E-038-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

RECEIVED
AUG 21 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Holy Cross Hospital		
Street Address: 2701 West 68th Street		
City and Zip Code: Chicago, IL 60629		
County: Cook	Health Service Area 6	Health Planning Area:A-03

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

Exact Legal Name: Holy Cross Hospital
Street Address:2701 West 68th Street
City and Zip Code: Chicago, IL 60629
Name of Registered Agent: Karen Teitelbaum
Registered Agent Street Address:1500 South California Avenue F104A
Registered Agent City and Zip Code: Chicago, IL 60608
Name of Chief Executive Officer: Karen Teitelbaum
CEO Street Address: 1500 South California Avenue F104A
CEO City and Zip Code: Chicago, IL 60608
CEO Telephone Number: 773/257-6434

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Jack Axel
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: Vice President, Strategy and Marketing
Company Name: Sinai Health System
Address: 1500 South Fairfield Avenue, Chicago, IL 60608
Telephone Number: 773-257-6441
E-mail Address: paul.berrini@sinai.org
Fax Number:

Name: Clare Connor
Title: Partner
Company Name: McDermott, Will & Emery LLP
Address: 444 West lake Street Chicago, Il 60606
Telephone Number: 312-984-3365
E-mail Address: cconnor@mwe.com
Fax Number:

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 3960]**

Name: Rachel Dvorken
Title: Executive Vice President and General Counsel
Company Name: Sinai Health System
Address: 1500 South Fairfield Avenue, Chicago, Il 60608
Telephone Number: 773-257-5733
E-mail Address: Rachel.dvorken@sinai.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Holy Cross Hospital
Address of Site Owner: 2701 West 68th Street, Chicago, Il 60629
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Holy Cross Hospital
Address: 2701 West 68th Street, Chicago, IL 60629
☒ 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. ○ **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[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 **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 #2006-5 **(http://** www.illinois.gov/sites/hfsrb**)**.

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:

- ☐ 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 Holy Cross Hospital's 34 –bed inpatient comprehensive physical rehabilitation ("rehabilitation") unit. The hospital is located at 2701 West 68th Street in Chicago.

Since becoming a member of Sinai Health System in 2012, Holy Cross Hospital has sought to identify opportunities to improve care by innovating across its service delivery profile through inter-System collaboration. This discontinuation would allow for the consolidation of services to Schwab Rehabilitation Hospital, also a member of Sinai Health System and located just 6.6 miles north, and would be consistent with best practice trends for community, home-based, sub-acute and acute treatment for rehabilitation care. Holy Cross has experienced a 34% decline in admissions since 2013 as patients have migrated to community, home based and specialty rehabilitation hospital settings. Patients requiring higher complexity inpatient rehabilitation services have benefited from the more comprehensive range of services provided by a rehabilitation specialty hospital such as Schwab.

Access to rehabilitation services for the patient population traditionally served by Holy Cross Hospital will not be significantly impacted by the proposed discontinuation. Holy Cross Hospital will be working with area health providers to coordinate other rehabilitation services, such as sub-acute and home based, and will utilize Schwab Rehabilitation Hospital for inpatient care. Schwab Rehabilitation Hospital will provide on-site liaison assistance to evaluate and facilitate the transfer of patients needing this level of care.

Rehabilitation outpatient and medical-unit therapy services will continue to be available for patients at Holy Cross Hospital.

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.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			$0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			**$0**

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 $ _____.

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): November 1, 2017

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment 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 [Section 1130.620(c)]

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.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of ____Holy Cross 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 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

Karen Teitelbaum
PRINTED NAME

CEO, Sinai Health System
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of August, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ROSA M ARELLANO
Notary Public, State of Illinois
My Commission Expires 11/30/2020

SIGNATURE

Lori Pacura LORI PACURA
PRINTED NAME

President, Holy Cross Hospital
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of August, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ROSA M ARELLANO
Notary Public, State of Illinois
My Commission Expires 11/30/2020

*Insert the EXACT legal name of the applicant

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY – Not Applicable

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 17, 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 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY – NOT APPLICABLE

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 19, IN NUMERIC SEQUENTIAL 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 ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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 20, 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 **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 21, 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:

INDEX OF ATTACHMENTS

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File Number 2073-273-3

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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

HOLY CROSS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 10, 1929, 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* 17TH *day of* JULY *A.D.* 2017 .

Authentication #: 1719901502 verifiable until 07/17/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

Attachment 1

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

I, Lori Pacura, President of Holy Cross Hospital do hereby attest that Holy Cross Hospital owns the property located at 2701 West 68th Street in Chicago where the Rehabilitation Unit is located.

Lori Pacura

Signed and sworn to
Before me on this 22nd
day of June, 2017

OFFICIAL SEAL
DEBORAH WOHLER
Notary Public - State of Illinois
My Commission Expires Oct 25, 2018

Deborah Wohler

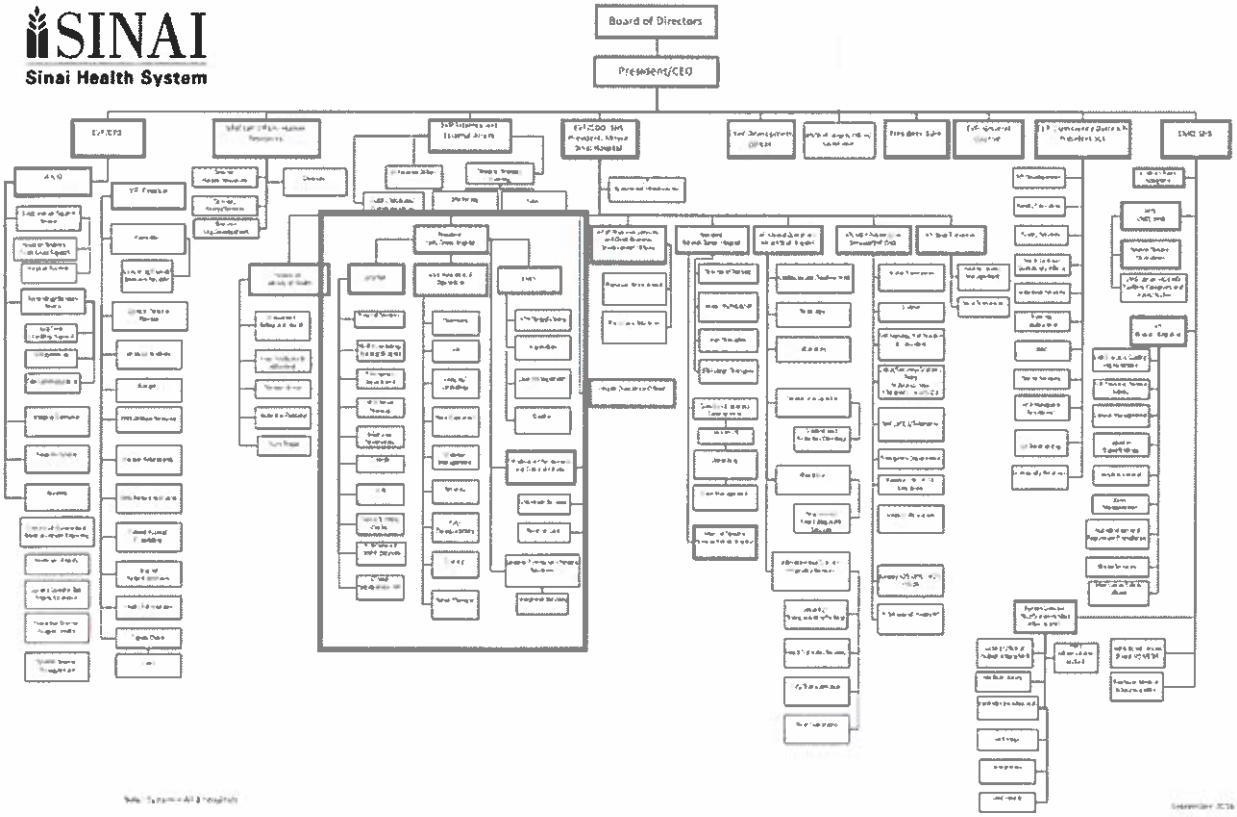
Attachment 2

Persons with 5% or greater interest in the licensee must be identified with the % ownership

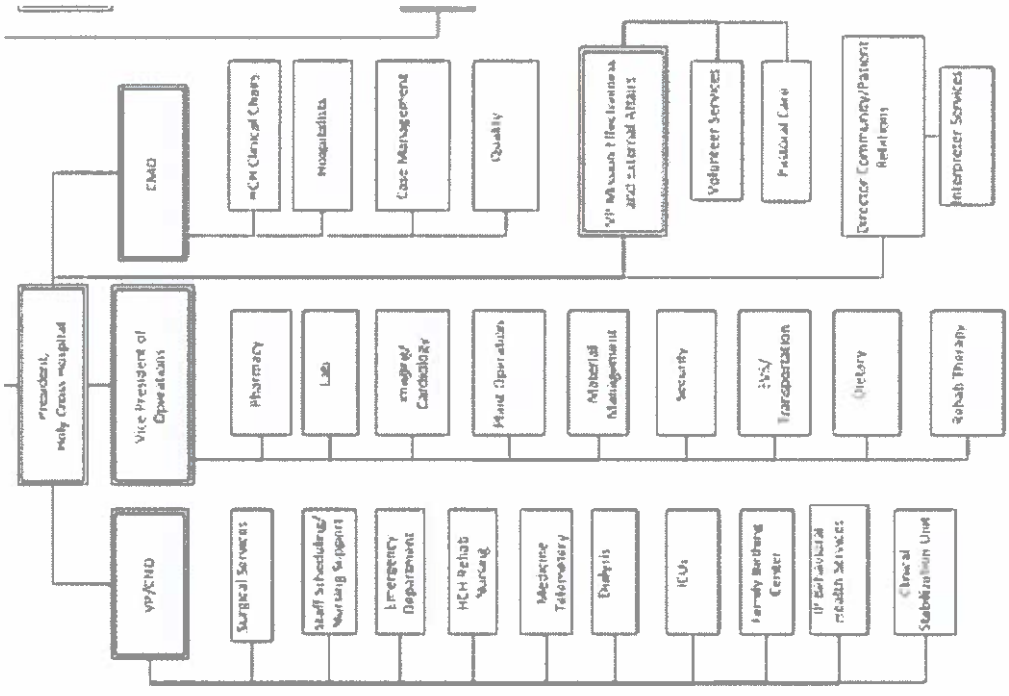
N/A

Holy Cross Hospital is a non-profit organization.

Organizational Chart – Sinai Health System



Organizational Chart – Holy Cross Hospital



Attachment 4

Discontinuation

General Information Requirements

Holy Cross Hospital of Chicago ("Holy Cross") proposes to discontinue its 34-bed inpatient rehabilitation category of service, effective November 1, 2017. Holy Cross' inpatient rehabilitation admissions have declined by 34% since 2013. No other categories of service or clinical services are intended to be discontinued.

The space currently occupied by Holy Cross' inpatient rehabilitation 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 rehabilitation 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 July 24, 2017, relating to the proposed discontinuation is attached.

MOUNT SINAI HOSPITAL
HCH Discontinue Ltc Bed
ADORDERNUMBER: 0001033417-01
PO NUMBER: HCH Discontinue Ltc Bed
AMOUNT: 144.00
NO OF AFFIDAVITS: 1

[redacted]

Chicago Sun-Times
Certificate of Publication

State of Illinois - County of Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisements 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, ¶¶28 Sec 1, EFF. July 1, 1874. Amended by Laws 1953, P1494, EFF. July 17, 1953. Formerly Ill. Rev. Stat. 1991, CH100, P.

Note: Notice appeared in the following checked positions.

PUBLICATION DATE(S): 07/24/2017

Chicago Sun-Times

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

by

Jeremy Gibbs
Account Manager - Public Legal Notices

This 24th Day of July 2017 A.D.

MOUNT SINAI HOSPITAL
1500 S FAIRFIELD AVE
AARON ROSMAN
DIGITAL MARKETING SPECIALIST
CHICAGO, IL 60608

Attachment 10

Discontinuation (Continued)

Reasons for Discontinuation
The reasons for proposing the discontinuation of the inpatient rehabilitation unit at Holy Cross are:

- Demand for inpatient rehabilitation services at Holy Cross has declined by 34% since 2013 with the trend expected to continue.
- The consolidation is consistent with best practice trends for community, home-based, sub-acute and acute treatment for rehabilitation care.
- The opportunity to consolidate services efficiently and efficaciously within the System to Schwab Rehabilitation Hospital, which has ample capacity, aligns with best practices to advance care for patients with conditions of greater complexity by providing improved access to a more comprehensive range of services.

The below table illustrates the ability for Schwab to adequately absorb the consolidated volumes at what will be considered peak levels. As it is unlikely all admissions would choose to transfer to Schwab, and at the same time equally likely that area demand will decrease for inpatient rehabilitation, we expect the true demand post the proposed consolidation to be less than those stated below.

	Admissions	Patient Days	Average Daily Census	IP Rehabilitation Beds	CON Occupancy %
Schwab (2016)	1112	15342	43	81	53%
Holy Cross Hospital (2016)	321	3891	11	34	32%
Schwab (Consolidated)	1433	19233	53	81	65%

Attachment 10

Discontinuation (Continued)

Impact on Access

The impact on access will not have an adverse impact on access to services for Holy Cross Hospital's traditional patient population. This is due to the availability of inpatient rehabilitation services at Schwab Rehabilitation Hospital as evidenced above, as well as reasonable access to regional hospital and non-hospital centers providing the service such as skilled nursing facilities.

Consistent with the requirements of Section 1110.130, letters requesting an impact statement were sent to all hospitals providing inpatient pediatrics units located within 36 minutes of Holy Cross Hospital. Below is a listing of those hospitals:

Advocate Illinois Masonic Medical Center	Louis A. Weiss Memorial Hospital	Mercy Hospital & Medical Center	Presence Resurrection Medical Center
Presence Saint Joseph Hospital Chicago	Presence Saint Mary of Nazareth Hospital	Shirley Ryan Ability Lab	Rush University Medical Center
Shriner's Hospital for Children	Swedish Covenant Hospital	University of Illinois Hospital & Health Science System	Adventist La grange Memorial Hospital
Advocate Christ Medical Center	Franciscan St. James Health – Chicago Heights	Ingalls Memorial 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 Holy Cross Hospital are attached. Those not yet returned will be sent upon receipt by Holy Cross Hospital.

Discontinuation **Attachment 10**

By Certified Mail
Delivery Receipt Requested

July XX, 2017

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

RE: Proposed Discontinuation of Inpatient Rehabilitation at Holy Cross Hospital

Dear [Insert name]

Holy Cross Hospital intends to file a Certificate of Exemption ("COE") application with the Illinois Health Facilities and Review Board ("IHFSRB"), addressing the discontinuation of the hospital's inpatient rehabilitation unit so they may be centralized at Schwab Rehabilitation Hospital. Holy Cross Hospital will continue to provide outpatient and medical unit rehabilitation therapy services.

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 Holy Cross Hospital's experienced caseload, and 2) whether any restrictions or limitations preclude providing service to residents of Holy Cross Hospital's service area.

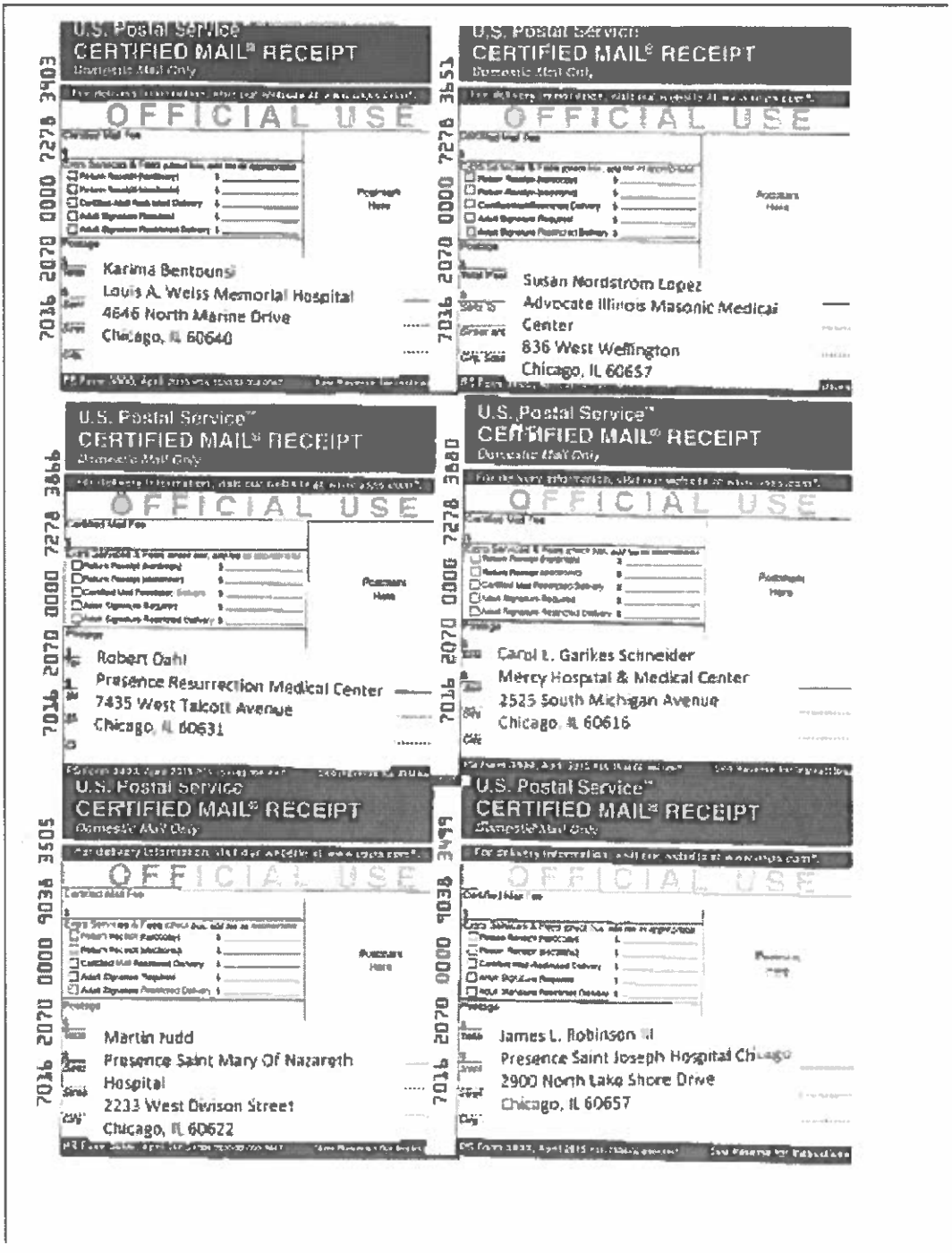
The anticipated date for discontinuation is by November 1, 2017.

During the 24 month period ending December 31, 2016, a total of 677 patients were admitted to Holy Cross Hospital's inpatient rehabilitation unit.

A copy of any response to this request received within 15 days of your receipt of this letter will be forwarded to the IHFSRB.

Sincerely,

Lori Pacura
President, Holy Cross Hospital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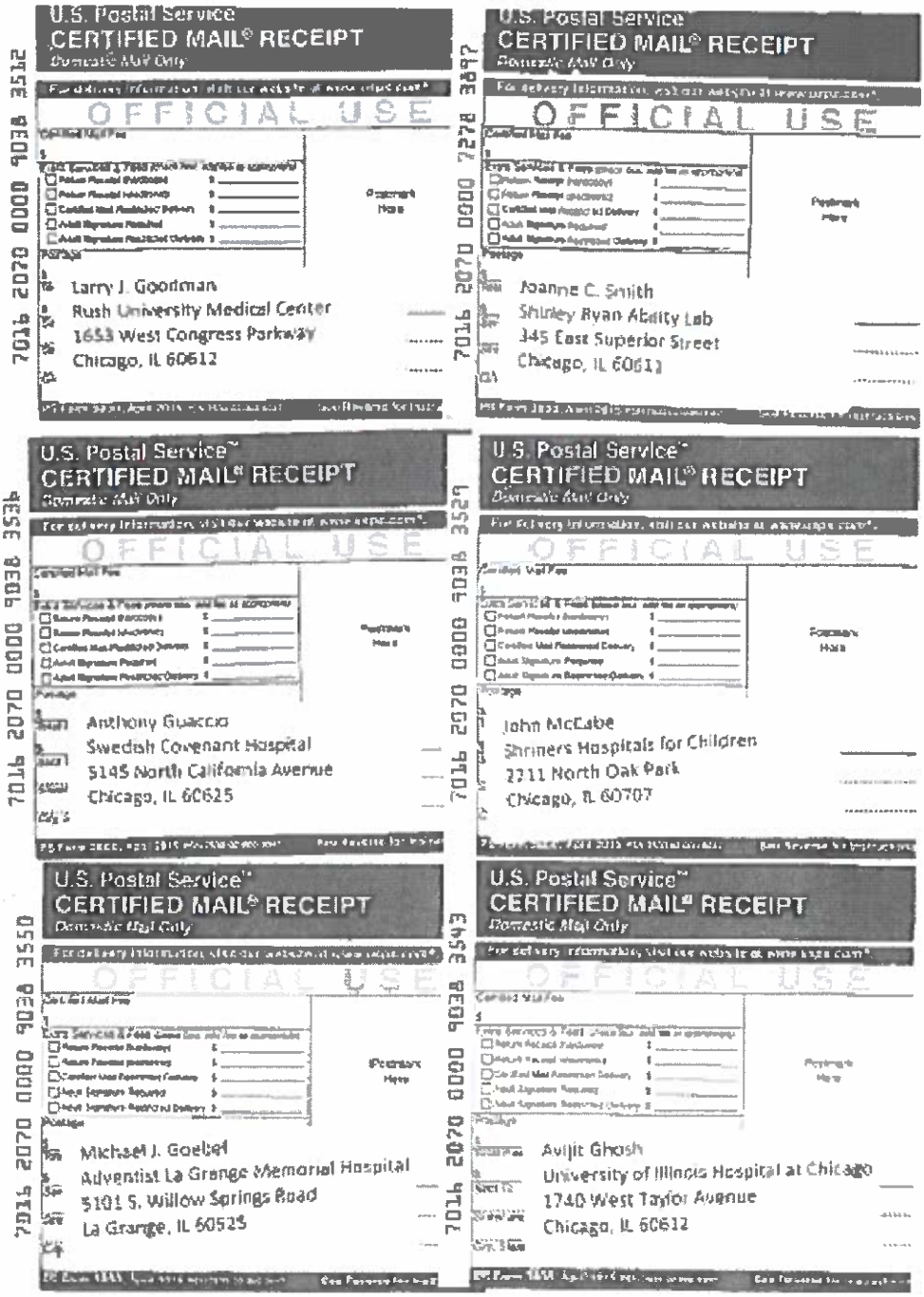
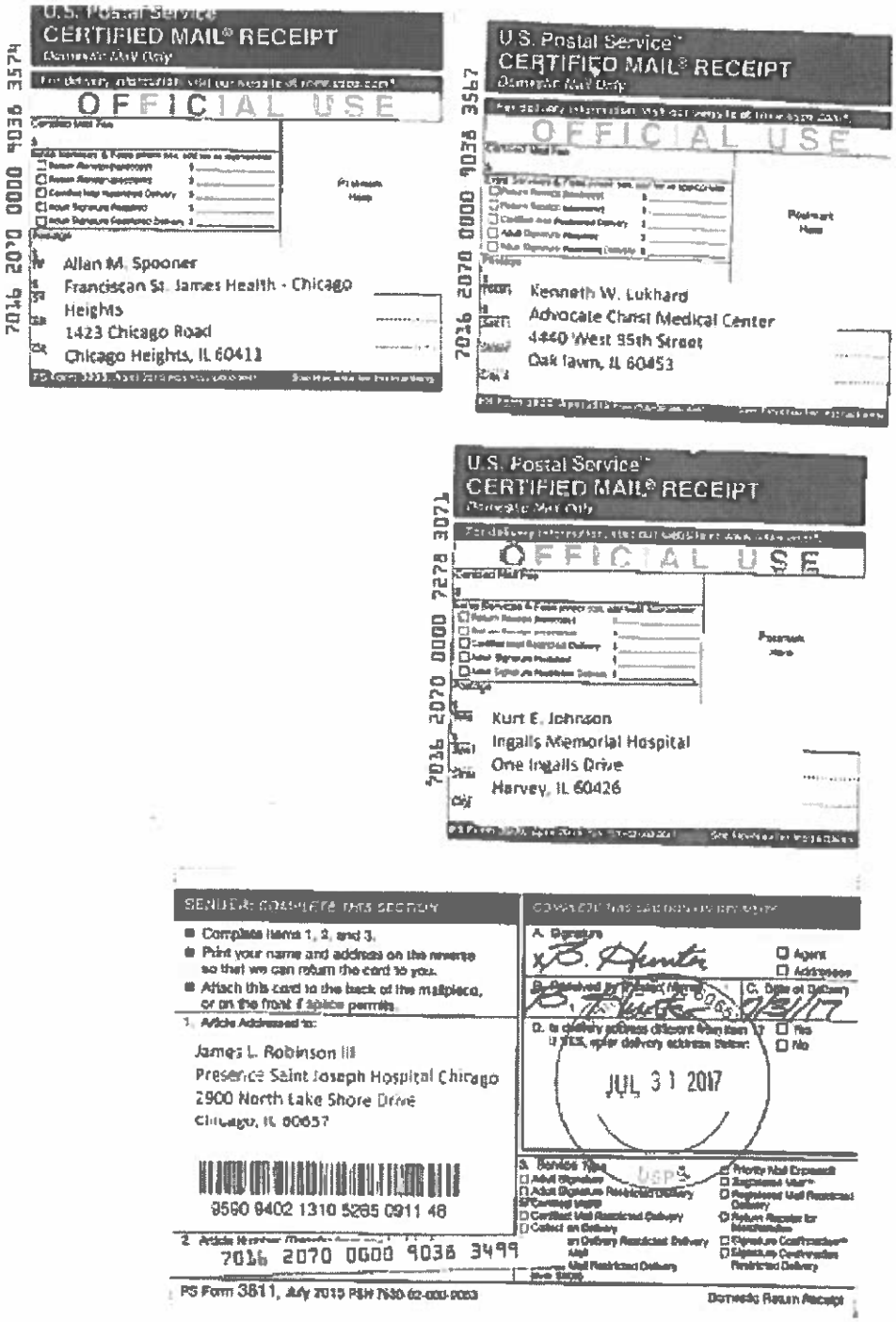
Karima Bentounsi
Louis A. Weiss Memorial Hospital
4646 North Marine Drive
Chicago, IL 60640
7016 2070 0000 7278 3651
Susan Nordstrom Lopez
Advocate Illinois Masonic Medical Center
836 West Wellington
Chicago, IL 60657
7016 2070 0000 7278 3866
Robert Dahl
Presence Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631
7016 2070 0000 7278 3880
Carol L. Garikes Schneider
Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, IL 60616
7016 2070 0000 9038 3505
Martin Judd
Presence Saint Mary Of Nazareth Hospital
2233 West Divison Street
Chicago, IL 60622
7016 2070 0000 9038 3499
James L. Robinson II
Presence Saint Joseph Hospital Chicago
2900 North Lake Shore Drive
Chicago, IL 60657



Attachment 10



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Allan M. Spooner
Franciscan St. James Health - Chicago Heights
1423 Chicago Road
Chicago Heights, IL 60411

U.S. Postal Service
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Kenneth W. Lukhard
Advocate Christ Medical Center
4440 West 95th Street
Oak lawn, IL 60453

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Kurt E. Johnson
Ingalls Memorial Hospital
One Ingalls Drive
Harvey, IL 60426

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

James L. Robinson III
Presence Saint Joseph Hospital Chicago
2900 North Lake Shore Drive
Chicago, IL 60657

9590 9402 1310 5285 0911 48

2. Article Number (Transfer from service label)
7016 2070 0000 9036 3499

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x B. Received by (Printed Name) C. Date of Delivery
JUL 31 2017
D. Is delivery address different from item 1? If YES, enter delivery address below:

3. Service Type
Adult Signature
Adult Signature Restricted Delivery
Certified Mail®
Certified Mail Restricted Delivery
Collect on Delivery
Collect on Delivery Restricted Delivery
Insured Mail
Insured Mail Restricted Delivery (over $500)
Priority Mail Express®
Registered Mail™
Registered Mail Restricted Delivery
Return Receipt for Merchandise
Signature Confirmation™
Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

Safety net Impact Statement

Section 1

Q1
Holy Cross Hospital believes that the consolidation of its inpatient services to Schwab Rehabilitation Hospital, just 6.6 miles north, with provision of on-site liaison from Schwab to evaluate and facilitate the transfer of patients, will help to ensure that ample access will be retained for this service and therefore will not have an adverse impact on essential safety net services within the community.

Q2
With the continued trend of decreasing demand at a year over year rate of 8.5% for inpatient rehabilitation services at Holy Cross and the ability to consolidate and support access to Schwab rehabilitation Hospital, which has ample capacity, Holy Cross Hospital believes that the project will not impact the ability of other providers or health care systems to subsidize safety net services.

Q3
Due to the above listed reasons, Holy Cross Hospital believes that other safety net providers in the area will not be negatively impacted.

Section 2

Holy Cross 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**
MEDICAID			
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**

Attachment 20

Charity Care Information Table

Holy Cross Hospital			
CHARITY CARE			
Net Patient Revenue	$78,847,128	$111,602,231	$89,393,016
Amount of Charity Care (Charges)	$45,464,340	$21,503,656	$36,746,098
Cost of Charity Care	**$3,727,040**	**$5,684,059**	**$8,083,500**

Attachment 21