

E-016-24

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

RECEIVED

AUG 14 2024

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

HEALTH FACILITIES &
SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family		
Street Address:	100 North River Road		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII Health Planning Area: A-07

Legislators

State Senator Name:	Laura M. Murphy
State Representative Name:	Martin Moylan

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

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family		
Street Address:	100 North River Road		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII
		Health Planning Area:	A-07

Legislators

State Senator Name:	Laura M. Murphy
State Representative Name:	Martin Moylan

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

Exact Legal Name:	Presence Chicago Hospitals Network
Street Address:	100 North River Road
City and Zip Code:	Des Plaines, IL 60016
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:	Yolande Wilson-Stubs
CEO Street Address:	100 North River Road
CEO City and Zip Code:	Des Plaines, IL 60016
CEO Telephone Number:	847/813-3164

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	<input type="checkbox"/>

- 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:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family		
Street Address:	100 North River Road		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII
		Health Planning Area:	A-07

Legislators

State Senator Name:	Laura M. Murphy
State Representative Name:	Martin Moylan

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

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input checked="" type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	<input type="checkbox"/>

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:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family		
Street Address:	100 North River Road		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII
		Health Planning Area:	A-07

Legislators

State Senator Name:	Laura M. Murphy
State Representative Name:	Martin Moylan

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

Exact Legal Name:	Holy Family Medical Center - Des Plaines, 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

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	<input type="checkbox"/>

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:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family		
Street Address:	100 North River Road		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII
		Health Planning Area:	A-07

Legislators

State Senator Name:	Laura M. Murphy
State Representative Name:	Martin Moylan

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

Exact Legal Name:	Presence Care Transformation Corporation
Street Address:	200 S. Wacker Drive
City and Zip Code:	Chicago, IL 60606
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Dana Gilbert
CEO Street Address:	200 S. Wacker Drive
CEO City and Zip Code:	Chicago, IL 60606
CEO Telephone Number:	(773) 339-0449

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	<input type="checkbox"/>

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:	

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:	Holy Family Medical Center – Des Plaines
Address:	100 North River Road Des Plaines, IL 60016
Telephone Number:	(847) 297-1800
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:	Holy Family Medical Center – Des Plaines
Address of Site Owner:	150 North River Road Des Plaines, IL 60016
Street Address or Legal Description of the Site:	100 North River Road Des Plaines, IL 60016
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 Central and Suburban Hospitals Network		
Address:	200 South Wacker Drive, Floor 12 Chicago, IL 60606		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
<input type="checkbox"/>	Other		<input type="checkbox"/>

Operating Identity/Licensee after the Project is Complete

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

Exact Legal Name: Holy Family Medical Center – Des Plaines, LLC

Address: 100 North River Road Des Plaines, IL 60016

- | | | | |
|--------------------------|---------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | Non-profit Corporation | <input type="checkbox"/> | Partnership |
| <input type="checkbox"/> | For-profit Corporation | <input type="checkbox"/> | Governmental |
| X | Limited Liability Company | <input type="checkbox"/> | Sole Proprietorship |
| <input type="checkbox"/> | Other | | |

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

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

Organizational Relationships

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

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

Narrative Description

In the space below, provide a brief narrative description of the change of ownership. Explain **WHAT** is to be done in **State Board defined terms, NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site.

Applicant Ascension Health, (“Ascension”), currently directly or indirectly through subsidiary entities owns and controls thirteen hospitals in the metropolitan Chicago area, has controlling interests in two ASTCs and has minority interests in three other ASTCs. This Certificate of Exemption application addresses the proposed change of ownership of Presence Central and Suburban Hospitals Network d/b/a Presence Holy Family Medical Center a/k/a Ascension Holy Family and applications have concurrently been filed for the change of ownership of eight other hospitals and two ASTCs controlled by Ascension. The eleven licensed health care facilities being addressed are listed below.

Upon the closing of the proposed transaction, Prime Healthcare Services, Inc. (“Prime”) will assume ownership and/or control of eight of the hospitals and the two ASTCs controlled by Ascension and identified above. Prime Healthcare Foundation, a not-for-profit subsidiary of Prime, will assume ownership of Ascension Saint Francis in Evanston. In addition, Prime will also be acquiring from Ascension a variety of other programs and facilities, outside of the purview of the HFSRB, including four long term care facilities, a home care program, a hospice, and medical groups/practices affiliated with the hospitals to be acquired. The facilities to be acquired are:

- Presence Chicago Hospitals Network d/b/a Ascension Resurrection in Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Saint Mary-Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Saint Elizabeth in Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Holy Family in Des Plaines
- Presence Central and Suburban Hospitals Network d/b/a Ascension Mercy in Aurora
- Presence Chicago Hospitals Network d/b/a Ascension Saint Francis in Evanston
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Joseph-Elgin
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Joseph-Joliet
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Mary-Kankakee
- Belmont/Harlem Surgery Center, LLC (51% ownership interest)
- Presence Lakeshore Gastroenterology, LLC d/b/a Des Plaines Endoscopy Center (51% ownership interest)

Prime is a well-established and award-winning acute care provider, currently operating 44 hospitals and approximately 300 outpatient centers in a variety of urban and rural settings in fourteen states. Prime’s mission is: *To save and improve hospitals so that they can deliver compassionate, quality care to patients and better healthcare for communities.*” Prime strives to fulfill that mission through a combination of advocacy, charitable contributions (in excess of \$12 billion since 2010), promotion and support of health equity initiatives, strengthening hospitals’ financial position, and community partnerships. Since 2016, Prime’s hospitals have received more Patient Safety Excellence awards from Healthgrades than any other health system in the nation; and has been named a Top 10 and Top 15 health system by IBM Watson Health.

Please refer to ATTACHMENT 6, Criterion 1130.520(b)(1)(C) Structure of Transaction for a description of the proposed transaction.

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: \$ _____

included in purchase price and fair market values
provided in ATTACHMENT 6

Fair Market Value: \$ _____

Project Status and Completion Schedules

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

Applicant Ascension currently has five active CON Permits, which are identified in ATTACHMENT 6. None of these projects will be complete when the transaction addressed in this COE application is completed.

Anticipated exemption completion date (refer to Part 1130.570): within 90 days of HFSRB approval

State Agency Submittals

Are the following submittals up to date as applicable:

Cancer Registry

APORS

All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the Application being deemed incomplete.

CERTIFICATION

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

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

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

Christine McCoy
SIGNATURE
Christine McCoy
PRINTED NAME
EVP & General Counsel
PRINTED TITLE

Elizabeth C. Foshage
SIGNATURE
Elizabeth Foshage
PRINTED NAME
EVP & Chief Financial Officer
PRINTED TITLE

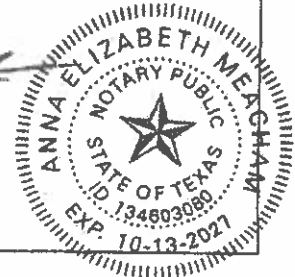
Notarization:
Subscribed and sworn to before me
this 1st day of August

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

Anna Elizabeth Meacham
Signature of Notary

Anna Elizabeth Meacham
Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o 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).
- o 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).
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o 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 Deavenport
SIGNATURE
Polly Deavenport
PRINTED NAME
President - market CEO
PRINTED TITLE

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

Notarization:
Subscribed and sworn to before me
this 31st day of July, 2024
Deborah A. Weaver
Signature of Notary

Notarization:
Subscribed and sworn to before me
this 31st day of July, 2024
Deborah A. Weaver
Signature of Notary



CERTIFICATION

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o 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).
- o 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).
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o 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.

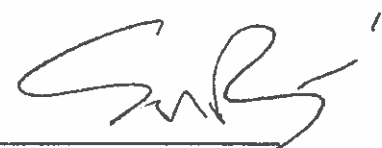

SIGNATURE

STEVE ALENAU
PRINTED NAME

Manager / CFO - OFFICER
PRINTED TITLE

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

Signature of Notary please see attached Jurat
Seal


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 See attached CA Jurat
Seal

*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

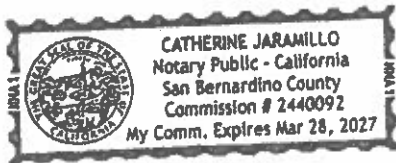
Subscribed and sworn to (or affirmed) before me on this 28th day of July, 2024, by
Date Month Year

(1) Steve Akman

(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.

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: _____

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.

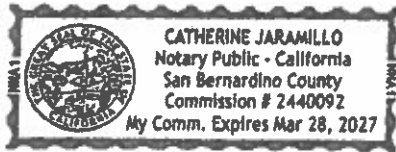
State of California

County of San Bernardino

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

(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.

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: _____


CERTIFICATION

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

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

This Application is filed on the behalf of **Holy Family Medical Center – Des Plaines, 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.

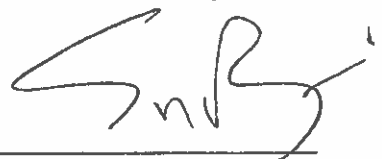


SIGNATURE

 STEVE ALEMAN
PRINTED NAME
 Manager/CEO OFFICER
PRINTED TITLE

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

~~Signature of Notary~~ *See attached CA Jurat*
~~Seal~~



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

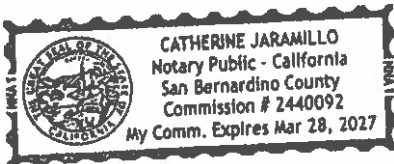
Subscribed and sworn to (or affirmed) before me on this 27th day of July, 2024, by
Date Month Year

(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.

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: _____

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
Date Month Year

(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.

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: _____



CERTIFICATION

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

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

This Application is filed on the behalf of Presence Care Transformation Corporation

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.

Dana Gilbert
SIGNATURE
Dana Gilbert
PRINTED NAME
President
PRINTED TITLE

Julia P. Rotnich
SIGNATURE
Julia Rotnich
PRINTED NAME
Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 31st day of July, 2024
Deborah A. Weaver
Signature of Notary

Notarization:
Subscribed and sworn to before me
this 31st day of July, 2024
Deborah A. Weaver
Signature of Notary

Seal
OFFICIAL SEAL
DEBORAH A WEAVER
Notary Public, State of Illinois
Commission No. 908404
My Commission Expires December 31, 2027

Seal
OFFICIAL SEAL
DEBORAH A WEAVER
Notary Public, State of Illinois
Commission No. 908404
My Commission Expires December 31, 2027

*Ins... My Commission Expires December 31, 2027 Applicant

SECTION II. BACKGROUND.

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application. Please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one Application, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

SECTION III. CHANGE OF OWNERSHIP (CHOW)

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

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

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

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.
3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X
<p>APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</p>	

SECTION IV.CHARITY CARE INFORMATION

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

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

A table in the following format must be provided for all facilities as part of Attachment 7.

Ascension Holy Family in Des Plaines

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	\$68,016,161	\$107,838,272	\$74,492,884
Amount of Charity Care (charges)	\$7,975,322	\$4,786,564	\$(694,580)
Cost of Charity Care	\$1,680,114	\$923,465	\$0

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

CERTIFICATION

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

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

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

Christine McCoy
SIGNATURE

Christine McCoy
PRINTED NAME

EVP & General Counsel
PRINTED TITLE

Elizabeth C Foshage
SIGNATURE

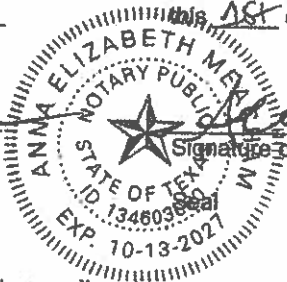
Elizabeth Foshage
PRINTED NAME

EVP & Chief Financial Officer
PRINTED TITLE

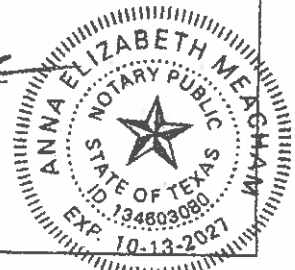
Notarization:
Subscribed and sworn to before me
this 25th day of August

Notarization:
Subscribed and sworn to before me
this 25th day of August

Anna Elizabeth Meacham
Signature of Notary



Anna Elizabeth Meacham
Signature of Notary



Seal

*Insert the EXACT legal name of the applicant

File Number

5380-798-4



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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>

A handwritten signature in cursive script, reading "Alexi Giannoulas".

SECRETARY OF STATE

ATTACHMENT 1

File Number

1431728-7



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

HOLY FAMILY MEDICAL CENTER - DES PLAINES, 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 #: 2409902688 verifiable until 04/08/2025
Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 1

File Number

6783-860-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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>

A handwritten signature in cursive script, appearing to read "Alexi Giannoulis".

SECRETARY OF STATE ATTACHMENT 1

Delaware

Page 1

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.



3201141 8300

SR# 20240389412

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

A handwritten signature in black ink, appearing to read "JBULLOCK", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

Authentication: 202754720

Date: 02-06-24

ATTACHMENT 1

File Number

5968-176-1



To all to whom these Presents Shall Come, Greeting:

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

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



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

Authentication #: 2331203096 verifiable until 11/08/2024
Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulis

SECRETARY OF STATE

ATTACHMENT 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 1 24
Date

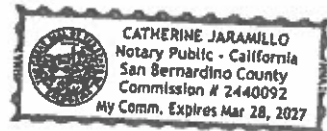
A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

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:



File Number

1431728-7



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

HOLY FAMILY MEDICAL CENTER - DES PLAINES, 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.

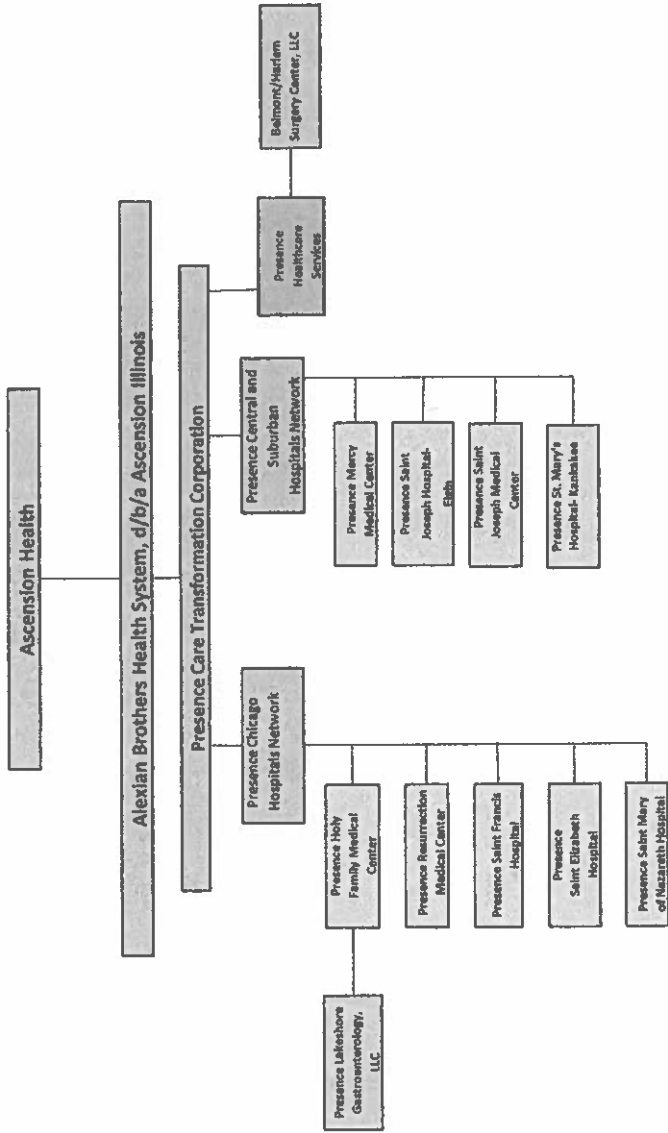


In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 8TH day of APRIL A.D. 2024 .

Authentication #: 2409902688 verifiable until 04/08/2025
Authenticate at: <https://www.ilsos.gov>

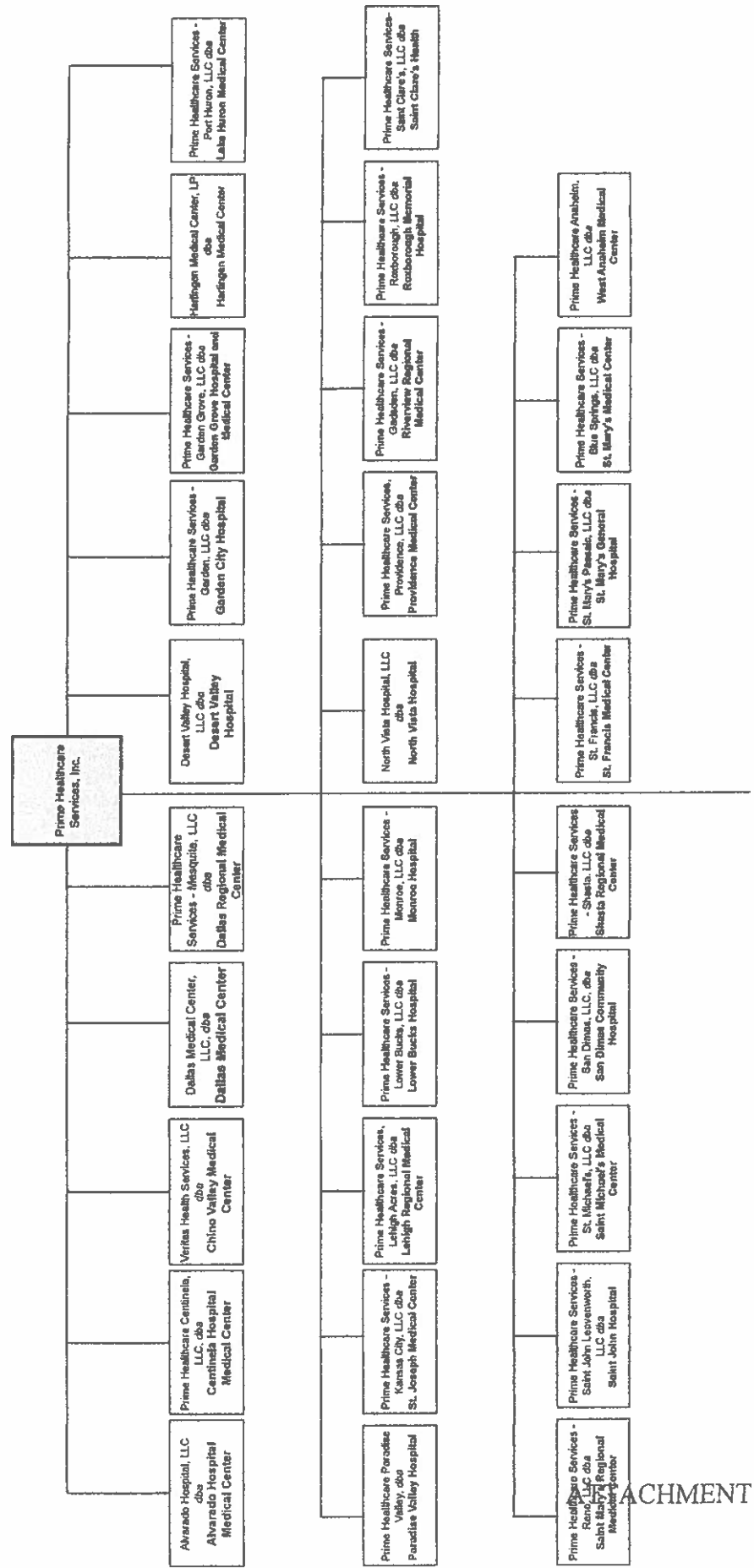
Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 3

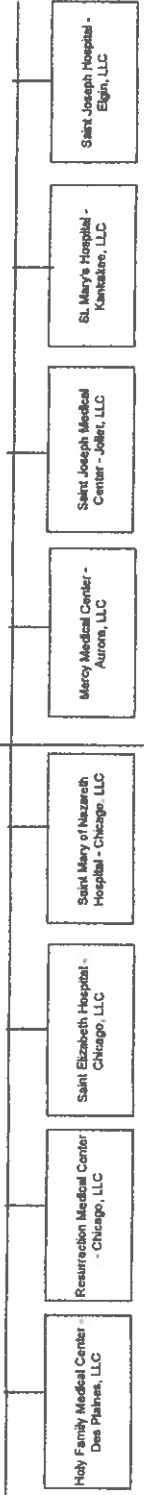


Prime Healthcare Services, Inc.

Prime Healthcare Services, Inc. Post-Closing Organizational Chart



Illinois Hospitals



Ambulatory Surgical Center

Prime Healthcare ASC - Northridge, LLC dba Prime Healthcare Surgical Center of the Valley (100% ownership)

ASC Joint Ventures

Shoreline Surgery Center, LLC (Prime Health ASC - Long Beach, LLC owns 56%)

Magnolia Surgery Center, LP (Prime Healthcare Huntington Beach, LLC owns 75%)

Kinship Surgical, LLC dba Robotic Outpatient Center Los Angeles (Prime Healthcare ASC - Los Angeles, LLC owns 40%)

Presence Lakeshore Gastroenterology, LLC (Prime Healthcare GI - Lakeshore, LLC owns 51%)

Baltimore/Harlem Surgery Center, LLC (Prime Healthcare ASC - Baltimore/Harlem, LLC owns 51%)

Prime Nevada Hospital

St. Mary's Outpatient Surgery Center at Galena, LLC
(Prime Healthcare Services - Reno, LLC owns 85%)

Prime Kansas Hospitals

South Kansas City Surgical Center, LLC (Prime Healthcare Services - Kansas City, LLC owns 51%)

St. Mary's Surgical Center, LLC (Prime Healthcare Services - Blue Springs, LLC owns 51%)

Prime Michigan Hospital

Newco Ambulatory Surgery Center, LLP (Port Huron, LLC owns 50%)

Prime Texas Hospitals

PVSSC, LLC dba Plain Valley Surgery Center (Konepp Medical Center owns 30%)

Complete Surgery - Mesquite, LLC (Prime Healthcare Services - Mesquite, LLC owns 25%)

BACKGROUND OF APPLICANTS

Applicant Ascension Health, directly or indirectly, owns approximately 139 hospitals in 19 states. Below is a listing of Ascension Health's Illinois hospitals:

- Presence Chicago Hospitals Network d/b/a Ascension Resurrection in Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Saint Mary-Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Saint Elizabeth in Chicago
- Presence Chicago Hospitals Network d/b/a Ascension Holy Family in Des Plaines
- Presence Central and Suburban Hospitals Network d/b/a Ascension Mercy in Aurora
- Presence Chicago Hospitals Network d/b/a Ascension Saint Francis in Evanston
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Joseph-Elgin
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Joseph-Joliet
- Presence Central and Suburban Hospitals Network d/b/a Ascension Saint Mary-Kankakee
- Alexian Brothers Medical Center, a/k/a Ascension Alexian Brothers in Elk Grove Village
- St. Alexius Medical Center, a/k/a St. Alexius in Hoffman estates
- Alexian Brothers Behavioral Health Hospital, a/k/a Ascension Alexian Brothers Behavioral Health Hospital in Hoffman Estates
- Presence Saint Joseph Hospital-Chicago, a/k/a Ascension Saint Joseph-Chicago

Additionally, applicant Ascension Health, holds, at minimum, a 5% ownership interest in five ASTCs in Illinois; and owns three skilled care facilities and eight other facilities in Illinois. Those facilities are:

- Hoffman Estates Surgery Center
- Presence Lakeshore Gastroenterology, LLC-Des Plaines
- Belmont/Harlem Surgery Center-Chicago
- PCAC GI JV, L.L.C., d/b/a Lincoln Park Endoscopy Center
- Center for Digestive Health, LLC
- Ascension Saint Joseph Surgery Center MSK-Chicago
- Ascension Living Casa Scalabrini Village
- Ascension Living Heritage Village

- Ascension Living Nazarethville Place
- Ascension Living Bethlehem Wood village
- Ascension Living Resurrection Place
- Ascension Living Resurrection Village Life Center
- Ascension Living Saint Benedict Village
- Ascension Village Villa Franciscan Place
- Ascension Living Fox Knoll Village
- Ascension Living Fox Knoll Village
- Ascension Living Saint Anne Place
- Ascension Living Saint Joseph Village

Prime Healthcare Services, Inc. does not, directly or indirectly own and/or operate any licensed health care facilities in Illinois. Among its holdings, however, are 44 hospitals in fourteen states.

Full listings of all health care facilities owned and or operated by any of the applicants will be provided to HFSRB staff upon request.

No individuals directly associated with any of the applicants own or are proposed to own at least 5% of the facility addressed in this Certificate of Exemption (“COE”) application.

With the signatures provided on the Certification pages of this COE application, each of the applicants attest that, to the best of their knowledge, no adverse action has been taken against any Illinois health care facility owned and/or operated by them, during the three years prior to the filing of this COE application. Further, with the signatures provided on the Certification pages of this COE application, each of the applicants authorize the Health Facilities and Services Review Board and the Illinois Department of Public Health access to any documents that it finds necessary to verify any information submitted, including, but not limited to official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Sameer Vohra, MD, JD, MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	LD NUMBER
12/31/2023		0006023

Long Term Acute Care Hospital

Effective: 01/01/2023

Presence Chicago Hospitals Network
dba Presence Holy Family Medical Center
100 North River Road
Des Plaines, IL 60016

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

Exp. Date 12/31/2023
Lic Number 0006023
Date Printed 10/27/2022

Presence Chicago Hospitals Network
dba Presence Holy Family Medical Ce
100 North River Road
Des Plaines, IL 60016

FEE RECEIPT NO.



December 2, 2022

Yolande Wilson-Stubbs
President, Holy Family Medical Center
Presence Chicago Hospitals Network
100 North River Road
Des Plaines, IL 60016

Joint Commission ID #: 7326
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 12/2/2022

Dear Ms. Wilson-Stubbs:

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

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning August 26, 2022 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

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

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

Congratulations on your achievement.

Sincerely,

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

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

Criterion 1130.520(b)(1)(A) Names of the parties

The parties named as an applicant are:

1. Ascension Health (hereafter referred to as “Ascension”), which currently has “ultimate control” over the licensee
 2. Prime Healthcare Services, Inc. (hereafter referred to as “Prime”), which will have “ultimate control” over the proposed licensee
 3. Presence Central and Suburban Hospitals Network, the current licensee
 4. Holy Family Medical Center – Des Plaines, LLC, the proposed licensee*
 5. Presence Care Transformation Corporation, a signatory on the transaction
- *legal name may be subject to change

Criterion 1130.520(b)(1)(B) Background of the parties

Provided in ATTACHMENT 1, as applicable, are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 5 are:

1. An identification of each applicant’s Illinois licensed health care facilities
2. An “adverse action” attestation
3. The applicants’ authorization permitting the HFSRB and IDPH access to documents necessary to verify the information submitted

Criterion 1130.520(b)(1)(C) Structure of transaction

The proposed transaction is an asset purchase agreement made and entered into by and among (i) Presence Care Transformation Corporation, an Illinois not-for-profit corporation, either directly or through one or more of its wholly-owned subsidiaries (each (including Presence) a “Seller Entity” and collectively, “Seller Group”) and Prime Healthcare Services, Inc., a Delaware corporation (“Buyer”), either directly or through one or more of its wholly-owned Subsidiaries.

Seller Group directly or indirectly through the applicable Seller Entity, owns and operates (i) acute care hospitals in Des Plaines, Evanston, Aurora, Joliet, Chicago, Elgin and Kankakee Illinois addressed through the proposed transaction (the “Hospitals”), and (ii) the Hospitals’ ancillary related healthcare delivery businesses including outpatient clinics, outpatient surgery centers, medical office buildings, senior housing, physician offices, and other properties and facilities (collectively, items (i) and (ii) above referred to as the “Facilities”).

Seller Group wishes to sell, assign, transfer, convey and deliver to Buyer, and Buyer wishes to purchase, assume, acquire and accept from Seller Group, substantially all of the assets of Seller Group used or held for use in connection with the operation of the Facilities, and Buyer is willing to assume from Seller Group certain liabilities relating thereto.

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

Please see Criterion 1130.520(b)(1)(A), above.

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

Current and proposed organizational charts are provided in ATTACHMENT 4.

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

The fair market value of the asset to be transferred is the purchase price identified in the response to Criterion 1130.520(b)(1)(G).

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

The purchase price for the entire transaction (nine hospitals and applicable interests in two ASTCs) was arrived at through negotiations between the two parties. The purchase prices assigned to the various facilities, for purposes of this COE application, were determined based on net revenue for the twelve-month period ending March 31, 2024, with the net revenue of the ASTCs adjusted for the ownership interests held by Ascension. Based on that process, a purchase price of \$13,566,799 has been allocated to the hospital. Please note, as is customary with transactions of this type, the consideration agreed upon at or immediately prior to closing may be adjusted based on a variety of factors such as the value of inventory on hand upon closing.

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

Applicant Ascension Health holds five Certificate of Need Permits:

Permit #20-043 addresses a modernization project at Ascension Mercy in Aurora (f/k/a AMITA Health Mercy Medical Center Aurora), has been obligated, and the project is proceeding

Permit #21-013 addresses a modernization project at Ascension Saint Alexius in Hoffman Estates (f/k/a AMITA Health Saint Alexius Medical Center), has been obligated, and the project is proceeding

Permit #21-017 addresses a modernization project at Ascension Resurrection in Chicago (f/k/a AMITA Health Resurrection Medical Center Chicago), does not involve a HFSRB-designated "Category of Service", has been obligated, and the project is proceeding

Permit #21-018 addresses a modernization project at Ascension Saint Mary-Chicago (f/k/a AMITA Health Saint Mary Hospital Chicago), does not involve a HFSRB-designated "Category of Service", has been obligated, and the project is proceeding

Permit #21-020 addresses a modernization project at Ascension Alexian Brothers Medical Center (f/k/a Alexian Brothers Medical Center), does not involve a HFSRB-designated "Category of Service", has been obligated, and the project is proceeding.

With the signatures on the certification pages of this Certificate of Exemption ("COE") application, the applicants affirm that it is anticipated by the applicants that each of the above-identified projects will be completed following the completion of the change of ownership transaction, and in accordance with all applicable provisions of Section 1130.

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

No changes to the charity care policy currently in effect are anticipated; and with the signatures on the applicable certification page of this COE application, applicant Prime affirms that the current charity care policy will remain in effect for, at minimum, a two-year period following the change of ownership transaction.

A copy of the charity care policy that was in effect one year prior to the filing of this Certificate of Exemption application will be made available to HFSRB staff upon request.

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

The financial commitment on the part of Prime associated with the proposed transaction is evidence of the buyer's commitment to the community and the continued provision of services to the community.

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

To date, no anticipated savings have been quantified by the applicants.

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

Both PHF and Ascension place great importance in quality control, and implement best practice models through their individual facilities. Quality improvement mechanisms at the facility will not initially change, but will be evaluated against parallel programs used in Prime facilities, with

adjustments being made as appropriate to enhance clinical and non-clinical opportunities for improvement.

Due to the size of the facility's quality assurance plan, a copy of the plan will be made available to HFSRB staff upon request.

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

The hospital's governing board structure will continue similar to that currently in place, with the appointment of 9-13 board members by the Prime Corporate Board, composed of community leaders, physicians and facility administration.

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

This COE application is limited to the acquisition (or in the case of an ASTC, the acquisition of a controlling ownership interest) in one of the eleven Illinois licensed health care facilities proposed to be acquired from Ascension by Prime Healthcare Services, Inc. or PHF. While there may be a need or desire for some changes in the services provided in the future or the manner in which services are provided because of financial conditions in the health care industry, or other factors, at this time, no changes to the scope of services or the levels of care provided at the facility are currently anticipated to occur within 24 months of the proposed transaction. During the proposed licensee's first 12-18 months of control, hospital/ASTC-wide assessments of each clinical and non-clinical service provided will be undertaken with the potential existing of decisions being made to modify the scope of or manner in which certain services are provided at the facility, the addition of services, or the discontinuation of services at the facility. Should such a decision(s) be made, and as applicable, all requirements of the HFSRB and IDPH will be complied with.