12-077

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August 28, 2012

RECEIVED
AUG 29 2012
HEALTH FACILITIES & SERVICES REVIEW BOARD

**FEDERAL EXPRESS**

Michael Constantino
Supervisor, Project Review Section
Illinois Department of Public Health
Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

**Re: Resurrection Medical Center Outpatient Dialysis Center**

Dear Mike:

Enclosed please find the Presence Health and Resurrection Medical Center certification pages for the Resurrection Medical Center Outpatient Dialysis Center certificate of need application filed on August 27, 2012.

If you need any additional information regarding the Resurrection certificate of need application, please feel free to contact me.

Sincerely,

Anne M. Cooper

AMC:
Encs.
064628 439832

## CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 for Permit is filed on the behalf of Resurrection Medical Center *
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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.**

| | |
|---|---|
| SIGNATURE | SIGNATURE |
| John Baird | Jeannie C. Frey |
| PRINTED NAME | PRINTED NAME |
| Executive Vice President & CEO, Resurrection Medical Center | Secretary |
| PRINTED TITLE | PRINTED TITLE |
| Notarization:<br>Subscribed and sworn to before me<br>this 23rd day of August, 2012 | Notarization:<br>Subscribed and sworn to before me<br>this 22 day of Aug 2012 |
| Signature of Notary | Signature of Notary |
| Seal<br>OFFICIAL SEAL<br>CHRISTINE J PAWLIK<br>NOTARY PUBLIC - STATE OF ILLINOIS<br>MY COMMISSION EXPIRES:09/02/16 | Seal<br>OFFICIAL SEAL<br>LINDA M NOYOLA<br>NOTARY PUBLIC - STATE OF ILLINOIS<br>MY COMMISSION EXPIRES:06/06/13 |

*Insert EXACT legal name of the applicant

## CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 for Permit is filed on the behalf of Provena-Resurrection Health Network d/b/a Presence 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.**

| | |
|---|---|
| SIGNATURE | SIGNATURE |
| Sandra Bruce | Jeannie C. Frey |
| PRINTED NAME | PRINTED NAME |
| President & CEO, Presence Health | Secretary, Presence Health |
| PRINTED TITLE | PRINTED TITLE |
| Notarization:<br>Subscribed and sworn to before me<br>this 7 day of Aug 2012 | Notarization:<br>Subscribed and sworn to before me<br>this 28 day of August |
| Signature of Notary | Signature of Notary |
| Seal<br>OFFICIAL SEAL<br>LINDA M NOYOLA<br>NOTARY PUBLIC - STATE OF ILLINOIS<br>MY COMMISSION EXPIRES:08/08/13 | Seal<br>OFFICIAL SEAL<br>LINDA M NOYOLA<br>NOTARY PUBLIC - STATE OF ILLINOIS<br>MY COMMISSION EXPIRES:08/08/13 |

*Insert EXACT legal name of the applicant