

ORIGINAL

12-100

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

RECEIVED

DEC 04 2012

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:	Saint Francis Hospital		
Street Address:	355 Ridge Avenue		
City and Zip Code:	Evanston, IL 60202		
County:	Cook	Health Service Area	VII
Health Planning Area:	A-08		

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Presence Saint Francis Hospital
Address:	355 Ridge Avenue Evanston, IL 60202
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	Jeff Murphy
CEO Address:	355 Ridge Avenue Evanston, IL 60202
Telephone Number:	847/316-4000

Type of Ownership of Applicant/Co-Applicant

<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

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o 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.

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 during the review period]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Ms. Nicolette Curth
Title:	Planning & Business Development
Company Name:	Presence Health
Address:	7435 West Talcott Avenue Chicago, IL 60631
Telephone Number:	773/594-8553
E-mail Address:	ncurth@presencehealth.org
Fax Number:	

**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

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Street Address:	355 Ridge Avenue		
City and Zip Code:	Evanston, IL 60202		
County:	Cook	Health Service Area	VII Health Planning Area: A-08

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Provena-Resurrection Health Network d/b/a Presence Health		
Address:	7435 West Talcott Avenue Chicago, IL 60631		
Name of Registered Agent:	Ms. Sandra Bruce		
Name of Chief Executive Officer:	Ms. Sandra Bruce		
CEO Address:	7435 West Talcott Avenue Chicago, IL 60631		
Telephone Number:	773/792-5555		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
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Fax Number:	847/776-7004

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Name:	Ms. Nicolette Curth
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Company Name:	Presence Health
Address:	7435 West Talcott Avenue Chicago, IL 60631
Telephone Number:	773/594-8553
E-mail Address:	ncurth@presencehealth.org
Fax Number:	

Post Permit Contact

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

Name:	Jeff Murphy
Title:	Executive Vice President & CEO
Company Name:	Saint Francis Hospital
Address:	355 Ridge Avenue Evanston, IL 60202
Telephone Number:	847/316-4000
E-mail Address:	Jeff.Murphy@presencehealth.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Presence RHC Corporation
Address of Site Owner:	7435 West Talcott Avenue Chicago, IL 60631
Street Address or Legal Description of Site:	355 Ridge Avenue Evanston, IL 60202
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Presence Saint Francis Hospital	
Address:	7435 West Talcott Avenue Chicago, IL 60631	
<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
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o 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.o 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 co-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.
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Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (<http://www.hfsrb.illinois.gov>).

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 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
<input checked="" type="checkbox"/> Substantive	<input type="checkbox"/> Part 1120 Not Applicable
<input type="checkbox"/> Non-substantive	<input checked="" type="checkbox"/> Category A Project
	<input type="checkbox"/> Category B Project
	<input type="checkbox"/> DHS or DVA Project

2. Narrative Description

Provide in the space below, 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 applicants propose to "discontinue" Saint Francis Hospital's pediatrics category of service. Saint Francis Hospital is located at 355 Ridge Avenue, in Evanston, Illinois.

This is a substantive project because it proposes the discontinuation of an IDPH-designated category of service.

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 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	\$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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price:	\$ _____	
Fair Market Value:	\$ _____	
The project involves the establishment of a new facility or a new category of service		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 \$ <u>not applicable</u> .		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>May 30, 2013</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
not applicable	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input type="checkbox"/> Project obligation 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

Are the following submittals up to date as applicable:
<input checked="" type="checkbox"/> Cancer Registry
<input checked="" type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> 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 department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		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 following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are 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: Saint Francis Hospital			CITY: Evanston		
REPORTING PERIOD DATES: From: January 1, 2011 to: December 31, 2011					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	206	5,786	26,949	None	206
Obstetrics	18	838	2,098	None	18
Pediatrics	12	208	528	-12	0
Intensive Care	35	1,535	7,201	None	35
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	271	8,367	36,776	-12	259

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Presence Saint Francis Hospital * 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.

Jeanne C. Frey
SIGNATURE
Jeanne Frey
PRINTED NAME
Secretary
PRINTED TITLE

Sandra Bruce
SIGNATURE
Sandra Bruce
PRINTED NAME
President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26~~th~~ day of Nov 2012

Notarization:
Subscribed and sworn to before me
this 26 day of Nov. 2012

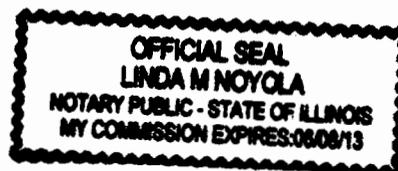
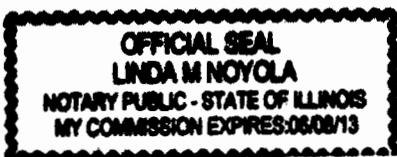
Luan M. Noyola
Signature of Notary

Luan M. Noyola
Signature of Notary

Seal

Seal

*Insert EXACT legal name of the applicant



SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - 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 is to be discontinued.
2. Identify all of 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. 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 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not 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 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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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)

VIII. - 1120.120 - Availability of Funds not applicable, no capitalized costs

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

_____	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <p style="margin-left: 40px;">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</p> <p style="margin-left: 40px;">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;</p>
_____	<p>b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.</p>
_____	<p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p>
_____	<p>d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:</p> <p style="margin-left: 40px;">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;</p> <p style="margin-left: 40px;">2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</p> <p style="margin-left: 40px;">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.;</p> <p style="margin-left: 40px;">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;</p> <p style="margin-left: 40px;">5) For any option to lease, a copy of the option, including all terms and conditions.</p>
_____	<p>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;</p>
_____	<p>f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;</p>
_____	<p>g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.</p>
TOTAL FUNDS AVAILABLE	

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

IX. 1120.130 - Financial Viability not applicable, no debt to be incurred

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. All of the projects capital expenditures are completely funded through internal sources
2. 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
3. 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-40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (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.

2. 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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility not applicable, no debt to be incurred, and no modernization or new construction

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

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 of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs not applicable, project is limited to discontinuation

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 not applicable, project is limited to discontinuation

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 -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

XI. Safety Net Impact Statement Saint Francis Hospital

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2009	2010	2011
Inpatient	127	169	137
Outpatient	1,404	1,089	1,043
Total	1,531	1,258	1,180
Charity (cost in dollars)			
Inpatient	\$1,883,268	\$1,572,454	\$1,924,355
Outpatient	\$1,461,036	\$1,826,620	\$1,465,440
Total	\$3,344,304	\$3,399,074	\$3,389,795
MEDICAID			
Medicaid (# of patients)	2009	2010	2011
Inpatient	1,806	1,865	2,165
Outpatient	23,699	20,952	21,500
Total	25,505	22,817	22,665
Medicaid (revenue)			
Inpatient	\$25,140,397	\$18,352,703	\$27,191,301
Outpatient	\$5,962,992	\$6,764,151	\$8,586,278
Total	\$31,103,389	\$25,116,854	\$35,777,579

APPEND DOCUMENTATION AS ATTACHMENT 43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Saint Francis Hospital

Charity Care information **MUST** be furnished for **ALL** projects.

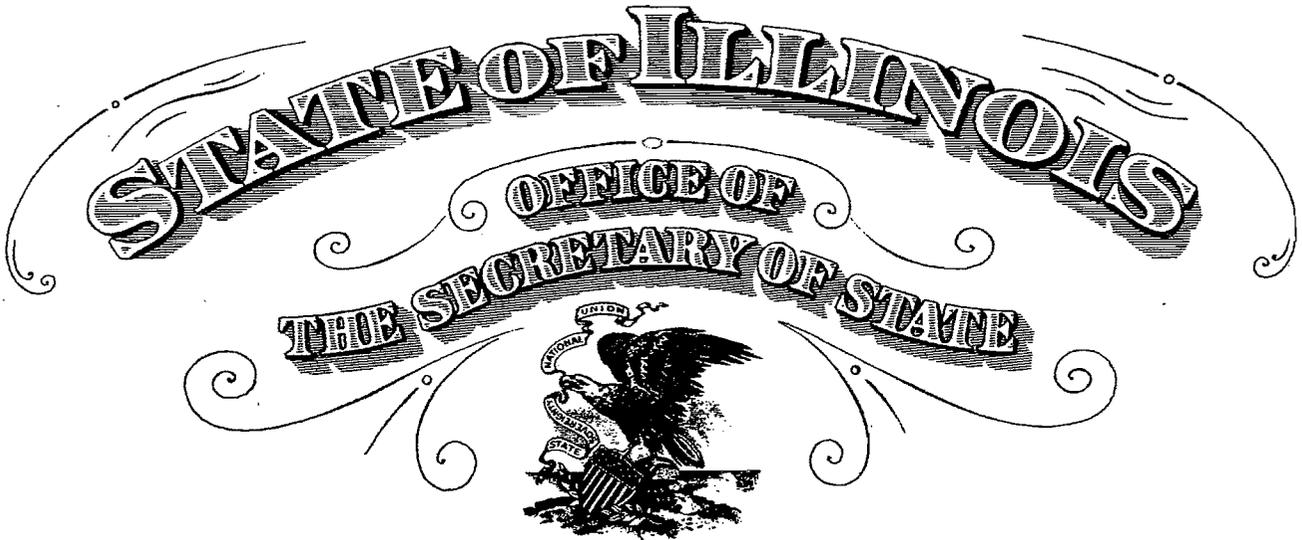
1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for 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 44.

CHARITY CARE			
	2009	2010	2011
Net Patient Revenue	\$165,830,866	\$167,533,892	\$170,403,505
Amount of Charity Care (charges)	\$11,617,074	\$13,440,905	\$14,328,465
Cost of Charity Care	\$3,344,304	\$3,399,074	\$3,389,795

APPEND DOCUMENTATION AS ATTACHMENT 44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PRESENCE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 05, 1939, 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.



Authentication #: 1232600772

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set
*my hand and cause to be affixed the Great Seal of
the State of Illinois, this 21ST
day of NOVEMBER A.D. 2012 .*

Jesse White

SECRETARY OF STATE

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PRESENCE SAINT FRANCIS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 15, 1969, 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.



Authentication #: 1231002208

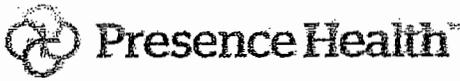
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of NOVEMBER A.D. 2012 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1



Jeannie Carmedelle Frey
Sr. Vice President/Chief Legal Officer
7435 W. Talcott POB #461
Chicago, IL 60631
JFrey@presencehealth.org
773-792-5034

November 20, 2012

Illinois Health Facilities
and Services Review Board
Springfield, IL

RE: Saint Francis Hospital
Evanston, Illinois

To Whom It May Concern:

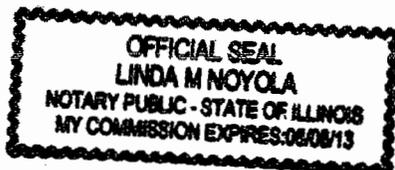
I hereby attest that the site occupied by Saint Francis Hospital, 355 Ridge Avenue in Evanston, Illinois, is owned by Presence RHC Corporation.

Sincerely,

Jeannie Carmedelle Frey, Esq.
Senior Vice President,
Chief Legal Officer and General Counsel

Notarized:

11.29.12





To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PRESENCE SAINT FRANCIS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 15, 1969, 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.



Authentication #: 1231002208

Authenticate at: <http://www.cyberdriveillinois.com>

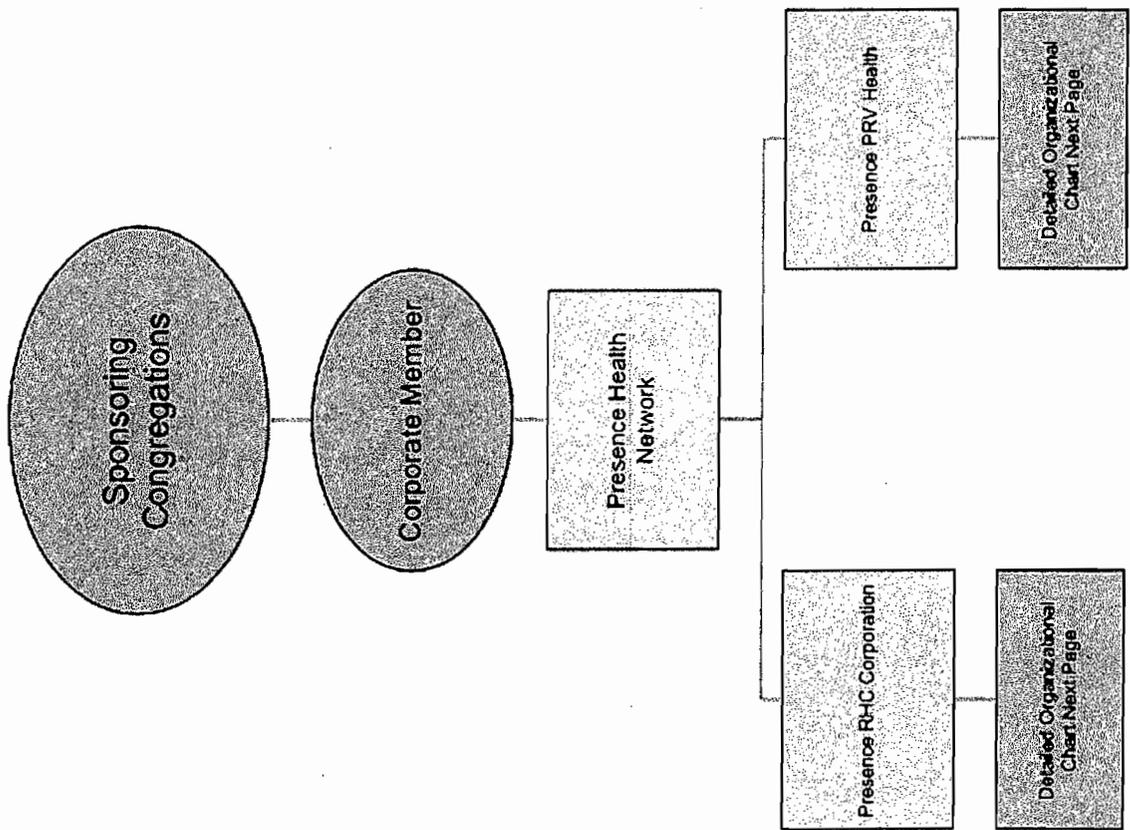
In Testimony Whereof, I hereto set
*my hand and cause to be affixed the Great Seal of
the State of Illinois, this 5TH
day of NOVEMBER A.D. 2012 .*

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

Presence Health Network
Organizational Chart
Effective October 1, 2012



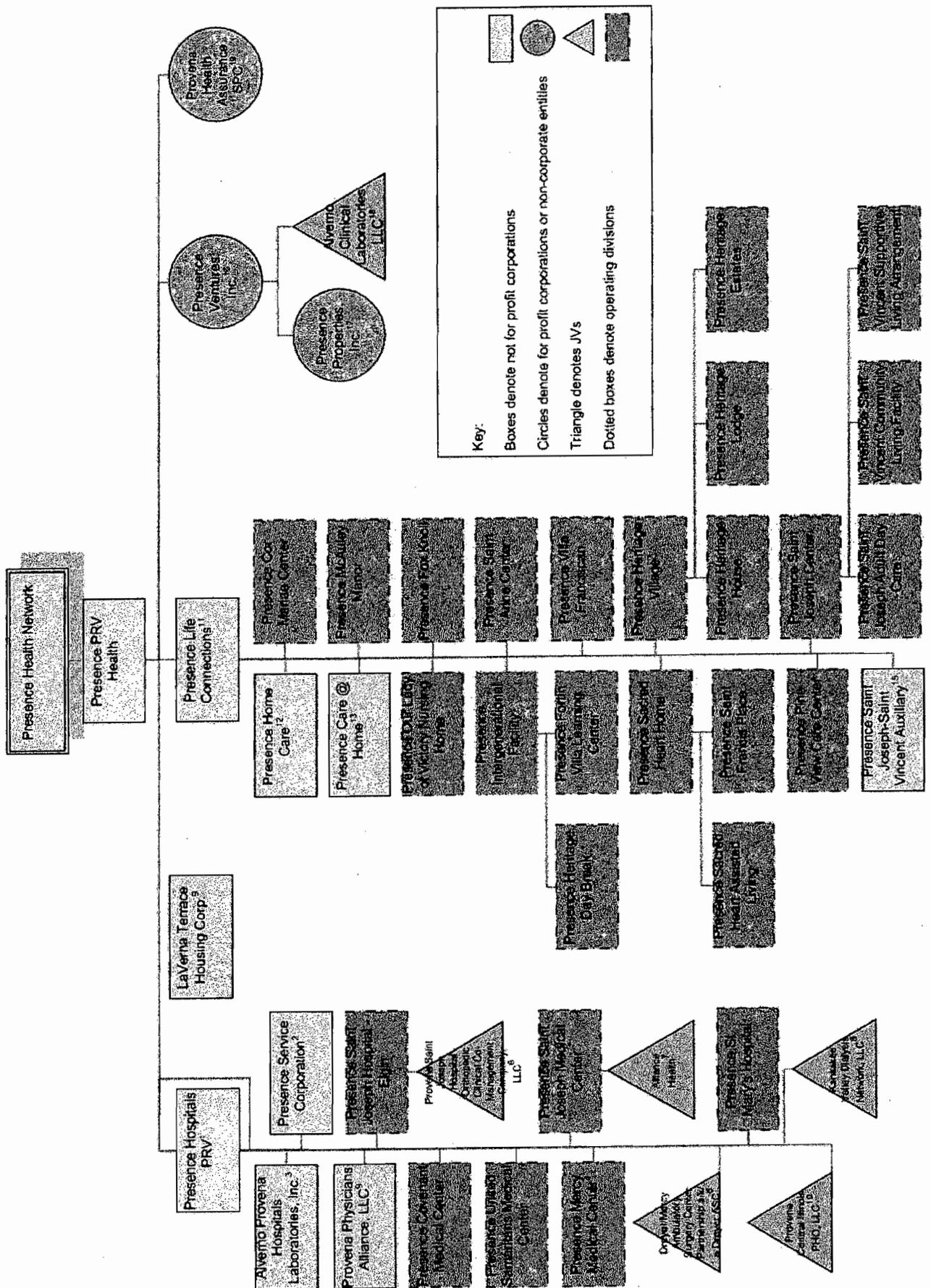
Presence Health Network

Legal Presence RHC Corporation Entities

Effective October 1, 2012

- A. Formerly named Saint Francis Hospital of Evanston (name change effective November 22, 2004).
- B. Became part of the Resurrection system effective March 1, 2001, as part of the agreement of co-sponsorship between the Sisters of the Resurrection, Immaculate Conception Province, and the Sisters of the Holy Family of Nazareth, Sacred Heart Province.
- C. Created from merger of Saint Elizabeth Hospital into Saint Mary of Nazareth Hospital Center, and name change of latter (surviving) corporation, both effective December 1, 2003. Saint Mary of Nazareth Hospital Center (now part of Saints Mary and Elizabeth Medical Center) became part of Resurrection system under the co-sponsorship agreement referenced in Footnote B above.
- D. Saint Joseph Hospital, f/k/a/ Cana Services Corporation, f/k/a/ Westlake Health System.
- E. Formerly known as West Suburban Health Services, this 501(c)(3) corporation had been the parent corporation of West Suburban Medical Center prior to the hospital corporation becoming part of the Resurrection Health Care system. Effective January 1, 2010, Resurrection Ambulatory Services assumed the assets and liabilities of Resurrection Services' ambulatory care services division. Resurrection Ambulatory Services also operates under the d/b/a Express Care Clinics (effective October 31, 2011).
- F. A Cayman Islands corporation registered to do business as an insurance company.
- G. Corporation formerly known as Westlake Nursing and Rehabilitation Center (also f/k/a Leyden Community Extended Care Center, Inc.). Scalabrini Life Center was voluntarily discontinued as a long term care facility on January 24, 2006. Control of Saint Francis Nursing and Rehabilitation Center was transferred to a third party effective July 1, 2010. The Ballard Nursing Center facility a/k/a Ballard Rehabilitation was purchased effective June 1, 2011; Holy Family Nursing and Rehabilitation Center ceased long term care operations effective October 8, 2011.
- H. Resurrection Home Health Services, f/k/a Health Connections, Inc., is the combined operations of Extended Health Services, Inc., Community Nursing Service West, Resurrection Home Care, and St. Francis Home Health Care (the assets of all of which were transferred to Health Connections, Inc. as of July 1, 1999).
- I. Resurrection Health Care Preferred, d/b/a Resurrection Health Preferred, f/k/a Saint Francis Health Preferred, operates under the following d/b/a's: Saints Mary and Elizabeth Health Preferred, Saint Joseph Health Preferred, Resurrection Health Preferred, and Saint Francis Health Preferred.
- J. Proviso Family Services does business as Resurrection Behavioral Health, also known as ProCare Centers and Employee Resource Centers (effective March 1, 2004), and Resurrection Express Care (effective October 31, 2011).
- K. Former parent of Holy Family Medical Center; non-operating 501(c)(3) "shell" available for future use.
- L. An Illinois General partnership between Saint Joseph Hospital and Advocate Northside Health System, an Illinois not for profit corporation.
- M. Resurrection Health Care Corporation is the Corporate Member of RMNY, with extensive reserve powers, including appointment/removal of all Directors and approval of amendments to the Corporation's Articles and Bylaws. The Sponsoring Member of the Corporation is the Sisters of the Resurrection New York, Inc.
- N. Resurrection Services owns over 50% of the membership interests of Belmont/Harlem, LLC, an Illinois limited liability company, which owns and operates an ambulatory surgery center.
- O. Resurrection Services owns a majority interest in the following Illinois limited liability companies which own and operate sleep disorder diagnostic centers; RES-Health Sleep Care Center of River Forest, LLC; RES-Health Sleep Care Center of Lincoln Park, LLC; RES-Health Sleep Care Center of Evanston, LLC; RES-Health Sleep Care Center of Chicago Northwest, LLC.
- P. Joint Venture for clinical lab services entered into with 2 other Catholic health care systems, Provena Health (prior to current affiliation) and Sisters of Saint Francis Health Services, Inc., consistent of an Indiana limited liability company of which Resurrection Services and a Provena affiliate are both 1/3 members, and a tax-exempt cooperative hospital service corporation, of which all Resurrection tax-exempt system hospitals collectively have a 1/3 interest, with Provena Hospitals also holding a 1/3 interest.
- Q. Provena-Resurrection Health Network was formerly named Cana Lakes Health Care; with prior name of Westlake Community Hospital (d/b/a Westlake Hospital); all Westlake Hospital and related operations were transferred to affiliates of Vanguard Health System on August 1, 2010. As of November 1, 2011, this corporation was repurposed to serve as the ultimate parent corporation of the combined system resulting from the affiliation of the Resurrection health Care and Provena Health systems as set forth in a System Merger Agreement dated as of June 30, 2011. From August 1, 2010 through October 31, 2011, there was no operating activity under this corporation.
- R. Resurrection University was formerly named West Suburban Medical Center; West Suburban Hospital Medical Center; and West Suburban Hospital Association. All hospital and other operations were transferred to affiliates of Vanguard Health System on August 1, 2010, such that there were no active operational activities within this corporation from such date until July 1, 2011, at which time the assets and liabilities associated with Resurrection University (formerly an operating division of West Suburban Medical Center known as West Suburban College of Nursing, through June 30, 2010, and from July 1, 2010 through June 30, 2011, an operating division, d/b/a Resurrection University, of Saints Mary and Elizabeth Medical Center.
- S. Effective January 1, 2012, Resurrection Senior Services replaced the Sisters of the Holy Family of Nazareth as the Sole Corporate Member of Nazarethville, an Illinois Not-For-Profit Corporation that operates a skilled nursing facility.

Presence Health Network Legacy Presence PRV Health Effective October 1, 2012



Key:

- Boxes denote not for profit corporations
- Circles denote for profit corporations or non-corporate entities
- Triangle denotes JVs
- Dotted boxes denote operating divisions

Presence Health Network Legacy Presence PRV Health

Effective October 1, 2012

1. Provena Hospitals, d/b/a Provena Surgery Center, Provena Acute Care, Provena United Samaritans Medical Center, Provena Mercy Medical Center, Mercy Medical Center, Mercy Professional Building Pharmacy, The Apothecary, Covenant Outpatient Pharmacy, Highland-Answering Service, Provena Immediate-Care, Plainfield, Provena Imaging, Plainfield, Provena Covenant Medical Center, Provena St. Mary's Hospital, Provena Saint Joseph Hospital, Provena Saint Joseph Medical Center, and Presence Hospitals, is comprised of 6 hospital divisions and was formed from the consolidation of Franciscan Sisters Health Care Corporation, Mercy Center of Health Care Services, St. Mary's Hospital of Kankakee, Illinois, Covenant Medical Center of Champaign/Urbana, and ServantCor.
2. Not-For-Profit, taxable subsidiary of Provena Hospitals; operates under d/b/a of Provena Medical Group, a/k/a PMG; was parent of Provena Imaging (dissolved).
3. Joint venture with the Sisters of St. Francis Health System in Mishawaka, Indiana which began operation in 2005, and was later expanded to include the Resurrection Health Care System; APHL is an Indiana not-for-profit providing hospital-based clinical laboratory services on a cooperative basis.
4. Division of Provena Hospitals; formerly known as Provena Mercy Center (name change effective 2005).
5. Partially owned by Provena Hospitals d/b/a Provena Mercy Medical Center; joint venture ambulatory surgery center; partnership agreement dated November 1, 1991.
6. Joint venture established December 16, 2011; PSJH holds a 20% interest, with remaining interests held by physicians (80%).
7. Joint venture providing PHO an MSO services (50/50 Hospital and Physicians); organized 1994.
8. Joint venture of Provena Hospitals, d/b/a Provena St. Mary's Hospital providing dialysis and associated services; organized in 2003.
9. An Illinois LLC organized in 2011 to develop a physician network working conjunction with Provena Hospitals in the process of clinical integration.
10. Managed Care contracting corporation.
11. Not-For-Profit corporation operating numerous nursing homes and other senior care and residential facilities; incorporated in 1997. Operates in alignment with Provena Home Care under the name Provena Life Connections in April 2010.
12. Not-For-Profit subsidiary of Provenan Senior Services providing home care/hospital services; incorporated April 15, 2002; assumed names include: Provena Hospice; Provena Hospice, Urbana; Provena Hospice, Elgin; Provena Home Care; Provena Home Health, Inc., Joliet; Provena Home Health, Inc., Champaign; Provena Home Health, Inc., Bourbonnais; Provena Home Health, Inc., Gurnee.
13. Not-For-Profit subsidiary of Provena Senior Services providing home care/hospice services; organized in 1999; f/k/a Provena Care @ Home, Inc.
14. ~~Not-For-Profit corporation established in 1994, formerly named McAuley Medical Properties, became LaVerna Terrace Housing Corporation on January 16, 1998, d/b/a Provena LaVerna Terrace.~~
15. Not-For-Profit corporation incorporated in 1999; f/k/a/ Saints Vincent, Joseph, and Francis Auxiliary.
16. For Profit corporation; holds LLC portion of Alverno lab joint venture; incorporated/organized 1997.
17. For Profit corporation organized to hold real property; organized in 1986.
18. Indiana taxable LLC that operates a clinical laboratory located in Hammond, Indiana, as part of the Alverno Clinical Laboratory for the joint venture; organized in 2005; Provena Ventures owns a 1/3/ interest (Resurrection Services also owns a 1/3 interest).
19. A Cayman Island corporation registered to do business as an insurance company.

DISCONTINUATION

The applicants propose the discontinuation of Saint Francis Hospital's pediatrics category of service, which consists of twelve (12) beds. No other clinical services will be discontinued in conjunction with the proposed project. The proposed discontinuation is the result of a historically-low census on the pediatrics unit, which has decreased from an average of 2.3 patients a day in 2009 to 1.7 patients per day in 2011, making the continued staffing of a unit impractical. Children seeking care in the hospital's Emergency Department will continue to be treated in that setting. Children fifteen years of age or older, and requiring admission, will be admitted to a medical/surgical unit on a case-by case basis. All children under the age of fifteen treated in the Emergency Department will be transferred to a hospital of the parents' and physicians' choice, when an inpatient admission is required.

There are numerous hospitals (please see listing at end of this ATTACHMENT'S narrative) in close proximity to Saint Francis Hospital that provide inpatient pediatrics services, and it is not anticipated that the proposed discontinuation will result in any adverse effect on the service area residents' access to pediatrics services.

Discontinuation will occur within sixty days of the Illinois Health Facilities and Services Review Board's (IHFSRB) issuance of a Certificate of Need Permit for the

applicants to do so. The proposed timeframe will allow the hospital to formally inform its medical staff and others of the discontinuation, as well as an exact date after which the hospital will no longer operate a pediatrics unit.

The pediatrics unit will be converted to a medical/surgical unit, and existing medical/surgical beds from semi-private rooms will be relocated to the vacated pediatrics unit, converting existing semi-private medical/surgical patient rooms into private patient rooms. There is no intention on the part of the applicants to increase Saint Francis Hospital's number of approved medical/surgical beds as a result of the proposed pediatrics discontinuation.

The medical records of past pediatrics patients will be retained at Saint Francis Hospital in the same or similar manner in which other medical records are kept. It is the practice of the hospital to retain all medical records for a minimum period of twelve years; for pediatrics patients the records are retained at minimum, for the longer of (a) twelve years or (b) until the patient's 21st birthday, as applicable.

On October 18, 2012 certified letters, consistent with Section 1110.130, were sent to all hospitals located within 45 minutes of Saint Francis Hospital, that are approved to provide pediatrics beds. A template of that letter is attached, as are the return receipts received, confirming delivery of the individual letters. As of the filing of this Application for Permit, two responses to the certified letters have been received. The only responses were from Shriner's Hospitals for Children, which indicated that the proposed

discontinuation would have no impact on that facility and Saint Anthony Hospital, which indicated that the discontinuation would have “minimal impact”. Letters were sent to the following hospitals:

Condell Memorial Hospital
Evanston Hospital
Skokie Hospital
Highland Park Hospital
Illinois Masonic Medical Center
Lake Forest Hospital
Loretto Hospital
Lurie Children’s Hospital
Lutheran General Hospital
Mount Sinai Hospital
Norwegian American Hospital
Rush University Medical Center
Saint Joseph Hospital, Chicago
Shriners Hospital for Children
St. Anthony Hospital, Chicago
St. Elizabeth Hospital
St. Mary of Nazareth Hospital
Stoger Hospital of Cook County
Swedish Covenant Hospital
University of Illinois at Chicago Medical Center

by Certified Mail

October 18, 2012

Name
Title
Facility name
Street address
City/state/ZIP

Dear :

Saint Francis Hospital in Evanston is preparing a Certificate of Need application to be filed with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of its 12-bed pediatrics category of service. The hospital is located at 355 Ridge Avenue in Evanston. The discontinuation is scheduled to occur following IHFSRB approval, in early 2013.

Over the past two years, the hospital has averaged approximately 230 pediatrics admissions per year.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130.c), you are hereby asked to, within fifteen days, identify what impact, if any, the proposed discontinuation of the pediatrics category of service will have on your operations; whether your facility has the available capacity to accommodate a portion or all of Saint Francis Hospital's pediatrics caseload, and whether your facility operates with any restrictions or limitations that would preclude providing service to residents of Saint Francis Hospital's market area.

Thank you for your prompt attention to this request.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10



Shriners Hospitals
for Children®

Chicago
Pediatric Specialty Care

Orthopaedics
Spinal Cord Injury
Cleft Lip & Palate

October 29, 2012

Shriners Hospitals for Children—Chicago
2211 North Oak Park Avenue
Chicago, IL 60707-3392
Main Tel: 773.622.5400
Main Fax: 773.385.5453
www.shrinershospitals.org

Jacob M. Axel
Axel & Associates, Inc.
675 North Court; Suite 210
Palatine, Illinois 60067

Dear Mr. Axel:

Your letter of October 17th has been received and reviewed in reference to St. Francis Hospital in Evanston preparing to file a CON application addressing the discontinuation of its 12-bed pediatrics category of service. I am writing this letter to inform you that the aforementioned discontinuation of services will have no impact on the operations of Shriners Hospitals for Children – Chicago. Shriners Hospitals for Children provides pediatric sub-specialty care in the areas of: orthopaedics, burns, spinal cord injuries, and cleft lip and palate. If you have any questions or comments, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark L. Niederpruem'.

Mark L. Niederpruem, FACHE
Administrator

MLN:jp

ATTACHMENT 10



November 8, 2012

Mr. Jacob M. Axel
President
Axel & Associates, Inc.
675 North Court – Suite 210
Palatine, IL 60067

RE: CON Application for Saint Francis Hospital - Evanston, IL

Dear Mr. Axel:

In response to your correspondence dated October 17, 2012, please be advised that the discontinuation of the 12-bed pediatrics category of service at Saint Francis Hospital would have minimal impact on Saint Anthony Hospital due to its location. Please note that Saint Anthony Hospital does have the available capacity to accommodate a portion or all of Saint Francis Hospital's pediatric caseload should the need occur and our facility does not operate with any restrictions or limitations that would preclude providing services to residents of Saint Francis Hospital's market area.

Should you need any additional information, please feel free to contact me at (773) 484-4831 or cbrobst@sahchicago.org.

Sincerely,

Charles R. Brobst
Senior Vice President and Chief Financial Officer

CRB/bes

cc: Aileen Brooks, VP and General Counsel
Jill Stemmerman, VP of Patient Care and Chief Nursing Officer

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 Kristen Nurtos
 Skokie Hospital
 9600 Gross Point Road
 Skokie, IL
 60076-1257



COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee

B. Received by (Printed Name)
 JOY BRADY

C. Date of Delivery

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) 7009 1410 0000 7633 1336

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 SUSAN NORDSTROM LOPEZ
 ADVOCATE ILLINOIS
 MASONIC MEDICAL CENTER
 836 W. WELLINGTON AVE.
 CHICAGO, IL
 60657-5193

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee

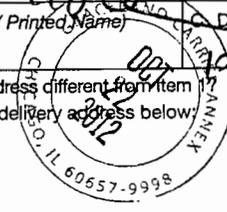
B. Received by (Printed Name)
 SK

C. Date of Delivery
 02/12/12

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes



2. Article Number (Transfer from service label) 7009 1410 0000 7634 4909

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 PATRICK M. MAGOON
 LURIE CHILDREN'S
 HOSPITAL OF CHICAGO
 225 EAST CHICAGO AVE.
 CHICAGO, IL 60611

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee

B. Received by (Printed Name)
 ALEX REZNIK

C. Date of Delivery

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) 7009 1410 0000 7634 4893

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Gay A. Medaglia
Saint Anthony Hospital
2875 West 19th Street
Chicago, IL 60623-3501

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 4992

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Marlo Yanco* Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

10/19/02

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Larry J. Goodman, M.D.
Rush University Medical
Center
1653 West Congress
Parkway
Chicago, IL 60612-3864

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 4978

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *R. J. Janso* Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

10/19/01

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

J. P. Gallagher
Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

2. Article Number

(Transfer from service label)

7009 1410 0000 7633 1329

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Ch...* Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

John J. DeNardo
Univ. of Illinois Medical
Center at Chicago
1740 W. Taylor Street
Ste. 1400, M/C 693
Chicago, IL 60612-7236

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 4954

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Atasha Semer*

- Agent
 Addressee

B. Received by (Printed Name)

C. Date of Delivery

10-18-12

- Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

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 Registered Return Receipt for Merchandise
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4. Restricted Delivery? (Extra Fee)

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1. Article Addressed to:

Anthony Armada
Advocate Lutheran
General Hospital
1775 Dempster Street
Park Ridge, IL
60068-1173

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 5036

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Robert Vignone*

- Agent
 Addressee

B. Received by (Printed Name)

C. Date of Delivery

10-19-12

- Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

- Yes

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Thomas S. McAfee
Northwestern Lake
Forest Hospital
660 North Westmoreland
Road
Lake Forest, IL
60045-9989

2. Article Number

(Transfer from service label)

7009 1410 0000 7633 1305

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Robert Vignone*

- Agent
 Addressee

B. Received by (Printed Name)

C. Date of Delivery

Robert Vignone

- Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

- Yes

ATTACHMENT 10

36

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 MARK NEWTON
 SWEDISH COVENANT
 HOSPITAL
 5145 N. CALIFORNIA AVE.
 CHICAGO, IL
 60625-3642

2. Article Number
 (Transfer from service label) 7009 1410 0000 7634 4916

PS Form 3811, February 2004 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 X *[Signature]*

B. Received by (Printed Name) C. Date of Delivery
 TOM FAY

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 Alan H. Channing
 Mount Sinai Hospital
 CALIFORNIA AVENUE AT
 15th STREET
 CHICAGO, IL
 60608-1797

2. Article Number
 (Transfer from service label) 7009 1410 0000 7634 5005

PS Form 3811, February 2004 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 X *[Signature]*

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
 Jesse Peterson Hall
 Highland Park Hospital
 777 Park Avenue West
 Highland Park, IL
 60035-2497

2. Article Number
 (Transfer from service label) 7009 1410 0000 7633 1312

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 X *[Signature]*

B. Received by (Printed Name) C. Date of Delivery
 JOE PANKWIN 10/19/12

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 10

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Margaret McDermott
Saints Mary + Elizabeth
Medical Center
2233 West Division Street
Chicago, IL
60622-3087

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 4961

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature] Agent Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

JAMES A. COHICK, JR
SHRINERS HOSPITALS FOR
CHILDREN - CHICAGO
2211 NORTH OAK PARK AVE
CHICAGO, IL
60707-3392

2. Article Number

(Transfer from service label)

7009 1410 0000 7634 4930

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature] Agent Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

10/19/12

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ann Errichetti, M.D.
Advocate Condell
Medical Center
801 South Milwaukee
Avenue
Libertyville, IL
60048-3199

2. Article Number

(Transfer from service label)

7009 1410 0000 7633 1299

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature] Agent Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

10/19/12

D. Is delivery address different from item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature Hector J. M. [Signature] <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
	B. Received by (Printed Name) [Signature]	C. Date of Delivery 10-19
1. Article Addressed to: Jose R. Sanchez Norwegian American Hospital 1044 North Francisco Avenue Chicago, IL 60622-2794	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7009 1410 0000 7634 4985	
	PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature Wayne Williams [Signature] <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
	B. Received by (Printed Name) Wayne Williams	C. Date of Delivery 10-19
1. Article Addressed to: STEVEN C. DRUCKER LORETTO HOSPITAL 645 SOUTH CENTRAL AVENUE CHICAGO, IL 60644-9987	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7009 1410 0000 7634 7511	
	PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540	

SAFETY NET STATEMENT

Saint Francis Hospital is a safety net provider for area residents. Saint Francis Hospital (SFH) operates under a system-wide charity care and financial assistance policy adopted by Presence Health in April 2012. A copy of that policy, which includes a sliding scale, identifying discounts for patients having a family income of up to 600% of the Federal Poverty Level, is attached. During 2011, the hospital's charity care as a percentage of net revenue was 2.0%. In addition, during 2011 21.3% of SFH's admissions were covered by Medicaid, the highest such percentage in Planning Area A-08.

The proposed project is limited to the discontinuation of SFH's pediatrics category of service, and because of the availability of alternative providers, it is not believed by the applicants that this project will have a material impact on the community's ability to access services.

Because of the nature of the proposed project, the cross-subsidizing of services is not applicable. In addition, with the low number of historical pediatrics admissions to SFH, the applicants do not believe that the proposed discontinuation will have a material impact on any other individual provider of pediatrics services.

SYSTEM POLICY

Section: Finance

Page: 1 of 12

Subject: Provision for Financial Assistance –Hospitals

Approval Date: 4/1/2012

Effective Date: 4/1/2012

Executive Owner: Executive Leadership-Finance

Last Review Date:

Revised Date:

Supersedes:

I. POLICY STATEMENT

- A. To promote the health and well-being of our communities, community residents with limited financial resources, and with no or insufficient insurance coverage shall be eligible for free or discounted hospital services as set forth in this Policy.
- B. Adoption of this Policy reflects the commitment of Presence Health hospitals to assure that patients with limited financial means have access to needed hospital services in a fair and equitable basis.
- C. This Policy is designed to be fully compliant with applicable law, including the Illinois Hospital Uninsured Patient Discount Act, the Illinois Fair Patient Billing Act, and Section 501 (r) of the Internal Revenue Code (instituted by the Patient Protection and Affordable Care Act). In many respects, this Policy exceeds such legal requirements, reflecting our commitment to assuring that the poor and underserved have access to needed health care.

II. PURPOSE

- A. This Policy sets forth the standards for providing Financial Assistance/Charity Care to hospital patients who lack ability to pay for medically necessary hospital services.
- B. This Policy applies to hospital charges and not independent physicians or independent company billings.

III. MISSION / VALUES RATIONALE

- A. Our Mission and Values call us to service those in need. Our hospitals have a long tradition of serving the poor and underserved members of our community. This Policy continues that tradition, while reflecting an appropriate stewardship of resources.
- B. This Policy is one aspect of the many ways in which our hospitals promote the health care needs of the underserved. In addition to providing financial assistance in accordance with the Policy, each Presence Health hospital will continue to play a leadership role in identifying and responding to community health needs, in coordination and partnership with government and private organizations.

IV. SPECIAL INSTRUCTIONS

This Policy is applicable to all Presence Health hospital ministries.

V. DEFINITIONS

- A. **Automatic Uninsured Self-Pay Discount:** A discount of 40% of gross charges, provided to all uninsured patients without requiring evidence of inability to pay. This discount is designed to assure that patients are charged at a rate generally comparable to that applied to insured patients.
1. There is no application process for the patient to receive the uninsured discount. The discount is applied based on the account's self-pay/uninsured status.
 2. Patients receiving pre-negotiated discounts (package pricing) for hospital services will not be eligible for this uninsured discount.
 3. If a patient is subsequently approved for financial assistance/charity care the automatic uninsured discount will be reversed so that the full amount can be recognized as a charity allowance.
- B. **Catastrophic Discount:** A discount provided when the patient responsibility specific to medical care at Provena Health – Resurrection Health Care Hospitals, even after payment by third-party payers, exceed a designated percentage of the patient's family annual gross income.
- C. **Charity Care:** Term often used to refer to the value (at cost) of free or discounted health care services provided to individuals who have been determined eligible for financial assistance based on financial need.
- D. **Exempt Assets:** The following assets are considered "Exempt Assets" for purposes of this Policy, such that the value of such assets will not be considered in determining a patient's ability to pay or financial need: the patient's primary residence; personal property exempt from judgment under Section 12-1001 of the Code of Civil Procedure; or any amounts held in pension or retirement plan (however, distribution and payments from pension or retirement plans will be included as income).
- E. **Family:** The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. For example, if the patient claims someone as a dependent on his/her income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
- F. **Family Income:** The sum of a family's gross annual earnings and cash benefits from all sources before taxes, less payment made for child support. Sources of income include but are not limited to: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

G. **Financial Assistance Committee**: A team of hospital leaders that meets monthly to review data relating to financial assistance applications and determinations. The committee will consist of the hospital Chief Executive Officer, Chief Financial Officer, VP Mission Services, Revenue Integrity Director (or designee), Director of Case/Care Management, Patient Financial Counselor, or a similar mix of responsible hospital leaders.

H. **Financial Assistance Guidelines and Eligibility Criteria**

1. **General**. The Financial Assistance Guidelines and Eligibility Criteria below are designed to assure that patients with financial need are charged at a rate substantially less than insured patients, including the opportunity to receive 100% free care. The table below is used to determine the financial assistance discounts by tier for uninsured patients.

Eligibility Criteria		
Percentage of Poverty Guidelines	Discount Percentage	Catastrophic Cap
Up to 200%	100%	15%
201 - 300%	90%	15%
301 - 400%	80%	15%
401 - 600%	75%	15%
Over 600%	Determined on an exception basis	15%

2. **Annual Updates of Criteria Levels**. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. The Eligibility Criteria discount percentage will be updated annually based on the calculation set forth by the Illinois Uninsured Patient Discount Act and Section 501(r) of the Internal Revenue Code (instituted by the Patient Protection and Affordable Care Act).
3. **Financial Assistance to Certain Crime Victims**. Individuals who are deemed eligible by the State of Illinois to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall first be evaluated for eligibility for financial assistance based on the Financial Assistance Guidelines and Eligibility Criteria. Applications for reimbursement under such Crime Victims Funds will be made only to the extent of any remaining patient liability after the financial assistance eligibility determination is made.
4. **Financial Assistance for Insured Patients**. Financial assistance/charity care in the form of 100% discounts (free care) is available for patient-liability amounts remaining after insurance payments, for insured patients who are Illinois residents with family gross income less than 200% of the Federal Poverty guidelines and after satisfying related co-payments/coinsurances up to \$300 per encounter.

- I. **Illinois resident:** A person who currently lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement. Acceptable verification of Illinois residency shall include any one (1) of the following:
1. Any of the documents listed in Paragraph (H);
 2. A valid state-issued identification card;
 3. A recent residential utility bill;
 4. A lease agreement;
 5. A vehicle registration card;
 6. A voter registration card;
 7. Mail addressed to the uninsured patient at an Illinois address from a government or other credible source;
 8. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or
 9. A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

All non-IL resident applications will be reviewed by the ministry Financial Assistance Committee.

- J. **Income Documentation:** Acceptable family income documentation shall include any one (1) of the following:
1. a copy of the most recent tax return;
 2. a copy of the most recent W-2 form and 1099 forms, or similar forms issued to members of partnerships, limited liability companies or other entities;
 3. copies of the two (2) most recent pay stubs;
 4. written income verification from an employer if paid in cash; or
 5. one (1) other reasonable form of third party income verification deemed acceptable to the hospital.
- K. **Medically Necessary Service:** Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity.

L. **Presumptive Financial Assistance/Charity Care Eligibility:** Presumptive eligibility for financial assistance/charity care may be determined on the basis of individual life circumstances that indicate financial need. In these situations, a patient is deemed to have family income of 200% or less of the Federal Poverty Level, and therefore eligible for a 100% reduction from charges (i.e., full charity write-off). A patient therefore does not need to complete a financial assistance application when sufficient evidence is provided that they meet one of the following presumed eligibility criteria:

1. Participation in state-funded prescription programs.
2. Participation in Women's Infants, and Children's Programs (WIC)
3. Food stamp eligibility (LINK Card)
4. Subsidized school lunch program eligibility.
5. Low income/subsidized housing is provided as a valid address (Section 8 certificate holder)
6. Patient is deceased with no known estate.
7. Patient receiving or qualifying for free care from a community clinic affiliated with the hospital or known to have eligibility standards substantially equivalent to that of the hospital under this Policy, and the community clinic refers the patient to the hospital Ministry for treatment or for a procedure.
8. Patient is or states that he/she is homeless, and such status is determined to be accurate after appropriate review of the available facts.
9. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
10. Patient is currently eligible for Medicaid, but was not eligible on a prior date of service; in such case, instead of making the patient duplicate the required paperwork, the hospital Ministry will rely on the financial assistance determination process from Medicaid and apply a 100% discount for such prior service.
11. Patient receives a MANG denial due to asset availability.

M. **Uninsured Patient:**

1. A patient of a hospital who is not covered under any commercial health insurance Policy (including third party liability coverage) and is not a beneficiary or eligible to be covered by any governmental or other coverage program, including Medicare, Medicaid, TriCare, high deductible insurance, or other coverage arrangements.\
2. If an insured patient's coverage is exhausted, or the patient's insurance does not cover the Medically Necessary hospital service provided to the patient, the patient will be considered uninsured for purposes of financial assistance and the uninsured discount will also apply to these cases.

VI. PROCEDURE

A. Identification of Potentially Eligible Patients

1. Prior to Admission. When possible prior to the admission or pre-registration of the patient, the hospital will conduct an appropriate pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission/pre-registration interview is not possible, this interview should be conducted upon admission or registration or as soon as possible thereafter. In case of patients who have come to the hospital's Emergency Department, the hospital's evaluation of payment ability should not take place until an appropriate medical screening has been provided, and in the case of patients determined to have an emergency medical condition, until after such condition has been stabilized.
2. Patient Interview. At the time of the initial patient interview, the following information should be gathered: (a) Routine and comprehensive demographic data and employment information; (b) Complete information regarding all existing third party coverage.
3. Patients Potentially Eligible for Public Programs. Patients who are identified as potentially eligible for healthcare coverage from a governmental program or other source will be referred to a Financial Counselor and expected to cooperate with efforts to determine their eligibility for coverage (e.g. Medicaid), prior to consideration for financial assistance. Such coverage eligibility efforts will be made at the hospital's expense, and will promote such public Policy goals by assuring eligible patients are covered by available health coverage programs.
4. Timing of Financial Assistance/Charity Care Application. A patient may apply for financial assistance at any time during the billing and collection process.

B. Determination of Eligibility

1. Provision of Financial Assistance Applications. All patients identified as uninsured will be provided a Financial Assistance application prior to discharge or at point of service (for outpatient services) and offered the opportunity to apply for financial assistance. If uninsured status is not determined until after the patient leaves the hospital, a Patient Financial Services representative will mail a financial assistance application to the uninsured patient upon request.
2. Expectations of Patient Cooperation. It is expected that patients will cooperate with the information gathering and assessment process in order to determine eligibility for financial assistance.

3. Application of Catastrophic Discount. The Catastrophic Discount will be available to patients who have medical expenses over a 12 month period for Medically Necessary Services from a Presence Health hospital that exceed 15% of the patient's family annual gross income, even after payment by third-party payers. Any patient responsibility in excess of the 15% will be written off to charity. Services that are not Medically Necessary will not be eligible for this discount.
4. Financial Assistance Committee Reviews of Special Circumstances. The Financial Assistance Committee will review patient accounts identified by a Financial Counselor that involve unique circumstances affecting financial need beyond the standard eligibility criteria.
 - a. The Committee may recommend to the System Chief Revenue Cycle Officer or his/her designee, specific exceptions to this Policy based on unusual or uncommon circumstances relating to financial need. All exception decisions must have the rationale clearly and formally documented by the Committee and maintained in the account file and must be made consistently across the System.
 - b. Special circumstances approvals of financial assistance for any person affiliated with the Hospital or System, such as employees, medical staff, board members, etc. or family member of such person, shall be subject to the approval of the Chief Legal Officer for Presence Health.
5. Assets Consideration. Assets will be used in the determination of the maximum collectible amount in a 12-month period. Assets will not be used for initial financial assistance eligibility, except to the extent of assets, other than Exempt Assets, that indicate the existence of unreported additional sources of income. (Patient may be excluded if patient has substantial assets, other than Exempt Assets defined as having a value in excess of 600% Federal Poverty Level). Distributions and payments from pension or retirement plans may be included as income.
 - a. Acceptable documentation of assets include:
 - i. Statements from financial institutions or some other third party verification of an asset's value.
 - ii. If no other third party exists the patient shall certify as to the estimated value of the asset.
6. Approval Authorities. The Business Office Financial Counselor may approve financial assistance for amounts up to \$25,000. The System Financial Assistance Manager may approve amounts greater than \$25,000 but lower than \$100,000. Amounts greater than \$100,000 will be approved by the hospital's CFO. Approval amounts must be in compliance with the Financial Assistance/Charity Care eligibility criteria.

C. Notification of Eligibility Determination

1. Normal Processing Period. Clear expectations as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turn-around and written decision, providing a reason(s) for denial (if appropriate) will be provided, generally within 45 days of the hospital's receipt of completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.
2. Suspension of Collection Activity. If a patient disagrees with the Financial Assistance eligibility determination, including regarding the extent of discount for which a patient is eligible, the patient may appeal in writing within 45 days of the denial. The Ministry's Chief Financial Officer will review the appeal, and make a recommendation to the Financial Assistance Committee. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee's final review.
3. Suspension of Collection Activities Pending Eligibility Determination. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any governmental or other available healthcare coverage (i.e. Medicare, or Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is completed. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration.
4. Other Determinations of Financial Need Based on Objective Data. When a patient has not completed a financial assistance application but there is adequate objective information to support a determination of the patient's likely inability to pay, the patient's case will be submitted for review to the Ministry's CFO, who will make a recommendation to the Financial Assistance Committee. If approved for assistance, a 100% write off to financial assistance/charity care will be granted for all open accounts. Eligibility for financial assistance discounts for future dates of service will be determined at the dates such services are provided.
5. Refunding Patient Payments. No refunds will be given for payments made prior to the first date the patient applies for financial assistance, except in cases approved by the Financial Assistance Committee or Chief Legal Officer involving lack of effective communication with the patient or other extenuating circumstances.

6. Change in Status Notifications. If the patient with an outstanding bill or payment obligation has a change in his/her financial status, the patient should promptly notify the Central Billing Office (CBO) or hospital designee. The patient may request his/her and apply for financial assistance or a change in their payment plan terms.
7. Payment Arrangements. After the financial assistance/charity care discount has been applied, any remaining patient balances will eligible for payment arrangements in accordance with Patient Financial Services policies. If a patient is unable to meet the payment arrangement guidelines due to special patient or family circumstances limiting the patient's payment ability, the Financial Counselor or similar representative may review and recommend additional financial assistance/charity care to the Ministry Financial Assistance Committee for the Committee's review and recommendation.
8. Application of Financial Assistance Discounts to Patient Accounts. Once a financial assistance eligibility determination is made, the applicable discount will be applied to all of the patient's open or bad debt accounts for services prior to the approval date. For subsequent applications made within six (6) months of an eligibility determination, patients may be asked to verify information that was provided during the initial application process.

D. Collection Practices

1. Pre-Litigation Review. Prior to an account being authorized for the filing of suit for non-payment of a patient bill, a final review of the account will be conducted and approved by the Financial Counseling Representative (or designee) to make sure that no application of financial assistance was ever received and that there exists objective evidence that the patient does have sufficient financial means to pay all or part of his/her bill. Prior to a collections suit being filed, the Self-pay Collections Director must review and approve.
2. Residential Liens. No hospital will place a lien on the primary residence of a patient who has been determined to be eligible for Financial Assistance/Charity Care, for payment of the patient's undiscounted balance due. Further, in no case will any hospital execute a lien by forcing the sale or foreclosure of the primary residence of any patient to pay for any outstanding medical bill.
3. No Use of Body Attachments. No hospital will use body attachment to require any person, whether receiving Financial Assistance/Charity Care discounts or not, to appear in court.
4. Collection Agency Referrals. Each hospital Finance accounting will ensure that all collection agencies used to collect patient bills promptly refer any patient who indicates financial need, or otherwise appears to qualify for Financial Assistance/Charity Care discounts, to a financial counselor to determine if the patient is eligible for such a charitable discount.

E. Patient Awareness of Policy and Availability of Assistance

1. Signage. Signs, placards or similar written notices regarding the availability of Financial Assistance Charity Care will be visible in all hospitals at points of registration and other patient intake areas, to create awareness of the Financial Assistance program. At a minimum, signage will be posted in the emergency department, and the admission/patient registration area. All public information and/or forms regarding the provision of Financial Assistance will use languages that are appropriate for the Ministry's service area in accordance with the state's Language Assistance Services Act. This Policy will be translated to and made available in Spanish and other languages appropriate for each hospital.
2. Hospital Bill/Invoice. Patient bills, invoices or other summary of charges shall include a prominent statement that patients who meets certain income requirements may qualify for financial assistance and information regarding how a patient may apply for consideration under the hospital's financial assistance Policy.
3. Policy Availability. Upon request, any member of the public or state governmental body will be provided with a copy of this Financial Assistance/Charity Care Policy. A summary of the financial assistance is available pursuant to this Policy and will be available on the Presence Health website.
4. Application Forms. Forms used to determine a patient's eligibility for financial assistance will be made available at each hospital, ministry, and provided at registration to all patients who are identified as uninsured or at other appropriate times or locations if the patient's uninsured status is determined after registration.

F. Monitoring and Reporting

1. Maintenance of Financial Assistance/Charity Care Logs. A financial assistance log from which periodic reports can be developed shall be maintained. Financial assistance logs will be maintained for a period of ten (10) years. At a minimum, the financial assistance logs are to include:
 - a. Account number
 - b. Date of Service
 - c. Application returned
 - d. Application completed
 - e. Total charges
 - f. Self-pay balances
 - g. Amount of Financial Assistance approved
 - h. Date financial assistance was approved or rejected

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2. Review of Financial Assistance/Charity Care Logs. The Financial Assistance log for each hospital will be printed monthly for review at the hospital Financial Assistance Committee meeting.
3. Financial Assistance Authorization Record Retention. A record, paper or electronic, should be maintained reflecting authorization of financial assistance. These documents shall be kept for a period of ten (10) years.
4. Annual Reports to Governmental Bodies. The cost of financial assistance will be reported annually in the Community Benefit Report to the Community, IRS 990 schedule H and in compliance with the IL Community Benefit Act. Charity Care will be reported as the cost of care provided (not charges) using the documented criteria for the reporting requirements.

FORMS AND OTHER DOCUMENTS

Eligibility Criteria for the Financial Assistance Program
 Hospital Financial Assistance Program Cover Letter and Application
 Room and Board Statement

REFERENCES

Section 12-1001 Illinois Code of Civil Procedure
 Title XVIII Federal Social Security Act
 Illinois Uninsured Patient Discount Act
 Illinois Fair Patient Billing Act
 Illinois Violent Crime Victims Compensation Act
 Illinois Sexual Crime Victims Compensation Act
 Women's, Infant, Children Program (WIC)
 IL Community Benefit Act
 Internal Revenue Service (IRS) 990 Schedule H
 Section 501(r) of the Internal Revenue Code (instituted by the Patient Protection and Affordable Care Act)
 Ethical and Religious Directives for Catholic Health Services, Part 1
 System Policy – Payment Arrangement

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