24-030

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SEP 11 2024
HEALTH FACILITIES & SERVICES REVIEW BOARD

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:	Presence Chicago Hospitals Network d/b/a Presence Saint Elizabeth Hospital a/k/a Ascension Saint Elizabeth*				
Street Address:	1431 North Claremont				
City and Zip Code:	Chicago, IL 60622				
County:	Cook	Health Service Area:	VI	Health Planning Area:	A-02

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

Exact Legal Name:	Presence Chicago Hospitals Network
Street Address:	1431 North Claremont
City and Zip Code:	Chicago, IL 60622
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Ellis Hawkins
CEO Street Address:	1431 North Claremont
CEO City and Zip Code:	Chicago, IL 60622
CEO Telephone Number:	312/770-3701

Type of Ownership of Applicants

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

- 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:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	
Fax Number:	

***PLEASE SEE NOTE ON FACILITY IDENTIFICATION ON FOLLOWING PAGE**

NOTE ON FACILITY IDENTIFICATION

At the time of the filing of this Certificate of Need application, a Certificate of Exemption (COE) application (E-024-24), addressing a change of ownership of the hospital, is under HFSRB review. Upon the approval of the COE application and the closure of the associated change of ownership transaction, the licensee and name of the hospital will change from Presence Chicago Hospitals Network (current licensee) d/b/a Presence Saint Elizabeth Hospital a/k/a Ascension Saint Elizabeth to Saint Elizabeth Hospital – Chicago, LLC.

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Street Address:	1431 North Claremont
City and Zip Code:	Chicago, IL 60622
County: Cook	Health Service Area: VI Health Planning Area: A-02

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

Exact Legal Name:	Ascension Health
Street Address:	4600 Edmundson Road
City and Zip Code:	St. Louis, MO 63134
Name of Registered Agent:	Corporation Service Company
Registered Agent Street Address:	221 Bolivar Street
Registered Agent City and Zip Code:	Jefferson City, MO 65101
Name of Chief Executive Officer:	Joseph Impicciche, CEO
CEO Street Address:	4600 Edmundson 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
- [ ] Other
- [ ] Partnership
- [ ] Governmental
- [ ] Sole Proprietorship

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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Facility/Project Identification

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Street Address:	1431 North Claremont				
City and Zip Code:	Chicago, IL 60622				
County:	Cook	Health Service Area:	VI	Health Planning Area:	A-02

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

Exact Legal Name:	Saint Elizabeth Hospital-Chicago, LLC
Street Address:	3480 E. Guasti Road
City and Zip Code:	Ontario, CA 91761
Name of Registered Agent:	Cogency Global, Inc.
Registered Agent Street Address:	850 New Burton Road, Suite 201
Registered Agent City and Zip Code:	Dover, DE 19904
Name of Chief Executive Officer:	Dr. Prem Reddy, Chairman/CEO
CEO Street Address:	3480 E. Guasti Road
CEO City and Zip Code:	Ontario, CA 91761
CEO Telephone Number:	(909)235-4400

Type of Ownership of Applicants

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

- 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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Title:	President
Company Name:	Axel & Associates, Inc.
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Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Chicago Hospitals Network d/b/a Presence Saint Elizabeth Hospital a/k/a Ascension Saint Elizabeth
Street Address:	1431 North Claremont
City and Zip Code:	Chicago, IL 60622
County: Cook	Health Service Area: VI Health Planning Area: A-02

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

Exact Legal Name:	Prime Healthcare Services, Inc.
Street Address:	3480 E. Guasti Road
City and Zip Code:	Ontario, CA 91761
Name of Registered Agent:	Cogency Global, Inc.
Registered Agent Street Address:	850 New Burton Road, Suite 201
Registered Agent City and Zip Code:	Dover, DE 19904
Name of Chief Executive Officer:	Dr. Prem Reddy, Chairman/CEO
CEO Street Address:	3480 E. Guasti Road
CEO City and Zip Code:	Ontario, CA 91761
CEO Telephone Number:	(909)235-4400

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Title:	President
Company Name:	Axel & Associates, Inc.
Address:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

Additional Contact [Person who is also authorized to discuss the Application]

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

Post Exemption Contact

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

Name:	to be named
Title:	CEO
Company Name:	Saint Elizabeth Hospital – Chicago, LLC
Address:	1431 North Claremont Chicago, IL 60622
Telephone Number:	(773) 278-2000
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: to be determined—please see Narrative Description

Address of Site Owner:

Street Address or Legal Description of the Site: 1431 North Claremont Chicago, IL 60622

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

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

Current Operating Identity/Licensee

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

Exact Legal Name: Presence Chicago Hospitals Network

Address: 200 South Wacker Drive, Floor 12 Chicago, IL 60606

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

Organizational Relationships

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

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

2. Narrative Description

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

The proposed project addressed in this Certificate of Need application is limited to the discontinuation of Presence Saint Elizabeth Hospital ("Saint Elizabeth"), located on the north side of Chicago. Saint Elizabeth currently is approved to operate 40 acute mental illness beds and a "stand-by" emergency department. The above-referenced beds represent the only HFSRB-designated category of service provided at Saint Elizabeth.

This application is being filed concurrent to the review of Certificate of Exemption applications addressing the sale of nine Chicago area hospitals, including Saint Elizabeth, by Ascension Health to Prime Healthcare Services, Inc. ("Prime"), or in the case of Ascension Saint Francis in Evanston, to Prime Healthcare Foundation. Also included in the transaction is the sale of Ascension Saint Mary-Chicago, located approximately 1.5 blocks from Saint Elizabeth. As a result of this proximity relationship, no material impact on the community's access to care is anticipated as a result of the proposed discontinuation.

Because it is unknown at the time of this application's filing whether the proposed discontinuation will take place prior to or following the change of ownership referenced above occurs, four applicants are being named: 1) Presence Chicago Hospitals Network, the licensee at the time of the COE application's filing; 2) Ascension Health, as the entity having "ultimate control" over the licensee in place at the time of the COE application's filing; 3) Saint Elizabeth Hospital-Chicago, LLC, which will be the hospital's licensee following the change of ownership; and 4) Prime Healthcare Services, Inc., as the entity having "final control" over the licensee at the time of the discontinuation.

During 2023, Saint Elizabeth's acute mental illness ("AMI") average daily census was 16.96 patients, and, on average, 0.3 patients were treated in the hospital's emergency department per day (approximately two patients per week). Sufficient capacity will exist at Ascension Saint Mary-Chicago to accommodate Saint Elizabeth's AMI patients.

This application is classified as being "substantive" because it addresses the discontinuation of an IDPH-licensed health care facility.

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 :

X Substantive

☐ Non-substantive

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$0	$0	$0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$0	$	$0

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 ☐ No
Purchase Price: $_____
Fair Market Value: $_____ not applicable

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:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___within 90 days of receipt of CON Permit____

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

not applicable

☐ 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

☐ 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 departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

not applicable

Not Reviewable Space [i.e., non-clinical]: *means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Presence Saint Elizabeth Hospital		**CITY:** Chicago			
REPORTING PERIOD DATES: From: January 1, 2023 to: December 31, 2023					
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	40	589	6,190	-40	0
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	40	589	6,190	-40	0

CERTIFICATION

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

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

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

Polly Davenport SIGNATURE	Julia P Roknich SIGNATURE
Polly Davenport PRINTED NAME	Julia Roknich PRINTED NAME
President - market CEO PRINTED TITLE	Secretary PRINTED TITLE
Notarization: Subscribed and sworn to before me this 31st day of July, 2024	Notarization: Subscribed and sworn to before me this 31st day of July, 2024
Deborah A. Weaver Signature of Notary	Deborah A. Weaver Signature of Notary
Seal OFFICIAL SEAL DEBORAH A WEAVER Notary Public, State of Illinois My Commission Expires December 31, 2027	Seal OFFICIAL SEAL DEBORAH A WEAVER Notary Public, State of Illinois Commission No. 906404 My Commission Expires December 31, 2027

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

Christine K McCoy
SIGNATURE

Christine McCoy
PRINTED NAME

EVP & General Counsel
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1st day of August

Anna Elizabeth Meacham
Signature of Notary

Seal

Elizabeth C Foshage
SIGNATURE

Elizabeth Foshage
PRINTED NAME

EVP & Chief Financial Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1st day of August

Anna Elizabeth Meacham
Signature of Notary

Seal

ANNA ELIZABETH MEACHAM NOTARY PUBLIC STATE OF TEXAS ID 134603080 EXP. 10-13-2027

ANNA ELIZABETH MEACHAM NOTARY PUBLIC STATE OF TEXAS ID 134603080 EXP. 10-13-2027

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

This Application is filed on the behalf of Saint Elizabeth Hospital – Chicago, 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.**

SIGNATURE

STEVE ALEMAN
PRINTED NAME

Manager / CFO - OFFICER
PRINTED TITLE

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

Signature of Notary

Seal See attached CA Jurat

SIGNATURE

Sunny Bhatia
PRINTED NAME

Manager/ President and Chief Medical officer
PRINTED TITLE

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

Signature of Notary

Seal See attached CA Jurat

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT GOVERNMENT CODE § 8202

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 San Bernardino

Subscribed and sworn to (or affirmed) before me on this 27th day of July, 2024, by

Date *Month* *Year*

(1) Steve Aleman

(and (2) —),

Name(s) of Signer(s)

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

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

Place Notary Seal and/or Stamp Above

Signature Catherine Jaramillo

Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

CALIFORNIA JURAT GOVERNMENT CODE § 8202

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 San Bernardino

Subscribed and sworn to (or affirmed) before me on this 30th (Date) day of July (Month), 2024 (Year), by

(1) Sunny Bhatia

(and (2) _____),

Name(s) of Signer(s)

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

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

Place Notary Seal and/or Stamp Above

Signature Catherine Jaramillo

Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

CERTIFICATION

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- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
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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 Prime Healthcare Services, 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

STEVE ALEMAN
PRINTED NAME

Manager/ CFO - OFFICER
PRINTED TITLE

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

Signature of Notary

Seal

please see attached CA Jurat

SIGNATURE

Sunny Bhatia
PRINTED NAME

Manager/ President and Chief Medical Officer
PRINTED TITLE

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

Signature of Notary

Seal

See attached CA Jurat

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT GOVERNMENT CODE § 8202

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 San Bernardino

Subscribed and sworn to (or affirmed) before me on this 29th day of July, 2024, by

(1) Steve Aleman

(and (2) _____),

Name(s) of Signer(s)

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

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

Place Notary Seal and/or Stamp Above

Signature Catherine Jaramillo

Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

CALIFORNIA JURAT **GOVERNMENT CODE § 8202**

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 San Bernardino

Subscribed and sworn to (or affirmed) before me on this 30th day of July, 2024, by

(1) Sunny Bhatia

(and (2) _____),

Name(s) of Signer(s)

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

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

Signature Catherine Jaramillo

Signature of Notary Public

Place Notary Seal and/or Stamp Above

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this Application for Discontinuation https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm**

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the **geographic service area**.

APPEND DOCUMENTATION AS ATTACHMENT 10, 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

not applicable

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:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

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)**

VII. 1120.120 - AVAILABILITY OF FUNDS

not applicable

The applicant shall document those 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, variable or permanent interest rates over the debt time, 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 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

not applicable

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 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

not applicable

A. Reasonableness of Financing Arrangements

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 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

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 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. 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]:

1. The project's material impact, if any, on essential safety net services in the community, ***including the impact on racial and health care disparities 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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)	2020	2021	2022
Inpatient	42	23	11
Outpatient	870	809	359
Total	**912**	**832**	**370**
Charity (cost in dollars)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	$0	$0	$0
MEDICAID			
Medicaid (# of patients)	2020	2021	2022
Inpatient	170	550	503
Outpatient	5,617	6,984	6,002
Total	5,787	7,534	6,505
Medicaid (revenue)			
Inpatient	$24,898,556	$17,262,578	$15,468,452
Outpatient	$6,713,267	$8,137,119	$8,377,457
Total	$31,611,823	$25,399,697	$23,845,909

APPEND DOCUMENTATION AS ATTACHMENT 38, 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.

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	$62,978,257	$41,270,513	$39,045,111
Amount of Charity Care (charges)	$0	$199	$1,534
Cost of Charity Care	$0	$0	$0

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 6783-860-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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* 8TH *day of* FEBRUARY *A.D.* 2024 .

Authentication #: 2403902304 verifiable until 02/08/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1

File Number 3128-198-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* NOVEMBER *A.D.* 2023 .

Authentication #: 2331203072 verifiable until 11/08/2024
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PRIME HEALTHCARE SERVICES, 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 SIXTH DAY OF FEBRUARY, A.D. 2024.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "PRIME HEALTHCARE SERVICES, INC." WAS INCORPORATED ON THE TWENTY-SEVENTH DAY OF MARCH, A.D. 2000.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

3201141 8300

SR# 20240389412

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

Authentication: 202754720

Date: 02-06-24

ATTACHMENT 1

File Number 5380-798-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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 CARE TRANSFORMATION CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 10, 1985, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* FEBRUARY *A.D.* 2024 .

Authentication #: 2403902246 verifiable until 02/08/2025
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACCHMENT 1

Prime Healthcare

Saving hospitals. Saving jobs. Saving lives.

Illinois Health Facilities and
Services Review Board
Springfield, Illinois

To Whom It May Concern:

This letter is being provided to address the requirements of Section 1 of the *Change of Ownership Exemption Application* addressing "Site Ownership After the Project is Complete".

Please be advised that following the closing of the relevant transaction, the facility site will be owned consistent with the information provided in the application section referenced above.

Sincerely,

Steve Aleman/ Chief Financial Officer
Printed Name and Title

8 | 24
Date

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 San Bernardino
Subscribed and sworn to (or affirmed) before me on this 1st day of August, 2024, by Steve Aleman

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

Signature Catherine Jaramillo (Seal)

Notarized:

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

File Number 1431708-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

SAINT ELIZABETH HOSPITAL - CHICAGO, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 26, 2024, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED 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* 8TH *day of* APRIL *A.D.* 2024 .

Authentication #: 2409902702 verifiable until 04/08/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 3

Organizational Chart for Certificate of Exemption Applications

ATTACHMENT 4

Prime Healthcare Services, Inc.

Prime Healthcare Services, Inc.
Post-Closing Organizational Chart

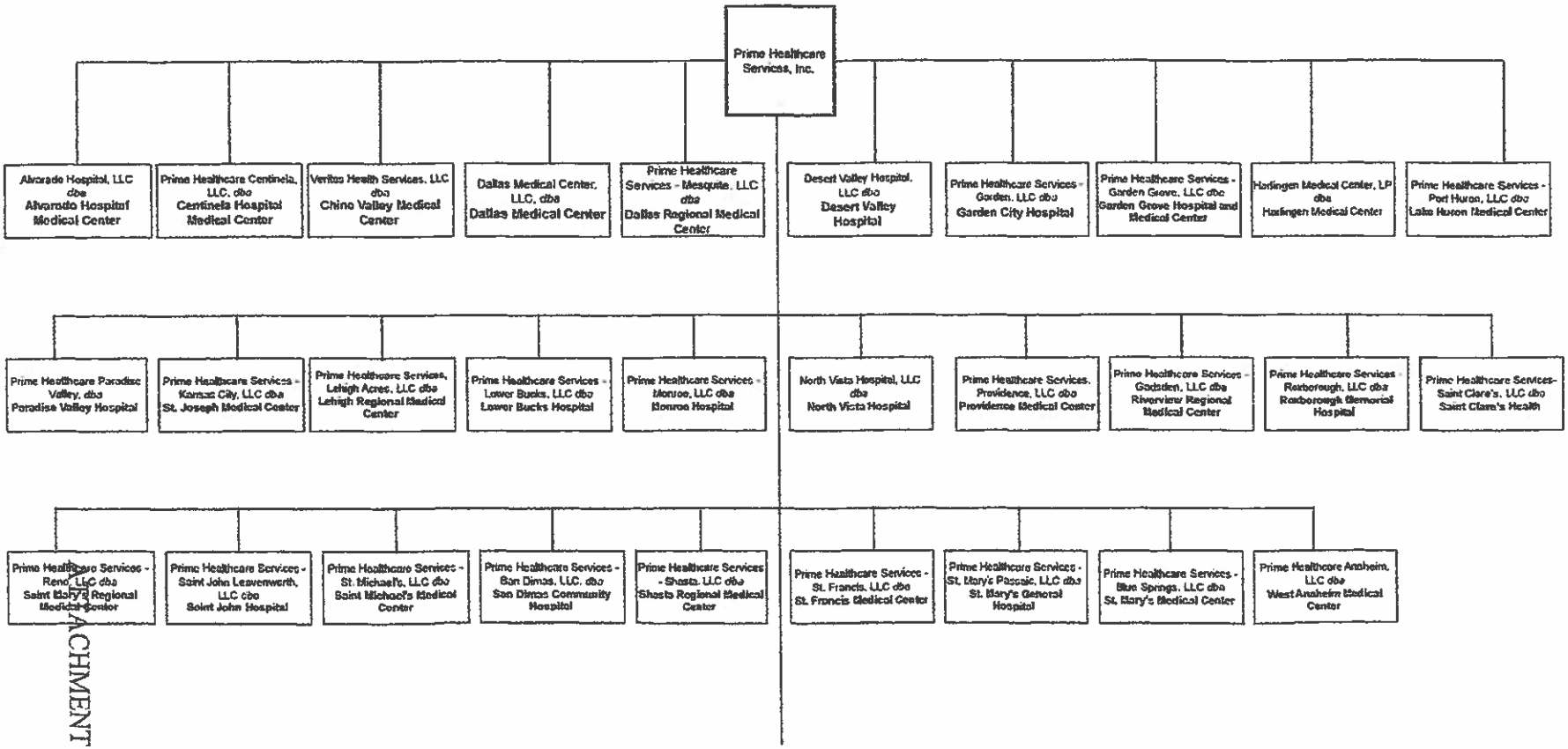

EXHIBIT 4

ATTACHMENT 4

ATTACHMENT 4

DISCONTINUATION

General Informational Requirements

The hospital is approved to provide forty acute mental illness ("AMI") beds. No other HFSRB-designated categories of service are provided. In addition, the hospital provides the other following clinical services: laboratory, stand-by emergency department, general radiography/fluoroscopy, CT, and MRI.

The hospital is anticipated to cease all services within ninety days of the receipt of the requested Certificate of Need ("CON") Permit to do so, pending any other required approvals, and with appropriate notification to the IDPH and the HFSRB. Prior to the formal discontinuation of services, one or more of the hospital's clinical services may be suspended due to a number of potential reasons, such as staffing difficulties or the availability of space in Saint Mary's Hospital to accommodate patients to be transferred.

As of the filing of this CON application, discussions have been initiated by both Ascension and Prime with community representatives relating to the future uses of the hospital building and grounds; and those discussions are anticipated to continue during the CON application review process and after. It is Prime's goal and intent to repurpose the building to house a variety of healthcare and non-healthcare-related programs and services, focusing on the needs of the community.

In addition, and upon closure of the proposed transaction, Prime will conduct an evaluation of the hospital's equipment. It is anticipated that a limited amount of equipment will be re-located

to other Prime facilities, with the remainder either being donated to area not-for-profit providers and organizations, or discarded.

Patient medical records will be re-located to Saint Mary's Hospital, which is located 1.5 blocks to the south of the hospital, and maintained consistent with all licensure requirements and accreditation standards.

Attached is a notice published by the *Chicago Sun Times* on September 9, 2024, addressing the anticipated filing of this CON application.

Consistent with 77 Ill. Adm. Code Section 1110.290.a)6), on August 8, 2024 written notification of the intended filing of this CON application was sent to the following individuals: State Senator Omar Aquino, State Representative Eva-Dina Delgado, Alderman Daniel LaSpata, IDPH Director Sameer Vohra, MD, JD, and IDHFS Director Elizabeth Whitehorn. Copies of the sent letters are attached.

With the signatures on the Certification pages of this CON application, the applicants confirm that all questionnaires and data requested by the HFSRB or the IDPH will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

Reasons for Discontinuation

Saint Elizabeth Hospital represents an unnecessary duplication of services, resulting in low utilization, unnecessary costs and staffing difficulties associated with low utilization. As discussed in other sections of this application, the hospital's inpatient services are limited to acute mental illness ("AMI"), it's emergency department is classified as "stand-by" (the lowest level of care as classified by the IDPH), and the hospital provides a minimal volume of its limited scope of

outpatient and ancillary services. Importantly, the hospital's entire caseload can be accommodated by Saint Mary's Hospital, which is located approximately 1½ blocks away, has sufficient capacity, provides a broad scope of inpatient and outpatient services (including all services provided at Saint Elizabeth), and has for a number of years had a common medical staff with Saint Elizabeth hospital. As a result, the relocation of the hospital's services, as proposed, will not compromise patient accessibility in any material fashion, and should be relatively "seamless".

Impact on Access

The HFSRB's designated geographic service area ("GSA") per 77 Ill. Adm. Code 1100.510(d) is that area within a 10-mile radius of the applicant hospital. That area includes the entire City of Chicago, as well as suburban communities to the north, northwest, west and southwest of Chicago. Per the HFSRB's December 2023 *Inventory of Health Care Facilities and Services and Need Determination*, there are 29 Chicago hospitals providing acute mental illness services within the GSA, approved to provide a total of 1,427 AMI beds and four suburban hospitals located with the GSA, approved to provide a total of 370 AMI beds. During 2021 (the most recent year incorporated into the *Inventory*), the combined occupancy rate for the thirty hospitals...nearly 1,800 AMI beds in the GSA...was 52.05%, compared to the HFSRB's target rate of 85%. As such, it is clear that sufficient bed capacity is available within the GSA to accommodate Saint Elizabeth Hospital's AMI patients, which had an average daily census of 16.96 patients during 2023.

Last, and critically important in terms of accessibility for Saint Elizabeth Hospital's AMI patient population is the close proximity to, and capacity at, Saint Mary's Hospital, as noted above.

As required by 77 Ill. Adm. Code 1110.290.d), prior to filing this application, letters, inviting hospitals to comment on this project's impact on their facility, were sent to the hospitals in planning area A-01 and listed below. A template of the letter is attached. Any responses received will be forwarded to the HFSRB staff.

ATTACHMENT 10

- Ascension Saint Mary's-Chicago
- Garfield Park Hospital
- Humbolt Park Hospital
- Loretto Hospital
- Mount Sinai Hospital Medical Center
- Rush University Medical center
- Saint Anthony Hospital
- UHS Hartgrove Hospital
- University of Illinois Hospital and Clinics

ATTACHMENT 10

NOTICE PLACED IN CHICAGO SUNTIMES 3-4 DAYS PRIOR TO THE APPLICATION'S FILING:

LEGAL NOTICE

XXXXXXXXXXXXXXXXXX intends to cease the operations of Ascension Saint Elizabeth Hospital, located at 1431 North Claremont Avenue in Chicago following the receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur within ninety days of the IHFSRB's approval. The required Certificate of Need application addressing approval will be submitted within fourteen days; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hfsrb.illiois.gov.

ATTACHMENT 10

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

August 29, 2024

RE: Ascension Saint Elizabeth
Discontinuation of Hospital
Request for Comment on Impact

name
title
hospital name
street address
city, state and ZIP code

Dear _____:

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

Please be aware that it is intended that a Certificate of Need ("CON") application will be filed within the next two weeks, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB") to discontinue Ascension Saint Elizabeth, which include an inpatient acute mental illness unit and a "stand-by" emergency department. The formal discontinuation of is anticipated to occur within thirty days following the IHFSRB's approval of that application.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing either of the above-identified services to residents from our service area. Any impact statement received will be forwarded to the IHFSRB. If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Ellis Hawkins
President and CEO

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Steven Airhart
CEO
Garfield Park Hospital
520 N Ridgeway Ave
Chicago, IL 60624

PS Form 3800, April 2015 PSN 7530-02-000-9047 See R

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Steven Airhart
Chief Executive Officer
UHS Hartgrove Hospital
5730 West Roosevelt Road
Chicago, IL 60644

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Mark I. Rosenblatt
CEO, Healthcare System
University of Illinois Hospital & Clinics
1740 West Taylor Street
Chicago, IL 60612

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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Jose R. Sanchez
President and CEO
Humboldt Park Health, Inc.
1044 N. Francisco Avenue
Chicago, IL 60622

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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Tesa Anewishki
CEO
Loretto Hospital
645 S Central Ave
Chicago, IL 60644

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SEP 04 2024

Sameer Shah
Site President, Mount Sinai Hospital
Mount Sinai Hospital Medical Center
2750 W 15th Street
Chicago, IL 60608

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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INDIANAPOLIS, INDIANA 46220
SEP 04 2024
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Omar Lateef, DO
CEO & President, Rush University Medical Center
Rush University Medical Center
1653 West Congress Parkway
Chicago, IL 60612

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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SEP 04 2024

Ellis Hawkins
President & CEO
Presence Saint Mary & Elizabeth Med Ctr - Chicago
2233 West Division Street
Chicago, IL 60622

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

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U.S.P.S. BACON STATION
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Guy A. Medaglia
President & CEO
Saint Anthony Hospital
2875 West 19th Street
Chicago, IL 60623

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7021 1970 0000 0996 0038

4/9

ATTACHMENT 10

LEGAL NOTICE

Ascension Saint Elizabeth Hospital, located at 1431 North Claremont Avenue in Chicago, intends to cease operation following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur within ninety days of the IHFSRB's approval. The required Certificate of Need application addressing approval of the discontinuation will be submitted within fourteen days; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hfsrb.illinois.gov.

ATTACHMENT 10

CHICAGO SUN-TIMES

Certificate of Publication

On Behalf of:

AMITA HEALTH PRESENCE HEALTH
Saint Elizabeth Hospital

Customer No: 102058
Ad No: 1278
Amount: $98.00
PO Number: #PO_NUMBER#

Public Notice
Ascension Saint Elizabeth Hospital, located at 1431 North Claremont Avenue in Chicago intends to cease operations following the receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur within ninety days of the IHFSRB's approval. The single inpatient service provided at the hospital will continue at Ascension Saint Mary located within one and a half blocks therefore, no disruption to patient care will occur. The required Certificate of Need application addressing approval of discontinuation will be submitted within fourteen days after which time additional information related to the proposed discontinuation can be found on the IHFSRB website at ihfsrb.illinois.gov.
9/4/2024 #1278

AMITA HEALTH PRESENCE HEALTH

200 S WACKER DR
ATTN: OLGA SOLARES
CHICAGO, IL 60606

ATTESTATION OF PUBLIC LEGAL NOTICE

STATE OF ILLINOIS, COUNTY OF COOK:

Chicago Sun-Times does hereby certify it has published the attached advertisements in the following secular newspapers. All newspapers meet Illinois Compiled Statue requirements for publication of Notices per Chapter 715 ILCS 5/0.01 et seq. R.S. 1874, P728 Sec 1, EFF. July 1, 1874. Amended by Laws 1959, P1494, EFF. July 17, 1959. Formerly Ill. Rev. Stat. 1991, CH100, Pl.

As published in Chicago Sun Times in the issue(s) of:

9/4/2024

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

Robin Munoz
Manager | Recruitment & Legals

Date: 9/4/2024

51

by FedEX

August 8, 2024

Senator Omar Aquino
2511 West Division Street
Chicago, IL 60622

Dear Senator Aquino:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

by FedEX

August 8, 2024

Representative Eva-Dina Delgado
6309 West Belmont Avenue
Chicago, IL 60634

Dear Representative Delgado:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

by FedEX

August 8, 2024

Sameer Vohra, MD, JD
Director
Illinois Department of Public Health
525 West Jefferson
Springfield, IL 62761

Dear Director Vohra:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

by FedEX

August 8, 2024

Elizabeth M. Whitehorn
Director
Illinois Department of Healthcare
and Family Services
201 S. Grand Avenue East, 3rd Floor
Springfield, IL 62763

Dear Director Whitehorn:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

by FedEX

August 8, 2024

Mayor Brandon Johnson
City of Chicago
121 N. LaSalle Street
Chicago, IL 60602

Dear Mayor Johnson:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

by FedEX

August 8, 2024

Alderman Daniel LaSpata
1958 N. Milwaukee Avenue
Chicago, IL 60647

Dear Alderman LaSpata:

This letter is being provided on behalf of Ascension Health and Prime Healthcare Services, Inc., consistent with the requirements of the Illinois Health Facilities and Services Review Board ("HFSRB"), in order to inform you of plans to discontinue Ascension Saint Elizabeth ("Saint Elizabeth").

The only inpatient service currently offered at Saint Elizabeth is acute mental illness ("AMI"), and during calendar 2023 the service's average daily census was 16.96 patients.

Saint Elizabeth is located approximately 1½ blocks from Ascension Saint Mary-Chicago (f/k/a Saint Mary of Nazareth Hospital), which provides AMI services as well as all of the ancillary and support services offered at Ascension Saint Elizabeth. As a result, it is not believed that the proposed discontinuation will hinder the ability of area residents to access hospital services in any appreciable manner.

Current plans are to discontinue Ascension Saint Elizabeth within approximately six months, and following appropriate notification of the community, local EMS, and other relevant care providers and individuals. A Certificate of Need Application addressing the proposed discontinuation will be filed with the HFSRB in approximately one month.

We would welcome the opportunity to discuss these plans with you in further detail at your convenience.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

FedEx Express **Package US Airbill**

FedEx Tracking Number **8176 5592 5086**

Form ID No. **0215**

1 From *Please print and press hard.*

Date 5/8/24 Sender's FedEx Account Number [redacted]

Sender's Name [redacted] Phone (312) 969 4782

Company AXEL & ASSOCIATES INC

Address 340 CHICORY LN

Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1937

2 Your Internal Billing Reference
First 24 characters will appear on invoice.

3 To

Recipient's Name EVA-DINA Delgado Phone ( )

Company

Address 6309 W Belmont

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Dept./Floor/Suite/Room

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City Chicago State IL ZIP 60634

Hold Weekday — FedEx location address REQUIRED. FedEx First Overnight.

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- ☒ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- ☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging *Declared value limit $500.

☒ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

☐ Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

☒ No Signature Required — Package may be left without obtaining a signature for delivery.
☐ Direct Signature — Someone at recipient's address may sign for delivery.
☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

☒ No ☐ Yes As per attached Shipper's Declaration ☐ Yes Shipper's Declaration not required ☐ Dry Ice Dry Ice, 9, UN 1845 _____ x _____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

☒ Sender (Acct. No. in Section 1 will be billed.) ☐ Recipient ☐ Third Party — Enter FedEx Acct. No. below

FedEx Acct. No.

This airbill can be used only when billing to a FedEx account number. For cash, check, or credit card transactions, please go to a staffed shipping location.

Total Packages _____ Total Weight _____ lbs. Total Declared Value† $ _____ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this airbill you agree to the service conditions on the back of this airbill and in the current FedEx Service Guide, including terms that limit our liability.

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FedEx Express **Package US Airbill**

FedEx Tracking Number **8182 4417 7848**

Form ID No. **0215**

1 From *Please print and press hard.*

Date 5/8/24 Sender's FedEx Account Number 1016-8335-4 SENDER'S FEDEX ACCOUNT NUMBER ONLY

Sender's Name [redacted] Phone 312 969 4759

Company AXEL ASSOCIATES INC

Address 340 CHICORY LN

Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1937

2 Your Internal Billing Reference
First 24 characters will appear on invoice. OPTIONAL

3 To

Recipient's Name OMAR AQUINO Phone ( )

Company

Address 2611 W DIVISION ST

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Dept./Floor/Suite/Room

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City CHICAGO State IL ZIP 60622

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Hold Saturday — FedEx location address REQUIRED. FedEx Priority Overnight and FedEx 2Day to select locations.

0141017503

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Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.

- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☒ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- ☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging *Declared value limit $500.

☒ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

☐ Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

☒ No Signature Required — Package may be left without obtaining a signature for delivery.
☐ Direct Signature — Someone at recipient's address may sign for delivery.
☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

☒ No ☐ Yes As per attached Shipper's Declaration ☐ Yes Shipper's Declaration not required ☐ Dry Ice Dry Ice, 9, UN 1845 _____ x _____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

☒ Sender (Acct. No. in Section 1 will be billed.) ☐ Recipient ☐ Third Party — Enter FedEx Acct. No. below

FedEx Acct. No.

This airbill can be used only when billing to a FedEx account number. For cash, check, or credit card transactions, please go to a staffed shipping location.

Total Packages _____ Total Weight _____ lbs. Total Declared Value† $ _____ .00

ATTACHMENT 10

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this airbill you agree to the service conditions on the back of this airbill and in the current FedEx Service Guide, including terms that limit our liability.

611

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58

FedEx Express **Package US Airbill**

FedEx Tracking Number **8182 4417 7837**

Form ID No. 0215

1 From *Please print and press hard.*

Date 8/5/24 Sender's FedEx Account Number 1016-8335-4

Sender's Name [illegible] Phone ( ) 312 969 4754

Company AXEL ASSOCIATES INC

Address 945 ONTARIO LN Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1837

2 Your Internal Billing Reference First 24 characters will appear on invoice. OPTIONAL

3 To

Recipient's Name JAMEER Vohra Phone ( )

Company IL DEPT OF Public Health

Address 525 W JEFFERSON Dept./Floor/Suite/Room

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City SPRINGFIELD State IL ZIP 62761

Hold Weekday FedEx location address REQUIRED. FedEx First Overnight.

Hold Saturday FedEx location address REQUIRED. FedEx Priority Overnight and FedEx 2Day to select locations.

0141017823

4 Express Package Service • To most locations. *Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.*

- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [x] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- [ ] FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging • Declared value limit $500.

- [x] FedEx Envelope*
- [ ] FedEx Pak*
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

- [ ] Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.
- [x] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery.
- [ ] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

- [x] No
- [ ] Yes As per associated Shipper's Declaration.
- [ ] Yes Shipper's Declaration not required.
- [ ] Dry Ice Dry Ice, 9, UN 1845 ____ x ____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. [ ] Cargo Aircraft Only

7 Payment *Bill to:*

- [x] Sender — Acct. No. in Section 1 will be billed.
- [ ] Recipient
- [ ] Third Party

Enter FedEx Acct. No. below

FedEx Acct. No.

This airbill can be used only when billing to a FedEx account number. For cash, check, or credit card transactions, please go to a staffed shipping location.

Total Packages ____ Total Weight ____ lbs. Total Declared Value† $ ____ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this airbill you agree to the service conditions on the back of this airbill and in the current FedEx Service Guide, including terms that limit our liability.

611

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FedEx Express **Package US Airbill**

FedEx Tracking Number **8182 4417 7826**

Form ID No. 0215

1 From *Please print and press hard.*

Date 8/5/24 Sender's FedEx Account Number 1016-8335-4

Sender's Name [illegible] Phone ( ) 312 969 4754

Company AXEL ASSOCIATES INC

Address 945 ONTARIO LN Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1837

2 Your Internal Billing Reference First 24 characters will appear on invoice. OPTIONAL

3 To

Recipient's Name Elizabeth Whitehorn Phone ( )

Company IL Dept of Children & Family Services

Address 201 S. GRAND AVE EAST Dept./Floor/Suite/Room

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address 3RD FLOOR

Use this line for the HOLD location address or for continuation of your shipping address.

City SPRINGFIELD State IL ZIP 62761

Hold Weekday FedEx location address REQUIRED. FedEx First Overnight.

Hold Saturday FedEx location address REQUIRED. FedEx Priority Overnight and FedEx 2Day to select locations.

0141017823

4 Express Package Service • To most locations. *Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.*

- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [x] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- [ ] FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging • Declared value limit $500.

- [x] FedEx Envelope*
- [ ] FedEx Pak*
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

- [ ] Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.
- [x] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery.
- [ ] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

- [x] No
- [ ] Yes As per associated Shipper's Declaration.
- [ ] Yes Shipper's Declaration not required.
- [ ] Dry Ice Dry Ice, 9, UN 1845 ____ x ____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. [ ] Cargo Aircraft Only

7 Payment *Bill to:*

- [x] Sender — Acct. No. in Section 1 will be billed.
- [ ] Recipient
- [ ] Third Party

Enter FedEx Acct. No. below

FedEx Acct. No. ATTACHMENT 10

This airbill can be used only when billing to a FedEx account number. For cash, check, or credit card transactions, please go to a staffed shipping location.

Total Packages ____ Total Weight ____ lbs. Total Declared Value† $ ____ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this airbill you agree to the service conditions on the back of this airbill and in the current FedEx Service Guide, including terms that limit our liability.

611

Fed Express **Package US Airbill**

FedEx Tracking Number **8176 5592 5101**

Form ID No. **0215**

1 From *Please print and press hard.*

Date _____ Sender's FedEx Account Number [redacted]

Sender's Name _____ Phone ( )

Company AXEL & ASSOCIATES INC

Address 345 CHICORY LN

Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1337

2 Your Internal Billing Reference
First 24 characters will appear on invoice.

3 To

Recipient's Name DANIEL LA SPATA Phone ( )

Company

Address 1958 N. MILWAUKEE

We cannot deliver to P.O. boxes or P.O. ZIP codes. Dept./Floor/Suite/Room

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City CHICAGO State IL ZIP 60647

Hold Weekday — FedEx location address REQUIRED. FedEx First Overnight.

Hold Saturday — FedEx location address REQUIRED. FedEx Priority Overnight and FedEx 2Day to select locations.

[redacted]

4 Express Package Service • To most locations.

Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.

- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☒ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- ☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging • Declared value limit $500.

☒ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.

☐ Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

☒ No Signature Required — Package may be left without obtaining a signature for delivery.
☐ Direct Signature — Someone at recipient's address may sign for delivery.
☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

☒ No ☐ Yes As per associated Shipper's Declaration. ☐ Yes Shipper's Declaration not required. ☐ Dry Ice Dry Ice, 9, UN 1845 _____ x _____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

☒ Sender Acct. No. in Section 1 will be billed. ☐ Enter FedEx Acct. No. below: ☐ Recipient ☐ Third Party

FedEx Acct. No. _____

Total Packages _____ Total Weight _____ lbs. Total Declared Value† $ _____ .00

This airbill can be used only when billing to a FedEx account number. For cash, check, or credit card transactions, please go to a staffed shipping location.

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this airbill you agree to the service conditions on the back of this airbill and in the current FedEx Service Guide, including terms that limit our liability.

611

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Fed Express **Package US Airbill**

FedEx Tracking Number **8176 5592 5134**

Form ID No. **0215**

1 From *Please print and press hard.*

Date _____ Sender's FedEx Account Number [redacted]

Sender's Name _____ Phone ( )

Company AXEL & ASSOCIATES INC

Address 345 CHICORY LN

Dept./Floor/Suite/Room

City BUFFALO GROVE State IL ZIP 60089-1337

2 Your Internal Billing Reference
First 24 characters will appear on invoice.

3 To

Recipient's Name BRANDON JOHNSON Phone ( )

Company OFFICE OF THE MAYOR

Address 121 N LASALLE ST

We cannot deliver to P.O. boxes or P.O. ZIP codes. Dept./Floor/Suite/Room

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City CHICAGO State IL ZIP 60602

Hold Weekday — FedEx location address REQUIRED. FedEx First Overnight.

Hold Saturday — FedEx location address REQUIRED. FedEx Priority Overnight and FedEx 2Day to select locations.

[redacted]

4 Express Package Service • To most locations.

Packages up to 150 lbs. For packages over 150 lbs., use the FedEx Express Freight US Airbill.

- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
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- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging • Declared value limit $500.

☒ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

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☐ Saturday Delivery — FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

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☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?

☒ No ☐ Yes As per associated Shipper's Declaration. ☐ Yes Shipper's Declaration not required. ☐ Dry Ice Dry Ice, 9, UN 1845 _____ x _____ kg

Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

☒ Sender Acct. No. in Section 1 will be billed. ☐ Enter FedEx Acct. No. below: ☐ Recipient ☐ Third Party

FedEx Acct. No. _____

Total Packages _____ Total Weight _____ lbs. Total Declared Value† $ _____ .00

ATTACHMENT 10

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611

[redacted]

bot

SAFETY NET STATEMENT

The proposed discontinuation of Ascension Saint Elizabeth ("the hospital") will have no material impact on essential safety net services, nor will it have a negative impact on racial or health care disparities in the community. The absence of any material impact on the provision of services, including safety net services, resulting from the discontinuation of a hospital is unique, and primarily the result of three factors: First, the scope of services currently provided at the hospital is very limited. The only inpatient service provided at the hospital is acute mental illness ("AMI"), with utilization of that program being very low. During 2023, the program's average daily census was 16.97 patients. Second, the hospital is located approximately 1½ blocks from Ascension Saint Mary-Chicago, with Ascension Saint Mary-Chicago providing all of the services currently provided at Ascension Saint Elizabeth, and having the physical capacity to accommodate the patients currently receiving care at Ascension Saint Elizabeth. Third, the two hospitals operate with a common medical staff, therein minimizing the diminished continuity of care typically associated with the discontinuation of a hospital.

It is not anticipated that the proposed discontinuation will have a material impact on any other providers' ability to provide safety net services.

ATTACHMENT 37

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	32
2	Site Ownership	36
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	37
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	38
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	42
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	
19	Comprehensive Physical Rehabilitation	
20	Acute Mental Illness	
21	Open Heart Surgery	
22	Cardiac Catheterization	
23	In-Center Hemodialysis	
24	Non-Hospital Based Ambulatory Surgery	
25	Selected Organ Transplantation	
26	Kidney Transplantation	
27	Subacute Care Hospital Model	
28	Community-Based Residential Rehabilitation Center	
29	Long Term Acute Care Hospital	
30	Clinical Service Areas Other than Categories of Service	
31	Freestanding Emergency Center Medical Services	
32	Birth Center	
	Financial and Economic Feasibility:	
33	Availability of Funds	
34	Financial Waiver	
35	Financial Viability	
36	Economic Feasibility	
37	Safety Net Impact Statement	61
38	Charity Care Information	
39	Flood Plain Information	