

ORIGINAL

15-060

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

DEC 11 2015

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Gottlieb Memorial Hospital		
Street Address:	701 W. North Avenue		
City and Zip Code:	Melrose Park	60160	
County:	Cook	Health Service Area 07	Health Planning Area: A-06

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Gottlieb Memorial Hospital		
Address:	701 W. North Avenue		
Name of Registered Agent:	CT Corporation 208 S. LaSalle St Chicago 60604		
Name of Chief Executive Officer:	Lori Price, FACHE, MSA, RN (President)		
CEO Address:	701 W. North Avenue	Melrose Park, IL	60160
Telephone Number:	708 681-3200		

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name:	Armand Andreoni
Title:	Director, Analytics and Community Benefit
Company Name:	Loyola University Health System
Address:	2160 South 1st Avenue
Telephone Number:	708 216-4600
E-mail Address:	aandreo@lumc.edu
Fax Number:	708 216-3825

Additional Contact

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

Name:	Ralph Weber
Title:	
Company Name:	Weber Alliance
Address:	920 Hoffman Lane Riverwoods, IL 60015

Telephone Number:	847 791-0830
E-mail Address:	rmweber90@gmail.com
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

Facility Name:	Gottlieb Memorial Hospital		
Street Address:	701 W. North Avenue		
City and Zip Code:	Melrose Park	60160	
County:	Cook	Health Service Area 07	Health Planning Area: A-06

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Loyola University Health System		
Address:	2160 S. 1 st Avenue	Maywood, IL	60153
Name of Registered Agent:	CT Corporation	208 S. LaSalle St	Chicago 60604
Name of Chief Executive Officer:	Larry M. Goldberg		
CEO Address:	2160 S. 1 st Avenue	Maywood, IL	60153
Telephone Number:	708 216-3215		

Type of Ownership of Applicant/Co-Applicant

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

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

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Primary Contact

[Person to receive ALL correspondence or inquiries)

Name:	Armand Andreoni
Title:	Director, Analytics and Community Benefit
Company Name:	Loyola University Health System
Address:	2160 South 1st Avenue
Telephone Number:	708 216-4600
E-mail Address:	aandreo@lumc.edu
Fax Number:	708 216-3825

Additional Contact

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

Name:	Ralph Weber
Title:	
Company Name:	Weber Alliance

Address:	920 Hoffman Lane	Riverwoods, IL 60015
Telephone Number:	847 791-0830	
E-mail Address:	rmweber90@gmail.com	
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

Facility Name:	Gottlieb Memorial Hospital		
Street Address:	701 W. North Avenue		
City and Zip Code:	Melrose Park	60160	
County:	Cook	Health Service Area 07	Health Planning Area: A-06

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Trinity Health Corporation		
Address:	20555 Victor Parkway Livonia, MI 46152		
Name of Registered Agent:	The Corporation Company 30600 Telegraph Rd Bingham Farms, MI		
Name of Chief Executive Officer:	Richard J. Gilfillan, MD		
CEO Address:	20555 Victor Parkway Livonia, MI 46152		
Telephone Number:	734 343-1000		

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ 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]

Name:	Armand Andreoni
Title:	Director, Analytics and Community Benefit
Company Name:	Loyola University Health System
Address:	2160 South 1st Avenue
Telephone Number:	708 216-4600
E-mail Address:	aandreo@lumc.edu
Fax Number:	708 216-3825

Additional Contact

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

Name:	Ralph Weber
Title:	
Company Name:	Weber Alliance
Address:	920 Hoffman Lane Riverwoods, IL 60015

Address:	920 Hoffman Lane	Riverwoods, IL 60015
Telephone Number:	847 791-0830	
E-mail Address:	rmweber90@gmail.com	
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:	Armand Andreoni		
Title:	Director, Analytics and Community Benefit		
Company Name:	Loyola University Health System		
Address:	2160 S. 1 st Avenue	Maywood, IL	60153
Telephone Number:	708 216-4600		
E-mail Address:	aandreo@lumc.edu		
Fax Number:	708 216-3825		

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Gottlieb Memorial Hospital		
Address of Site Owner:	701 W. North Avenue	Melrose Park, IL	60160
Street Address or Legal Description of Site:	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 <u>ATTACHMENT-2</u>, 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:	Gottlieb Memorial Hospital		
Address:	701 W. North Avenue	Melrose Park, IL	60160
☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Other	☐ Partnership ☐ Governmental ☐ Sole Proprietorship	☐	
- 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 <u>ATTACHMENT-3</u>, 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.

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:

- ☒ Substantive
☐ Non-substantive

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.

Loyola University Health System (LUHS) and Gottlieb Memorial Hospital (GMH), part of LUHS, propose the establishment of a 20 bed inpatient Comprehensive Physical Rehabilitation service at Gottlieb Memorial Hospital, 701 W. North Avenue, Melrose Park.

LUHS presently operates a 32 bed Comprehensive Physical Rehabilitation service at Loyola University Medical Center (LUMC) in Maywood, 4 miles from GMH. The proposed plan is to relocate this service to a downsized inpatient unit at GMH. A related permit application proposes the discontinuation of the Comprehensive Physical Rehabilitation service at LUMC.

The plan is to convert GMH's 6th floor West nursing unit from a 21 bed medical/surgical unit to a 20 bed Comprehensive Physical Rehabilitation service. Space on the 4th floor will house the physical and occupational therapy function, Activities for Daily Living (ADL kitchen, bathroom and bedroom), staff offices and other support. Total dgsf for the project on the two floors is 19,549. 13,071 dgsf is clinical space; 6,478 dgsf is non-clinical space.

The proposed project will increase the Comprehensive Physical Rehabilitation bed count at GMH from 0 to 20, and will reduce the medical/surgical bed count by 21, from 154 to 133 medical/surgical beds.

GMH is located in HSA 07.

Total project cost is \$1,503,522.

The anticipated completion date is December 1, 2016.

As the establishment of a new clinical service, the project is classified as Substantive.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must 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	\$458,785	\$247,038	\$705,823
Contingencies	45,825	24,675	70,500
Architectural/Engineering Fees	36,660	19,740	56,400
Consulting and Other Fees	46,150	24,850	71,000
Movable or Other Equipment (not in construction contracts)	515,827	83,972	599,799
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	1,103,247	400,275	1,503,522
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	1,103,247	400,275	1,503,522
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	1,103,247	400,275	1,503,522
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: \$ _____ Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service ☒ Yes ☐ 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 \$ 3,265,350.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☒ Preliminary ☐ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): December 1, 2016.
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies ☒ 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: ☒ Cancer Registry ☒ APORS ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.
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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: Gottlieb Memorial Hospital		CITY: Melrose Park			
REPORTING PERIOD DATES: From: Jan 1, 2014 to: Dec 31, 2014					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	154	6,600	26,481	-21	133
Obstetrics	27	1,274	2,975	0	27
Pediatrics	4	35	47	0	4
Intensive Care	24	847 (1)	3,737	0	24
Comprehensive Physical Rehabilitation	0	0	0	+20	20
Acute/Chronic Mental Illness	12	242	3,565	0	12
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	34	710	9,275	0	34
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	255	9,708	46,080	-1	254

Note: (1) Direct admissions only

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

This Application for Permit is filed on the behalf of Gottlieb Memorial 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.

Lori Price
SIGNATURE
LORI PRICE
PRINTED NAME
PRESIDENT
PRINTED TITLE

Larry L. Goldberg
SIGNATURE
LARRY L. GOLDBERG
PRINTED NAME
PRESIDENT & CEO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 7th day of December

Notarization:

Subscribed and sworn to before me
this 7 day of December 2015

Jodi Palmer
Signature of Notary
Seal
OFFICIAL SEAL
JODI PALMER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/23/16

Joanne L. Pason
Signature of Notary
Seal
OFFICIAL SEAL
JOANNE L. PASON
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 08/31/16

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Loyola University Health System* 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.

Daniel P. Isackson, Jr.
SIGNATURE

Daniel P. Isackson, Jr.
PRINTED NAME

Senior Vice President, Finance
PRINTED TITLE

Larry L. Goldberg
SIGNATURE

LARRY L. GOLDBERG
PRINTED NAME

PRESIDENT & CEO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 7 day of December, 2015

Notarization:

Subscribed and sworn to before me
this 7 day of December, 2015

Lori L. Kmet
Signature of Notary



*Insert EXACT legal name of the applicant

Joanne L. Pason
Signature of Notary

Seal

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

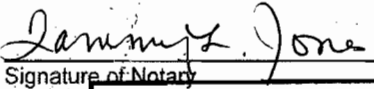
This Application for Permit is filed on the behalf of Trinity Health Corporation * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of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


 SIGNATURE
BENJAMIN CARTER
 PRINTED NAME
TREASURER
 PRINTED TITLE


 SIGNATURE
AGNES D. HAGERTY
 PRINTED NAME
ASSISTANT SECRETARY
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 4th day of December, 2015

Notarization:
 Subscribed and sworn to before me
 this 4th day of December, 2015


 Signature of Notary

Seal

TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne

*Insert EXACT legal name of the applicant


 Signature of Notary

Seal TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne

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**Not applicable to this permit application**

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.

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110. Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

B. Criterion 1110.630 - Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize Comprehensive Physical Rehabilitation category of service must submit the following information:
2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Comprehensive Physical Rehabilitation	0	20

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.630(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.630(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.630(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.630(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.630(b)(5) - Planning Area Need - Service Accessibility	X		
1110.630(c)(1) - Unnecessary Duplication of Services	X		
1110.630(c)(2) - Maldistribution	X		
1110.630(c)(3) - Impact of Project on Other Area Providers	X		
1110.630(d)(1) - Deteriorated Facilities			X
1110.630(d)(2) - Documentation			X
1110.630(d)(3) - Documentation Related to Cited Problems			X
1110.630(d)(4) - Occupancy			X
1110.630(e)(1) and (2) - Staffing	X	X	
1110.630(e)(2) - Personnel Qualifications	X		
1110.630(f) - Performance Requirements	X	X	X
1110.630(g) - Assurances	X	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT-21</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

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:**

	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
	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:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

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

X. 1120.140 - Economic Feasibility

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

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

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

XI. Safety Net Impact Statement

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 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

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 41.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	1-6, 28-30
2	Site Ownership	7, 31
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	--
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	32
5	Flood Plain Requirements	33-35
6	Historic Preservation Act Requirements	36
7	Project and Sources of Funds Itemization	10, 37-38
8	Obligation Document if required	--
9	Cost Space Requirements	39
10	Discontinuation	--
11	Background of the Applicant	40-49
2	Purpose of the Project	50-55
13	Alternatives to the Project	56-58
14	Size of the Project	59-61
15	Project Service Utilization	62
16	Unfinished or Shell Space	--
17	Assurances for Unfinished/Shell Space	--
18	Master Design Project	--
19	Mergers, Consolidations and Acquisitions	--
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	--
21	Comprehensive Physical Rehabilitation	63-84
22	Acute Mental Illness	--
23	Neonatal Intensive Care	--
24	Open Heart Surgery	--
25	Cardiac Catheterization	--
26	In-Center Hemodialysis	--
27	Non-Hospital Based Ambulatory Surgery	--
28	Selected Organ Transplantation	--
29	Kidney Transplantation	--
30	Subacute Care Hospital Model	--
31	Children's Community-Based Health Care Center	--
32	Community-Based Residential Rehabilitation Center	--
33	Long Term Acute Care Hospital	--
34	Clinical Service Areas Other than Categories of Service	--
35	Freestanding Emergency Center Medical Services	--
	Financial and Economic Feasibility:	
36	Availability of Funds	85-108
37	Financial Waiver	--
38	Financial Viability	109-110
39	Economic Feasibility	111-112
40	Safety Net Impact Statement	113-116
41	Charity Care Information	116



To all to whom these Presents Shall Come, Greeting:

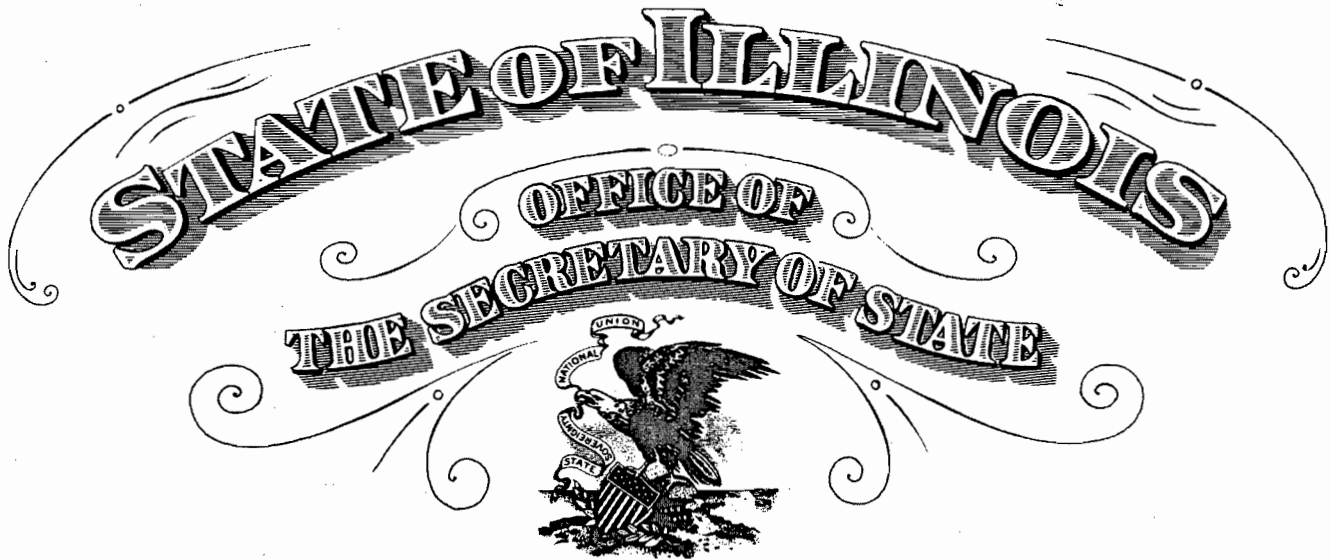
I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

GOTTLIEB MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 08, 1956, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 22ND
day of SEPTEMBER A.D. 2015 .***

Jesse White



To all to whom these Presents Shall Come, Greeting:

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

LOYOLA UNIVERSITY HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 11, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 22ND
day of SEPTEMBER A.D. 2015 .***

Jesse White

SECRETARY OF STATE

**STATE OF INDIANA
OFFICE OF THE SECRETARY OF STATE
CERTIFICATE OF EXISTENCE**

To Whom These Presents Come, Greetings:

I, Connie Lawson, Secretary of State of Indiana, do hereby certify that I am, by virtue of the laws of the State of Indiana, the custodian of the corporate records, and proper official to execute this certificate.

I further certify that records of this office disclose that

TRINITY HEALTH CORPORATION

duly filed the requisite documents to commence business activities under the laws of State of Indiana on November 10, 1978, and was in existence or authorized to transact business in the State of Indiana on September 22, 2015.

I further certify this Non-Profit Domestic Corporation has filed its most recent report required by Indiana law with the Secretary of State, or is not yet required to file such report, and that no notice of withdrawal, dissolution or expiration has been filed or taken place.



In Witness Whereof, I have hereunto set my hand and affixed the seal of the State of Indiana, at the city of Indianapolis, this Twenty-Second Day of September, 2015.

Connie Lawson

Connie Lawson, Secretary of State

197811-279 / 2015092280966



Gottlieb Memorial Hospital

November 30, 2015

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Re: Ownership of Gottlieb Memorial Hospital

Dear Ms. Avery:

I hereby certify that Gottlieb Memorial Hospital, located at 701 West North Avenue, Melrose Park, Illinois is owned by Gottlieb Memorial Hospital.

Sincerely,

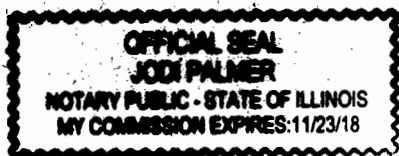
Lori Price, FACHE, MSA, RN
President
Gottlieb Memorial Hospital

Notarization:

Subscribed and sworn to before me
this 7th day of December, 2015

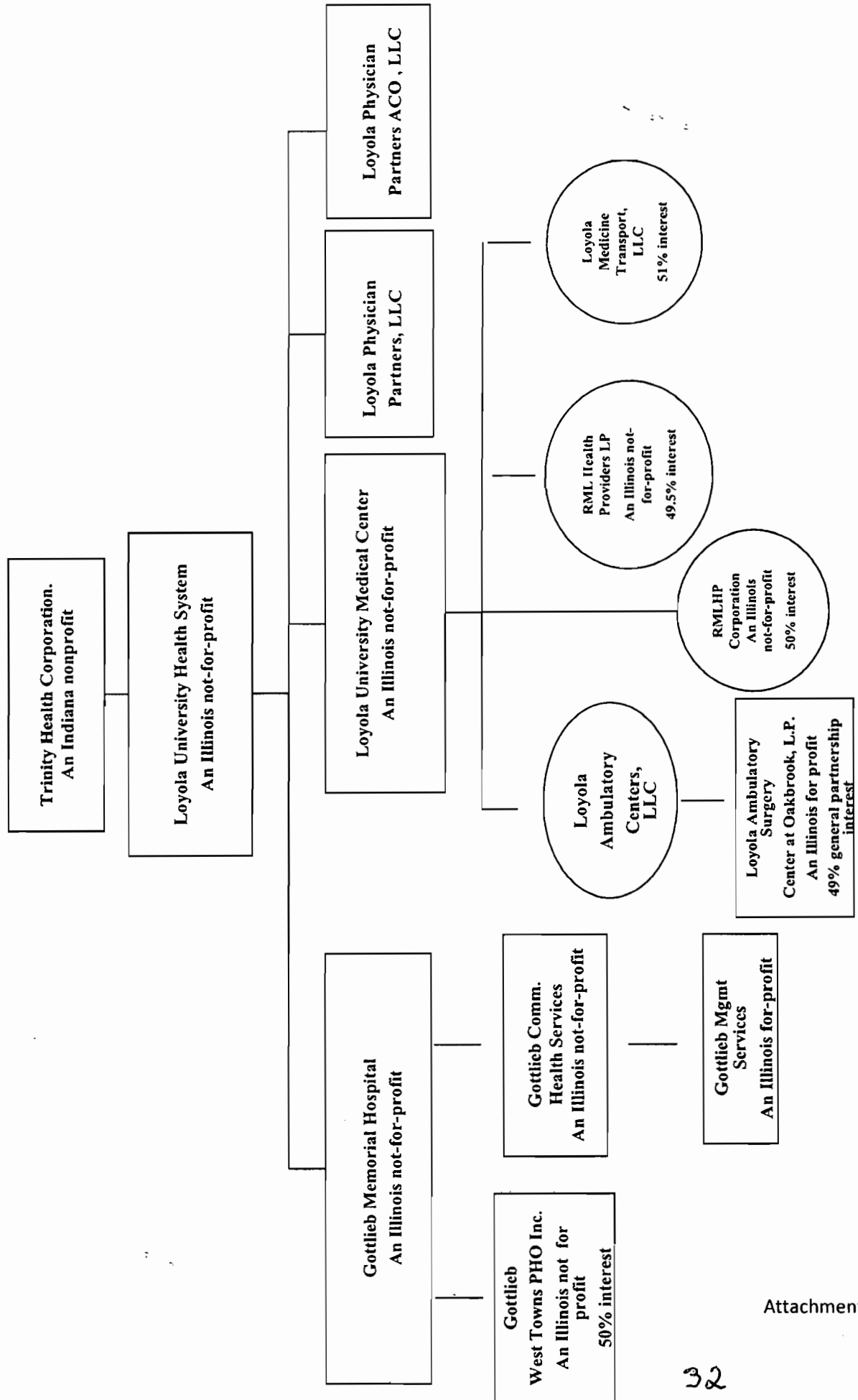
Signature of Notary Public

Seal



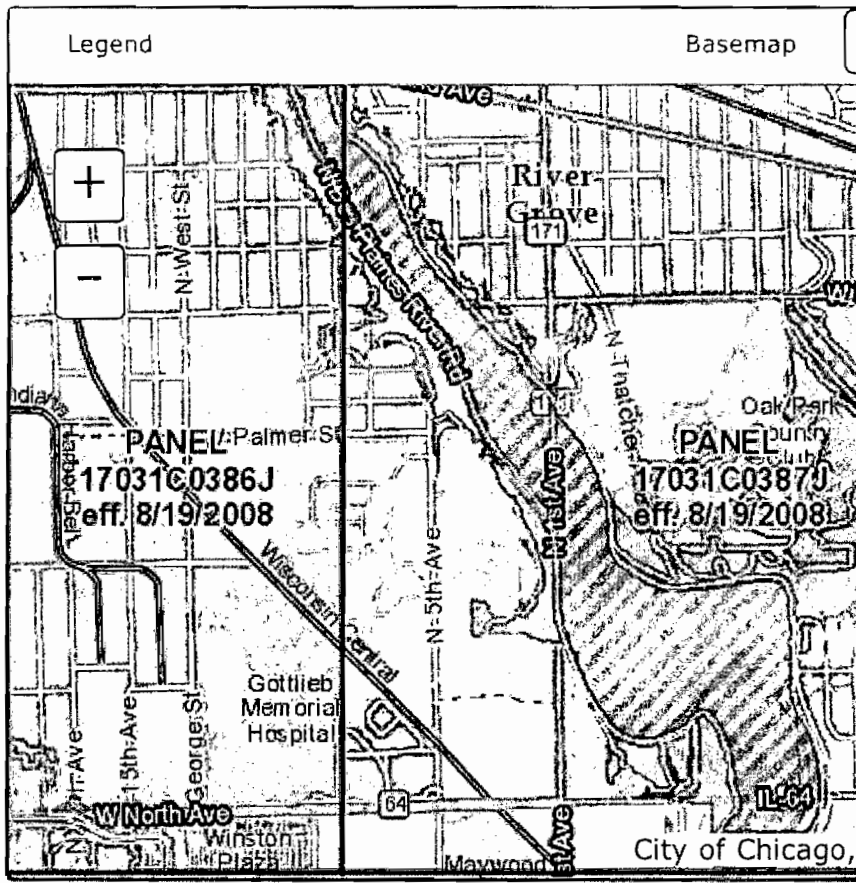
Attachment 2

Loyola University Health System (7/8/15)

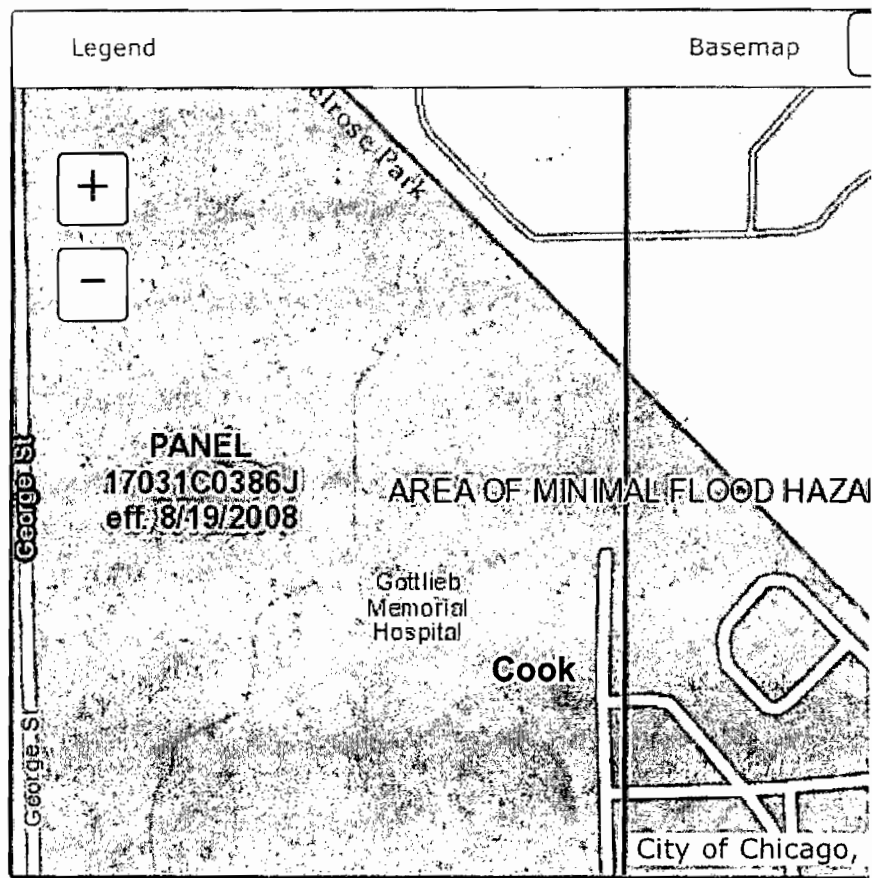


Floor Plain Requirements

The maps on the following two pages demonstrate that Gottlieb Memorial Hospital is not located within a flood plain area.



© 2015 • University of Illinois Board of Trustees; Email the Web Administrator with questions and comments.



© 2015 • University of Illinois Board of Trustees; Email the Web Administrator with questions and comments.

Attachment 5

35



Illinois Historic Preservation Agency

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX (217) 524-7525

www.illinoishistory.gov

Cook County

Maywood and Melrose Park

CON - Interior Rehabilitation for Relocation of Inpatient Clinical Service

Existing - Loyola University Medical Center, 2160 S. 1st Ave., Maywood; Proposed - Loyola Gottlieb

Memorial Hospital, 701 W. North Ave., Melrose Park

IHPA Log #021092815

October 14, 2015

Ralph Weber

920 Hoffman Lane

Riverwoods, IL 60015

Dear Mr. Weber:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

Rachel Leibowitz, Ph.D.

Deputy State Historic

Preservation Officer

Attachment 6

Project Costs and Sources of Funds

The following information provides detail regarding cost line items for the Project Costs and Sources of Funds table:

Modernization Contracts \$705,823

This line item includes the following projects on the 6th floor, Gottlieb Memorial Hospital:

- conversion of one existing med/surg patient room and one nurse station to dining and ADL space
- conversion of 20 med/surg rooms to 20 inpatient rehabilitation rooms
- replacement of ceiling tiles and lighting fixtures
- new flooring, wall finishes, handrails, doors/hardware
- relocation of sinks in all patient rooms to allow handicapped maneuverability

On the 4th floor of Gottlieb

- new ADL bath in PT/OT space
- ADL bedroom and kitchen
- refurbishment of staff offices
- therapist lockers and break room

Contingency \$70,500

- allowance for unforeseen costs

Architect/Engineering fees \$56,400

This work includes:

- schematic design
- design development
- construction documents
- bidding and negotiation services

Consulting and other fees \$71,000

- State and local permitting

Movable or other Equipment \$599,799

This line item includes medical equipment, PT/OT equipment, IT/telecommunications, and furnishings. Because this unit is the relocation of an existing inpatient rehabilitation service from LUMC, some of the equipment with remaining useful life will be brought from LUMC, and is Assessed based on its Net Book Value. Other equipment is being purchased new for the 6th floor unit.

Medical equipment includes: 20 new Stryker S3 beds, 10 Work Stations on Wheels, 2 Verathon bladderscans, EKG machine, Seca Weighing Scale, GE Dynamap, 1 Carefusion PYXIS (medication dispensing cabinet), a crashcart and other items.

PT/OT equipment includes: a Hi-Lo bariatric mat table to accommodate the bariatric patient population, standard mat tables, parallel bars, body weighted support with treadmill, hot and cold hydrocollators, Bioness L 300, Bioness H 200, D2 Dynavision, tilt table, Nu step, dynamometer set, Welch Allen vital signs monitor machine, Hoyer lift, equipment and furnishings for the ADL room, biofeedback for swallowing, Kay Pentax digital video fees system, and other items. The addition of the Bioness L 300 and Bioness H 200 and D2 Dynavision enhances treatment of the neuro-cognitive, balance and visual-motor rehabilitation for the stroke and neuro population and support stroke certification requirements. The additional therapy equipment provides resources to restore best possible function or improve capacity for normal activity.

IT/telecommunications includes: 3 multifunction printers, PCs, 5 data switches, vmail for 35 mailboxes, cubical wiring, phones, and gym devices/workstations.

Furniture includes inpatient over-bed tables, sleeper couches, patient chairs and bedside cabinets, and other items.

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.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing (1)	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical		9566	--				
PT/OT		4412	--				
Rehabilitation	\$1,103,247	--	13,071		13,071		
Total Clinical	1,103,247	13,978	13,071		13,071		
NON REVIEWABLE							
Storage & closet	63,750	588	1,283		1,283		
Locker / break	70,725	628	1,177		1,177		
Staff / public toilet	45,500	187	363		363		
Admin / offices	220,300	4,168	3,655		3,655		
Total Non-clinical	400,275	5,571	6,478		6,478		
TOTAL	\$1,503,522	19,549	19,549		19,549		
APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Notes:

All space figures are dgsf

- (1) "Existing Space" refers to GMH 6th floor (being converted from med/surg unit to the inpatient rehabilitation unit) and 4th floor offices and PT/OT space.

The existing 32 bed Rehabilitation unit at LUMC occupies 16,804 dgsf.

1110.230 Background of Applicant, Purpose of the Project, and Alternatives

Background of the Applicant

Included in this Attachment are the following:

Listing of health care facilities owned by Loyola University Health System, including the following three licensed health care facilities:

- Gottlieb Memorial Hospital

- Loyola University Medical Center

- Ambulatory Surgery Treatment Center (Loyola Outpatient Center, 2160 S 1st Avenue, Maywood)

IDPH licenses for the above three licensed health care facilities

Joint Commission accreditation for

- Gottlieb Memorial Hospital

- Loyola University Medical Center

- (including the Ambulatory Surgery Treatment Center, Loyola Outpatient Center, at 2160 S 1st Avenue, Maywood)

CARF Accreditation (Committee on the Accreditation of Rehabilitation Facilities)

Letter by LUHS President and CEO that there have been no adverse actions, and authorizing access to Information

Loyola University Health System

Facility Locations

October 2015

Hospitals			
Loyola University Medical Center (Foster G. McGaw Hospital)	Maywood	IL	60153
Gottlieb Memorial Hospital	Melrose Park	IL	60160
Ambulatory Care Sites			
Cardinal Bernardin Cancer Center	Maywood	IL	60153
Loyola Outpatient Center	Maywood	IL	60153
Loyola Cancer Care & Research at the Marjorie G. Weinberg Cancer Center at Melrose Park	Melrose Park	IL	60160
Loyola Center for Cancer Care & Research at Kishwaukee Community Hospital	DeKalb	IL	60115
Loyola Center for Dialysis at Roosevelt Road	Maywood	IL	60153
Loyola Center for Health at Burr Ridge	Burr Ridge	IL	60527
Loyola Center for Health at Chicago	Chicago	IL	60634
Loyola Center for Health at Elmhurst	Elmhurst	IL	60126
Loyola Center for Health at Elmhurst North	Elmhurst	IL	60126
Loyola Center for Health at Elmwood Park	Elmwood Park	IL	60707
Loyola Center for Health at Hickory Hills	Hickory Hills	IL	60457
Loyola Center for Health at Homer Glen	Lockport	IL	60491
Loyola Center for Health at LaGrange Park	LaGrange Park	IL	60526
Loyola Center for Health at Melrose Park	Melrose Park	IL	60160
Loyola Center for Health at Norridge	Norridge	IL	60706
Loyola Center for Health at North Riverside	North Riverside	IL	60546
Loyola Center for Health at Oak Park	Oak Park	IL	60302
Loyola Center for Health at Oak Park South	Oak Park	IL	60301
Loyola Center for Health at Oakbrook Terrace	Oakbrook Terrace	IL	60181
Loyola Center for Health at Orland Park	Orland Park	IL	60467
Loyola Center for Health at River Forest	River Forest	IL	60305
Loyola Center for Health at Roosevelt Road	Maywood	IL	60153
Loyola Center for Health at Wheaton	Wheaton	IL	60189
Loyola Center for Hearing at Woodridge	Woodridge	IL	60517
Loyola Center for Heart & Vascular Medicine	Maywood	IL	60153
Loyola Center for Heart & Vascular Medicine at Park Ridge	Park Ridge	IL	60068
Loyola Center for Metabolic Surgery & Bariatric Care at Melrose Park	Melrose Park	IL	60160
Loyola Center for Oral Health	Maywood	IL	60153
Loyola Center for Rehabilitation at Roosevelt Road	Maywood	IL	60153
Loyola Gottlieb Professional Office Building	Melrose Park	IL	60160
Ambulatory Surgery Center			
Loyola University ASC - Loyola Outpatient	Maywood	IL	60153

Attachment 11



**Illinois Department of
PUBLIC HEALTH**

HF108311

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
06/29/2016		0005793
General Hospital		
Effective: 06/30/2015		

**Gottlieb Memorial Hospital
dba Loyola Health System at Gottlieb
701 West North Avenue
Melrose Park, IL 60160**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

← **DISPLAY THIS PART IN A
CONSPICUOUS PLACE**

Exp. Date 06/29/2016

Lic Number 0005793

Date Printed 05/12/2015

**Gottlieb Memorial Hospital
dba Loyola Health System at Gottlieb
701 West North Avenue
Melrose Park, IL 60160**

FEE RECEIPT NO.

Attachment 11

DISPLAY THIS PART IN A
CONSPICUOUS PLACE

HF108312



**Illinois Department of
PUBLIC HEALTH**

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Nirav D. Shah, M.D., J.D.

Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/29/2016	General Hospital	0005801
Effective: 06/30/2015		

Foster G. McGaw Hospital Loyola University Medical Center
2160 South 1st Street
Maywood, IL 60153

Exp. Date 06/29/2016

Lic Number 0005801

Date Printed 05/12/2015

Foster G. McGaw Hospital Loyola Univ

2160 South 1st Street
Maywood, IL 60153

FEE RECEIPT NO.

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Attachment 11

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HF108128

**Illinois Department of
PUBLIC HEALTH**



LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Nirav D. Shah, M.D., J.D.

Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LC NUMBER
06/29/2016		7003164
Ambulatory Surgery Treatment Center		
Effective: 06/30/2015		

Loyola University Medical Center
dba Loyola University ASC- Loyola Outpatient
2160 South First Avenue, Bldg. 201
Maywood, IL 60153

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Exp. Date 06/29/2016

Llc Number 7003164

Date Printed 04/22/2015

Loyola University Medical Center
dba Loyola University ASC- Loyola Out
2160 South First Avenue, Bldg. 201
Maywood, IL 60153

FEE RECEIPT NO.

Gottlieb Memorial Hospital

Melrose Park, IL

has been Accredited by

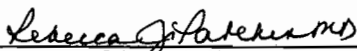


The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

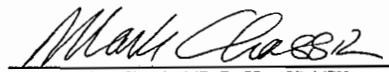
January 11, 2014

Accreditation is customarily valid for up to 36 months.



Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7400
Print/Reprint Date: 03/21/2014



Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



Loyola University Medical Center

Maywood, IL

has been Accredited by

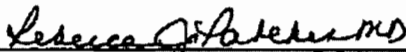


The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

September 28, 2013

Accreditation is customarily valid for up to 36 months.



Rebecca J. Patchin, MD
Chair, Board of Commissioners

Organization ID #7288

Print/Reprint Date: 02/04/2014



Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



AMA
AMERICAN
MEDICAL
ASSOCIATION





March 25, 2013

Paul Gorski, M.P.H., OTR/L
Loyola University Medical Center - Acute Rehabilitation Unit
2160 South First Avenue, Building 104, Room 1381
Maywood, IL 60153

Dear Mr. Gorski:

It is my pleasure to inform you that Loyola University Medical Center - Acute Rehabilitation Unit has been accredited by CARF International for a period of three years for the following programs:

Inpatient Rehabilitation Programs Hospital (Adults)
Inpatient Rehabilitation Programs Hospital: Stroke Specialty Program (Adults)

This accreditation will extend through March 2016. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of practice excellence.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation, and we encourage you to make this accomplishment known throughout your community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

The survey report is intended to support a continuation of the quality improvement of your programs. It contains comments on your organization's strengths as well as suggestions and recommendations. A quality improvement plan (QIP) demonstrating your efforts to implement the survey recommendations must be submitted within the next 90 days to retain accreditation. Guidelines and the form for completing the QIP have been posted on Customer Connect (customerconnect.carf.org), our secure, dedicated website for accredited organizations and organizations seeking accreditation. Please submit the QIP to the attention of the customer service unit identified in the QIP instructions.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation, you are encouraged to seek support from a Resource Specialist in your customer service unit by calling extension 7174.

We encourage your organization to continue fully and productively using the CARF standards as part of your ongoing commitment to accreditation. We commend your commitment and consistent efforts to improve the quality of your programs. We look forward to working with your organization in the future.

Sincerely,

A handwritten signature in black ink, reading "Brian J. Boon". The signature is fluid and cursive, with the first name "Brian" and last name "Boon" clearly distinguishable.

Brian J. Boon, Ph.D.
President/CEO

AEP
Enclosures



LOYOLA
UNIVERSITY
HEALTH SYSTEM

Larry Goldberg
President & Chief Executive Officer
Tel: (708) 216-3215
Fax: (708) 216-6227
lgoldberg@lumc.edu

December 7, 2015

Ms. Kathryn J. Olson
Chairperson
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Dear Ms Olson,

As President and CEO of Loyola University Health System, I hereby certify that no adverse action has been taken against Loyola University Medical Center, Gottlieb Memorial Hospital, or Loyola University Health System, directly or indirectly, within three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.

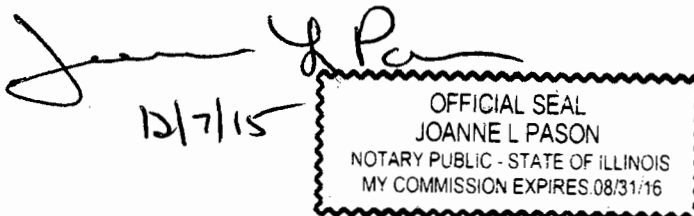
I hereby authorize the Health Facilities and Services Review Board and IDPH to access any documentation which it finds necessary to verify any information submitted, including but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

If you have any questions, please call Armand Andreoni, Director, Analytics and Community Benefit at 708 216-4601.

Sincerely,

Larry M. Goldberg
President & CEO
Loyola University Health System

Cc: Armand Andreoni, Director, Analytics and Community Benefit



PURPOSE STATEMENT

How the project will improve health service delivery. There are several reasons for relocating Loyola University Health System's (LUHS) Comprehensive Physical Rehabilitation unit from Loyola University Medical Center (LUMC) to Gottlieb Memorial Hospital (GMH), benefitting health care delivery to residents of Suburban Cook and DuPage Counties and western parts of the City of Chicago.

- The project co-locates the post-acute care rehabilitation with other post-acute care programs now at GMH. These programs include the 34 bed Transitional Care Unit, home health care, adult day care, and geriatric behavioral health. Collectively these programs create a post-acute care continuum of clinical services that enhances the delivery of clinical care in a controlled setting, enabling the implementation of care pathways and consistent quality outcomes. Throughput is increased, with anticipated reductions in length of stays and readmissions. In addition, the lower cost structure at GMH enables a more cost effective inpatient rehabilitation service, consistent with the Affordable Care Act.

- The project consolidates at GMH those LUHS programs overseen by the Marianjoy Medical Group -- the Transitional Care Unit and the LUMC inpatient rehabilitation unit. This will enable efficiencies in staffing and operations for both programs. In 2014, Loyola and Marianjoy entered into a collaborative relationship for oversight of the Transitional Care Unit at Gottlieb and the rehabilitation unit at Loyola University Medical Center.

- By establishing the rehabilitation service at GMH, LUHS further honors the commitment made in 2008 when it acquired Gottlieb Memorial Hospital to invest in clinical program and service development at Gottlieb. During the past 6 years, LUHS has funded the remodeling of several nursing floors, the mammography suite and the emergency department; established the EPIC medical record system at Gottlieb; and installed telemetry and anesthesiology equipment. These investments are strengthening GMH as a viable community health resource.

- The relocation of the rehabilitation unit from the 5th floor at LUMC makes that floor available for other clinical use, at a time that LUMC is stressed with high occupancies and capacity limitations. These conditions result in unavailability of inpatient beds, external transfer requests being denied or delayed, and emergency room bypass. LUMC has the highest Case Mix Index in the State of Illinois, with a growing need for beds to accommodate this acute care population. The relocation of the rehab unit promotes a better management of facility resources within the LUHS system.

Planning Area. The "Identified Planning Area" for the project is defined as the LUMC Central Service Area (CSA), the source of 57% of patients cared for in the LUMC inpatient rehabilitation unit in 2015. Over 99% of GMH's inpatients reside within LUMC's CSA. The zip codes comprising this area are shown on the table and map on the next pages. The Year 2015 population of the LUMC CSA is 1,904,423

It is important to note that the Gottlieb's Central Service Area and Secondary Service Areas are entirely located within the Loyola Central Service Area, except for one of Gottlieb's 30 zip codes -- 60647 on the eastern edge of Gottlieb's Secondary Service Area and the source of 23 patients (0.3% Gottlieb admissions). Since Loyola's CSA is the Planning Area for the discontinuation, there is significant overlap with Gottlieb's planning area for the establishment of the rehabilitation service.

Issues to be addressed. LUMC has the highest Case Mix Index in the State of Illinois. It is a measurement of the complexity of Loyola's patients and intensity of care required to treat them. This

level of intensity of care results in unavailability of inpatient beds due to high occupancy, external transfer requests being denied or delayed, and emergency room bypass.

How the project will address the above stated issues. The project will enhance the coordination of post-acute care services within the LUHS system, and promote a lower cost inpatient rehabilitation service at GMH than can be achieved at LUMC. By continuing oversight by the Marianjoy Medical Group and transferring the unit's staff to GMH, high quality of service will be maintained within the Loyola University Health System. The relocation of the inpatient unit from LUMC to GMH also makes needed clinical space available at LUMC for higher intensity acute care services.

Information sources. These include:

- Loyola's EPIC electronic medical record system: source of patient volume and physician referral information.
- Truven Health: source for population estimates and projections
- Inventory of Health Facilities and Services and Need Determinations, IDPH; August 25, 2015
- Mapquest for travel time estimates
- CMS.gov/Case Mix Index

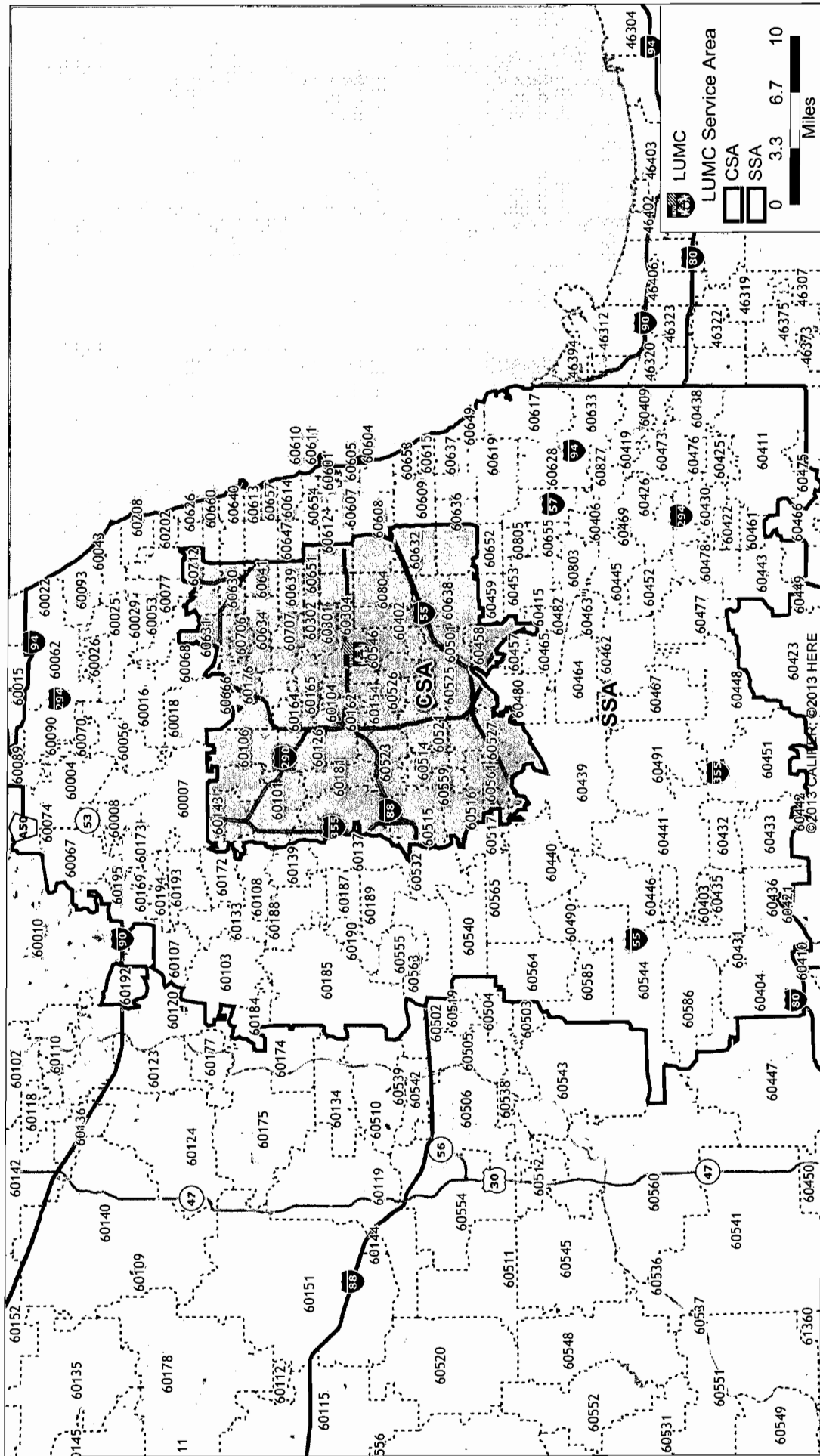
Measurable goals.

- Establish the inpatient rehabilitation unit at GMH by July 1, 2016; close out for CON by Dec 1, 2016.
- Reduce cost of inpatient rehabilitation care delivery by 6 – 8%.

LUMC Central and Secondary Service Areas based on Patient Origin

		Total Inpatients, FY 2015			Inpatient Rehabilitation		
ZIP Code	City	Discharges	%	Cum. %	Discharges	%	Cum. %
Central Service Area (CSA)							
60153	Maywood	1,322	5.7%	5.7%	39	6.0%	6.0%
60546	Riverside	506	2.2%	7.9%	23	3.5%	9.5%
60402	Berwyn	856	3.7%	11.7%	17	2.6%	12.1%
60302	Oak Park	320	1.4%	13.0%	16	2.5%	14.5%
60513	Brookfield	404	1.8%	14.8%	16	2.5%	17.0%
60104	Bellwood	700	3.0%	17.8%	15	2.3%	19.3%
60130	Forest Park	360	1.6%	19.4%	14	2.1%	21.4%
60638	Chicago	406	1.8%	21.2%	13	2.0%	23.4%
60639	Chicago	257	1.1%	22.3%	12	1.8%	25.3%
60155	Broadview	406	1.8%	24.0%	11	1.7%	27.0%
60160	Melrose Park	388	1.7%	25.7%	11	1.7%	28.6%
60534	Lyons	192	0.8%	26.6%	11	1.7%	30.3%
60707	Elmwood Park	471	2.0%	28.6%	11	1.7%	32.0%
60154	Westchester	391	1.7%	30.3%	9	1.4%	33.4%
60171	River Grove	156	0.7%	31.0%	9	1.4%	34.8%
60804	Cicero	701	3.0%	34.0%	9	1.4%	36.1%
60126	Elmhurst	223	1.0%	35.0%	8	1.2%	37.4%
60148	Lombard	224	1.0%	36.0%	8	1.2%	38.6%
60305	River Forest	161	0.7%	36.7%	8	1.2%	39.8%
60644	Chicago	337	1.5%	38.1%	8	1.2%	41.0%
60304	Oak Park	205	0.9%	39.0%	7	1.1%	42.1%
60164	Melrose Park	264	1.1%	40.2%	6	0.9%	43.0%
60526	La Grange Park	176	0.8%	40.9%	6	0.9%	44.0%
60521	Hinsdale	68	0.3%	41.2%	5	0.8%	44.7%
60527	Willowbrook	128	0.6%	41.8%	5	0.8%	45.5%
60561	Darien	116	0.5%	42.3%	5	0.8%	46.2%
60634	Chicago	277	1.2%	43.5%	5	0.8%	47.0%
60651	Chicago	226	1.0%	44.5%	5	0.8%	47.8%
60162	Hillside	144	0.6%	45.1%	4	0.6%	48.4%
60176	Schiller Park	77	0.3%	45.4%	4	0.6%	49.0%
60559	Westmont	113	0.5%	45.9%	4	0.6%	49.6%
60101	Addison	168	0.7%	46.7%	3	0.5%	50.1%
60181	Villa Park	182	0.8%	47.4%	3	0.5%	50.5%
60458	Justice	111	0.5%	47.9%	3	0.5%	51.0%
60516	Downers Grove	90	0.4%	48.3%	3	0.5%	51.5%
60623	Chicago	170	0.7%	49.1%	3	0.5%	51.9%
60624	Chicago	118	0.5%	49.6%	3	0.5%	52.4%
60656	Chicago	99	0.4%	50.0%	3	0.5%	52.8%
60706	Harwood Heights	120	0.5%	50.5%	3	0.5%	53.3%
60106	Bensenville	105	0.5%	51.0%	2	0.3%	53.6%
60163	Berkeley	60	0.3%	51.2%	2	0.3%	53.9%
60514	Clarendon Hills	17	0.1%	51.3%	2	0.3%	54.2%
60525	La Grange	218	0.9%	52.3%	2	0.3%	54.5%
60558	Western Springs	63	0.3%	52.5%	2	0.3%	54.8%
60629	Chicago	137	0.6%	53.1%	2	0.3%	55.1%
60631	Chicago	56	0.2%	53.4%	2	0.3%	55.4%
60632	Chicago	112	0.5%	53.9%	2	0.3%	55.7%
60455	Bridgeview	81	0.4%	54.2%	1	0.2%	55.9%
60501	Summit Argo	111	0.5%	54.7%	1	0.2%	56.0%
60515	Downers Grove	90	0.4%	55.1%	1	0.2%	56.2%
60523	Oak Brook	86	0.4%	55.4%	1	0.2%	56.4%
60630	Chicago	79	0.3%	55.8%	1	0.2%	56.5%
60641	Chicago	117	0.5%	56.3%	1	0.2%	56.7%
60131	Franklin Park	185	0.8%	57.1%	-	-	56.7%
60165	Stone Park	64	0.3%	57.4%	-	-	56.7%
60191	Wood Dale	42	0.2%	57.6%	-	-	56.7%
60143	Itasca	33	0.1%	57.7%	-	-	56.7%
60646	Chicago	28	0.1%	57.8%	-	-	56.7%
60141	Hines	27	0.1%	57.9%	-	-	56.7%
60301	Oak Park	21	0.1%	58.0%	-	-	56.7%
60712	Lincolnwood	7	0.0%	58.1%	-	-	56.7%
60157	Medinah	4	0.0%	58.1%	-	-	56.7%
Total CSA		13,376	58.1%	58.1%	370	56.7%	56.7%
Secondary Service Area (SSA)		5,786	25.1%	83.2%	185	28.3%	85.0%
Total CSA and SSA		19,162	83.2%	83.2%	555	85.0%	85.0%
All Other ZIPs		3,866	16.8%	100.0%	98	15.0%	100.0%
Total		23,028	100.0%	100.0%	653	100.0%	100.0%

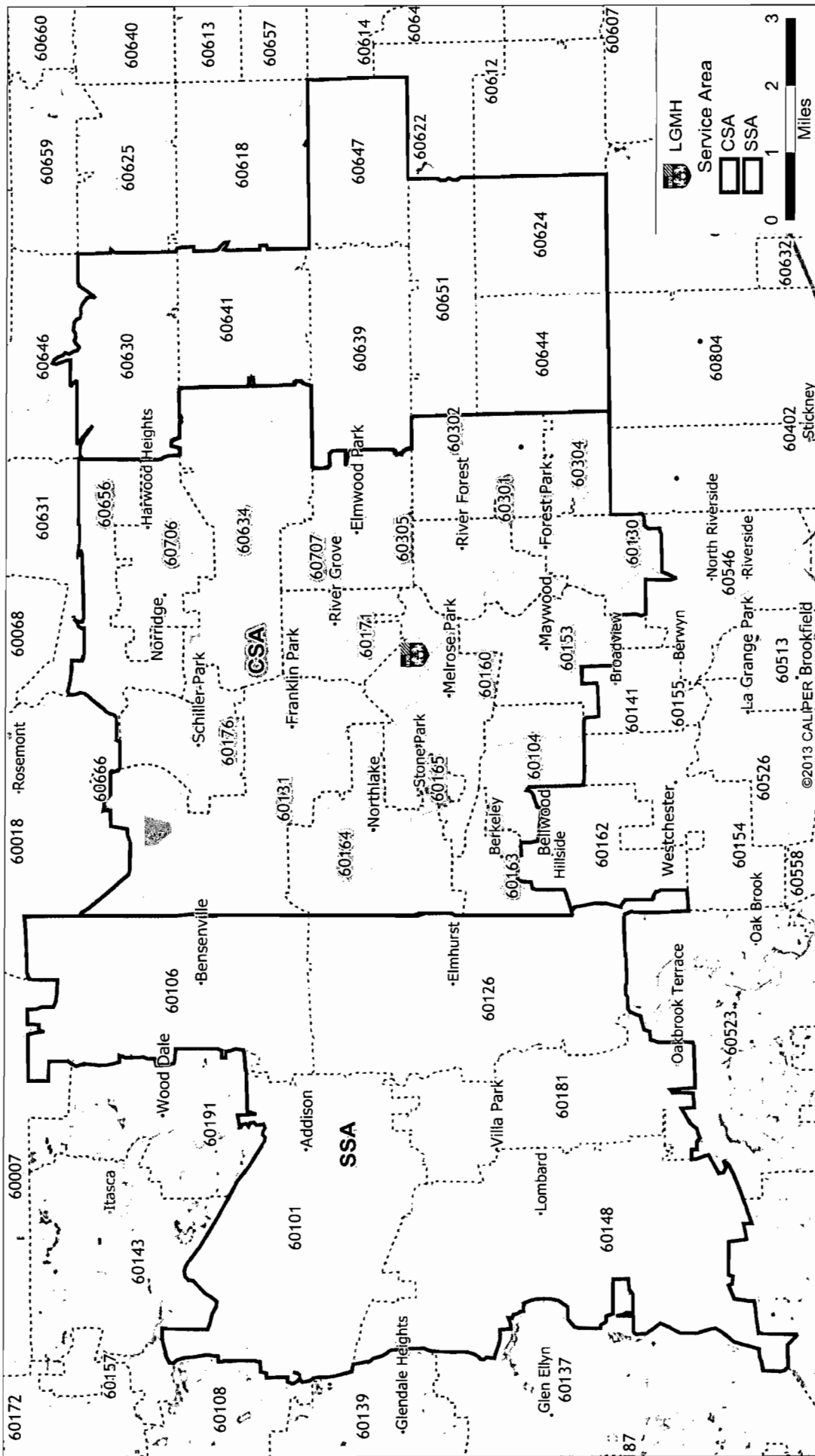
LUMC Inpatient Service Area



GMH Central and Secondary Service Areas based on Patient Origin

		Total Inpatients, FY 2015			Population		
ZIP Code	City	Discharges	%	Cum.%	2015	%	Cum.%
Central Service Area (CSA)							
60707	Elmwood Park	1,175	15.4%	15.4%	43,102	4.2%	4.2%
60160	Melrose Park	795	10.4%	25.8%	26,072	2.5%	6.7%
60164	Melrose Park	775	10.2%	36.0%	22,239	2.2%	8.9%
60131	Franklin Park	599	7.9%	43.9%	18,106	1.8%	10.6%
60171	River Grove	440	5.8%	49.6%	10,498	1.0%	11.7%
60153	Maywood	383	5.0%	54.7%	23,635	2.3%	13.9%
60634	Chicago	312	4.1%	58.8%	75,577	7.3%	21.3%
60176	Schiller Park	254	3.3%	62.1%	11,803	1.1%	22.4%
60104	Bellwood	236	3.1%	65.2%	19,097	1.9%	24.3%
60302	Oak Park	118	1.5%	66.7%	32,612	3.2%	27.5%
60706	Harwood Heights	116	1.5%	68.3%	22,616	2.2%	29.7%
60165	Stone Park	93	1.2%	69.5%	5,182	0.5%	30.2%
60305	River Forest	65	0.9%	70.3%	10,992	1.1%	31.2%
60130	Forest Park	64	0.8%	71.2%	13,877	1.3%	32.6%
60656	Chicago	63	0.8%	72.0%	29,186	2.8%	35.4%
60163	Berkeley	35	0.5%	72.5%	5,197	0.5%	35.9%
60304	Oak Park	27	0.4%	72.8%	17,179	1.7%	37.6%
60301	Oak Park	20	0.3%	73.1%	2,317	0.2%	37.8%
Total CSA		5,570	73.1%	73.1%	389,287	37.8%	37.8%
Secondary Service Area (SSA)							
60639	Chicago	145	1.9%	75.0%	90,215	8.8%	46.6%
60651	Chicago	130	1.7%	76.7%	63,113	6.1%	52.7%
60644	Chicago	81	1.1%	77.7%	48,016	4.7%	57.4%
60126	Elmhurst	60	0.8%	78.5%	47,078	4.6%	61.9%
60641	Chicago	57	0.7%	79.3%	71,071	6.9%	68.8%
60106	Bensenville	39	0.5%	79.8%	20,556	2.0%	70.8%
60630	Chicago	34	0.4%	80.2%	54,168	5.3%	76.1%
60148	Lombard	34	0.4%	80.7%	52,775	5.1%	81.2%
60181	Villa Park	27	0.4%	81.0%	28,663	2.8%	84.0%
60624	Chicago	26	0.3%	81.4%	37,535	3.6%	87.6%
60101	Addison	26	0.3%	81.7%	39,407	3.8%	91.5%
60647	Chicago	23	0.3%	82.0%	87,920	8.5%	100.0%
Total SSA		682	8.9%	82.0%	640,517	62.2%	100.0%
Total CSA and SSA		6,252	82.0%	82.0%	1,029,804	100.0%	100.0%
All Other ZIPs		1,370	18.0%	100.0%			
Total		7,622	100.0%	100.0%			

GMH Inpatient Service Area



ALTERNATIVES TO THE PROJECT

The proposed project establishes a 20 bed inpatient Comprehensive Physical Rehabilitation Service at Gottlieb Memorial Hospital (GMH) in 6th floor space that is currently occupied by a 21 bed medical/surgical unit. Additional space on the GMH 4th floor provides the physical and occupational therapy function, Activities for Daily Living (ADL kitchen, bathroom and bedroom) and staff offices. The rehabilitation unit replaces the 32 bed Comprehensive Rehabilitation unit at Loyola University Medical Center, which is being discontinued.

The following alternatives were considered in the planning of this project:

Alternative 1: Status Quo: Maintain 32 bed rehabilitation unit at LUMC

Keeping the current unit at LUMC does not allow synergies to be achieved at Gottlieb Memorial Hospital (GMH) with other post-acute care services already at GMH. These post-acute services include the 34 bed Transitional Care Unit (TCU), home health care services, adult day care and geriatric behavioral health. Loyola University Health System contracted with Marianjoy Medical Group in 2014 to oversee the inpatient rehabilitation unit at LUMC and the TCU at GMH. Having both located at GMH will allow the physician group to be located on the same campus for management of the TCU and the acute rehabilitation unit. Additionally, efficiencies will be developed by cross training therapy staff and support staff in these units.

LUMC needs additional clinical space for its high intensity acute care services. LUMC's case mix index has been the highest in the State, and among the top three consistently over the past decades. The relocation of the rehabilitation unit from the 5th floor makes this floor available for high intensity clinical programs. Planning is now underway to determine the best use for this floor. The re-use of this floor will relieve pressures that have restricted LUMC's capacity to accept requests for patient transfers for high level services from community hospitals on a timely basis, and the ability of the LUMC ER to avoid frequent bypass.

GMH has a cost structure that is 8.5% lower than LUMC's. Keeping the rehabilitation unit at LUMC would forego the opportunity to provide rehabilitation services within the system at a lower cost setting. Delivery of care in lower cost settings is an objective of the Affordable Care Act. Locating the rehabilitation unit at GMH enhances the ability to bundle services in a cost effective way.

The capital cost of this alternative is \$0, since no construction is involved. However, operational efficiencies and cost savings would not be achieved if the unit is maintained on the current 5th floor.

Alternative 2: Establish rehabilitation unit at GMH with 32 beds, same size as at LUMC

The 6th floor nursing unit at GMH can accommodate at most 20 private beds for inpatient rehabilitation care. There are 21 patient rooms on the 6th floor. One of these rooms would need to be converted to ADL space (Activities for Daily Living). Only 20 rooms are available for single occupancy patient rooms.

The GMH rooms are each approximately 168 sq ft in size, including patient toilet and shower. To accommodate 32 beds on the floor, 12 rooms would have to be double occupancy and 8 rooms for single occupancy. The small room size prohibits placing two patients in any of these rooms.

Another option to construct a 32 bed rehabilitation service was considered, converting each of two medical/surgical wings on the third floor to 16 bed rehabilitation units, providing a total of 32 beds. An additional wing accommodated space for physical therapy, dining, offices and ADL space. This option had a total project capital cost of \$8,870,000 and was ruled out as too expensive.

Locating two units on two different floors was also ruled out. Nurse staffing works well for rehabilitation units at the ratio of one nurse to five patients. Staffing of two 16 bed units is not as efficient as the staffing of a 20 bed unit. Nursing unit sizes and floorplates at GMH are not able to accommodate 32 bed nursing units.

Because of high capital costs and inefficiencies associated with splitting nursing units, options to establish 32 bed nursing units at GMH were not feasible.

Alternative 3: Establish 28 bed rehabilitation unit at GMH

The inpatient rehabilitation unit at LUMC has an average daily census of 23.9 patients in Year 2014. At the State occupancy standard of 85% utilization, this volume would justify 28 inpatient beds.

There is no floor available at GMH that can accommodate 28 inpatient rehabilitation beds and the related support services. The 6th floor can accommodate only 20 rehabilitation patients. Year to-date 2015 inpatient rehabilitation average daily census is 18.3, with a peak month of 19.6. These volumes can be accommodated in a 20 bed unit and be consistent with CARF requirements.

There were 650 inpatient rehabilitation patients in the unit in FY 2015. ADC in September was 18.3. In the event that 20 beds does not accommodate patient demand, certain patients may be transferred to Marianjoy or other area rehabilitation facilities.

This option was rejected because there is no floor at GMH that can accommodate a 28 bed unit, and because a 20 bed unit can usually accommodate the anticipated patient service demand.

Alternative 4: Discontinue rehabilitation service within LUHS

This option would involve closing the unit and sending patients requiring rehabilitation post-acute care to Marianjoy Rehabilitation Center and other area hospitals with rehabilitation units.

Loyola University Medical Center is a tertiary care academic medical center, with a Level 1 trauma center and one of the three burn units in metropolitan Chicago. It has the highest case mix index (intensity of care) in the State of Illinois. A rehabilitation service within the LUHS system is essential for continuity of care, for tertiary and quaternary patients who are not ready for home or nursing home immediately following their acute care phase. Loyola's tertiary and quaternary services include: transplant, cardiac cases that include transplant and Left Ventricular Assist device, burn, medically complex, neurological (especially Parkinsons), stroke, brain injury and trauma.

It is important that physicians who oversaw patients for acute care at Loyola have the opportunity to consult during the rehabilitation phase for many patients. Closing the unit would make this follow-on care logistically difficult and expensive.

Finally, discontinuing the service within the Loyola system would impair the residency training program, and risk loss of residency accreditation.

For these several reasons, the closure of the inpatient rehabilitation program was not considered as a serious option.

Alternative 5 (PREFERRED ALTERNATIVE): Establish 20 bed rehabilitation unit at Gottlieb

This option was selected for several reasons:

- It continues care within the LUHS system
- It honors commitment made by Loyola when it acquired GMH to invest in clinical program and service development at GMH
- A rehabilitation service at GMH relates well to other programs being enhanced at GMH, especially cardiovascular surgery, orthopedics/trauma, neurology and cardiology.
- The Marianjoy Medical Group is the contracted provider overseeing the Transitional Care Unit (TCU) at GMH and the inpatient rehabilitation unit at LUMC, based on a June 2014 agreement. Co-location of rehabilitation with other post acute care programs at GMH achieves operational efficiencies. The physician group managing the TCU and the acute rehabilitation unit will be able to work across both units. Additionally, efficiencies through cross-training are anticipated with therapy staff and support staff. Home health services are also coordinated through GMH, allowing patients to receive support for each level of post-acute care. As the TCU, acute rehab and home health teams develop team-based approaches, the continuity of care for each patient will be optimized.
- GMH has an 8.5% lower cost structure than LUMC, which will enable a more cost effective rehabilitation service within the LUHS system
- The program at Gottlieb will allow the PM&R (Physical Medicine and Rehabilitation) program to be continued within the LUHS academic system.

Total capital cost of the relocation to GMH is \$1,503,522.

SIZE OF THE PROJECT

The project is located on two floors (6th and 4th) of Gottlieb Memorial Hospital. The project includes the conversion of a medical/surgical unit on the 6th floor of GMH and modernization as an inpatient rehabilitation unit. The current space is 10,238 dgsf. 8,338 dgsf will be clinical space; 1,900 dgsf will be non clinical space (locker room, closets, public toilet, office, and other functional spaces).

Existing PT/OT space on the 4th floor to be used in support of the unit totals 9,311 dgsf. 4,733 dgsf will be clinical space; 4,578 dgsf will be non-clinical space (closets, storage and offices).

Conversion of space on GMH 4th and 6th floor (sq ft)

Area	6 th floor	4 th floor	Total
Clinical	8,338	4,733	13,071
Non-clinical	1,900	4,578	6,478
	10,238	9,311	19,549

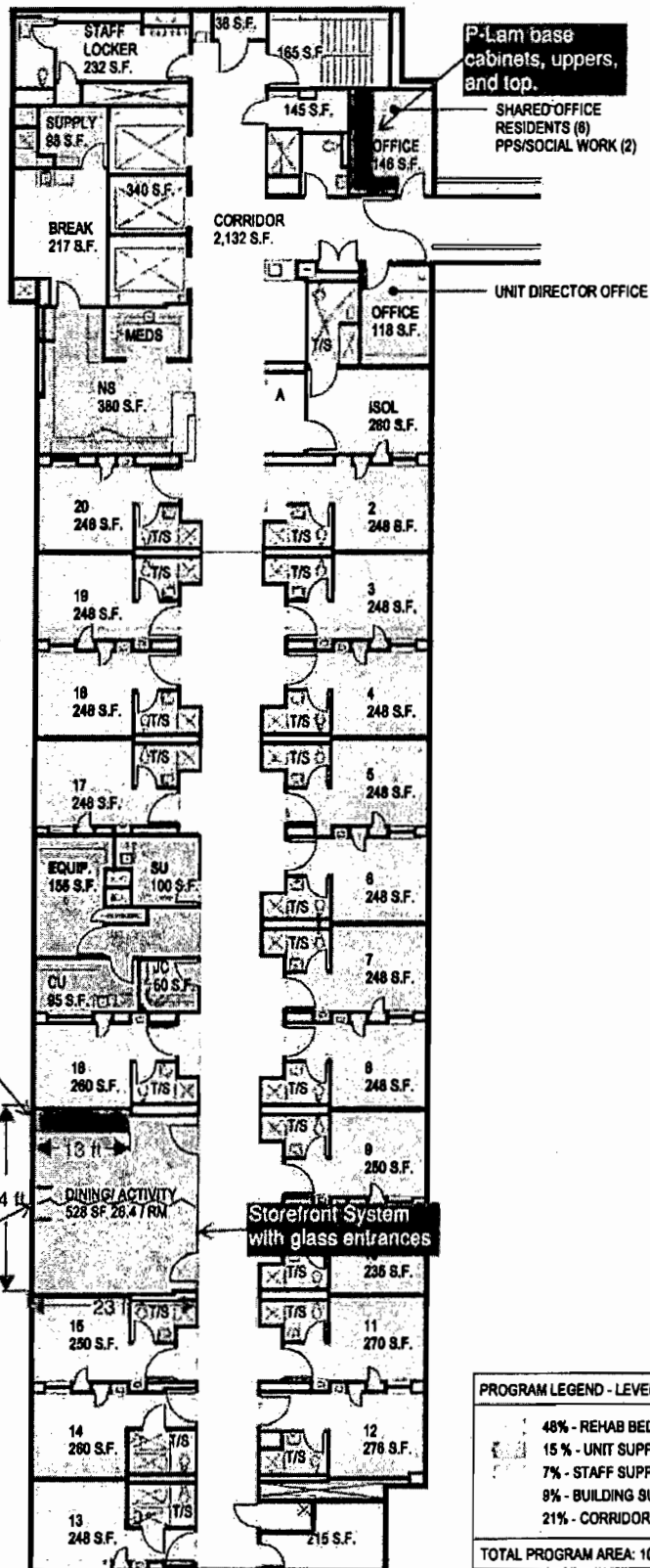
The clinical space on the 6th floor will be composed of 20 single occupancy rehabilitation rooms each with patient toilet and shower, a dining/activity room, nurse station, and medication room. 4th floor clinical space includes the physical therapy gym dedicated to rehabilitation patients, OT, hydrotherapy, ADL kitchen, ADL bedroom and ADL bathroom.

Program space on the two floors totals 19,549 dgsf. Clinical space on the two floors totals 13,071 dgsf, or 653.6 dgsf per bed.

The size of the project is within the State sq footage standard of 525 to 660 dgsf per bed for Comprehensive Physical Rehabilitation.

<u>Department</u>	<u>Proposed DGSF</u>	<u>State Standard</u>	<u>Difference</u>	<u>Met Standard?</u>
Comprehensive Physical Rehabilitation (20 beds)	13,071 (653.6 dgsf/bed)	13,200 (660 dgsf/bed)	129 dgsf (6.4 dgsf/bed)	Yes

The floor plans for the 6th and 4th floors are shown on the following pages.



PROGRAM LEGEND - LEVEL 6	
48% - REHAB BEDS:	4,998 S.F.
15% - UNIT SUPPORT:	1,490 S.F.
7% - STAFF SUPPORT:	712 S.F.
9% - BUILDING SUPPORT:	905 S.F.
21% - CORRIDOR:	2,133 S.F.
TOTAL PROGRAM AREA: 10,236 S.F.	

60

Attachment 14

tvS

THOMPSON, VENTULETTI, STAINBACK
& ASSOCIATES, INC.
THE ROOKERY BUILDING,
200 SOUTH LASALLE STREET, SUITE 400
CHICAGO, ILLINOIS 60604
312-251-1564 FAX: 312-251-1888

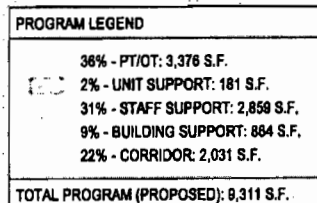


LEVEL 6
1/16" = 1'-0"

PROJECT LOYOLA GOTTLIEB PT/OT RENOVATION
701 W. NORTH AVENUE, MELROSE PARK, IL 60160
TITLE GOTTLIEB L8 PT/OT - PROPOSED
SCALE AS NOTED DATE 11/17/2015 REFERENCES PROJECT NO. 04930*999

DWG NO.

ASK-206



Attachment 14

PROJECT SERVICES UTILIZATION

GMH projects that the proposed 20 bed inpatient Comprehensive Physical Rehabilitation unit will serve an estimated 580 – 585 patients annually in its second year of operation. The 20 bed size of the unit, dictated by the available space on the 6th floor is a limiting factor on the projected volume of utilization. At 6400 patient days per year, average daily census will be 17.5 patients, for an occupancy of 88%. This level exceeds the State standard of 85%.

The following table shows historic utilization of the unit at LUMC, and projections for the relocated unit to GMH. The unit will become operational in mid 2016.

	H I S T O R I C			P R O J E C T E D		
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Admissions	732	697	625	620	615	621
Patient Days	9211	9056	7419	6863	6600	6400
ALOS	12.6	13.0	11.19	11.1	10.7	10.3
ADC	25.2	24.8	20.3	18.8	18.1	17.5

During 2015, census has continued to decline slightly. The average daily census for the 12 months through September has been 19.4 patients; two months had averages of 13 and 16 patients. For the past two years, LUMC has staffed 24 of the 32 authorized beds. The sizing of the proposed new inpatient rehabilitation at GMH is based on available space on the 6th floor (20 beds), right sized to accommodate current census levels.

One of the reasons that the smaller unit size is practical relates to increasing pressure for efficient and cost effective post-acute care services. Most patients will continue to require inpatient hospitalization, but some will experience shorter lengths of stay and earlier discharge to home or skilled nursing. Other incentives are likely to encourage rehabilitation in non-acute care settings. As a result, a lower volume of patient days is forecast for years 2016 and 2017.

It is anticipated that there will be occasions when the new 20 bed unit will not be able to accommodate all patients during some peak demand times. The relationship with Marianjoy provides a back-up referral option for those occasions. In addition, physicians on staff at GMH have been referring their patients to other area hospital inpatient rehabilitation services in addition to LUMC. While they will have the convenient option of hospitalizing their patients needing acute rehab at GMH, many may continue to prefer their established referral patterns.

Criterion 1110.630 – Comprehensive Physical Rehabilitation

1. 1110.630(c)(1) Planning Area Need –Formula Calculation

For Planning Area HSA 7, the Inventory of Health Care Facilities and Service and Need Determinations shows an excess of 130 inpatient rehabilitation beds (published August, 2015). The project proposes the establishment of a 20 bed unit at Gottlieb Memorial Hospital in conjunction with the discontinuation of a 32 bed inpatient rehabilitation unit at Loyola University Medical Center. The relocation of the inpatient facility from LUMC to GMH results in a net reduction of 12 Comprehensive Physical Rehabilitation beds. Both hospitals are located in HSA 7, four miles apart from each other.

2. 1110.630(c)(2) Planning Area Need – Service to Planning Area Residents

The table on the next page shows the zip codes comprising the Central (Primary) Service Area and Secondary Service Area for Gottlieb Memorial Hospital. Collectively these areas are the source of 82% of GMH discharges for FY 2015, by residence of patient. The table also includes population estimates for year 2015; the total population of the CSA and SSA is 1,209,804.

The following table shows the zip codes comprising the Central (Primary) Service Area and Secondary Service Area for Loyola University Medical Center. The table shows patient origin data for all LUMC inpatients, and also for inpatients cared for in the LUMC inpatient rehabilitation unit. Because the hospitals are only 4 miles from each other, the distribution of rehabilitation patients at Loyola is a surrogate for the likely distribution of patients to the relocated rehabilitation unit at Gottlieb Memorial Hospital. That is because 29 of the 30 zip codes in Gottlieb's CSA and SSA are within the Central Service Area of LUMC. Also, 58.1% of inpatients at LUMC's rehabilitation unit come from this Central Service Area of LUMC. The LUMC CSA has a year 2015 population of 1,904,423, and is the "Identified Planning Area" for the project.

The patient origin table for LUMC shows that in FY 2015 (year ending June 30, 2015), 370 patients cared for in the inpatient rehabilitation unit at LUMC resided in LUMC's CSA, the Identified Planning Area for the project. This is 57% of the total 653 LUMC rehab inpatients in FY 2015 (59% of the total 625 LUMC rehab inpatients in CY 2014). These data validate the claim that the project primarily serves residents of the Identified Planning Area.

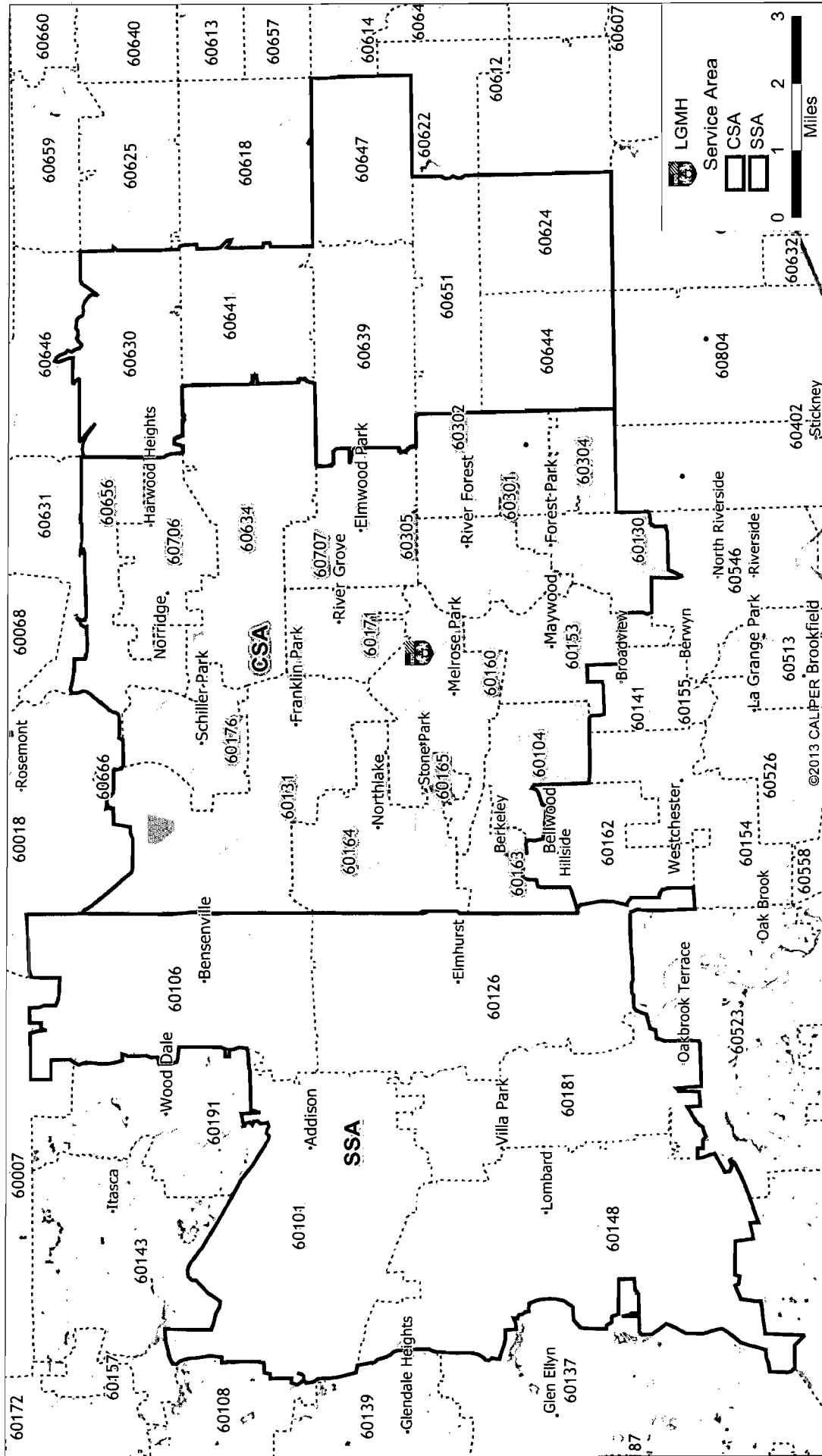
An additional 55 inpatients at Gottlieb Memorial Hospital were referred to post-acute care rehab in 2015. 13 were admitted for rehab at LUMC and are included in the patient counts at LUMC. 42 were patients at other area rehab facilities. It is expected that physicians at GMH will refer patients requiring post-acute rehab to the new unit at GMH, as well as continue to refer some patients to area rehab programs based on their past and current referral relationships. Because a) 100% of GMH's inpatients reside in its CSA and SSA, and b) 29 of the 30 zip codes in GMH's CSA and SSA are contained within LUMC's CSA (the Identified Planning Area), then any addition of referrals from GMH further reinforces that the project will serve residents of the Identified Planning Area.

Following the tables are maps of the Central Service Areas and Secondary Service Areas of Loyola University Medical Center and Gottlieb Memorial Hospital.

GMH Central and Secondary Service Areas based on Patient Origin

		Total Inpatients, FY 2015			Population		
ZIP Code	City	Discharges	%	Cum.%	2015	%	Cum.%
Central Service Area (CSA)							
60707	Elmwood Park	1,175	15.4%	15.4%	43,102	4.2%	4.2%
60160	Melrose Park	795	10.4%	25.8%	26,072	2.5%	6.7%
60164	Melrose Park	775	10.2%	36.0%	22,239	2.2%	8.9%
60131	Franklin Park	599	7.9%	43.9%	18,106	1.8%	10.6%
60171	River Grove	440	5.8%	49.6%	10,498	1.0%	11.7%
60153	Maywood	383	5.0%	54.7%	23,635	2.3%	13.9%
60634	Chicago	312	4.1%	58.8%	75,577	7.3%	21.3%
60176	Schiller Park	254	3.3%	62.1%	11,803	1.1%	22.4%
60104	Bellwood	236	3.1%	65.2%	19,097	1.9%	24.3%
60302	Oak Park	118	1.5%	66.7%	32,612	3.2%	27.5%
60706	Harwood Heights	116	1.5%	68.3%	22,616	2.2%	29.7%
60165	Stone Park	93	1.2%	69.5%	5,182	0.5%	30.2%
60305	River Forest	65	0.9%	70.3%	10,992	1.1%	31.2%
60130	Forest Park	64	0.8%	71.2%	13,877	1.3%	32.6%
60656	Chicago	63	0.8%	72.0%	29,186	2.8%	35.4%
60163	Berkeley	35	0.5%	72.5%	5,197	0.5%	35.9%
60304	Oak Park	27	0.4%	72.8%	17,179	1.7%	37.6%
60301	Oak Park	20	0.3%	73.1%	2,317	0.2%	37.8%
Total CSA		5,570	73.1%	73.1%	389,287	37.8%	37.8%
Secondary Service Area (SSA)							
60639	Chicago	145	1.9%	75.0%	90,215	8.8%	46.6%
60651	Chicago	130	1.7%	76.7%	63,113	6.1%	52.7%
60644	Chicago	81	1.1%	77.7%	48,016	4.7%	57.4%
60126	Elmhurst	60	0.8%	78.5%	47,078	4.6%	61.9%
60641	Chicago	57	0.7%	79.3%	71,071	6.9%	68.8%
60106	Bensenville	39	0.5%	79.8%	20,556	2.0%	70.8%
60630	Chicago	34	0.4%	80.2%	54,168	5.3%	76.1%
60148	Lombard	34	0.4%	80.7%	52,775	5.1%	81.2%
60181	Villa Park	27	0.4%	81.0%	28,663	2.8%	84.0%
60624	Chicago	26	0.3%	81.4%	37,535	3.6%	87.6%
60101	Addison	26	0.3%	81.7%	39,407	3.8%	91.5%
60647	Chicago	23	0.3%	82.0%	87,920	8.5%	100.0%
Total SSA		682	8.9%	82.0%	640,517	62.2%	100.0%
Total CSA and SSA		6,252	82.0%	82.0%	1,029,804	100.0%	100.0%
All Other ZIPs		1,370	18.0%	100.0%			
Total		7,622	100.0%	100.0%			

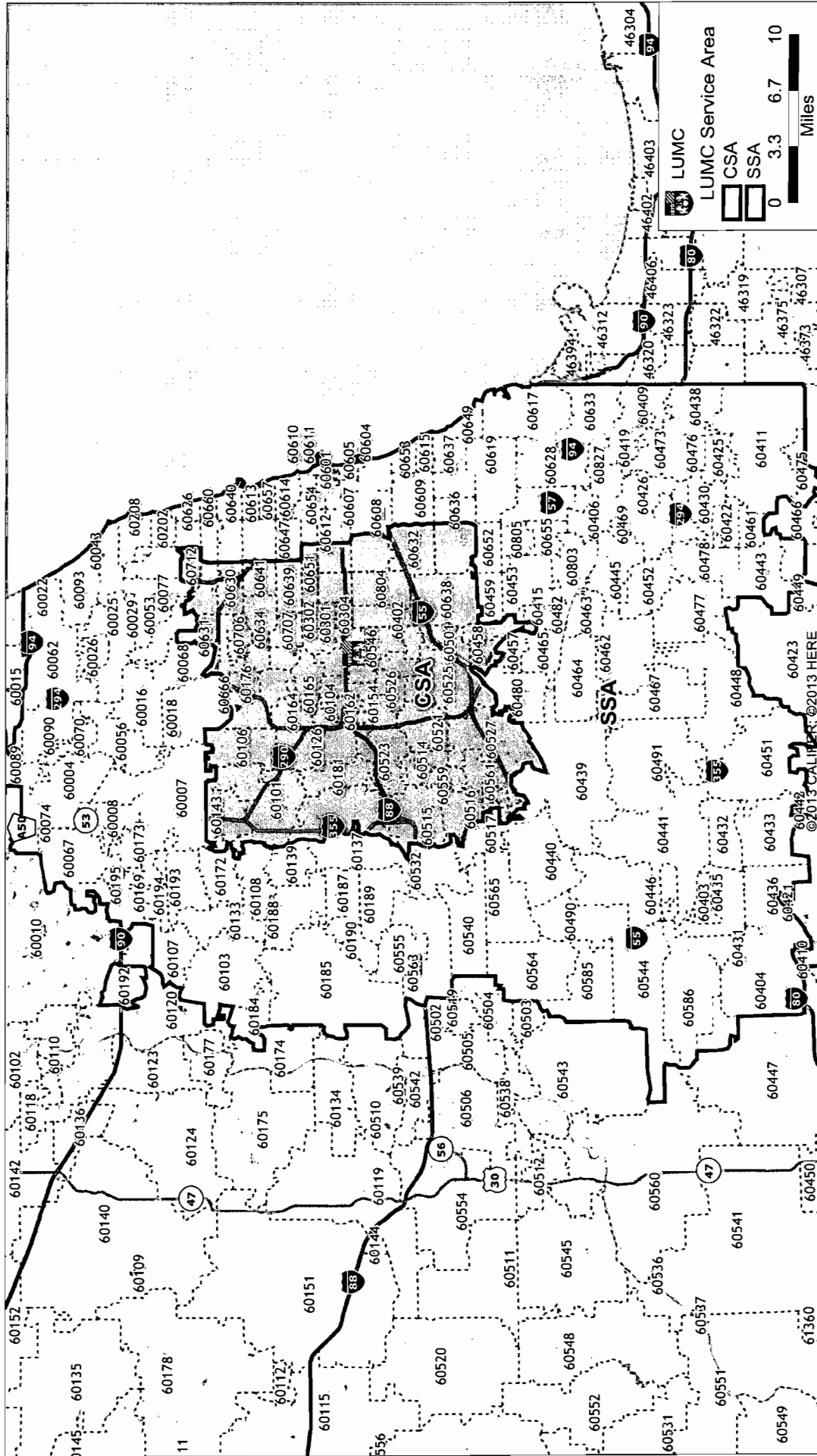
GMH Inpatient Service Area



LUMC Central and Secondary Service Areas based on Patient Origin

		Total Inpatients, FY 2015			Inpatient Rehabilitation		
ZIP Code	City	Discharges	%	Cum. %	Discharges	%	Cum. %
Central Service Area (CSA)							
60153	Maywood	1,322	5.7%	5.7%	39	6.0%	6.0%
60546	Riverside	506	2.2%	7.9%	23	3.5%	9.5%
60402	Berwyn	856	3.7%	11.7%	17	2.6%	12.1%
60302	Oak Park	320	1.4%	13.0%	16	2.5%	14.5%
60513	Brookfield	404	1.8%	14.8%	16	2.5%	17.0%
60104	Bellwood	700	3.0%	17.8%	15	2.3%	19.3%
60130	Forest Park	360	1.6%	19.4%	14	2.1%	21.4%
60638	Chicago	406	1.8%	21.2%	13	2.0%	23.4%
60639	Chicago	257	1.1%	22.3%	12	1.8%	25.3%
60155	Broadview	406	1.8%	24.0%	11	1.7%	27.0%
60160	Melrose Park	388	1.7%	25.7%	11	1.7%	28.6%
60534	Lyons	192	0.8%	26.6%	11	1.7%	30.3%
60707	Elmwood Park	471	2.0%	28.6%	11	1.7%	32.0%
60154	Westchester	391	1.7%	30.3%	9	1.4%	33.4%
60171	River Grove	156	0.7%	31.0%	9	1.4%	34.8%
60804	Cicero	701	3.0%	34.0%	9	1.4%	36.1%
60126	Elmhurst	223	1.0%	35.0%	8	1.2%	37.4%
60148	Lombard	224	1.0%	36.0%	8	1.2%	38.6%
60305	River Forest	161	0.7%	36.7%	8	1.2%	39.8%
60644	Chicago	337	1.5%	38.1%	8	1.2%	41.0%
60304	Oak Park	205	0.9%	39.0%	7	1.1%	42.1%
60164	Melrose Park	264	1.1%	40.2%	6	0.9%	43.0%
60526	La Grange Park	176	0.8%	40.9%	6	0.9%	44.0%
60521	Hinsdale	68	0.3%	41.2%	5	0.8%	44.7%
60527	Willowbrook	128	0.6%	41.8%	5	0.8%	45.5%
60561	Darien	116	0.5%	42.3%	5	0.8%	46.2%
60634	Chicago	277	1.2%	43.5%	5	0.8%	47.0%
60651	Chicago	226	1.0%	44.5%	5	0.8%	47.8%
60162	Hillside	144	0.6%	45.1%	4	0.6%	48.4%
60176	Schiller Park	77	0.3%	45.4%	4	0.6%	49.0%
60559	Westmont	113	0.5%	45.9%	4	0.6%	49.6%
60101	Addison	168	0.7%	46.7%	3	0.5%	50.1%
60181	Villa Park	182	0.8%	47.4%	3	0.5%	50.5%
60458	Justice	111	0.5%	47.9%	3	0.5%	51.0%
60516	Downers Grove	90	0.4%	48.3%	3	0.5%	51.5%
60623	Chicago	170	0.7%	49.1%	3	0.5%	51.9%
60624	Chicago	118	0.5%	49.6%	3	0.5%	52.4%
60656	Chicago	99	0.4%	50.0%	3	0.5%	52.8%
60706	Harwood Heights	120	0.5%	50.5%	3	0.5%	53.3%
60106	Bensenville	105	0.5%	51.0%	2	0.3%	53.6%
60163	Berkeley	60	0.3%	51.2%	2	0.3%	53.9%
60514	Clarendon Hills	17	0.1%	51.3%	2	0.3%	54.2%
60525	La Grange	218	0.9%	52.3%	2	0.3%	54.5%
60558	Western Springs	63	0.3%	52.5%	2	0.3%	54.8%
60629	Chicago	137	0.6%	53.1%	2	0.3%	55.1%
60631	Chicago	56	0.2%	53.4%	2	0.3%	55.4%
60632	Chicago	112	0.5%	53.9%	2	0.3%	55.7%
60455	Bridgeview	81	0.4%	54.2%	1	0.2%	55.9%
60501	Summit Argo	111	0.5%	54.7%	1	0.2%	56.0%
60515	Downers Grove	90	0.4%	55.1%	1	0.2%	56.2%
60523	Oak Brook	86	0.4%	55.4%	1	0.2%	56.4%
60630	Chicago	79	0.3%	55.8%	1	0.2%	56.5%
60641	Chicago	117	0.5%	56.3%	1	0.2%	56.7%
60131	Franklin Park	185	0.8%	57.1%	-	-	56.7%
60165	Stone Park	64	0.3%	57.4%	-	-	56.7%
60191	Wood Dale	42	0.2%	57.6%	-	-	56.7%
60143	Itasca	33	0.1%	57.7%	-	-	56.7%
60646	Chicago	28	0.1%	57.8%	-	-	56.7%
60141	Hines	27	0.1%	57.9%	-	-	56.7%
60301	Oak Park	21	0.1%	58.0%	-	-	56.7%
60712	Lincolnwood	7	0.0%	58.1%	-	-	56.7%
60157	Medinah	4	0.0%	58.1%	-	-	56.7%
Total CSA		13,376	58.1%	58.1%	370	56.7%	56.7%
Secondary Service Area (SSA)		5,786	25.1%	83.2%	185	28.3%	85.0%
Total CSA and SSA		19,162	83.2%	83.2%	555	85.0%	85.0%
All Other ZIPs		3,866	16.8%	100.0%	98	15.0%	100.0%
Total		23,028	100.0%	100.0%	653	100.0%	100.0%

LUMC Inpatient Service Area



3. 1110.630(c)(3) Planning Area Need – Service Demand – Establishment of Comprehensive Physical Rehabilitation Service

The unit being established at GMH is the relocation of the existing inpatient rehabilitation unit at LUMC. Historic utilization of the 32 bed inpatient unit at LUMC is as follows:

	HISTORIC			PROJECTED		
	CY 2012	CY 2013	CY2014	CY 2015	CY 2016	CY 2017
Admissions	732	697	625	620	615	621
Patient Days	9211	9056	7419	6863	6600	6400
ALOS	12.6	13.0	11.19	11.1	10.7	10.3
ADC	25.2	24.8	20.3	18.8	18.1	17.5

During 2015, census has continued to decline slightly. The average daily census for the 12 months through September has been 19.4 patients. During this time, the hospital has staffed 24 of the 32 authorized beds. The sizing of the proposed new inpatient rehabilitation unit at GMH is based on available space on the 6th floor (20 beds), right-sized to accommodate the current census levels.

The table on the next page documents physician referrals to the LUMC inpatient rehabilitation unit by physicians in 2014 and 2015 (this information is compiled by fiscal years ending June 30). In 2014, 171 physicians (137 on the staff at LUMC) referred a total of 669 patients. This year, 190 physicians (145 on the staff at LUMC) referred a total of 653 patients.

Physicians who are full time members of the medical staff at Loyola University Medical Center (92% of 919 physicians) admit exclusively to either LUMC or GMH. As a result, the chairmen of key departments at LUMC - neurology, neurosurgery and orthopedics – have signed a joint letter acknowledging that their departmental physicians will commit to refer patients to the new unit at GMH. These departments are responsible for more than 50% of referrals to the rehabilitation unit at Loyola. This letter is included in Appendix I. Similarly, patient origin data is submitted in aggregate for rehabilitation patients admitted to the rehabilitation unit at LUMC.

In 2014, LUMC entered into an agreement with the Marianjoy Medical Group to oversee the inpatient rehabilitation unit. Dr. Thomas Pang, director of the unit, is engaged in the transition planning to the new unit at GMH.

One of the reasons that the smaller sized unit is practical relates to increasing pressure for efficient and cost effective post-acute care services. Most patients will continue to require inpatient hospital rehabilitation, but some will be experiencing shorter lengths of stay and earlier discharge to home or skilled nursing. Other incentives are likely to encourage rehabilitation in non-acute care settings. As a result, a lower volume of patient days is forecast for years 2016 and 2017. 6400 patient days is the forecast for year 2017, the first full year after

Patients Referred to LUMC Inpatient Rehabilitation Service, by physician, FY 2014 and 2015

Name	Specialty	FY2014	FY2015
LUHS Physicians			
Nockels, Russell P	Neurosurgery	31	34
Morales-Vidal, Sarkis	Neurology	27	23
Prabhu, Vikram C	Neurosurgery	13	21
Hopkinson, William J	Orthopedics	21	17
Flaster, Murray S	Neurology	19	17
Amin, Beejal	Neurosurgery	19	16
Schwartz, Jeffrey P	Thoracic/Cardiovascular	6	16
Shetty, Sonia	Physical Medicine and Rehab		16
Schneck, Michael J	Neurology	20	15
Xenidis, Melissa	Physical Medicine and Rehab		15
Ruland, Sean D	Neurology	16	14
Rees, Harold W	Orthopedics	12	13
Oken, Jeffrey	Physical Medicine and Rehab		12
Summers, Hobie D	Orthopedics	16	11
Tsimpas, Asterios	Neurosurgery	5	11
Ashley, William Wallace	Neurosurgery	15	10
Nystrom, Lukas	Orthopedics	7	10
Ton-That, Hieu H	Trauma, Surgical Critical Care/Burns	3	10
Greenhalgh, Sean E	Hospitalist	2	10
Biller, Jose	Neurology	5	9
Baldea, Anthony J	Trauma, Surgical Critical Care/Burns	5	9
Lack, William	Orthopedics	5	8
Anderson, Douglas E	Neurosurgery	17	7
Pinzur, Michael S	Orthopedics	10	7
Burns Msiska, Melody	Hospitalist		7
Santa, Edwin	Hospitalist	7	6
Hershberger, Richard C	Vascular Surgery	3	6
Aulivola, Bernadette	Vascular Surgery	3	6
Santaniello, John M	Trauma, Surgical Critical Care/Burns	2	6
Bashir, Atif	Hospitalist		6
Wu, Karen	Orthopedics	13	5
Borrowdale, Richard	Ent-Otolaryngology	8	5
Bakhos, Mamdouh	Thoracic/Cardiovascular	8	5
Heroux, Alain L	Cardiology	6	5
Speyer, Mark A	Hospitalist	4	5
Mcasey, Craig	Orthopedics	4	5
Gagermeier, James P	Pulmonary Disease/Critical Care Medicine	3	5
Wojewnik, Bartosz	Orthopedics	2	5
George, Nina	Hospitalist		5
Qazi, Sameer	Hospitalist		5
Parthasarathy, Padmavathy	Hospitalist		5
Yonter, Simge J	Physical Medicine and Rehab	19	4
Komorowski, Monica M	Hospitalist	8	4
Mayhew, Ryan F	Hospitalist	5	4
Wantuch, Elizabeth	Hospitalist	4	4
Dilling, Daniel F	Pulmonary Disease/Critical Care Medicine	4	4
Luchette, Frederick A	General Surgery	3	4

Patients Referred to LUMC Inpatient Rehabilitation Service, by physician, FY 2014 and 2015

Name	Specialty	FY2014	FY2015
Gurza, Edward J	Internal Medicine	2	4
Poonja, Shirin	Hospitalist	2	4
Smith, Scott E	Hematology/Oncology	1	4
Schulwolf, Elizabeth	Hospitalist	1	4
Halandras, Pegge	Vascular Surgery	1	4
Bernstein, Mitchell	Orthopedics		4
Gonzalez, Richard	Trauma, Surgical Critical Care/Burns		4
Lu, Amy	General Surgery	6	3
Henry, Elizabeth	Hematology/Oncology	4	3
Henry, Kelly M	Hospitalist	4	3
Perez-Tamayo, R Anthony	Thoracic/Cardiovascular	3	3
Kartha, Ninith V	Neurology		3
Dasilva, Marcelo	Thoracic/Cardiovascular		3
Mcgee Jr, Edwin	Thoracic/Cardiovascular		3
Gnatz, Steve M	Physical Medicine and Rehab	9	2
Go, Aileen	Hematology/Oncology	6	2
Garbis, Nickolas	Orthopedics	6	2
Mashruwala, Anar	Hospitalist	6	2
Lowery, Erin M	Pulmonary Disease/Critical Care Medicine	5	2
Kim, Amy Yang	Hospitalist	4	2
Evans, Douglas A	Orthopedics	4	2
Tuchek, James M	Thoracic/Cardiovascular	3	2
Mosier, Michael J	Trauma, Surgical Critical Care/Burns	3	2
Liebo, Max	Cardiology	2	2
Loftus, Christopher	Neurosurgery	2	2
Vavra, Timothy M	Internal Medicine	2	2
Tsonis, Lambros	Cardiac Surgery	2	2
Wai, Philip	General Surgery	1	2
Crisostomo, Paul	Vascular Surgery	1	2
Mckiernan, Thomas L	Cardiology	1	2
Pittman, Amy	Otolaryngology	1	2
Libot, Agnes	Hospitalist	1	2
Albain, Kathy S	Hematology/Oncology	1	2
De Vita, Michael	Hospitalist		2
Ricci Goodman, Jean	Maternal Fetal Medicine		2
Abood, Gerard	Surgical Oncology		2
Thorpe, Eric	Otolaryngology		2
Eng, Michael	Thoracic/Cardiovascular		2
Sanford, Arthur	Trauma, Surgical Critical Care/Burns	6	1
Coglianesse, Erin	Cardiology	5	1
Stiff, Patrick J	Hematology/Oncology	5	1
Smith, Kevin R	Hospitalist	5	1
Cho, Jae Sung	Vascular Surgery	4	1
Gilbert, Emily	Pulmonary Disease/Critical Care Medicine	4	1
Rodriguez, Tulio E	Hematology/Oncology	3	1
Montevecchi, Mauro	Cardiology	3	1
Ghanayem, Alexander J	Orthopedics	3	1
Tobin, Martin J	Pulmonary Disease/Critical Care Medicine	2	1

Patients Referred to LUMC Inpatient Rehabilitation Service, by physician, FY 2014 and 2015

Name	Specialty	FY2014	FY2015
Jacobs, William R	Cardiology	2	1
Lewis, Bruce E	Cardiology	2	1
Potkul, Ronald K	Gynecologic Oncology	2	1
Parker, Frank	Physical Medicine and Rehab	10	
Wright, Franklin L	Trauma, Surgical Critical Care/Burns	8	
Kozodoy, Nataliya	Hospitalist	7	
Kilari, Rakesh	Hospitalist	6	
Esposito, Thomas J	Trauma, Surgical Critical Care/Burns	5	
Clark, Joseph	Hematology/Oncology	4	
Abraham, Seena	Hospitalist	4	
Robinson, Patricia A	Hematology/Oncology	4	
Ansari, Aziz	Hospitalist	4	
Leonetti, John P	Ent-Otolaryngology	3	
Gaynor, Ellen R	Hematology/Oncology	3	
Pappas, Sam	Surgical Oncology	3	
Asconape, Jorge	Neurology	3	
Von Roenn, Natasha	Hepatology	2	
Fitz, Matthew	Internal Medicine	2	
Barron, John T	Cardiology	2	
Ahmed, Syed	Hospitalist	2	
Trabolsi, Mais	Hospitalist	2	
Mahendra, Disha	Hospitalist	2	
Jaber, James	Otolaryngology	2	
Di Sabato, Diego	General Surgery	2	
Kallwitz, Eric	Hepatology	2	
Asolati, Massimo	General Surgery	2	
Godellas, Constantine	Surgical Oncology	2	
Boblick, John	Pediatrics	2	
Helfrich, Rebecca	Hospitalist	2	
Other LUHS Referring Physicians with Only One Admission		32	48
Subtotal, LUHS Referring Physicians		632	605
Non-Staff Referring Physicians			
Fitzpatrick, Collins T	Physical Medicine and Rehab	2	3
Slavin, Konstantine	Neurosurgery	2	
Petrak, Richard	Pulmonary Disease/Critical Care Medicine	2	
Lukas, Rimas V	Neurology		2
Other Non-Staff Referring Physicians with Only One Admission		31	43
Subtotal, Non-Staff Referring Physicians		37	48
Total, All Physicians		669	653

project completion. 6400 patient days yields an average daily census of 17.5 patients, with a unit occupancy of 87.5%, which is above the State standard of 85%.

It is anticipated that there will be occasions when the new 20 bed unit may not be able to accommodate all patients during some peak demand periods. The relationship with Marianjoy provides a back-up referral option for those occasions. In addition, physicians at GMH have been referring their patients to other area hospital rehabilitation services in addition to LUMC. While they will have the convenient option of hospitalizing their patients needing acute rehab at GMH, many may continue to prefer their established referral patterns.

The table on the next page shows referrals of GMH patients for post-acute care rehabilitation by physicians on staff at GMH to LUMC and other area hospitals. The Gottlieb physicians referred 55 patients to rehab last year – 13 to LUMC and 42 to six other area hospitals. One physician referred 4 patients; one referred 3; no other physician referred more than 2 patients. In 2014, 13 GMH physicians referred 17 patients for rehab at 5 area hospitals. No physician referred more than one patient to any one hospital. Based on these data, the project is not expected to have a significant impact on any area provider of rehabilitation services.

4. 1110.630(c)(4) Planning Area Need – Service Demand – Expansion of a Comprehensive Physical Rehabilitation

Not applicable; this is not a project expanding an existing service.

5. Planning Area Need – Service Accessibility

This project proposes the establishment of a 20 bed inpatient rehabilitation service, as the relocation of the inpatient rehabilitation unit being discontinued at LUMC. The projected utilization of the 20 bed inpatient rehabilitation unit anticipates about 6400 inpatient days during the first full year after project completion. This is comparable to but less than the volume of rehabilitation patient days now being provided in the rehabilitation unit at LUMC.

The following table lists hospitals with rehabilitation units within 30 minute travel times of GMH. Collectively, these hospitals have a total of 805 inpatient rehabilitation beds.

While there is a calculated excess of rehabilitation beds, it cannot be concluded that all providers have the capability to deal with many of the LUMC patients who have received specialized tertiary and quaternary services at LUMC. Many patients are medically complex and require close and continuing supervision while in the post-acute care phase. Such patients include those with Left Ventricular Assist Devices (LVAD) / heart failure, burns, cardiac conditions and stroke, transplant, and significant trauma. Some of the hospitals do not share the EPIC medical information system in place at LUMC and GMH and is required for patient monitoring and continuity of care. Moreover, it is important that physicians caring for complex patients in their acute care phase have convenient access (geographically and organizationally) to continue to observe patient progress through rounding during the post-acute care recovery.

GMH External Acute Rehab Transfers, FY 2015

Physician	Westlake	Loyola	Marianjoy	Kindred Northlake	RML	Resurrection	Others (<1 Referral)	Total
HOPKINSON, W.		4	2					6
SAWLANI, H.	2						3	5
FATIMA, S.		1	1	2				4
PATEL, D.	2	1			1			4
MATTIS, R.			1		1		1	3
QURESHI, M.	2						1	3
BENDIN, N.	1	1						2
GAFOOR, M.			1				1	2
JOO, P.	1	1						2
PATEL, K.	1						1	2
SANDOVAL, M.	1		1					2
SUNG, T.	1					1		2
VATEV, D.	1	1						2
BOBLICK, W.			1					1
BOLMEY, C.						1		1
COURET, L.	1							1
COX, C.		1						1
DHINGRA, R.	1							1
DWORETZKY, J.	1							1
KELLEY, E.	1							1
KOOP, J.		1						1
MADAPPALLIL, M.			1					1
MCASEY, C.			1					1
MORSO, E.				1				1
NSIMA-OBOT, E.		1						1
REES, H.		1						1
SARANTOS, W.	1							1
SCHAINIS, R.	1							1
SHIVAKUMAR, D.	1							1
Total	19	13	9	3	2	2	7	55

GMH External Acute Rehab Transfers, FY 2014

Physician	Westlake	Loyola	Schwab	Rehab Institute of Chicago	Resurrection	Total
GANESAN, D.	1	1				2
GUO, Y.	1	1				2
JOO, P.		1		1		2
KELLEY, E.	1		1			2
DHINGRA, R.	1					1
GAFOOR, M.	1					1
JAMES, T.	1					1
MACKEY, P.	1					1
PATEL, A.	1					1
PATEL, D.	1					1
ROMERO, W.	1					1
SCHAINIS, R.					1	1
SHIVAKUMAR, D.	1					1
Total	11	3	1	1	1	17

Hospitals with rehabilitation units located within 30 minute travel time of Gottlieb Memorial Hospital

Hospitals with Rehabilitation Units	Municipality	Dist from Gottlieb (miles)	Travel time (min)	Adj trav time (1.15 factor) (min)	rehab beds (CY 2014)	% occupancy (CY 2014)
HSA 6						
Mercy Hospital & Medical Center	Chicago	15.84	26	30	24	41.3
Presence Resurrection Medical Center	Chicago	7.23	16	18	65	63.1
Presence Saint Mary of Nazareth Hospital	Chicago	12.62	21	24	15	61.5
Rehabilitation Institute of Chicago	Chicago	16.02	25	29	242	67.5
Rush University Medical Center	Chicago	11.59	16	18	59	48.6
Schwab Rehabilitation Center	Chicago	11.04	17	20	81	67
Shriners Hospital for Children - Chicago	Chicago	3.14	8	9	6	46.4
Swedish Covenant Hospital	Chicago	11.06	26	30	25	52.7
University of Illinois Hospital at Chicago	Chicago	11.91	18	21	18	72.4
HSA 7						
Adventist Hinsdale Hospital	Hinsdale	12.44	21	24	0	54.3 (1)
Adventist LaGrange Memorial Hospital	LaGrange	10.57	22	25	16	---
Alexian Brothers Medical Center	Elk Grove Village	14.54	20	23	72	83.3
Loyola University Medical Center	Maywood	3.92	9	10	32	77.5
Lutheran General Hospital - Advocate	Park Ridge	12.34	18	21	45	75.1
MacNeal Hospital	Berwyn	7.65	17	20	12	0 (2)
Northwest Community Hospital	Arlington Heights	17.59	25	29	17	--- (3)
Rush Oak Park Hospital	Oak Park	4.01	10	12	36	11.2
Westlake Hospital	Melrose Park	1.84	4	5	40	24.4
HSA 8						
No hospitals with rehabilitation units are within 30 minutes						
HSA 9						
No hospitals with rehabilitation units are within 30 minutes						

Sources:

Beds and occupancy statistics: Inventory of Health Care Facilities and Services and Need Determinations, 2015

Travel distances and travel times: Mapquest

Notes:

- (1) Patient days are attributed to unit in operation at Hinsdale Hospital, prior to relocation to LaGrange
- (2) New service approved March 10, 2015
- (3) New service approved in August, 2014; due to open in fall, 2015

ZIP Codes within 30 Minutes Travel Time of Gottlieb Memorial Hospital

ZIP Code	City	2015 Population	2020 Population
60005	Arlington Heights	30,253	30,471
60007	Elk Grove Village	33,294	33,354
60008	Rolling Meadows	23,410	24,005
60016	Des Plaines	61,073	62,591
60018	Des Plaines	30,827	31,691
60025	Glenview	40,063	40,620
60026	Glenview	14,249	15,120
60029	Golf	317	319
60053	Morton Grove	23,314	23,649
60056	Mount Prospect	55,525	56,076
60062	Northbrook	39,856	40,121
60067	Palatine	39,564	40,330
60068	Park Ridge	37,678	37,925
60070	Prospect Heights	15,245	15,461
60076	Skokie	33,518	33,680
60077	Skokie	27,786	28,720
60090	Wheeling	39,346	40,482
60101	Addison	39,407	40,111
60104	Bellwood	19,097	19,134
60106	Bensenville	20,556	20,798
60108	Bloomingtondale	23,506	23,969
60126	Elmhurst	47,078	47,559
60130	Forest Park	13,877	13,842
60131	Franklin Park	18,106	18,082
60133	Hanover Park	38,077	38,699
60137	Glen Ellyn	39,156	39,852
60139	Glendale Heights	35,238	36,230
60141	Hines	262	264
60143	Itasca	10,250	10,500
60148	Lombard	52,775	53,877
60153	Maywood	23,635	23,307
60154	Westchester	16,519	16,724
60155	Broadview	7,779	7,807
60157	Medinah	2,542	2,570
60160	Melrose Park	26,072	26,778
60162	Hillside	8,421	8,558
60163	Berkeley	5,197	5,293
60164	Melrose Park	22,239	22,487
60165	Stone Park	5,182	5,207
60169	Hoffman Estates	32,982	33,452
60171	River Grove	10,498	10,632
60172	Roselle	24,910	25,271
60173	Schaumburg	13,303	13,896
60176	Schiller Park	11,803	11,961
60181	Villa Park	28,663	28,987

ZIP Codes within 30 Minutes Travel Time of Gottlieb Memorial Hospital

ZIP Code	City	2015 Population	2020 Population
60185	West Chicago	38,226	39,957
60187	Wheaton	29,236	29,311
60188	Carol Stream	43,653	44,353
60189	Wheaton	30,171	30,277
60190	Winfield	10,796	10,891
60191	Wood Dale	15,032	15,369
60193	Schaumburg	41,221	41,732
60194	Schaumburg	20,767	20,943
60195	Schaumburg	5,313	5,456
60301	Oak Park	2,317	2,441
60302	Oak Park	32,612	32,621
60304	Oak Park	17,179	17,224
60305	River Forest	10,992	11,003
60402	Berwyn	63,545	64,305
60439	Lemont	23,874	24,918
60455	Bridgeview	16,978	17,397
60457	Hickory Hills	14,120	14,304
60458	Justice	15,379	16,249
60459	Burbank	29,519	29,945
60480	Willow Springs	5,528	5,716
60501	Summit Argo	11,622	11,611
60513	Brookfield	19,126	19,218
60514	Clarendon Hills	10,186	10,434
60515	Downers Grove	27,866	28,131
60516	Downers Grove	29,619	29,926
60517	Woodridge	32,782	33,489
60521	Hinsdale	18,214	18,331
60523	Oak Brook	9,471	9,505
60525	La Grange	31,521	31,867
60526	La Grange Park	14,024	14,225
60527	Willowbrook	29,355	30,378
60532	Lisle	27,562	27,799
60534	Lyons	10,909	11,058
60540	Naperville	43,440	44,095
60546	Riverside	15,850	15,905
60555	Warrenville	13,934	14,149
60558	Western Springs	12,916	13,100
60559	Westmont	25,808	26,369
60561	Darien	22,542	22,816
60563	Naperville	38,486	40,321
60601	Chicago	12,810	14,422
60602	Chicago	1,413	1,526
60603	Chicago	1,087	1,159
60604	Chicago	882	944
60605	Chicago	27,418	30,256

ZIP Codes within 30 Minutes Travel Time of Gottlieb Memorial Hospital

ZIP Code	City	2015 Population	2020 Population
60606	Chicago	3,068	3,443
60607	Chicago	26,062	27,827
60608	Chicago	74,796	75,965
60609	Chicago	65,452	65,574
60610	Chicago	38,067	39,312
60611	Chicago	31,833	34,224
60612	Chicago	34,877	35,957
60614	Chicago	67,362	68,291
60616	Chicago	51,387	53,779
60618	Chicago	92,017	92,228
60622	Chicago	53,330	53,981
60623	Chicago	100,324	99,595
60624	Chicago	37,535	37,160
60625	Chicago	78,438	78,414
60629	Chicago	114,307	115,058
60630	Chicago	54,168	54,484
60631	Chicago	29,088	29,269
60632	Chicago	91,353	91,997
60634	Chicago	75,577	76,457
60638	Chicago	55,701	56,263
60639	Chicago	90,215	90,573
60641	Chicago	71,071	70,785
60642	Chicago	19,148	19,682
60644	Chicago	48,016	47,607
60646	Chicago	26,669	26,711
60647	Chicago	87,920	88,655
60651	Chicago	63,113	62,138
60653	Chicago	32,087	33,855
60654	Chicago	18,891	20,902
60656	Chicago	29,186	30,254
60657	Chicago	67,688	69,269
60659	Chicago	38,043	37,962
60661	Chicago	9,147	10,135
60666	Chicago	-	-
60706	Harwood Heights	22,616	22,839
60707	Elmwood Park	43,102	43,315
60712	Lincolnwood	13,030	13,279
60714	Niles	30,760	31,296
60804	Cicero	86,331	87,652

Total Population 4,069,524 4,132,095

Just as the service at LUMC has been, the service at GMH will be a referral resource for physicians at community hospitals in the area. For example, last year 45 physicians at other area hospitals referred one or more patients to the rehab unit at LUMC.

6. 1110.630(c)(1) Unnecessary Duplication / Maldistribution

The table on the next page lists zip codes within 30 minute travel times from GMH. The accompanying map shows those zip codes. The table also shows 2015 and 2020 population estimates for the travel time-defined geographic area.

The Identified Planning Area for the proposed rehabilitation project is the LUMC Central Service Area. There are nine hospitals with approved inpatient rehabilitation units located within the LUMC Central Service Area. The data on these rehabilitation programs are for year 2013, from the State Inventory of Health Facilities and Services and Need Determinations.

Hospital	Location	# rehab beds	Rehab pt days
Adventist Hinsdale Hospital	Hinsdale	0	4159
Adventist LaGrange Hospital	LaGrange	16	--
MacNeal Hospital	Berwyn	12	--
Loyola University Medical Center	Maywood	32	9056
Rush Oak Park Hospital	Oak Park	36	1477
Westlake Hospital	Melrose Park	40	3556
Presence Resurrection	Chicago	65	14,961
Holy Cross Hospital	Chicago	34	5186
Shriners Hospital for Children	Chicago	4	1017
		239	39,412

The table below presents comparison information on rehabilitation services for a) State of Illinois, b) HSA-7 and c) LUMC's Central Service Area (the Identified Area). The table shows that the Experience Use Rate (rehab patient days divided by population) is 0.0207 based on admissions to rehab units at hospitals in the Identified Area. This is considerably lower than the Experience Use Rates for the State of Illinois (0.0306) and HSA-7 (0.0335).

	State of Illinois	HSA - 7	LUMC Central Service Area (CSA) "Identified Area"
Inpatient Rehab Beds	1735	505	239
Rehab Patient Days at hospitals in designated area	392,908	115,294	39,412
Base Year Population	12,842,000	3,439,500 (1)	1,904,423 (2)
Beds to 1000 Population	0.135	0.147	0.125
Planning Area Experience Use Rate	0.0306	0.0335	0.0207

Source: Inventory of Health Care Facilities and Services and Need Determinations, August, 2015

Notes:

All data are Year 2013 unless otherwise noted.

(1) Year 2015, interpolated from 3,337,000 (Year 2010) and 3,501,000 (Year 2018).

(2) Year 2015 (Truven Health)

The proposed establishment of an inpatient rehabilitation service does not result in a maldistribution of facilities in the HSA. One of the State's criteria for determining maldistribution is when the Identified Area (within the Planning Area) has a supply of beds that results in a ratio of beds to population that exceeds one and one half times the State average. Based on the table's information, the Identified Area (defined as LUMC's Central Service Area) within the Planning Area (HSA-7) has a ratio of rehab beds to population of 0.125. The State average is 0.135. One and one half times the state average is 0.203. The establishment of a 20 bed rehabilitation unit at GMH will increase the bed to population ratio for the Identified Area to 0.136. The establishment of a 20 bed unit at GMH does not raise the ratio of rehabilitation beds to population to more than one and one half times the State average. In fact, in conjunction with the discontinuation of the 32 bed unit at LUMC, the ratio of rehabilitation beds to population in the Identified Area is reduced to 0.119. As a result, the establishment of a 20 bed unit does not result in a maldistribution of rehabilitation beds.

Nor does the establishment of a 20 bed unit at GMH create an unnecessary duplication of rehabilitation beds. The 20 bed project replaces some of the 32 beds that are being discontinued at LUMC, 4 miles to the south of the GMH campus and within HSA-7.

7. 111.630(c)(3) Impact of the Project on Other Area Providers

Because the establishment of a Comprehensive Physical Rehabilitation service at GMH does not create an unnecessary duplication of beds and does not result in a maldistribution of service, it does not have a negative impact on other area providers. In fact, the establishment of a smaller rehabilitation unit than the 32 bed unit at LUMC which is being discontinued is likely to result in small increases in utilization at other area hospital rehabilitation units. The projected annual volume of 6400 inpatient days at GMH is less than the current volume at LUMC, and will result in a rehabilitation unit occupancy at GMH exceeding the State standard of 85%. As a result, there will be times when the unit at GMH is at full utilization and additional patients will need to be admitted at Marianjoy Rehabilitation Center and other area rehabilitation units. A letter from the President and CEO of Marianjoy is included in Appendix I.

8. 1110.630(e)(1) and (2) Staffing

Staff currently in place at the LUMC inpatient rehabilitation unit will transfer to the unit at GMH. A listing of staff by functional area follows on the next page. The unit will continue under the medical direction of Dr. Thomas Pang. Dr. Pang is a physiatrist on staff at Marianjoy Medical Center as well as medical director of the inpatient rehabilitation unit at Loyola University Medical Center.

GMH will meet all licensing requirements set forth by the State of Illinois as well as staffing standards established by the Joint Commission and by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Staffing

The proposed unit at Gottlieb Memorial Hospital will be staffed by the same people who staff the unit at Loyola University Medical Center.

Medical Director:	Dr Thomas Pang	
Physiatrists:	Dr Sonia Shetty Dr Melissa Xenidis Dr Rachna Shah Marianjoy Medical Group for weekend on-call	
Rehabilitation Nursing:	Maria Benette Macailing, manager Joseleen Acuna Lily Alvarado Mark Baluga Julie Barnstable Kevin Barry Marillette Daguro Loriza David Gemmelyn DeJesus Karen Graening Michelle Leche Belinda Llauderres	Nikki Lazaro Patricia Owusu Margarita Pantoja Jean Parziale Christina Roth Staci Serafini Anna Smaga Gemma Sumagaysay Maria Theresa Wulff Janet Zach
PPS Coordinator:	Kathleen Xenakis	
Patient Care technicians:	Paquito Carpio, Jr Ashley Dawson Marie Fernando Tanisha Gross Sharon Henderson Katherine Kanney	Sheena Lewis Ebonique Lofton Jeanette Valdez Eduardo Villalobos Nicole Wade
Physical Therapists:	Jennifer Camamo Rebecca Oliver Sarah Smith	
Occupational Therapists:	Kathryn Boudouris Grace Krantz Elizabeth Lynch Jomil Nebrida Kathleen Needham	
Speech Pathologist	Moira Aronson-Brown	

Staffing (continued)

Social Worker / Case Manager:	Judith Gorski Sherill-Lyn Garcia
Dietician:	Melanie Trapp
Pharmacist:	Not based on the unit; hospital based
Psychologist:	Susan Walsh
Prosthetists/Orthotists:	Outsourced to Scheck and Siress
Audiologist, Dentist	Providers in adjacent medical building

9. 1110.630(f) Performance Requirements

The minimum size for a freestanding Comprehensive Physical Rehabilitation facility is 100 beds. The minimum size for a hospital rehabilitation unit is 16 beds. The proposed project establishes a 20 bed Comprehensive Physical Rehabilitation unit with 20 beds. Therefore, the standard is met.

10. 1110.630(g) Assurances

Attached is a letter from Lori Price, President of Gottlieb Memorial Hospital, attesting that the 20 bed unit will achieve the State standard of 85% occupancy by the second year of operation after project completion.



Gottlieb Memorial Hospital

November 2, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I hereby certify and attest to the understanding and commitment by Gottlieb Memorial Hospital that the new inpatient Comprehensive Physical rehabilitation service will achieve the 85% occupancy standard in Illinois Administrative Code 1110 within two years of operation after project completion.

Sincerely,

Lori Price, FACHE, MSA, RN
President
Gottlieb Memorial Hospital



Jodi Palmer, Notary
11/2/15

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Attachment 21

We also treat the human spirit.

A PART OF  TRINITY HEALTH
Livonia, MI

1120.120 – Availability of Funds

Not applicable. See attached proofs of bond ratings:

Standard & Poors Ratings Services

FitchRatings

Moody's Investor Services

RatingsDirect®

CHE Trinity Health Credit Group, Michigan; CP; System

Primary Credit Analyst:

J. Kevin Holloran, Dallas (1) 214-871-1412; kevin.holloran@standardandpoors.com

Secondary Contact:

Martin D Arrick, New York (1) 212-438-7963; martin.arrick@standardandpoors.com

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CHE Trinity Health Credit Group, Michigan; CP; System

Credit Profile

US\$640.24 mil hosp rev & rfg bnds (trinity health credit group) (CHE Trinity Hlth Credit Grp) ser 2015MI due 06/30/2044

<i>Long Term Rating</i>	AA-/Stable	New
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US\$350.0 mil taxable bnds due 06/30/2045

<i>Long Term Rating</i>	AA-/Stable	New
-------------------------	------------	-----

US\$169.61 mil rev bnds (trinity health credit group) (CHE Trinity Hlth Credit Grp) ser 2015MD due 06/30/2045

<i>Long Term Rating</i>	AA-/Stable	New
-------------------------	------------	-----

US\$151.06 mil rev bnds (trinity health credit group) (CHE Trinity Hlth Credit Grp) ser 2015ID due 06/30/2045

<i>Long Term Rating</i>	AA-/Stable	New
-------------------------	------------	-----

US\$100.0 mil variable rate bnds (CHE Trinity Hlth Credit Grp) due 06/30/2043

<i>Long Term Rating</i>	AA-/Stable	New
-------------------------	------------	-----

Rationale

Standard & Poor's Ratings Services assigned its 'AA-' long-term rating to the Michigan Finance Authority's \$640.24 million series 2015MI bonds and \$100.0 million series 2015MI(FRN) floating-rate notes, to the Idaho Health Facilities Authority's \$169.61 million series 2015ID bonds, to Montgomery County, Md.'s \$151.06 million series 2015MD bonds, and to the CHE Trinity Health Credit Group, Mich.'s \$350.0 million series 2015 taxable bonds, all issued for the CHE Trinity Health Credit Group. (doing business as Trinity Health).

In addition, Standard & Poor's affirmed its 'AA-' long-term rating and 'AA-/A-1+' dual rating (where applicable) on various series of bonds previously issued for Trinity Health. The outlook is stable.

The 'AA-' rating is based on our view of Trinity's group credit profile (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP.

The 'A-1+' short-term component of the dual ratings reflects our view of the credit strengths inherent in the 'AA-' long-term rating, as well as our view that Trinity's assets provide sufficient self-liquidity support for its variable-rate debt. Trinity has clear and detailed procedures to meet any liquidity demands on a timely basis. We monitor the liquidity and sufficiency of Trinity's fixed-income assets on a monthly basis.

In our opinion, the merger of the former Trinity Health and CHE has created opportunities for operational efficiencies and growth based on size, scale, and ability to respond to the inherent challenges in the health care sector. We believe that Trinity's enterprise profile has been enhanced, but key financial profile metrics, most specifically balance sheet metrics, remain diluted and more consistent with our 'AA-' medians. Our longer-term view is that balance sheet metrics will improve as Trinity continues to realize the benefits of the merger.

The 'AA-' rating reflects our assessment of Trinity's:

Attachment 36

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- National footprint, with a distributed geographic presence through its 86 inpatient facilities (59 owned and operated) in 21 states predominantly on the East Coast and in the Midwest;
- Strong balance sheet, highlighted by excellent operational liquidity equal to approximately 205 days' cash on hand (per our calculations) as of fiscal year-end 2014 (audited results through June 30, 2014);
- Consistent financial performance, which generates good 4.6x coverage of pro forma maximum annual debt service (MADS) using fiscal 2014's results; and
- Strong management team that has demonstrated consistent operating income during periods of economic stress, combined with a very measured approach to capital expenditures.

Partly offsetting the above strengths, in our view, are Trinity's:

- Projected capital expenditures (including routine, technology, and expansion) of about \$1 billion in fiscal 2015, which could also limit liquidity growth; and
- Need to continue to identify and successfully implement cost savings now that the initial merger has become a reality.

Bond proceeds of approximately \$ 1.4 billion will be utilized for a variety of purposes, with the majority refunding various series of debt and commercial paper outstanding, another approximately \$250 million reimbursing prior capital expenditures, and about \$350 million going toward capital purposes.

The financial results reported in this report include audited full-year results for the now combined Trinity Health (audited year ended June 30, 2014) and pro forma financial results for fiscal 2013 (based on the former Trinity Health's audited full year ended June 30, 2013 and the former CHE's unaudited 12-month financial results through the same date) and fiscal 2012. Direct comparability between year-end results is therefore somewhat limited.

Outlook

The stable outlook reflects our opinion that Trinity will continue to meet operating income projections, which in turn should continue to generate good MADS coverage for the two-year outlook period. In addition, we anticipate that Trinity will maintain a solid balance sheet with approximately 200 days' cash on hand and leverage of less than 40%. Given that Trinity Health is a sizable organization that continues to develop its markets with strategic mergers and acquisitions, the stable outlook also reflects our anticipation that any future additions to the larger Trinity Health system have no dilutive impact on credit fundamentals.

Upside scenario

We could revise the outlook to positive or raise the rating during the two-year outlook period in case of continued successful integration efforts that lead to improved operating margins, and gradually improving balance sheet metrics.

Downside scenario

Conversely, we could revise the outlook to negative if, in the two-year outlook period, Trinity borrows significantly more than anticipated or if its balance sheet or operating margins weaken.

Enterprise Profile

Market position/Organizational overview

Trinity has a presence in 21 states, with operating revenue of more than \$13.6 billion, 86 hospitals (59 owned and operated), more than 89,000 full-time equivalent (FTE) employees, and approximately 3,300 employed physicians and residents, making it one of the largest not-for-profit health care and home health organizations in the country. Trinity consists of the former Trinity Health, largely in the Midwest (particularly Michigan and Ohio), and CHE, which has great market diversification with hospitals in states up and down the Eastern Seaboard. The former Trinity Health and CHE hospitals are typically not the dominant providers in their respective markets and face competition from other hospitals or health systems, and also tend toward mature markets with slower population growth.

Combined patient service volume shows that Trinity saw more than 500,000 discharges and approximately 13.8 million outpatient visits in 2014. We anticipate that inpatient volume will level off and gradually decline (the industry norm in most markets) as the shift to the outpatient setting continues, partly because of low population growth (which increases utilization). However, we anticipate that the combined organization will see an increase in emergency room visits, home health visits, and skilled nursing days as a result of this shift, and Trinity has put considerable efforts into expanding these service line segments.

Management

Trinity has stabilized its management team after a period of anticipated leadership movement. The Trinity CEO is Richard Gilfillan, M.D., who has extensive experience throughout the health care sector. The chief financial officer (CFO) is Benjamin Carter, the former Trinity Health (pre-merger) CFO, and the organization is further stabilized by West Group and East Group leaders Sally Jeffcoat and Rick O'Connell, respectively.

We believe that the combined system will remain financially disciplined and focused, but that challenges lie ahead in continuing to integrate two very large and diverse operations, especially in light of continued reform and uncertainty in the sector. We believe that the leadership team has the ability to affect health care on a national level through its advocacy efforts.

Financial Profile

Operations

Trinity's financial performance moderated in fiscal 2014, producing an operating income of \$293 million (per our calculations), which is equal to a 2.2% operating margin, a slight decline from the \$415 million operating income level, or 3.1% operating margin, in fiscal 2013. The operational decline in fiscal 2014 reflects severe winter weather in both the Midwest and East Coast markets, resulting in lower-than-anticipated inpatient volumes as well as added utilities and campus maintenance costs.

Trinity's operating income of \$293 million excludes losses associated with any facilities classified as discontinued operations. Trinity still owns several facilities (e.g., Saint Michael's Medical Center, Saint James Mercy Hospital, and Mercy Health Partners North) that are pending sale, and accounts for the facilities' operations as discontinued

operations. We would take a positive view of the divestiture of these operations, as the facilities generate a loss, albeit a much smaller loss than in previous years.

First-quarter results (unaudited results through Sept. 30, 2014) show that Trinity has improved operating income levels to \$89.2 million, equal to a 2.6% operating margin, largely the result of increased volumes and patient activity. Trinity has budgeted an operating margin of 2.7% for fiscal 2015.

Operational improvements originally identified through synergies derived from the consolidation of CHE and Trinity Health were identified at \$300 million in annual cost savings, which management is well positioned to realize, exceeding first-year projections and with full implementation anticipated by fiscal 2016. Savings are in the broad areas of improvements in the revenue cycle, supply chain management, clinical initiatives, and information systems.

In addition to these initial merger improvements, Trinity has identified additional cost savings that its leadership believes are necessary to weather the changing health care environment. The cost savings are transformative and will span Trinity's 24 regional health ministries (RHMs) and two national health ministries.

Trinity produced excess income of \$875 million, or a 6.2% excess margin, in fiscal 2014 (per our calculations). Excess income, as with operating income, excludes discontinued operations but does include realized equity earnings in unconsolidated organizations. Equity earnings in unconsolidated subsidiaries (primarily BayCare Health System, a multihospital system in and around Tampa) totaled \$266 million in fiscal 2014. Because these unconsolidated organizations do not return cash to Trinity, their earnings do not contribute to debt service coverage or liquidity growth and we eliminate them from our coverage calculations. Trinity produced good pro forma MADS coverage of 4.6x in fiscal 2014 with this adjustment.

Balance sheet

Unrestricted reserves at Trinity stayed level at approximately \$7 billion, or 205 days' cash on hand (per our calculations), in fiscal 2014. First-quarter results (unaudited results through Sept. 30, 2014) show that Trinity's unrestricted reserves have remained essentially level at \$6.9 billion, equal to 195 days' cash on hand.

With this debt issuance, Trinity's overall leverage (debt to capitalization) will weaken slightly to a little more than 35% on a pro forma basis. Similarly, unrestricted reserves to pro-forma debt will decrease slightly to a little less than 130% using fiscal 2014's figures.

Trinity anticipates maintaining balance sheet strength during the next several years in addition to its historical operating margins. Trinity has moved toward a more balanced asset allocation, with 30% fixed income and cash, 30% equities, and 40% hedge funds, real assets, and other investments, wanting to preserve self-liquidity opportunities and modeling itself after 'AA' medians.

Trinity has an unfunded pension obligation of about \$700 million (approximately 89% funded status). Management has, effective June 2014, frozen the pension plan to all future benefit accruals as of December 2014. It will continue to make contributions to the pension plan, anticipated at \$192.2 million in 2015. The unfunded pension obligation level has come down significantly from fiscal 2012's \$1.4 billion. Although the unfunded obligation is significant in absolute terms, the liabilities have improved and Trinity retains some financial flexibility because substantially all of the defined

benefit plans have church plan status.

Management has capital plans totaling about \$1 billion in fiscal 2015, and Trinity has historically funded or reimbursed itself for part of its strategic capital expenditures with debt issuances. Management anticipates no additional deb.

Legal security

After the merger, Trinity Health has consolidated the obligations of the former Trinity Health obligated group and the former CHE obligated group under an amended and restated Trinity Health master trust indenture (MTI). All future bond obligations will be issued by Trinity, as the sole obligated group member, under and pursuant to the amended and restated Trinity master trust indenture. The Trinity Health MTI provides for security interests in the "pledged property" of the Trinity Health Obligated Group and certain designated affiliates, with pledged property being described as all receipts, revenue, income, and other money received and including rights to receive accounts and health care insurance receivables.

St. Peter's Health Partners (St. Peter's) in New York is a subsidiary of Trinity that we rate separately because New York regulations prohibit St. Peter's from joining an out-of-state obligated group.

Saint Michael's Medical Center's debt was also issued outside the former CHE obligated group, under the New Jersey Hospital Asset Transformation Program. The debt is supported by state appropriations.

Trinity Health Financial Summary				
	--First quarter ended Sept. 30--	--Fiscal year ended June 30--		
	2015	2014	2013	2012
Financial performance				
Net patient revenue (\$000s)	3,042,601	11,775,295	11,636,786	11,060,558
Total operating revenue (\$000s)	3,498,474	13,511,356	13,293,722	12,480,452
Total operating expenses (\$000s)	3,409,243	13,218,476	12,878,650	12,108,924
Operating income (\$000s)	89,231	292,880	415,072	371,528
Operating margin (%)	2.55	2.17	3.12	2.98
Net non-operating income (\$000s)	140,266	581,928	346,669	126,779
Excess income (\$000s)	229,497	874,808	761,741	498,307
Excess margin (%)	6.31	6.21	5.58	3.95
Operating EBIDA margin (%)	8.90	8.58	9.39	9.29
EBIDA margin (%)	12.41	12.36	11.69	10.20
Net available for debt service (\$000s)	451,490	1,741,743	1,594,628	1,286,276
Maximum annual debt service (MADS; \$000s) - pro forma	322,039	322,039	322,039	322,039
MADS coverage (x) - pro forma	5.61	5.41	4.95	3.99
Liquidity and financial flexibility				
Unrestricted reserves (\$000s)	6,911,545	7,024,390	6,711,936	6,158,321
Unrestricted days' cash on hand	195.4	204.9	200.8	196.0
Unrestricted reserves/total long-term debt (%)	145.2	148.1	152.3	139.3
Debt and liabilities				
Total long-term debt (\$000s)	4,761,159	4,742,857	4,406,059	4,419,546

Trinity Health Financial Summary (cont.)				
Long-term debt/capitalization (%)	31.4	31.8	32.7	36.2
Debt burden (%)	2.21	2.28	2.12	2.30
Defined benefit plan funded status (%)	N/A	88.71		
Pro forma ratios				
Unrestricted reserves (\$000s)	7,161,545	7,274,390		
Total long-term debt (\$000s)	5,693,856	5,693,856		
Unrestricted days' cash on hand	202.51	212.23		
Unrestricted cash/total long-term debt (%)	125.78	127.76		
Long-term debt/capitalization (%)	35.41	35.91		

Note: Fiscal years 2012 and 2013 are unaudited pro forma; fiscal 2014 is audited final. N/A--Not applicable.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief , Dec. 17, 2014
- U.S. Not-For-Profit Health Care System Ratios: Operating Performance Weakened In 2013, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

Ratings Detail (As Of February 2, 2015)

Catholic Health East Series 1999G

Unenhanced Rating AA-(SPUR)/Stable Affirmed

Series 2008

Short Term Rating A-1+ Affirmed

Athens Clarke Cnty Unif Govt, Georgia

CHE Trinity Hlth Credit Grp, Michigan

Series 2002D & 2009

Long Term Rating AA-/Stable Affirmed

California Statewide Communities Dev Auth, California

CHE Trinity Hlth Credit Grp, Michigan

Series 2011CA

Long Term Rating AA-/Stable Affirmed

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Ratings Detail (As Of February 2, 2015) (cont.)

Connecticut Hlth & Educl Facs Auth, Connecticut

CHE Trinity Hlth Credit Grp, Michigan

Series 2010

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Franklin Cnty, Ohio

CHE Trinity Hlth Credit Grp, Michigan

Franklin Cnty (CHE Trinity Health Credit Group)

<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Series 1995

<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Series 2005A, 2010C

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Series 2011OH

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Greene Cnty Dev Auth, Georgia

CHE Trinity Hlth Credit Grp, Michigan

series 2012A

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Idaho Hlth Fac Auth, Idaho

CHE Trinity Hlth Credit Grp, Michigan

Idaho Hlth Fac Auth (CHE Trinity Health Credit Group)

<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Series 2008B, 2010D

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Illinois Fin Auth, Illinois

CHE Trinity Hlth Credit Grp, Michigan

Series 2011IL

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Indiana Fin Auth, Indiana

CHE Trinity Hlth Credit Grp, Michigan

Conversion of Series 2008D-2

<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Series 2006B, 2009A

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Series 2010B

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Ratings Detail (As Of February 2, 2015) (cont.)

Iowa Fin Auth, Iowa

CHE Trinity Hlth Credit Grp, Michigan

Iowa Fin Auth (CHE Trinity Hlth Credit Grp) hosp rev bnds (Trinity Hlth Credit Group) ser 2000D dtd 11/30/2000 due 12/01/2030

Long Term Rating	AA-/A-1+/Stable	Affirmed
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Massachusetts Development Finance Agency, Massachusetts

CHE Trinity Hlth Credit Grp, Michigan

Series 2002E, 2007, 2009 & 2010

Long Term Rating	AA-/Stable	Affirmed
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Michigan Fin Auth, Michigan

CHE Trinity Hlth Credit Grp, Michigan

Michigan Fin Auth (CHE Trinity Health Credit Group)

Long Term Rating	AA-/A-1+/Stable	Affirmed
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Series 2008C

Long Term Rating	AA-/Stable	Affirmed
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Series 2009B&C

Long Term Rating	AA-/Stable	Affirmed
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Series 2010A

Long Term Rating	AA-/Stable	Affirmed
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Series 2011MI

Long Term Rating	AA-/Stable	Affirmed
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Michigan St Hosp Fin Auth, Michigan

CHE Trinity Hlth Credit Grp, Michigan

Michigan St Hosp Fin Auth (Trinity Health) Series 2005D

Unenhanced Rating	AA-(SPUR)/Stable	Affirmed
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Series 2005E, 2005F, 2008C, 2009B&C

Long Term Rating	AA-/A-1+/Stable	Affirmed
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Series 2012MI, 2005D, 2006A, 2008A

Long Term Rating	AA-/Stable	Affirmed
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Montgomery Cnty, Maryland

CHE Trinity Hlth Credit Grp, Michigan

Montgomery Cnty (CHE Trinity Health Credit Group)

Long Term Rating	AA-/A-1+/Stable	Affirmed
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Series 2011MD

Long Term Rating	AA-/Stable	Affirmed
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Montgomery Cnty Hgr Ed & Hlth Auth, Pennsylvania

CHE Trinity Hlth Credit Grp, Michigan

Series 2004C, 2007 & 2009

Attachment 36

Ratings Detail (As Of February 2, 2015) (cont.)

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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New Jersey Hlth Care Facs Fincg Auth, New Jersey

CHE Trinity Hlth Credit Grp, Michigan

Series 2007, 2009E & 2010

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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North Carolina Med Care Comm, North Carolina

CHE Trinity Hlth Credit Grp, Michigan

North Carolina Med Care Comm (CHE Trinity Health Credit Group) ser 2008

<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Series 2010 & 2012A

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Ontario Hosp Fac Auth, Oregon

CHE Trinity Hlth Credit Grp, Michigan

Series 2010E

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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St. Mary Hosp Auth, Pennsylvania

CHE Trinity Hlth Credit Grp, Michigan

Series 2004A&B, 2007, 2009, 2010A&B and 2012A

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Series 2012B

<i>Unenhanced Rating</i>	NR(SPUR)	
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<i>Long Term Rating</i>	AA-/A-1+/Stable	Affirmed
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Tampa, Florida

CHE Trinity Hlth Credit Grp, Michigan

Series 2010 & 2012A

<i>Long Term Rating</i>	AA-/Stable	Affirmed
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Many issues are enhanced by bond insurance.

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FITCH RATES TRINITY HEALTH CREDIT GROUP'S (MI) 2015 REVS 'AA'; STABLE OUTLOOK

Fitch Ratings-San Francisco-27 January 2015: Fitch Ratings has assigned 'AA' ratings to the various series 2015 bonds issued by or on behalf of Trinity Health Credit Group (Trinity; formerly CHE Trinity) listed below:

--\$640.2 million Michigan Finance Authority Hospital revenue bonds (Trinity Health Credit Group) series 2015MI;

--\$151 million Montgomery County, Maryland revenue bonds (Trinity Health Credit Group) series 2015MD;

--\$169.6 million Idaho Health Facilities Authority Hospital revenue bonds (Trinity Health Credit Group) series 2015ID

--\$100 million Michigan Finance Authority variable rate bonds series 2015;

--\$350 million taxable Bonds, Series 2015

The Rating Outlook is Stable.

The series 2015 bonds are expected to be structured as traditional fixed-rate, variable-rate, and taxable debt and will be priced the weeks of Feb. 2 and Feb. 16, 2015 through negotiated sale. Bond proceeds will be used for refunding of certain maturities of currently outstanding debt, reimbursement of approximately \$251 million for prior capital expenditures, provide \$260 million for the redemption of outstanding commercial paper, fund approximately \$347 million in new money for various capital needs, and pay associated costs of issuance.

In addition, Fitch affirms the 'AA' rating on Trinity's currently outstanding \$4.8 billion of long-term debt.

SECURITY

The series 2015 bonds are general unsecured obligations of the Trinity Health Credit Group. The master indenture provides for security interests in 'pledged property' of members at the obligated group and certain designated affiliates with pledged property including: all receipts, revenues, income and other moneys received, and including rights to receive accounts and health care insurance receivables.

KEY RATING DRIVERS

GEOGRAPHICALLY DIVERSE SYSTEM: Trinity Health Credit Group (formerly CHE Trinity) is the second largest nonprofit healthcare provider in the U.S. with approximately \$13.6 billion in total revenue owned and operating 59 hospitals in 21 states with more than 89,000 FTEs. Fitch views the system's size, scope of operations, and geographic dispersion as a primary credit strength that helps protect the organization from adverse economic events that could severely affect any of its core markets.

STRONG MANAGEMENT PRACTICES: Fitch views Trinity's management team as a primary credit strength. The team's strong management practices are evident through continued improved revenue collection efforts, consolidation of duplicate services, and a willingness to close or divest in poor performing markets.

GOOD PROFITABILITY: As of June 30, 2014 (year-end consolidated; audited), Trinity earned nearly \$382 million from operations, which translated into 2.8% operating margin and 9.2% operating EBITDA margin. Fitch believes the system's profitability continues to be sufficient to generate adequate pro forma debt service coverage metrics for the 'AA' rating level.

MODERATE DEBT BURDEN: Pro forma maximum annual debt service (MADS) of approximately \$322 million represented 2.4% of fiscal 2014 revenues, which is consistent with Fitch's 'AA' category median of 2.6%.

ADEQUATE LIQUIDITY: Trinity had sound balance sheet indicators at fiscal year-end 2014 (year end June 30) with approximately \$7.3 billion in pro forma unrestricted cash and investments, which equated to 212.5 days cash on hand, 22.6x cushion ratio, and 130.5% cash to debt. Additionally, Fitch views the system's absolute liquidity growth favorably.

RATING SENSITIVITIES

LARGE CAPITAL PLANS: Over the next three years management has a large spending plan approaching 200% of annual depreciation which includes major facility renovations, information technology, and routine capital spending. Fitch expects Trinity to maintain its existing financial profile as it embarks on its strategic capital spending plans.

CREDIT PROFILE

Trinity is one of the largest Catholic health care delivery systems in the U.S. With operations in 21 states with 59 owned and operated hospitals, 115 continuing care facilities and home health and hospice programs providing nearly 1.7 million home health visits annually. The organization has total revenues of approximately \$13.6 billion employing more than 89,000 FTE's including 3,300 physicians.

As of June 30, 2014 (audited year-end) Trinity operated acute care hospitals, long-term care facilities, skilled nursing and behavioral health facilities with an aggregate of 10,600 staffed beds, 3,400 skilled nursing beds, and more than 1,000 assisted living units. Combined, the obligated group makes up approximately 79.4% of net revenues of the consolidated system.

The credit factors supporting Trinity's 'AA' rating include the benefits that accrue from the size and scale of the system's operations, a solid overall financial profile, and effective management practices. Trinity's geographic diversity of its operations, providing care in 21 states, allows the organization to realize economies of scale through on-going consolidation of certain shared administrative and financial services, as well as the ability to export clinical and operational 'best practices' across the system. Fitch believes that the system can generate further clinical and operational efficiencies throughout the system over the medium term, which should offset the effects of tighter reimbursement and pockets of sluggish volume growth.

SOLID FINANCIAL PROFILE

In fiscal 2014 Trinity generated \$382 million of income from operations, which equated to a 2.8% operating margin and a 9.2% operating EBITDA margin. These metrics, while lower, are consistent with Fitch's 'AA' medians of 3.9% and 11%, respectively. Fitch views favorably Trinity's ability to consistently generate solid operating profits despite heavy capital investment throughout the system

on an annual basis. Going forward, management plans to produce similar operating margins, which should enable further balance sheet growth and satisfactory levels of debt service coverage.

At June 30, 2014 Trinity unrestricted pro forma cash and investments was approximately \$7.3 billion, which translated into 212.5 days cash on hand, 22.6x pro forma cushion ratio, and 130.5% pro forma cash to debt. Despite the organization's liquidity metrics being below Fitch's 'AA' category medians, absolute liquidity growth is a credit strength as unrestricted liquidity improved by nearly \$560 million from fiscal 2013 to fiscal 2014 (pro forma).

Pro forma MADS of \$322 million represented 2.4% of fiscal 2014 revenues, which is consistent with the 'AA' category median of 2.6% reflecting a moderate overall debt burden. Coverage of pro forma MADS by EBITDA was a solid 5.5x and 3.9x by operating EBITDA, which is consistent with the respective 'AA' category medians of 5.4x and 4.4x.

ENHANCED CAPITAL SPENDING PROGRAM

Over the next three years Trinity anticipates funding a total of \$4.5 billion for its capital investment program, which will be funded from a combination of operational cash flow, investment earnings, and an additional \$800 million of debt. Specific uses of these funds will go towards routine maintenance of the organization's various facilities, certain major facility replacement and expansion projects, and further investment in Trinity's information systems. Additionally, Trinity expects to fund at least \$300 million on capital projects for Loyola University Health System through fiscal 2018.

Fitch expects Trinity to maintain its current financial profile (i.e. liquidity, profitability and leverage) as it invests in its facilities and strategies.

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Applicable Criteria and Related Research:
--'Nonprofit Hospitals and Health Systems Rating Criteria' (May 30, 2014).

Applicable Criteria and Related Research:

U.S. Nonprofit Hospitals and Health Systems Rating Criteria

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=746860

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MOODY'S

INVESTORS SERVICE

New Issue: Moody's assigns Aa3 to Trinity Health Credit Group's (MI) Series 2015; outlook is stable

Global Credit Research - 28 Jan 2015

\$5.3 billion rated pro forma debt

MICHIGAN FINANCE AUTHORITY
Hospitals & Health Service Providers
MI

Moody's Rating

ISSUE		RATING
Taxable Bonds, Series 2015		Aa3
Sale Amount	\$350,000,000	
Expected Sale Date	02/03/15	
Rating Description	Revenue: Other	
Hospital Revenue and Refunding Bonds, Series 2015MI		Aa3
Sale Amount	\$640,630,000	
Expected Sale Date	02/03/15	
Rating Description	Revenue: Other	
Revenue Bonds, Series 2015ID		Aa3
Sale Amount	\$169,740,000	
Expected Sale Date	02/03/15	
Rating Description	Revenue: Other	
Revenue Bonds, Series 2015MD		Aa3
Sale Amount	\$151,060,000	
Expected Sale Date	02/03/15	
Rating Description	Revenue: Other	

Moody's Outlook STA

NEW YORK, January 28, 2015 --Moody's Investors Service assigned Aa3 ratings to Trinity Health Credit Group's (MI) proposed Series 2015MD (\$151 million) to be issued through Montgomery County, MD; Series 2015MI (\$640 million) to be issued through Michigan Finance Authority; Series 2015ID (\$169 million) to be issued through Idaho Health Facilities Authority; and Series 2015 Taxable Bonds (\$350 million) (all debt series mature in 30 years).

Concurrently, we downgraded the ratings to Aa3, Aa3/VMIG 1, Aa3/P-1, from Aa2, Aa2/VMIG 1 and Aa2/P-1, on the outstanding debt of Trinity Health, Trinity Health Credit Group, CHE Trinity Health and Catholic Health East. The rating outlook was revised to stable from negative at the lower rating level. Outstanding short-term ratings of VMIG 1 and P-1 were affirmed with today's action.

SUMMARY RATING RATIONALE

The rating downgrade reflects the lower than anticipated financial performance in fiscal year (FY) 2014. The ratings also reflect the increase in debt associated with the proposed financing and the effect on debt service

coverage and leverage measures. The acquisition strategy notably increases the business and financial risks of the system. Management announced in late December 2014 a proposed acquisition of Saint Francis Care (Hartford, CT) which will be evaluated upon execution.

The Aa3 rating reflects Trinity's size as one of the largest not-for-profit healthcare systems in the US, enabling good cash flow diversification across several states. This diversification exponentially increases the scale of efficiencies to be garnered from the May 2013 merger. We expect Trinity to continue to assess its portfolio of assets and engage in divestiture and acquisitive strategies; some of the divestitures of weaker hospitals remain ongoing and continue to usurp management resources. The VMIG 1 and P-1 ratings on Trinity's variable rate debt and commercial paper supported by internal liquidity reflect adequate coverage provided by daily assets (after applying Moody's discounts) and bank facilities.

OUTLOOK

The stable rating outlook reflects our belief that FY 2015 financial performance should be on par with FY 2014 levels given continued efficiencies gained from the merger. Trinity's absolute and relative liquidity position also provides rating stability. However, any unexpected integration challenges, contraction in liquidity or cash flow could result in a negative outlook.

WHAT COULD MAKE THE RATING GO UP

- Improved and sustained financial performance through same-store operations that results in stronger debt service coverage metrics
- Ongoing, demonstrable efficiencies that contribute to stronger financial performance
- Growth in absolute and relative liquidity metrics

WHAT COULD MAKE THE RATING GO DOWN

- Material reduction in financial performance either with same-store operations or the addition of dilutive assets through mergers and acquisitions
- Reduction in absolute and relative liquidity metrics
- Issuance of additional debt that results in material weakening of debt service coverage metrics
- Protracted efforts to divest stressed assets continue
- Integration challenges that impair financial performance

STRENGTHS

- Large size (\$13.6 billion in total revenues in FY 2014) and strong diversification of cash flow across 21 states provides scale and leverage, driving material efficiencies if consolidation plans are realized as planned
- Senior management positions are now fully staffed, removing a prior credit concern of c-suite vacancies
- Demonstrated willingness to divest stressed assets
- Good cash position with pro forma \$7.3 billion or 214 days cash on hand as of FYE 2014
- A sizable unrestricted liquidity portfolio along with a dedicated syndicated line of credit, solid treasury management, and appropriate liquidation procedures support the tender features on variable rate demand debt supported by internal liquidity

CHALLENGES

- Softer-than-anticipated financial performance in FY 2014; operating cash flow margin declined to 8.4% in FY 2014 from 9.0% (based on management prepared statements for FY 2013) after Moody's adjustments and below the Aa2 median of 10.6%; volume declines in key markets played a part in the lower-than-expected results
- Increase in debt associated with the proposed financings result in weaker adjusted debt service coverage metrics; pro forma adjusted debt to cash flow measures 3.20 times

- Protracted divestiture strategies for two challenged markets, namely Newark, NJ and Port Huron, MI are demands on management's time and resources
- Both legacy pension plans are named in a lawsuit challenging the Church Plan status of its defined benefit pension plan

RECENT DEVELOPMENTS

Please see information in Detailed Rating Rationale below.

DETAILED RATING RATIONALE

MARKET POSITION: FAVORABLE DISTRIBUTION OF CASH FLOW

An important credit strength, Trinity Health reports \$13.6 billion in total revenues (FY 2014) with acute care operations in 21 states. This scale generates good cash flow diversification, with five ministry organizations (St. Joseph's, MI; Mt. Carmel, OH; Loyola, IL; St. Peter's Health Partners, NY; Mercy Health, West MI) accounting for more than 10% of system operating cash flow each, and reducing the exposure to unfavorable fluctuations in any one state to only 31% of the system (Michigan). The top 10 largest markets by regional health ministry account for 66.2% of revenues. All but one of these ministries were profitable in FY 2014.

Management continues to work toward a divestiture of two distressed assets: St. Michael's Medical Center in Newark, NJ and St. Joseph Mercy Port Huron in Port Huron, MI. Both are awaiting regulatory approval. Other assets are under consideration for divestiture, emblematic of management's willingness to divest assets in order to strengthen the system's fiscal health and judicious expenditure of capital. Concomitantly, management is contemplating growth strategies and in December 2014 announced the proposed merger of St. Francis Care in Hartford, CT. When combined with Trinity's facility in Springfield, MA (30 miles away), this newly formed regional health ministry will have about \$1 billion in revenues and likely become the system's 5th largest market (by revenues). We expect that management will examine other strategic additions in the normal course of business.

OPERATING PERFORMANCE, BALANCE SHEET AND CAPITAL PLANS: DECLINE IN FY 2014 RESULTS; GOOD LIQUIDITY POSITION

Audited financial statements for CHE Trinity Health, Inc. ending June 30, 2014 (FY 2014) represents the first audited year following the merger. The audited results were compared to management-prepared combined results for FY 2013. After applying Moody's adjustments, operating performance showed some weakening with an 8.4% operating cash flow margin in FY 2014, compared to 9.0% in FY 2013. The decline largely reflects the effect of lower volumes in many markets and the shift to lower-paying observation stays. First quarter FY 2015 results ending September 30, 2014 report an 8.8% operating cash flow margin. Management reports that \$200 million of cost avoidance and savings have been achieved since the May 2013 merger of Trinity Health and Catholic Health East, with another \$200 million expected during FY 2015. Pro forma Moody's adjusted debt service coverage metrics show some weakening with the proposed issuance: 3.20 times debt to cash flow (from 3.06 times) and maximum annual debt service (MADS) coverage of 5.5 times (from 6.3 times) in FY 2014. These pro forma measures compare unfavorably to the Aa3 medians of 2.6 times and 6.0 times, respectively.

Liquidity

Trinity Health's cash position is good at \$7.1 billion in unrestricted cash and investments or 208 days cash on hand as of FY end 2014. With the \$241 million of reimbursement proceeds, days cash increases to 214. Trinity's debt structure is 61% fixed rate and 39% variable rate. Trinity provides adequate coverage of its self liquidity debt which is comprised of \$366 million in weekly variable rate demand bonds and \$770 million in commercial paper comprised of variable rate demand bonds in a CP mode and a taxable CP program (as of December 31, 2014). Daily assets totaled \$765 million (after applying Moody's discounts) as of December 31, 2014. Trinity has an extensive bank facility program that Moody's includes in its coverage computations. Ten banks provide \$931 million in committed capital; these bank agreements have staggered expiration dates. As part of the Issuing Paying Agreement executed in October 2014, management directed the agent to adhere to the procedures memo which limits the amount of commercial paper that can roll within a five-day period to \$400 million. Trinity also has \$245 million in working capital lines of credit for general corporate needs. Headroom to the MTI and bank covenants is expected to remain ample.

DEBT AND OTHER LIABILITIES

Trinity has two series of Windows with Aa3/P-1 ratings (Series 2013ID and 2013OH). The P-1 rating is based on

Moody's market access approach to self-liquidity on longer-term variable rate instruments and reflects our estimation of Trinity's ability to timely pay mandatory tenders at the close of the "Mandatory Tender Window". We expect that Trinity will be able to access the market in a timely manner to pay tenders given its high quality rating (Aa rating category and frequency of market participation). Factored into the P-1 rating is the six month notice Trinity will be given, following a failed remarketing, to restructure the bonds or issue refunding bonds, a time frame we believe is sufficient to execute either strategy. Trinity also has variable rate bonds in the quarterly mode with good experience in remarketing these.

Debt Structure

Trinity has a combination of secured debt under the Master Trust Indenture as well as secured debt outside of the MTI. The MTI debt (which is the majority) is secured by a gross revenue pledge and negative mortgage lien; the Series 2015 proposed borrowing is parity to the existing MTI debt. Trinity also has a small amount of debt that is secured by revenues and property outside of the MTI, enabling these bondholders have claim on their respective revenues and properties. Mercy Hospital in Chicago has \$62 million of FHA debt and St. Peter's Hospital in Albany with \$235 million of debt; both of these are secured by revenues and property. St. Peter's outstanding debt will be refunded with the proceeds from the financing.

Derivatives

Trinity has an extensive swap portfolio with \$2.44 billion in outstanding notional amount with good diversification of counterparties across six firms. As of June 30, 2014 Trinity posted \$10 million of collateral which is very manageable. We expect postings to remain consistent with recent experience.

Pensions and OPEB

The recent freezing of Trinity Health's legacy defined benefit pension plan (effective December 31, 2014) reduces Trinity's future indirect debt. CHE's legacy defined benefit pension plans had been frozen earlier. Both legacy health plans are named in two lawsuits challenging their Church Plan status.

MANAGEMENT AND GOVERNANCE

All senior management positions have been filled, removing a prior credit concern. A new Chief Clinical Officer who joined earlier this year fill the last vacancy in the executive suite.

KEY STATISTICS

Assumptions & Adjustments:

- Based on financial statements for CHE Trinity Inc., FY 2014 ended June 30, 2014 with pro forma debt added

- Investment returns normalized at 6%

- Comprehensive debt includes direct debt, operating leases, and pension obligation, if applicable

- *Inpatient admissions: 508,258

- *Medicare % of gross revenues: 45.3%

- *Medicaid % of gross revenues: 14.9%

- *Total operating revenues (\$): \$13.6 billion

- *Operating cash flow margin (%): 8.4%

- *Direct debt-to-cash flow (x): 3.20 times

- *Days cash on hand (\$): 215 days

- *Maximum annual debt service (MADS): \$329 million (pro forma)

- *MADS Coverage with reported investment income (x): 5.01 times

- *Moody's-adjusted MADS Coverage with normalized investment income (x): 5.52 times

*Moody's-adjusted net revenue available for debt service (\$): \$1.8 billion

*Direct debt outstanding (\$): \$5.3 billion

*Cash-to-direct debt (%): 139%

*Cash-to-comprehensive debt (%): 102.3% (FY 2014)

OBLIGOR PROFILE

Trinity Health is a \$13.6 billion healthcare system and represents the May 1, 2013 merger of Trinity Health and Catholic Health East. The system is headquartered in Livonia, Michigan.

LEGAL SECURITY

All debt of the legacy organizations are secured on parity through Master Trust Indenture dated October 3, 2013. Trinity Health may not withdraw from the Obligated Group. The Credit Group consists of Members of the Obligated Group and the Designated Affiliates. The Designated Affiliates include the majority of the hospitals except for the New York facilities and Mercy Chicago. The Obligated Group pledges to cause the Designated Affiliates to pay, loan or otherwise transfer to the Obligated Group such moneys as are necessary to pay amounts due on the bonds. Rate covenant of 1.1 times. Pledge of revenue derived from the operation of all facilities of the majority of the Designated Affiliates, including rights to receivable accounts and health care insurance receivables. Bank covenants vary between facilities: cash on hand (75 days), debt to capitalization (65% and 70%) and debt service coverage (1.25 times and 1.50 times). Trinity Health has additional non-rated debt with different collateral pledges, some of which is structurally senior to rated debt although the amount is de minimis.

USE OF PROCEEDS

Bond proceeds from the Series 2015 tax-exempt, taxable and upcoming FRN program (totaling \$1.410 billion) will be used to: 1) reimburse the system for prior capital expenditures of \$241 million; 2) redeem commercial paper in the amount of \$260 million; 3) fund \$346 million of future capital needs to be spent over the next 12 months; and 4) refund \$635 million of outstanding bonds, rates permitting.

METHODOLOGY

The principal methodology used in this rating was Not-for-Profit Healthcare Rating Methodology published in March 2012. The additional methodology used in the short term rating was Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

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1120.130 – Financial Viability

See attached proof of bond rating of Trinity Health Credit Group. Loyola University Health System, Loyola University Medical Center and Gottlieb Memorial Hospital do not have independent bond ratings.

The project is being funded by Gottlieb Memorial Hospital. The attached letter attests to the fact that Gottlieb has funds available to complete the project. Trinity Health Corporation plays the role of guarantor for hospitals within the system.



LOYOLA
UNIVERSITY
HEALTH SYSTEM

November 12, 2015

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Gottlieb Memorial Hospital Project to Establish Inpatient Rehabilitation Service

Dear Ms. Avery,

Please be advised that as a member of Trinity Health, Gottlieb Memorial Hospital does not have its own stand-alone financial statements. Every fiscal year, Trinity Health approves an overall allocation of capital funds to Gottlieb to fund local capital projects. The total estimated project cost for the Inpatient Rehabilitation Service project will be funded from this allocation of capital funds.

Sincerely,

Daniel P. Isacksen, Jr.
Senior Vice President, Finance
Loyola University Health System

Notarization:

Subscribed and sworn to before me

This 16 day of November, 2015

Signature of Notary Public

Seal



Attachment 37

*We also treat the human spirit.**

A MEMBER OF  TRINITY HEALTH

Loyola University Medical Center | 2160 S. First Ave. Maywood, IL 60153 | (888) LUHS-888 | LoyolaMedicine.org

1120.140 - Economic Feasibility

C. Reasonableness of Project and Related Costs

COST AND SQUARE FOOT BY DEPARTMENT									
Department	A	B	C	D	E	F	G	H	
	Cost/Square Ft		DGSF		DGSF		Const \$	Mod \$	Total Cost
	New	Mod	New	Circ	Mod	Circ	(A x C)	(B x E)	(G + H)
CLINICAL									
Rehabilitation		\$38.61			13,071	21%		\$504,610	\$504,610
Clinical subtotal		38.61			13,071	21%		504,610	504,610
NON-CLINICAL									
Storage, closet		36.00			1,283	22%		46,188	46,188
Locker/break		38.00			1,177	22%		44,726	44,726
Staff/public toilet		85.25			363	22%		30,944	30,944
Admin offices		41.00			3,655	22%		149,855	149,855
Non-clin subtotal		41.94			6,478	22%		271,713	271,713
GRAND TOTAL		\$39.71			19,549	21.3%		\$776,323	\$776,323

Note: Total cost of \$776,323 includes modernization estimate of \$705,823 and \$70,500 contingency.

1120.140 - Economic Feasibility

D. Projected Operating Costs

Project Direct Operating Expenses - FY 2017

	Project
Total Operating Costs	\$3,265,350
Equivalent Patient Days	11,840
Direct Costs per Equivalent Patient Day	\$275.79

E. Total Effect of the Project on Capital Costs

Projected Capital Costs - FY 2017

	Project FY 2017	Total GMH FY 2017
Equivalent Patient Days	11,840	106,197
Total Project Cost	\$1,503,522	--
Useful Life (years)	10	--
Total Annual Depreciation	\$150,352	\$9,993,300
Depreciation Cost Per Equivalent Patient Day	\$12.70	\$94.10

SAFETY NET IMPACT STATEMENT

This Safety Net Impact Statement describes how the re-location of the inpatient physical rehabilitation service at Loyola University Medical Center Project to Gottlieb Memorial Hospital (GMH) addresses the following areas:

1. Safety net services at Gottlieb Memorial Hospital
2. The capability at affiliated health care organization, Loyola University Medical Center, to provide safety net services
3. Impact on the ability of other area hospitals/health care providers to provide safety net services
4. No discontinuation of any safety net services
5. GMH charity care and Medicaid volumes
6. GMH broader community benefit engagement

Safety Net Services at Gottlieb Memorial Hospital

Gottlieb Memorial Hospital provides subsidized healthcare services to the community. During FY2015 GMH provided \$21,921 in subsidized support for its adult day care center. While operating at a loss, the program continues to be offered because of a community need. GMH began running the center after a local church could no longer afford to provide this community service. The center provides care for persons with diabetes, dementia, depression and other mental and medical diagnoses. The program serves 18 adults on a daily basis throughout the year.

Impact of the proposed project on both Loyola University Medical Center and Gottlieb Memorial Hospital

The discontinuation of the Comprehensive Physical Rehabilitation service at LUMC and its relocation to GMH will not impact the subsidized programs provided at either LUMC or GMH. Inpatient rehabilitation services will continue to serve patients referred for care within the Loyola University Health System.

Safety net services at other area hospitals and health care providers

The discontinuation of the Comprehensive Inpatient Rehabilitation service at LUMC and its relocation to GMH will not have a negative impact on essential safety net services at other health care providers in the community. This project does not increase the size of the rehabilitation service at LUMC, but relocates it to GMH and reduces it in size. As a result, it is possible that rehabilitation units at other area providers may realize a small increase in their patient service volumes. This project will not impact the ability of other providers to cross-subsidize safety net services.

Discontinuation of Safety Net Services

There is no discontinuation of a safety net service. The re-location of the rehabilitation inpatient unit will enhance the Loyola University Health System's ability to provide excellent care in a lower cost setting. The safety net programs to be offered through GMH will not be negatively impacted.

XI. Safety Net Impact

Charity # of patients

	GMH		
	2013	2014	2015
Inpatient	87	49	12
Outpatient	174	107	105
Total	261	156	117

Charity Care Cost in Dollars

Inpatient	1,963,784	1,309,779	503,783
Outpatient	1,833,903	1,699,133	1,997,624
Total	3,797,687	3,008,912	2,501,407

Medicaid # of Patients

Inpatient	1,982	2,158	2,133
Outpatient	13,399	16,470	16,043
Total	15,381	18,628	18,176

Medicaid Revenue

Inpatient	8,135,961	8,939,812	12,430,946
Outpatient	5,002,136	8,662,944	13,414,454
Total	13,138,097	17,602,756	25,845,400

GMH Community Benefit

In fiscal year 2015, GMH provided a total of \$10,791,906 in uncompensated care, based on preliminary figures. This amount covers \$2,501,407 in charity care, \$6,346,869 in care not fully funded by Medicaid, \$258,385 in care not fully funded by Medicare and \$1,685,245 in services where payment was expected, but not received (bad debt).

GMH provided a total of \$106,541 subsidized health services in fiscal year 2015, which includes programs operating at a loss and community health improvement activities.

- Community Health and Screening Programs:
 - GMH provided \$84,620 in community and screening services during FY15. GMH provided transportation van service for those with no means of transport to diagnostic testing and ancillary programs; provided space to a not-for-profit organization for conducting a children's exercise and nutrition 8-week program offered free to the community as part of GMH's initiative to address childhood obesity; offered support groups and free

community presentations with expert speakers on caring for aging family members.

- GMH and its staff allergist Joseph Leija, MD, provide daily allergy counts (from April through October) for the entire Chicagoland. The count is provided, at no cost, to news outlets and all Chicago meteorologists. The count also is available on GMH's Web site, via Twitter and by a telephone hotline each weekday morning during allergy season. It is a relied-upon resource by people in the Chicago area who need to determine whether to take allergy medication before stepping out the door in the morning.

During fiscal year 2015, GMH provided \$80,743 in language assistance and interpreter services. GMH provided free language-assistance services, including interpretation services and translation of vital documents for patients with limited-English proficiency or deaf and hard-of-hearing patients. In fiscal year 2015, GMH cared for patients who spoke one of over 12 languages from around the world. GMH has a direct interpreter-access line which allows patients to call GMH via a dedicated 800-number with a phone interpreter facilitating their call into GMH. This makes it easier for patients to communicate with GMH staff when they are not at GMH. Also provided was a remote video interpreting capability in the Emergency Department and inpatient units so that ASL interpreter services can be provided immediately upon a patient's entry to the ED, or around-the-clock if hospitalized on an inpatient unit.

GMH provided \$230,000 in total employee and non-employee volunteer services in fiscal year 2015. In addition, non-employee volunteers provided 19,750 hours of time in furtherance of the hospital's mission of care.

XII. Charity Care Information

Net Patient Revenue

Amount of Charity Care (charges)

Cost of Charity Care

2013	2014	2015
124,448,155	114,999,469	106,734,525
20,913,067	13,772,342	11,449,397
3,797,687	3,008,912	2,501,407

APPENDICES

Appendix I

Letter from physician leadership at Loyola University Medical Center committing referrals to rehabilitation unit at Gottlieb Memorial Hospital

Letter of support, Kathleen Yosko, President & CEO, Marianjoy Rehabilitation Hospital

Appendix II

Example of page from MapQuest, used to determine travel times from area hospitals to Gottlieb Memorial Hospital.



**LOYOLA
UNIVERSITY
HEALTH SYSTEM**

November 2, 2015

Ms. Kathryn J. Olson
Chairperson
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street 2nd floor
Springfield, IL 62761

Dear Ms. Olson

We are writing in collective support of the planned relocation of the Comprehensive Inpatient Rehabilitation unit from Loyola University Medical Center to Gottlieb Memorial Hospital.

As Chairmen of the Departments of Orthopaedic Surgery and Rehabilitation, Neurology and Neurological Surgery, we further can commit that faculty physicians in our departments will embrace this relocation and refer their patients to the new unit being established at Gottlieb Memorial Hospital. All physicians who are full-time members of the medical staff practice at Loyola University Medical Center or at other sites on behalf of LUHS.

Last year 30 of the 67 Loyola non-hospitalist physicians who referred more than one patient to LUMC's inpatient rehabilitation unit were members of our three departments. That includes 15 of the top 16 physicians who referred patients to the unit. They referred the majority of the patients who received post-acute rehabilitation care in that unit. These patients come from throughout the Central and Secondary Service Areas of LUMC. Referral volumes by these 30 physicians are expected to be comparable next year and following the first full year of operations of the new unit at GMH. They have not committed to refer patients to other area inpatient rehabilitation units in operation or planned.

As Department Chairmen, we speak on behalf of our faculty physicians in committing ongoing referrals of patients to the proposed inpatient rehabilitation unit at GMH.

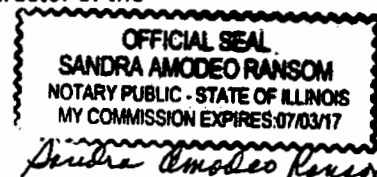
If you have any questions, please contact Lynette Wilkos-Prostran, Executive Director of the Musculoskeletal Service Line at 708-216-2614.

Sincerely,

Terry Light, MD
Chairman
Orthopaedic Surgery
And Rehabilitation

Jose Biller, MD
Chairman
Neurology

Christopher Loftus, MD
Chairman
Neurological Surgery



*We also treat the human spirit.**



Marianjoy Rehabilitation Hospital

Wheaton Franciscan Healthcare

26W171 Roosevelt Road
Wheaton, Illinois 60187

Kathleen C. Yosko
President and CEO

Tel 630.909.7502
Fax 630.909.7501

November 2, 2015

Ms. Kathryn J. Olson
Chairperson
Illinois Health Facilities and Services review Board
525 W. Jefferson St. 2nd floor
Springfield, IL 62761

Dear Ms. Olson

I am writing in support of the proposal for the establishment of an inpatient Comprehensive Rehabilitation service at Gottlieb Memorial Hospital to accommodate the relocation of the inpatient rehabilitation unit being closed at Loyola University Medical Center.

In July, 2014 Marianjoy Rehabilitation Hospital & Clinics, Inc. and Loyola University Medical Center entered into an agreement to provide medical direction and medical staff coverage for the inpatient rehabilitation unit at LUMC. Also, in February, 2015 GMH entered an agreement with Marianjoy for the medical direction and medical staff coverage of the transitional long term care unit. These arrangements have worked very well for the patients of both organizations and their staffs. Marianjoy also operates the 34 bed Transitional Care Unit at GMH. The relocation of the rehabilitation unit from LUMC to GMH will enable operational improvements and efficiencies in both programs through cross training of staff, shared patient protocols and increased throughput.

The 20 bed unit at GMH will be smaller than the current unit at LUMC. As a result, there may be times when peak census results in full occupancy of the unit at GMH. Marianjoy Rehabilitation Hospital & Clinics commits to receiving medically appropriate patient referrals from GMH and also directing patients to other area hospital rehabilitation units when such peak census occurs.

Members of Marianjoy's Medical Group have been involved in the planning of the new unit at GMH and look forward to our ongoing involvement in the operation of the new unit.

If you have any questions, please contact me at 630-909-7500.

Sincerely,

Kathleen Yosko
President & CEO

Suggested Routes

Presented by  Comfort InnI-290 W to S 1st Ave 15.84 miles
26 mins / 47 mins based on current trafficEst. Fuel Cost
CalculateI-290 W to Chicago Ave 15.52 miles
35 mins / 35 mins based on current trafficEst. Fuel Cost
CalculateI-55 S 20.50 miles
30 mins / 42 mins based on current trafficEst. Fuel Cost
Calculate

Rested. Set. Go. Save up to 20%

Travel Options

Hotel	Air	Car
Location Melrose Park, IL		
Check-in 09/20/2015		Check-out 09/21/2015
Number of Rooms 1		Book Now
View Suggested Hotels		Starting at \$54



Driving Directions & Maps - findyourmaps.com - Easy to Follow Directions, Maps and More with the Free Maps Toolbar
 Valley View Dental - vvfdental.us/mapaville_dentist - Comfortable & Convenient Dental Care. Call Today For A \$50 Credit!