E-028-17 ORIGINAL E-028-11

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **APPLICATION FOR EXEMPTION PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION This Section must be completed for all projects. RECEIVED

| Facility/Project Identification  | JUN 2 2 2017                                |
|--|---|
| Facility Name: Mount Sinai Hospital  | 0011 <u>2 2</u> 2011                        |
| Street Address: 2750 W 15 <sup>th</sup> Street                               | MEATH EACHITIES                             |
| City and Zip Code: Chicago, 60608  | HEALTH FACILITIES &                         |
| County: Cook Health Service Area: 6  | Health Planning Area A-02                   |
|  |   |
| Applicant(s) [Provide for each applicant (refer to Part                      | 1130.220)]                                  |
| Exact Legal Name: Mount Sinai Hospital Medical Center of Chica               |   |
| Street Address: 2750 W 15 <sup>th</sup> Place Floor 1st                      |   |
| City and Zip Code: Chicago, 60608  |   |
| Name of Registered Agent: Loren F. Chandler                                  |   |
| Registered Agent Street Address: 2750 W 15 <sup>th</sup> Street              |   |
| Registered Agent City and Zip Code: Chicago, 60608                           |   |
| Name of Chief Executive Officer: Karen Teitelbaum                            |   |
| CEO Street Address: California at 15 <sup>th</sup> Street                    |   |
| CEO City and Zip Code: Chicago, 60608-1797                                   |   |
| CEO Telephone Number: 773-257-6434   |   |
|  |   |
| Type of Ownership of Applicants  |   |
| Type of entitioning of Application   |   |
| X Non-profit Corporation  Partners   | hin   |
| For-profit Corporation Governm   | '   |
|  | prietorship                                 |
| E sist to  | p. 101.01.01.01.01.01.01.01.01.01.01.01.01. |
| o Corporations and limited liability companies must provide                  | an Illinois certificate of good             |
| standing.  | · ·   |
| <ul> <li>Partnerships must provide the name of the state in which</li> </ul> | they are organized and the name and         |
| address of each partner specifying whether each is a gen-                    | eral or limited partner.                    |
|  |   |
| APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL                   | ODDED AFTED THE LAST DAGE OF THE            |
| APPLICATION FORM.  | ORDER AFTER THE EAST FAGE OF THE            |
|  |   |
| Primary Contact [Person to receive ALL corresponder                          | nce or inquiries]                           |
| Name: Jacob Axel   | 1 -1  |
| Title: President   |   |
| Company Name: Axel & Associates  |   |
| Address: 675 North Court, Suite 210, Palatine, IL 60067                      |   |
| Telephone Number: (847) 776-7101   |   |
| E-mail Address: jacobmaxel@msn.com   |   |
| Fax Number:  |   |
|  |   |
| Additional Contact [Person who is also authorized to                         | discuss the application for                 |
| exemption permit]  |   |
| Name: Paul Berrini   |   |
| Title: VP of Strategy and Marketing  |   |
| Company Name: Sinai Health System  |   |
| Address: 1500 South Fairfield Avenue, Chicago, IL 60652                      |   |
| Telephone Number: 773-257-6441   |   |
| E-mail Address: paul.berrini@sinai.org                                       |   |
| Fax Number:  |   |

# **Additional Contact** [Person who is also authorized to discuss the application for exemption permit]

## **Post Exemption 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 39601

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

3

| F | lo | od | P | lai | n | Red | qui | rem | en | ts |
|---|----|----|---|-----|---|-----|-----|-----|----|----|
|---|----|----|---|-----|---|-----|-----|-----|----|----|

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at <a href="www.FEMA.gov">www.FEMA.gov</a> or <a href="www.FEMA.gov">www.illinoisfloodmaps.org</a>. This map must be in a readable format. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (http:// www.illinois.gov/sites/hfsrb).

APPEND DOCUMENTATION AS <u>ATTACHMENT 5</u>, 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 <u>ATTACHMENT 6</u>, 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)]

| 110 Classification:   |
|---|
| Change of Ownership   |
| Discontinuation of an Existing Health Care Facility or of a category of service |
| Establishment or expansion of a neonatal intensive care or beds                 |
|   |

## 2. Narrative Description

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

The applicant proposes to discontinue Mount Sinai Hospital's 31-bed inpatient pediatrics unit. The hospital is located at California Avenue at 15<sup>th</sup> Street in Chicago.

The discontinuation of the inpatient unit is the result of the diminishing community need for inpatient pediatric services, resulting in fewer admissions to most Illinois hospitals (admissions are down 16% in Illinois and 18% at Mount Sinai Hospital since 2012), an average daily census of six patients, increased utilization of outpatient pediatric services, including surgery, and a centralizing of inpatient pediatric services in freestanding children's hospitals. As a result of these facts, the applicants have concluded that Mount Sinai Hospital can best serve the pediatrics needs of its community through focusing its pediatrics care on broad-based outpatient clinics and services, onsite pediatric specialists, and emergency services.

Access to pediatric services for the patient population traditionally served by Mount Sinai Hospital will not be significantly impacted by the proposed discontinuation. Mount Sinai Hospital is working on developing transfer agreements with neighboring providers. In addition, and importantly, Mount Sinai Hospital is maintaining its commitment to pediatric care through the broad variety of outpatient-based pediatric services that it will continue to provide, including:

- outpatient pediatric clinics
- outpatient pediatric surgery
- outpatient pediatric specialty services, such as genetics, hematology/oncology, delayed development, nephrology, infectious disease, pulmonology/allergy, endocrinology, cardiology, and gastroenterology
- pediatric emergency room services
- Level III NICU
- newborn nursery
- pediatrics observation services
- child and adolescent behavioral health programs (one of the largest providers in the Chicago area, with nearly 3,000 new patients during the past year).

## Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

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

| USE OF FUNDS   | CLINICAL | NONCLINICAL | TOTAL |
|--|----------|-------------|-------|
| Preplanning Costs  | •        |             |       |
| Site Survey and Soil Investigation                         |          |             |       |
| Site Preparation   |          |             |       |
| Off Site Work  |          |             |       |
| New Construction Contracts                                 | ***      |             |       |
| Modernization Contracts                                    |          |             | •     |
| Contingencies  |          |             |       |
| Architectural/Engineering Fees                             | 1:       |             |       |
| Consulting and Other Fees                                  |          |             |       |
| Movable or Other Equipment (not in construction contracts) |          |             |       |
| Bond Issuance Expense (project related)                    |          |             |       |
| Net Interest Expense During Construction (project related) |          |             |       |
| Fair Market Value of Leased Space or Equipment             |          |             |       |
| Other Costs To Be Capitalized                              |          |             |       |
| Acquisition of Building or Other Property (excluding land) |          |             |       |
| TOTAL USES OF FUNDS  |          |             |       |
| SOURCE OF FUNDS  | CLINICAL | NONCLINICAL | TOTAL |
| Cash and Securities  |          |             |       |
| Pledges  |          |             |       |
| Gifts and Bequests   |          |             |       |
| Bond Issues (project related)                              |          |             |       |
| Mortgages  |          |             |       |
| Leases (fair market value)                                 |          |             |       |
| Governmental Appropriations                                |          |             |       |
| Grants   |          |             |       |
| Other Funds and Sources                                    |          |             |       |
| TOTAL SOURCES OF FUNDS                                     |          |             | N/A   |

NOTE ITEMIZATION OF EACH LINE ITEM MUSTREE PROVIDED AT ATTACHMENTY, 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:

#### CERTIFICATION

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

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

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

SIGNATURE

SIGNATURE

SIGNATURE

Loren Chandler
PRINTED NAME

PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 20 day of Chandler
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 20 day of Chandler
PRINTED TITLE

Signature of Notary

Seal \$

"OFFICIAL SEAL" ROSA M'ARELLANO

Notary Public, State of Illinois
\*Inser th My Edwarnius from Επρίτε εσί 1/189/2ρβθος απ

-A 1.0-1

Signature of Notary

Seal

"OFFICIAL SEAL"
ROSA M ARELLANO
Notary Public, State of Minds

My Commission Expires 11/30/2020

#### **SECTION II. DISCONTINUATION**

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

#### Type of Discontinuation

|   | Discontinuation of an Existing Health Care Facility |
|---|---|
| х | Discontinuation of a category of service            |
|   |   |
|   |   |

### Criterion 1110.130 - Discontinuation

## READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

- 1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
- 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, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
- 7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
- 8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local

newspaper will be accepted.

#### **REASONS FOR DISCONTINUATION**

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

#### **IMPACT ON ACCESS**

- 1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
- 2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS <u>ATTACHMENT 10</u>, 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.

### **Background**

#### 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 that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

## Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

#### **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 relevant area, per the applicant's definition.
- 3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
- 4. Cite the sources of the 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 the age and condition of the project site, as well as 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 <u>ATTACHMENT 12.</u> 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.
- 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 <u>ATTACHMENT 13.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

### **SECTION VII. 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:

- "A" Bond rating or better.
- 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 <u>ATTACHMENT 17,</u> 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<br>3 Years | Projected |
|--|-----------------------|-----------|
| Enter Historical and/or Projected Years: |                       |           |
| Current Ratio                            |                       |           |
| Net Margin Percentage                    |                       |           |
| Percent Debt to Total<br>Capitalization  |                       |           |
| Projected Debt Service<br>Coverage       |                       |           |
| Days Cash on Hand                        |                       | ·         |
| Cushion Ratio                            |                       |           |

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

#### Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS <u>ATTACHMENT 18,</u> IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

## SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for <u>ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:</u>

- 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.

|                           | nformation po                         |      |          |
|---------------------------|---------------------------------------|------|----------|
|                           | CHARITY CAR                           | RE   |          |
| 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                 | · · · · · · · · · · · · · · · · · · · |      | <u> </u> |
| Outpatient                |                                       |      |          |
| Total                     |                                       |      |          |

APPEND DOCUMENTATION AS <u>ATTACHMENT 20</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

## SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

#### Charity Care information MUST be furnished for ALL projects [1120.20(c)].

- 1. All applicants and co-applicants shall indicate the amount of charity care for the latest three <a href="mailto:audited"><u>audited</u></a> 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 <u>must</u> 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 <u>ATTACHMENT 21</u>, 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 included attachments:

| NO. |  | PAGES |
|-----|--|-------|
|     | Applicant Identification including Certificate of Good Standing  | 17    |
| 2   | Site Ownership   | 18    |
| 3   | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | 19    |
| 4   | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.                  | 20    |
| 5   | Flood Plain Requirements   | N/A   |
| 6   | Historic Preservation Act Requirements   | N/A   |
| 7   | Project and Sources of Funds Itemization   | N/A   |
| 8   | Financial Commitment Document if required  | N/A   |
| 9   | Cost Space Requirements  | N/A   |
| 10  | Discontinuation  | 21-30 |
| 11  | Background of the Applicant  | N/A   |
| 12  | Purpose of the Project   | N/A   |
| 13  | Alternatives to the Project  | N/A   |
|     | Service Specific:  |       |
| 14  | Neonatal Intensive Care Services   | N/A   |
| 15  | Change of Ownership  | N/A   |
|     | Financial and Economic Feasibility:  |       |
| 16  | Availability of Funds  | N/A   |
| 17  | Financial Waiver   | N/A   |
| 18  | Financial Viability  | N/A   |
| 19  | Economic Feasibility   | N/A   |
| 20  | Safety Net Impact Statement  | 31-32 |
| 21  | Charity Care Information   | 33    |



## 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

MOUNT SINAI HOSPITAL MEDICAL CENTER OF CHICAGO, A DOMESTIC CORPORATION, ENCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 26, 1918, 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

MAY

A.D. 2017 .

Authentication #: 1714202596 verifiable until 05/22/2018
Authenticate at: http://www.cybendrivellinois.com

SECRETARY OF STATE



I, Loren Chandler, President of Mount Sinai Hospital Medical Center do hereby attest that Mount Sinai Hospital Medical Center of Chicago d/b/a Mount Sinai Hospital Medical Center owns the property at 2750 W. 15<sup>th</sup> Street in Chicago where the hospital is located.

Signed and sworn to Before me this

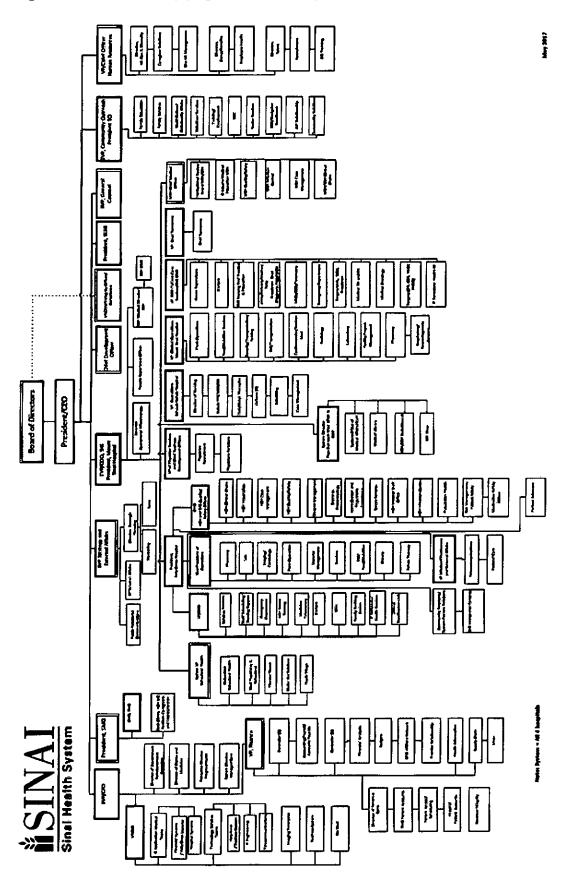
day of Onne



Persons with 5 percent or greater interest in the licensee must be identifies with the % of ownership

N/A

Mount Sinai Hospital Medical Center is a non-profit organization.



Attachment 4

#### **General Information Requirements**

Mount Sinai Hospital Medical Center of Chicago ("Mount Sinai") proposes to discontinue its 31-bed pediatric category of service, effective November 1, 2017. Mount Sinai's pediatric occupancy rate has approximated 25% in recent years. No other categories of service or clinical services are intended to be discontinued.

The space currently occupied by Mount Sinai's inpatient pediatrics unit will be used for the future expansion of existing services, although no specific use has been identified at this time.

Medical records of patients discharged from the pediatrics unit will be maintained by the hospital, consistent with the hospital's health record retention policies.

A copy of the public notice published in the Chicago Sun Times on May 30, 2017, relating to the proposed discontinuation is attached.

MOUNT STINAL HOSPITAL
Oteominus Lis Beat
ADORDERNUMBER: Discontinus Lis Bed
AMOUNT: 185.00
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## Chicago Sun-Times Certificate of Publication

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PUBLICATION CATE(S): 9536/2017

Chicago Sun-Times

IN WITNESS WHEREOF, the undersigned, being duly authorized,

Account Manager - Public Legal Notices

This Min Day of May 2017 A.O.

MOUNT SINAI NOSPITAL 1500 S FARFIELD AYE AARON ROSMAN DIGITAL MARKETING SPECIALIST CHICAGO, IL 60608

MOUNT SINAL HOSPITAL Discontinue Lic Bed

ADORDERNUMBER: 0001027212-01

PO NUMBER: Discontinue Lic Bed

**AMOUNT: 186.00** 

NO OF AFFIDAVITS: 1

Mount Sinai Hospital (MSH) in Chicago, Illimois intends to discontinue the licensed bed "category of service" for its thirty-one (31) licensed bed Pediatric In-patient Unit after approval to do so is issued by the Illinois Health Facilities and Services Review Board (HFSRB). MSH will continue to offer a broad array of outpatient pediatric services, including emergency and observational care, as well as Level III Neonatal intensive Care.

The discontinuation will occur after approval is granted by the HFSRB, but no later than November 1, 2017. MSH anticipates submitting the required Certificate of Exemption application is submitted on the HFSRB in June 2017, and a copy of it can be found after the application is submitted on the HFSRB website at www.illimois.gov/sites/fiscb.

submitted on the HFSHB web-site at www.illinois.gov/ sites/hfsrb.
For additional information, please contact Dianne Hunter at (773) 257-5228. 5/30/17 #1027212

## **Chicago Sun-Times Certificate of Publication**

State of Illinois - County of

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

Formerly III. Rev. Stat. 1991, CH100, Pl.

Note: Notice appeared in the following checked positions.

PUBLICATION DATE(S): 05/30/2017

Chicago Sun-Times

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

by

Account Manager - Public Legal Notices

This 30th Day of May 2017 A.D.

#### **Reasons for Discontinuation**

The primary reason for proposing discontinuation of the inpatient pediatrics unit is the unit's low occupancy rate resulting from insufficient demand, and the utilization trends discussed in this application's Narrative Description, which include a greater reliance on outpatient services and the centralization of inpatient pediatrics care.

Mount Sinai is located in Hospital Planning Area A-02 for inpatient pediatric services, and is one of seven hospitals currently providing inpatient pediatric services in the Planning Area. Four of those hospitals are located within a 6-minute drive of Mount Sinai, with none of those facilities operating at the HFSRB's occupancy. As evidenced in the table below, those inpatient pediatrics providers located closest to Mount Sinai have occupancy rates on their pediatrics units ranging from 14.4% to 55.4%.

| Hospital                          | # Licensed Pediatrics Beds | 2015 Occupancy Rate |
|-----------------------------------|----------------------------|---------------------|
| John H. Stroger Hospital          |                            |                     |
| of Cook County                    | 40                         | 14.8%               |
| Rush University Medical Center    | 22                         | 55.4%               |
| St. Anthony Hospital              | 12                         | 40.5%               |
| University of Illinois at Chicago | 44                         | 23.4%               |

#### Impact on Access

The proposed discontinuation will not have an adverse impact on access to services for Mount Sinai's traditional patient population. This is due to the availability of inpatient pediatric services at the hospitals in the table above, as well as reasonable access to regional providers of inpatient pediatric care such as Lurie Children's Hospital and Comer Children's Hospital.

Consistent with the requirements of Section 1110.130, letters requesting an impact statement were sent to all hospitals providing inpatient pediatrics units located within 45 minutes of Mount Sinai. Below is a listing of those hospitals:

| Saint Anthony Hospital   | John H. Stroger, Jr.    | University of Illinois | Rush University        |
|--------------------------|-------------------------|------------------------|------------------------|
|                          | Hospital of Cook County | Hospital               | Medical Center         |
| Presence Saint Mary and  | Norwegian American      | Ann & Robert H. Lurie  | MacNeal Hospital       |
| Elizabeth Medical Center | Hospital                | Children's Hospital    |                        |
| Mercy Hospital           | Comer Children's        | 5t. Bernard Hospital   | Presence Saint Joseph  |
|                          | Hospital                |                        | Hospital               |
| Advocate Christ Medical  | Advocate Hope           | Ingalls Health System  | Advocate South         |
| Center                   | Children's Hospital     |                        | Suburban Hospital      |
| La Rabida Children's     | Jackson Park Hospital & | Presence Resurrection  | Shriners Hospitals for |
| Hospital                 | Medical Center          | Medical Center         | Children               |
| Swedish Covenant         | Little Company of Mary  | AMITA Health           | Elmhurst Memorial      |
| Hospital                 | Hospital                | Adventist Medical      | Hospital               |
|                          |                         | Center, Hinsdale       |                        |
| Advocate Good            | Gottlieb Memorial       | Loyola University      | West Suburban          |
| Samaritan Hospital       | Hospital                | Medical Center         | Medical Center         |
| Westlake Hospital        |                         |                        |                        |

Copies of responses received are attached, and should any additional responses be received subsequent to this COE application's filing, they will be forwarded to HFSRB Staff. In addition, photocopies of the Certified Mail delivery receipts returned to Mount Sinai are attached.

By Certified Mail Delivery Receipt Requested

May 25, 2017

[Insert Name] [Insert Address Line 1] [Insert Address Line 2] [Insert Address Line 3]

RE: Proposed Discontinuation of Inpatient Pediatrics Service at Mount Sinai Hospital

Dear [Insert Name]:

Mount Sinai Hospital intends to file a Certificate of Exemption ("COE") application with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of the hospital's inpatient pediatrics unit. The hospital will continue to operate a broad variety of pediatric outpatient programs, as well as its Level III nursery/NICU.

Through this letter and consistent with the provisions of Section 1110.130, you are requested, should you elect to do so, to provide an impact statement, consistent with the identified requested information contained in the above-referenced section; including: 1) whether your hospital has or will have available capacity to accommodate a portion or all of Mount Sinai Hospital's experienced caseload, and 2) whether any restrictions or limitations preclude providing service to residents of Mount Sinai Hospital's service area.

The anticipated date for discontinuation is November 1, 2017.

During the 24-month period ending December 31, 2016, a total of 2,072 children were admitted to Mount Sinai Hospital's inpatient pediatrics unit.

A copy of any response to this request received within fifteen days of your receipt of this letter will be forwarded to the IHFSRB.

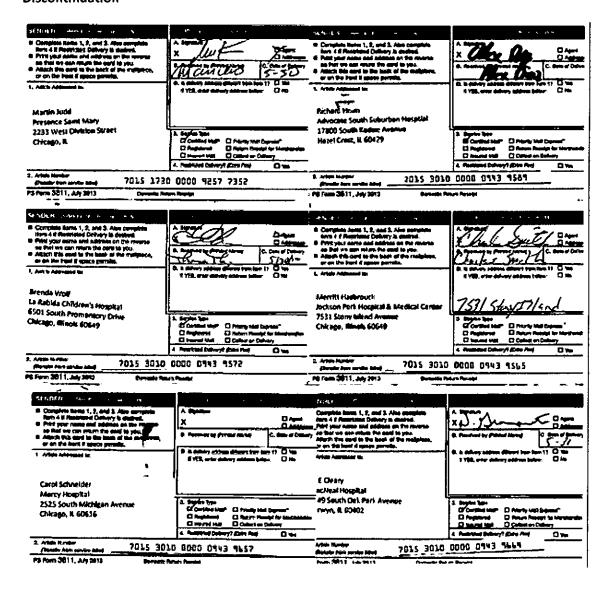
Sincerely,

Loren Chandler President of Mount Sinai Hospital EVP & COO of Sinai Health System

Attached are the Certified mail receipts returned from providers who received the latter.

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COOK COUNTY HEALTH & HOSPITALS SYSTEM 1900 West Polk Street, Chicago, Illinois 60612 www.cookcountyhts.org (312) 864-6000

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June 14, 2017

Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery:

On June 1, 2017 the Cook County Health & Hospitals System (CCHHS) and the John H. Stroger, Jr. Hospital (Stroger Hospital) received notice from Sinai Health System of their Proposed Discontinuation of Inpatient Pediatrics Service at Mount Sinai Hospital. Pursuant to Section 1110.130 of the Administrative Code of the Joint Committee on Administrative Rules this letter serves as an Impact Statement by CCHHS' Stroger Hospital pertaining to the aforementioned notice.

Stroger Hospital has the available capacity to accommodate Mount Sinai Hospital's experienced caseload and has no restrictions or limitations that would preclude providing service to residents of Mount Sinai Hospital's market area. Further, CCHHS does not believe the discontinuation of inpatient pediatric services at Mount Sinai Hospital will have an adverse impact on Stroger Hospital.

Sincerely,

John Jay Shannon, MD

CEO



Via Certified Mail

June 5, 2017

Loren Chandler Mount Sinai Hospital 1500 South Fairfield Avenue Chicago, it 60608

RE: Impact Statement re: The Oiscontinuation of inpatient Pediatrics Service at Mount Sinai Hospital

Dear Mr. Loren Chandler:

We are in receipt of your letter dated May 25, 2017. Saint Anthony Hospital appreciates the open communication shared between health care facilities in our neighborhood. Thank you for notifying us of your intent to discontinue the inpatient Pediatrics Service at your facility.

Saint Anthony Hospital offers our full support of your decision to file this permit and remains committed to providing healthcare to all patients in need, including pediatric patients. To that end, our hospital has fourteen (14) Pediatric beds and four (4) Intermediate Care beds where we can care for children with acute Pediatric conditions as well as critically ill children that require continuous monitoring and non-invasive ventilation. On staff, Saint Anthony Hospital has University of Chicago residents, Pediatric Intensivist coverage, and 24/7 in-house neonatal intensivists. We also have a Pediatric subspecialty coverage partnership with the University of Chicago. Please note, however, that we are currently unable to treat pediatric trauma patients. With our current census, Saint Anthony Hospital has the capacity to treat additional patients that may be effected by the closure of your program.

With the information provided above and consistent with Section 1110.130, please accept this letter as our impact statement. Should you have any questions or concerns, or require any additional information, please don't hesitate to contact us. We look forward to working together in the future and ensuring all patient needs are met. Thank you.

Sincerely,

Romeen Lavani, M.D. Clinical Department Chair

Saint Anthony Hospital - 2875 West 19th Street - Chicago, IL 60623

Main Hospital: (773) 484-1000 · www.SAHChicago.org



Sharma O'Keefe

MC 1000 S 415 5841 South Maryland Avenue Chicago, Blinois (0637-1470 phme (773) 702 4990 fee (773) 702 4997 durrow.obset@Ouchauptodo.edu

June 6, 2017

Loren Chandler President, Mount Sinai Hospital EVP & COO Sinai Health System 1500 S. Fairfield Avenue Chicago, 1L 60608

Re: Proposed Discontinuation of Pediatric Inpatient Service at Mount Sinai Hospital

Dear Mr. Chandler:

Thank you for your letter dated May 25, 2017, informing us of Mount Sinai Hospital's intention to file a Certificate of Exemption to discontinue its Pediatric Inpatient Service. You indicated that Mt. Sinai has admitted approximately 1000 pediatric patients each year for the two-year period ending December 31, 2016 and that November 1, 2017 is the anticipated date of discontinuation.

Please accept this letter as timely confirmation that the University of Chicago Medical Center's Comer Children's Hospital ("Comer") has the capacity to accommodate all of Mt. Sinai's experienced case load. We can provide services to residents of Mt. Sinai's service area without restriction or limitation consistent with our other inpatient admissions. Comer also has the capability to provide inpatient services for both general and specialty pediatric patients and maintains its designation as a Level I Pediatric Trauma Center.

Sincerely,

The University of Chicago Medical Center

Sharon O'Keefe President

c: Ms. Courtney R. Avery

Administrator

Illinois Health Facilities and Services Review Board

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

AT THE FOREFRONT OF MEDICINE

#### **Safety Net Impact Statement**

#### Section 1

Q1

As described previously in the statement regarding impact on access, Mount Sinai Hospital believes that due to the significant supply of pediatric beds with ample capacity within the health planning area (A-02), and even more specifically within a 6 minute drive (see table in section "Impact on Access"), that this project will not have a material impact on essential safety net services within the community.

Q2

Due to decreasing demand for inpatient pediatric services coupled with the oversupply of resources in the health planning area (A-02) in which Mount Sinai Hospital resides, Mount Sinai Hospital believes that this project will not impact the ability of other providers or health care systems to subsidize safety net services.

Q3

Due to the reasons above, Mount Sinai Hospital believes that other safety net providers in the area will be positively impacted as the excess bed total in the area.

#### Section 2

Q3

Mount Sinai Hospital is committed to maintaining access to pediatric care for its communities and will continue to provide a broad range of outpatient and emergency pediatric services in addition to delivering Level III neonatal intensive care. With the continuation of these services and the excess availability of inpatient beds in the area, Mount Sinai Hospital believes that resources will continue to be accessible to the surrounding communities.

|                                       | Mount 5    | Sinai Hospital |               |               |  |  |
|---------------------------------------|------------|----------------|---------------|---------------|--|--|
| Safety Net Information per PA 96-0031 |            |                |               |               |  |  |
| CHARITY CARE                          |            |                |               |               |  |  |
| Charity (# of patients)               |            | 2014           | 2015          | 2016          |  |  |
|                                       | Inpatient  | 1,275          | 378           | 724           |  |  |
|                                       | Outpatient | 16,065         | 7,017         | 9,880         |  |  |
| Total                                 |            | 17,340         | 7,395         | 10,604        |  |  |
| Charity (cost In dollars)             |            |                |               |               |  |  |
|                                       | Inpatient  | \$9,626,867    | \$7,211,764   | \$7,575,800   |  |  |
|                                       | Outpatient | \$13,029,915   | \$9,761,086   | \$14,357,000  |  |  |
| Total                                 |            | \$22,656,782   | \$16,972,850  | \$21,932,800  |  |  |
|                                       | M          | EDICAID        |               |               |  |  |
| Medicaid (# of patients)              |            | 2014           | 2015          | 2016          |  |  |
| ••••                                  | Inpatient  | 4,618          | 9,353         | 8,912         |  |  |
|                                       | Outpatient | 52,133         | 71,649        | 109,717       |  |  |
| Total                                 |            | 56,751         | 81,002        | 118,629       |  |  |
| Medicaid (revenue)                    |            |                |               |               |  |  |
|                                       | Inpatient  | \$129,055,243  | \$121,745,165 | \$89,469,525  |  |  |
|                                       | Outpatient | \$11,691,073   | \$5,866,041   | \$30,253,073  |  |  |
| Total                                 |            | \$140,746,316  | \$127,611,206 | \$119,722,598 |  |  |

| Holy Cr                               | oss Hospital |              |              |  |  |
|---------------------------------------|--------------|--------------|--------------|--|--|
| Safety Net Information per PA 96-0031 |              |              |              |  |  |
| CHARITY CARE                          |              |              |              |  |  |
| Charity (# of patients)               | 2014         | 2015         | 2016         |  |  |
| Inpatient                             | 260          | 240          | 363          |  |  |
| Outpatient                            | 6,551        | 2,506        | 6,673        |  |  |
| Total                                 | 6,811        | 2,746        | 7,036        |  |  |
| Charity (cost In dollars)             |              |              |              |  |  |
| Inpatient                             | \$1,421,424  | \$1,153,864  | \$2,480,400  |  |  |
| Outpatient                            | \$2,305,616  | \$4,530,195  | \$5,603,100  |  |  |
| Total                                 | \$3,727,040  | \$5,684,059  | \$8,083,500  |  |  |
| ME                                    | DICAID       | _            |              |  |  |
| Medicaid (# of patients)              | 2014         | 2015         | 2016         |  |  |
| Inpatient                             | 2,035        | 3,740        | 3,573        |  |  |
| Outpatient                            | 18,393       | 11,994       | 33,889       |  |  |
| Total                                 | 20,428       | 15,734       | 37,462       |  |  |
| Medicaid (revenue)                    |              |              |              |  |  |
| Inpatient                             | \$10,109,269 | \$32,876,743 | \$22,602,163 |  |  |
| Outpatient                            | \$3,230,733  | \$7,323,613  | \$12,543,221 |  |  |
| Total                                 | \$13,340,002 | \$40,200,356 | \$35,145,384 |  |  |

## **Charity Care Information Table**

| Mount Sinai Hospital             |                   |                   |                   |
|----------------------------------|-------------------|-------------------|-------------------|
| CHARITY CARE                     |                   |                   |                   |
|                                  | 2014              | 2015              | 2016              |
| Net Patient Revenue              | \$ 260,099,873.00 | \$ 293,434,215.00 | \$ 212,291,107.00 |
| Amount of Charity Care (charges) | \$ 97,855,982.00  | \$ 57,386,679.00  | \$ 64,500,623.00  |
| Cost of Charity Care             | \$ 22,656,782.00  | \$ 16,972,850.00  | \$ 21,932,800.00  |

| Holy Cross Hospital              |                     |                      |                     |
|----------------------------------|---------------------|----------------------|---------------------|
| CHARITY CARE                     |                     |                      |                     |
|                                  | 2014                | 2015                 | 2016                |
| Net Patient Revenue              | \$<br>78,847,128.00 | \$<br>111,602,231.00 | \$<br>89,393,016.00 |
| Amount of Charity Care (charges) | \$<br>45,464,340.00 | \$<br>21,503,656.00  | \$<br>36,746,098.00 |
| Cost of Charity Care             | \$<br>3,727,040.00  | \$<br>5,684,059.00   | \$<br>8,083,500.00  |