 07/01/2021

Midwestern Regional Medical Center
2520 Elisha Ave
Zion, IL 60099

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-483-001 10M 9/18

Exp. Date 06/30/2022

Lic Number 0002956

Date Printed 05/14/2021

Midwestern Regional Medical Center

2520 Elisha Ave
Zion, IL 60099

FEE RECEIPT NO.

ATTACHMENT 5

The Joint Commission

October 28, 2019

Re: # 7448
CCN: #140100
Program: Hospital
Accreditation Expiration Date: August 30, 2022

Pete Govorchin
CEO
CTCA at Midwestern Regional Medical Center
2520 Elisha Avenue
Zion, Illinois 60099

Dear Mr. Govorchin:

This letter confirms that your August 26, 2019 - August 29, 2019 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on October 16, 2019 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on October 11, 2019, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of August 30, 2019. We congratulate you on your effective resolution of these deficiencies.

§482.51 Surgical Services

The Joint Commission is also recommending your organization for continued Medicare certification effective August 30, 2019. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

CTCA at Midwestern Regional Medical Center
2520 Elisha Avenue, Zion, IL, 60099

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630.792.5000 Voice

ATTACHMENT 5

The Joint Commission

Mark Pelletier

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

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 5 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

REQUIREMENTS FOR EXEMPTIONS INVOLVING
THE CHANGE OF OWNERSHIP OF A HEALTH CARE FACILITY
SECTION 1130.520

Criterion 1130.520(b)(1)(A) Names of the parties
The parties named as an applicant are:

- Midwestern Regional Medical Center, LLC, the current and post-transaction licensee;
- Sheridan Trust U/A/D 4/1/12, which holds a majority voting control over Midwestern Regional Medical Center, LLC;
- Northeast Illinois Medical Properties, L.P., ("NIMP") which owns the real estate being addressed in this Certificate of Exemption application;
- RJS Capital Investment Company d/b/a International Capital Investment Company holds final control over NIMP by virtue of a 50.194% ownership interest in NIMP;
- Robert W. Mayo, general partner of NIMP, who has the authority to direct the sale of NIMP assets;
- COH HoldCO Inc., which will have operational control of the real estate; and
- City of Hope, which will hold final control over COH HoldCO Inc., and the real estate

Criterion 1130.520(b)(1)(B) Background of the parties
Provided in ATTACHMENT 1 are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 5 are:

1. A listings of each applicant's licensed health care facilities
2. An identification of each applicants' licensed health care facilities outside of Illinois, and
3. The applicants' authorization permitting HFSRB, the State Agency, and IDPH access to documents necessary to verify the information submitted

Criterion 1130.520(b)(1)(C) Structure of transaction
Midwestern Regional Medical Center, LLC holds the IDPH license of Midwestern Regional Medical Center. Upon the closing of the proposed transaction, COH HoldCo Inc., a nonprofit Delaware corporation of which City of Hope is the sole corporate member, will acquire 100% of the membership interests in Midwestern Regional Medical Center, LLC. The IDPH license holder, Midwestern Regional Medical Center, LLC will remain responsible for the day-to-day operations of the Hospital. Thus, the licensee, as well as, the scope of the license, will remain unchanged. This organizational change will have no impact on Midwestern Regional Medical Center, LLC's legal name, federal tax identification number, location, supervising personnel, operating procedures, or services.

In order to finance the purchase of the equity interests in Midwestern Regional Medical Center, LLC (the "Acquisition"), COH HoldCo Inc. plans to enter into a temporary bridge loan to finance the Acquisition, which loan will be guaranteed by City of Hope on behalf of itself and other members of the City of Hope Obligated Group. The purchase of both Midwestern Regional Medical Center's real estate (addressed in this COE application) and the licensee (addressed in an accompanying COE application) by COH HoldCo Inc. are to be addressed in

the same transaction; and prior to the closing of the transaction, Northeast Illinois Medical Properties, L.P., will be converted to an LLC.

Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.

This Certificate of exemption application is limited to the change of ownership of real estate, and does not address the change of ownership of a licensed or certified entity.

Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred

The health care facility's fair market value is the allocated purchase price identified below, that being $7,883,000. This amount is identified as the facility's fair market value for purposes of this Certificate of Exemption application, exclusively.

Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets

The purchase price allocated to the assets addressed in this COE application is $7,883,000.*

*to potentially be adjusted upon closing

City of Hope's YE September 30, 2020 Audited Financial Statement and confirmation of its bond rating are provided as appendixes to the accompanying Certificate of Exemption application addressing the change of ownership of the hospital's operating entity.

Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.

By its respective signatures on the Certification Pages of this Certificate of Exemption application, the applicants affirm that none of the applicants hold Illinois COEs or Certificate of Need ("CON") Permits that have not been completed.

Criterion 1130.520(b)(3) If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the charity care policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(4) A statement as to the anticipated benefits of the proposed changes in ownership to the community

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(5) The anticipated or potential cost savings, if any, that will result for the community and facility because of the change in ownership.

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(6) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(7) A description of the selection process that the acquiring entity will use to select the facility's governing body

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.

Criterion 1130.520(b)(9) A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.

This Certificate of exemption application is limited to the change of ownership of real estate. Please refer to the accompanying application addressing the change of ownership of the operating entity.