E-046-17

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

OCT 11 2017

HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Advocate South Suburban Hospital
Street Address:	17800 South Kedzie Avenue
City and Zip Code:	Hazel Crest 60429
County: Cook	Health Service Area 7 Health Planning Area: A-04

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

Exact Legal Name: Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital
Street Address: 17800 South Kedzie Avenue
City and Zip Code: Hazel Crest, IL 60429
Name of Registered Agent: Earl Barnes
Registered Agent Street Address: 3075 Highland Parkway
Registered Agent City and Zip Code: Downers Grove, IL 60515
Name of Chief Executive Officer: Richard Heim
CEO Street Address: 17800 South Kedzie Avenue
CEO City and Zip Code: Hazel Crest, IL 60429
CEO Telephone Number: (708) 213-3002

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:	Joseph Newsome
Title:	Director, Inpatient Care Services
Company Name:	Advocate South Suburban Hospital
Address:	17800 South Kedzie Avenue, Hazel Crest, IL 60429
Telephone Number:	(708) 213-3696
E-mail Address:	joseph.newsome@advocatehealth.com
Fax Number:	(708)-213-0205

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

Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health and Hospitals Corporation
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 268-5757

Facility/Project Identification

Facility Name:	Advocate South Suburban Hospital
Street Address:	17800 South Kedzie Avenue
City and Zip Code:	Hazel Crest 60429
County: Cook	Health Service Area 7 Health Planning Area: A-04

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

Exact Legal Name: Advocate Health Care Network
Street Address: 3075 Highland Parkway
City and Zip Code: Downers Grove, IL 60515
Name of Registered Agent: Earl Barnes
Registered Agent Street Address: 3075 Highland Parkway
Registered Agent City and Zip Code: Downers Grove, IL 60515
Name of Chief Executive Officer: Richard Heim
CEO Street Address: 17800 South Kedzie Avenue
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- 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.

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Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 268-5757

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:	Joseph Newsome
Title:	Director, Inpatient Care Services
Company Name:	Advocate South Suburban Hospital
Address:	17800 South Kedzie Avenue, Hazel Crest, IL 60429
Telephone Number:	(708) 213-3696
E-mail Address:	joseph.newsome@advocatehealth.com
Fax Number:	708-213-0205

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation

Address of Site Owner: 3075 Highland Parkway, Downers Grove, IL 60515

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: : Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital

Address: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

- ☒ 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 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 N/A Discontinuation of service

[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

N/A Discontinuation of service

[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.

Advocate Health and Hospitals Corporation, d/b/a/ Advocate South Suburban Hospital, and Advocate Health Care Network, the applicants, are proposing to discontinue long term care and pediatrics categories of service at Advocate South Suburban Hospital. The discontinuance will take effect immediately upon State Board approval. The hospital is located at 17800 South Kedzie Avenue, Hazel Crest, IL 60429.

There are 41 long term care beds and 10 pediatric beds proposed to be taken out of the hospital inventory. The hospital has a total of 284 authorized CON beds. After the proposed discontinuance, there will be 233 beds.

There were 27 pediatric admissions in 2016 and zero in 2017. With no patients, the unit has been closed since 2016. As of March 29, 2016, there was a calculated excess of 423 medical/surgical/ pediatrics beds in Health Planning Area A-04 where Advocate South Suburban is located. Letters were sent asking for an impact statement from hospitals in the geographic service area regarding the proposed closure of pediatric beds. No expectation of any adverse impact was reported. Two letters were received indicating that hospital could accommodate pediatric referrals or transfers.

The average length of stay for the 820 patients admitted to the LTC unit in 2016 was 11 days. Medicare has been informed of the pending closure and patients will be notified accordingly. Letters were sent asking for an impact statement from nursing homes in the geographic service area. No expectation of any adverse impact was reported. Six letters were received saying there is capacity at those facilities for patients needing skilled nursing care.

The vacated rooms will be used to create private rooms for some of the medical surgical beds that are currently in multiple occupancy rooms.

Pursuant to Section 1110.40 of the Illinois Administrative Code, this project is classified as substantive because it is discontinuing a category of service.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)
N/A Discontinuation of service

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			
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			

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 N/A Discontinuation of service

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 N/A Discontinuation of service

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): _____

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.

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 Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban 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

Richard Heim
PRINTED NAME

President Advocate South Suburban Hospital
PRINTED TITLE

Signature of Notary

Seal

SIGNATURE

William P. Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Signature of Notary

Seal

OFFICIAL SEAL
CYNTHIA N TOLLIVER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/18

*Insert the EXACT legal name of the applicant

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);
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SIGNATURE	SIGNATURE
Richard Heim PRINTED NAME	William P. Santulli PRINTED NAME
President Advocate South Suburban Hospital PRINTED TITLE	Executive Vice President/COO PRINTED TITLE
Signature of Notary	Signature of Notary
Seal	Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

*Insert the EXACT legal name of the applicant

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

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

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

SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of August 2017

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

SIGNATURE

William P. Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Notarization:
-Subscribed and sworn to before me
this 25 day of August 2017

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

*Insert 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 III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES
N/A Discontinuation of service

- 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 ATTACHMENT 11, 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 ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

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

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing **a** joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION IV. SERVICE SPECIFIC REVIEW CRITERIA (Neonatal Intensive Care Services Only) N/A Discontinuation of service

Criterion 1130.531 Requirements for Exemptions for the Establishment or Expansion of Neonatal Intensive Care Service and Beds

This Section is applicable to all projects proposing the establishment, or expansion of Neonatal Intensive Care Service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements, as well as charts for the service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1130.531 - Neonatal Intensive Care Services

1. Applicants proposing to establish, expand and/or modernize the Neonatal Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Neonatal Intensive Care		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand
1130.531(a) - A description of the project that identifies the location of the neonatal intensive care unit and the number of neonatal intensive care beds proposed;	X	X
1130.531(b) - Verification that a final cost report will be submitted to the Agency no later than 90 days following the anticipated project completion date;	X	X
1130.531(c) - Verification that failure to complete the project within the 24 months after the Board approved the exemption will invalidate the exemption.	X	X

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

SECTION V. CHANGE OF OWNERSHIP (CHOW) N/A Discontinuation of service

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X

1130.520(b)(2) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

Application for Change of Ownership Among Related Persons

When *a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership.* [20 ILCS 3960/8.5(a)]

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

VI. 1120.120 - AVAILABILITY OF FUNDS (Neonatal Intensive Care Services only)

N/A Discontinuation of service

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

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

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY N/A Discontinuation of service

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 N/A Discontinuation of service

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 OROER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

N/A Discontinuation of service

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

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	26
2	Site Ownership	29
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	31
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	34
5	Flood Plain Requirements	--
6	Historic Preservation Act Requirements	--
7	Project and Sources of Funds Itemization	--
8	Financial Commitment Document if required	--
9	Cost Space Requirements	--
10	Discontinuation	36
11	Background of the Applicant	--
12	Purpose of the Project	--
13	Alternatives to the Project	--
		--
	Service Specific:	--
14	Neonatal Intensive Care Services	--
15	Change of Ownership	--
		--
	Financial and Economic Feasibility:	--
16	Availability of Funds	--
17	Financial Waiver	--
18	Financial Viability	--
19	Economic Feasibility	--
20	Safety Net Impact Statement	79
21	Charity Care Information	--

☒	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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPENO OOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See Attachment 1, Exhibits 1 and 2.

File Number 1004-695-5

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1722501434 verifiable until 08/14/2018
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 14TH *day of* AUGUST *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1722501354 verifiable until 08/14/2018
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 14TH *day of* AUGUST *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Health and Hospitals Corporation
Address of Site Owner: 3075 Highland Parkway, Downers Grove, IL 60515
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.

Advocate Health Care

3075 Highland Parkway, Suite 600 || Downers Grove, Illinois 60515 || T 630.572.9393|| advocatehealth.com

August 14, 2017

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

RE: Advocate South Suburban Hospital
Certificate of Exemption
Discontinuation of Long Term Care and Pediatrics Categories of Service

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate Health and Hospitals Corporation owns the Advocate South Suburban Hospital site.

We trust this attestation complies with the Proof of Ownership requirement indicated in the Certificate of Exemption Permit Application – January 2017 edition.

Respectfully,

William Santulli
Executive Vice President/COO
Advocate Health Care

Notarization:
Subscribed and sworn to before me

This 25 day of August, 2017

Cristin G. Foster
Signature of Notary

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Mar 4, 2019

ATTACHMENT #2
EXHIBIT #1

Operating Identity/Licensee

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

Exact Legal Name: : Advocate Health and Hospitals Corporation d/b/a Advocate South Suburban Hospital

Address: 17800 South Kedzie Avenue, Hazel Crest, IL 60429

☒	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.

File Number 1004-695-5

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1722501434 verifiable until 08/14/2018
Authenticate at: http://www.cyberdrivelllinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 14TH *day of* AUGUST *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

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

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1722501364 verifiable until 08/14/2018
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 14TH *day of* AUGUST *A.D.* 2017 .

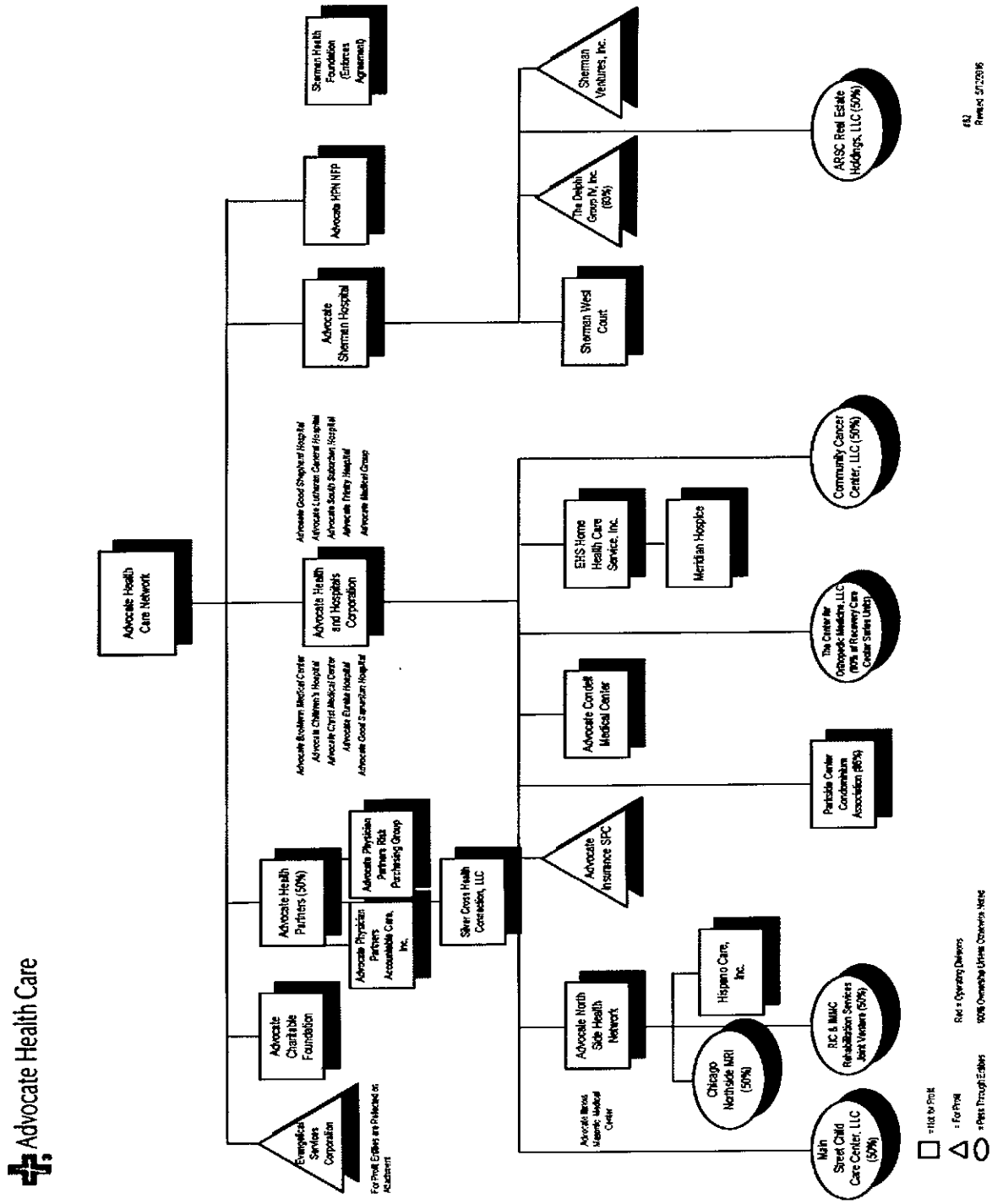
Jesse White

SECRETARY OF STATE

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.

See Attachment #4, Exhibit #1.


Advocate Health Care
Advocate Health Care Network
Advocate Health and Hospitals Corporation
Advocate Good Shepherd Hospital
Advocate Lutheran General Hospital
Advocate South Suburban Hospital
Advocate Trinity Hospital
Advocate Medical Group
Advocate Sherman Hospital
Advocate HCN NFP
Sherman Health Foundation (Endorses Agreement)
Sherman Ventures, Inc.
The Delphi Group IV, Inc. (83%)
Sherman West Court
ARSC Real Estate Holdings, LLC (50%)
Advocate Health Partners (50%)
Advocate Physician Partners Risk Purchasing Group
Advocate Physician Partners Accountable Care, Inc.
Advocate Charitable Foundation
Evangelical Services Corporation
For Profit Entities are Reflected on Attachment
Silver Cross Health Corporation, LLC
Advocate Insurance SPC
EHS Home Health Care Service, Inc.
Meridian Hospice
Community Cancer Center, LLC (50%)
The Center for Orthopedic Medicine, LLC (50% of Recovery Care Center Series Units)
Advocate Condell Medical Center
Parkside Center Condominium Association (85%)
Advocate North Side Health Network
Advocate Illinois Masonic Medical Center
Hispano Care, Inc.
Chicago Northside NRI (50%)
RIC & MAC Rehabilitation Services Joint Venture (50%)
Main Street Child Care Center, LLC (50%)
= Not for Profit
= For Profit
= Pass Through Entities
Rate = Operating Delivers
100% Ownership Unless Otherwise Noted
#82
Revised 5/12/2016

GENERAL INFORMATION REQUIREMENTS

9. Identify the categories of service and the number of beds, if any, that are to be discontinued.
   Long Term Care, 41 beds, and Pediatric, 10 beds

10. Identify all of the other clinical services that are to be discontinued.
    No clinical services will be discontinued.

11. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
    As soon as the certificate of exemption is granted

12. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
    The patient rooms will be used to provide more private rooms for medical/ surgical beds. No new beds will be added but will be relocated from multiple-bed rooms.

13. 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.
    The medical records will be maintained with the rest of Advocate South Suburban Hospital's patient records in accordance with record retention policies.

14. 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. N/A

15. 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.

    Copies of the printed notices and letters to the State Representative and Senator are included as exhibits 1, 2, 3, 4, and 5.

16. 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.
    See attached information as printed in the Daily Southtown newspaper.

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

3. **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.**

4. **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.

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

August 30, 2017

Representative Al Riley
3649 W. 183rd St., Suite 102
Hazel Crest, IL 60429

Re: Discontinuance of Long Term Care and Pediatrics Beds at
Advocate South Suburban Hospital

Dear Representative Riley:

This letter is to let you know that Advocate South Suburban Hospital intends to discontinue the authorized bed categories of service for its forty one (41) bed long term care and ten (10) bed pediatric inpatient services. The discontinuance is pending approval by the Illinois Health Facilities and Services Review Board (HFSRB).

Advocate South Suburban Hospital believes that right-sizing its complement of inpatient beds is important to meet community needs and be prudent stewards of health care resources. The need for long term care is adequately met in the area nursing homes. Likewise, the demand of pediatrics beds has shifted to larger facilities with a full array of pediatric specialists.

The greater need at South Suburban is for private rooms for the medical-surgical patients. This proposed change will provide more single occupancy rather than the current predominantly dual occupancy inpatient rooms. Single occupancy rooms have been demonstrated previously as being advantageous in limiting the spread of infection, enhancing patient privacy, and promoting an environment of healing. As more patients shift to outpatient care, the mix of remaining inpatients becomes more complex requiring the private rooms to manage their care.

The Hospital plans to submit the required Certificate of Exemption application to the HFSRB to be considered by November 14, 2017. A copy of the application will be posted on the HFSRB website at:

https://www.illinois.gov/sites/hfsrb/Projects/Pages/CompApps.aspx.

For additional information, contact me at (708) 213-3002 or Joseph Newsome, (708) 213-3696, at Advocate South Suburban Hospital.

Sincerely,

Richard Heim
President

A faith-based health system serving individuals, families and communities

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

August 30, 2017

Senator Michael E. Hastings
B13 School Road
Matteson, IL 60443

Re: Discontinuance of Long Term Care and Pediatrics Beds at
Advocate South Suburban Hospital

Dear Senator Hastings:

This letter is to let you know that Advocate South Suburban Hospital intends to discontinue the authorized bed categories of service for its forty one (41) bed long term care and ten (10) bed pediatric inpatient services. The discontinuance is pending approval by the Illinois Health Facilities and Services Review Board (HFSRB).

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The greater need at South Suburban is for private rooms for the medical-surgical patients. This proposed change will provide more single occupancy rather than the current predominantly dual occupancy inpatient rooms. Single occupancy rooms have been demonstrated previously as being advantageous in limiting the spread of infection, enhancing patient privacy, and promoting an environment of healing. As more patients shift to outpatient care, the mix of remaining inpatients becomes more complex requiring the private rooms to manage their care.

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https://www.illinois.gov/sites/hfsrb/Projects/Pages/CompApps.aspx.

For additional information, contact me at (708) 213-3002 or Joseph Newsome, (708) 213-3696, at Advocate South Suburban Hospital.

Sincerely,

Richard Heim
President

A faith-based health system serving individuals, families and communities

Daily Southtown | Section 2 | Sunday, August 27, 2017 7

RIER-NEWS NAPERVILLE SUN NEWS-SUN Post-Tribune Southtown

ssifieds

cars.com HomeFinder.com

SSIFIED AD ONLINE AT: PLACEANAD.TRIBUNESUBURBS.COM OR CALL: 866-399-0537

Help Wanted Full Time

amazon

Amazon is Hiring

Work less, earn more in Joliet & Monee, IL

At Amazon, your benefits start day one!

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- Dental
- Vision
- Stock award program
- Earn top pay rates
- Tuition assistance
- Performance-based bonuses
- Overtime opportunities

Walk in, apply, and walk away with an on-the-spot job offer!

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Joliet, IL 60435
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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT - CHANCERY DIVISION
WELLS FARGO BANK, NA Plaintiff,
-v.-
RONALD LEVON, ... UNKNOWN OWNERS AND NONRECORD CLAIMANTS Defendants
22456 LAKESHORE DRIVE RICHTON PARK, IL 60471
NOTICE OF SALE

[illegible]

LEGALS

Assumed Name

ASSUMED NAME

Notice is hereby given, pursuant to "An Act in relation to the use of an Assumed Business Name in the conduct of transaction of Business in the State," as amended, that a certification was registered by the undersigned with the County Clerk of Cook County. Registration Number: 0171517... on 08/..../2017 Under the Assumed Business Name of ... with the business located at 738 East 193rd Place, Glenwood, IL 60425. The true and real full name(s) and the residence address of the owner(s)/partner(s) is: Dorothy W Gill 738 East 193rd Place, Glenwood, IL 60425
8/27, 9/3, 9/10/2017 5154505

Legal Notices

Advocate South Suburban Hospital, 17800 South Kedzie Avenue, Hazel Crest, IL 60429 intends to discontinue the authorized bed categories of service for its forty one (41) bed long term care and ten (10) bed pediatric inpatient services, pending approval by the Illinois Health Facilities and Services Review Board (HFSRB). The hospital plans to submit the required Certificate of Exemption Application to the HFSRB to be considered by November 14, 2017. A copy of the application will be posted on the HFSRB website at https://www.illinois.gov/sites/hfsrb/Projects/Pages/Compappl.aspx. For additional information, contact Joseph Newmore (708) 213-3495, at Advocate South Suburban Hospital.
8/27 - 8/29/2017 5153777

Exhibit 2
Location: W/S I-294 N/O 159th Street
PIN # 28-13-405-008-0000 and 009
Comments: The property is owned by POW Media, Inc. and the company seeks to erect a billboard on the property. Zoning change to ... status from 159th Street to 158th Street is required. POW Media, Inc. will transfer property ownership to the City of Markham in return for an easement in perpetuity. ...

NOTICE IS HEREBY GIVEN by the Board of Education of South Holland School District Number 150, Cook County, Illinois, that the tentative budget for said School District for the fiscal year beginning July 1, 2017 will be on file and conveniently available for public inspection at the Office of the Superintendent ...

4 Daily Southtown | Section 2 | Monday, August 28, 2017

Beacon-News COURIER-NEWS NAPERVILLE SUN NEWS-SUN Post-Tribune Southtown

Classifieds

network Chicago Tribune cars.com HomeFinder.com

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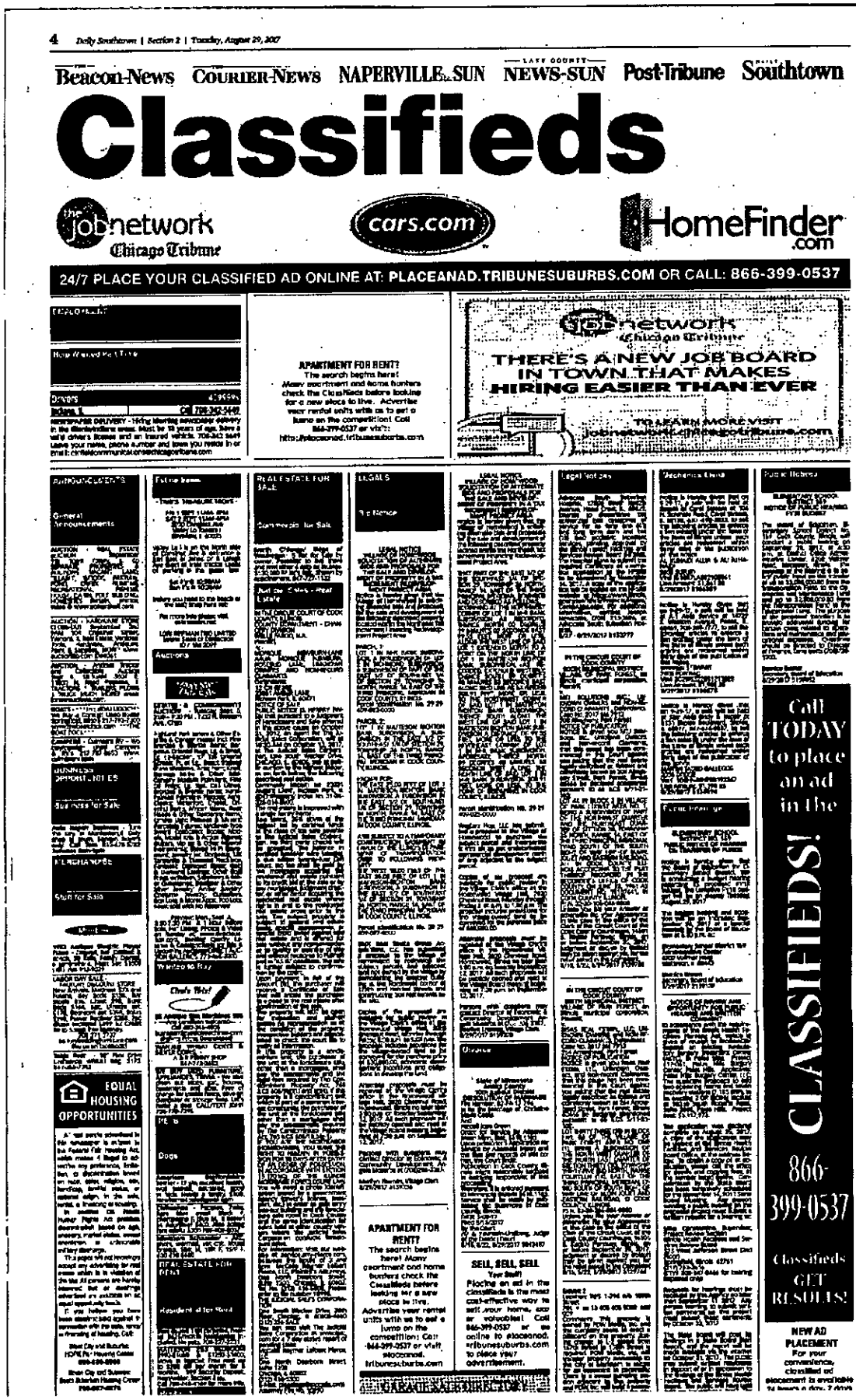
To Place An Ad Call: 866-399-0537



4 Daily Southtown | Section 2 | Tuesday, August 29, 2017

Beacon-News COURIER-NEWS NAPERVILLE SUN LAKE COUNTY NEWS-SUN Post-Tribune Southtown

Classifieds

the jobnetwork Chicago Tribune cars.com HomeFinder.com

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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.

The primary reason that Advocate South Suburban Hospital is seeking to discontinue offering long term care and pediatrics services is based on the need to have more space to place medical surgical beds in single occupancy rooms. The advantages of private rooms are well documented. Currently the Hospital has 184 of its 197 medical surgical beds or 93% in dual occupancy rooms which has limited the flexibility to fully utilize them.

An analysis of the use of the beds was made for the calendar year 2016. There were 1,899 instances of beds being blocked. Of these, 1396 were directly related to patient select conditions. The total time those beds were blocked added up to 3,681 days a bed was not available. Selected patient care associated reasons that beds were blocked included the following:

Expired Patient	6
Isolation	1,254
Medical Issues	37
Neutropenia (low white cell count)	61
Police Arrest, Private	10
Suicidal (needing a sitter)	28
Total Instances	1,396

That represented 73% of the total 1,899 blocked beds. In addition to the patient care reasons, there were times during the year when other circumstances blocked the whole room so both beds were not available, such as an air-handler replacement project (18 times beds blocked) and maintenance (254 times beds blocked).

In 2016, the Emergency Department experienced 50,039 visits. Of those, 4.9% (2,452 patients) left without being treated due to increased Emergency Department wait times. Additionally, the Emergency Department experienced 913 hours of peak census and 213 hours of by-pass in 2016. The average conversion from an emergency department visit to an admission is 0.65. Missed opportunities for patient admissions due to being on by-pass was 139.

It is evident that by increasing the availability of private rooms that will decrease the amount of blocked beds, thus improving Emergency Department throughput. When beds are not available, peak census conditions directly impact Emergency Department throughput leading to increased Emergency Room waiting times, increased Emergency Department boarding, and ultimately, the Emergency Department must go on by-pass and divert emergency patients to other facilities. Currently there are only 13 medical surgical beds in private rooms. This proposed change will open up 31 rooms (21 long term care rooms and 10 pediatric rooms) to provide more single occupancy rather than the current predominantly dual occupancy medical surgical rooms. By taking a bed out of the dual occupancy room and moving it to a single occupancy room, there will be 13 + (31x2) = 75 medical surgical patients in single occupancy (private) rooms.

Single occupancy rooms have been demonstrated previously as being advantageous in limiting the spread of infection, enhancing patient privacy, and promoting an environment of healing. As

more patients shift to outpatient care, the mix of remaining inpatients becomes more complex requiring the private rooms to manage their care.

Advocate South Suburban Hospital believes that right-sizing its complement of inpatient beds is important to meet community needs and be prudent stewards of health care resources. The need for long term care is adequately met in the area nursing homes. Likewise, the demand of pediatrics beds has shifted to larger facilities with a full array of pediatric specialists. That has been demonstrated in the fact there have been no pediatric admissions in 2017. The proposed change will not result in any deficit in long term or pediatric care and will improve the medical surgical patients' care.

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

August 9, 2017

Certified Mail

Administrator
Facility
Address
City, State

Request for Impact Statement

Dear Administrator:

This letter is to inform you that Advocate South Suburban Hospital is seeking a Certificate of Exemption from the Illinois Health Facilities and Services Review Board to discontinue its long term care (LTC) category of service and its 41 LTC beds. The anticipated date of closure is September 30, 2017.

In 2015, Advocate South Suburban Hospital admitted 795 LTC patients who received 9,908 days of inpatient care. In 2016, there were 820 LTC patients admitted and 9,278 days of inpatient care. Between January 1 and June 30, 2017, there were 368 patients admitted and 4,220 days of inpatient care for an average length of stay of 11.5 days.

The purpose of this letter is to inquire whether your facility has or will have available capacity to accommodate a portion or all of the experienced caseload. In addition, please indicate whether any restrictions or limitations preclude providing service to the residents of Advocate South Suburban Hospital's market area.

Please respond within 15 days of receiving this letter. Failure to respond within the prescribed 15-day response period shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact on your facility.

Thank you for your consideration of this request.

Sincerely,

Richard Heim
President

LTC FACNAME	ADDRESS	CITY	St	Receipt page
Aperion Care Chicago Heights	490 West 16th Place	Chicago Heights	IL	77
Aperion Care Midlothian	3249 West 147 Street	Midlothian	IL	74
Bria of Chicago Heights	120 West 26th Street	S Chicago Hts	IL	73
Generations at Applewood	21020 Kostner Avenue	Matteson	IL	67
Glenshire Nsg & Rehab Centre	22660 South Cicero Ave	Richton Park	IL	71
Heather Healthcare Center	15600 Honore Ave	Harvey	IL	66
Manorcare of Homewood	940 Maple Avenue	Homewood	IL	64
Pine Crest Health Care	3300 West 175th Street	Hazel Crest	IL	70
Prairie Manor Nsg & Rehab Ctr	345 Dixie Highway	Chicago Heights	IL	72
Providence Palos Heights	13259 South Central Ave	Palos Heights	IL	70
South Suburban Rehab Center	19000 Halsted Street	Homewood	IL	63
Symphony of Crestwood	14255 South Cicero Ave	Midlothian	IL	75
The Villa at South Holland	16300 Wausau Street	South Holland	IL	65
Windmill Nursing Pavilion	16000 South Wabash	South Holland	IL	68
Windsor Estates Nursing & Rehab	18300 South Lavergne Ave	Country Club Hills	IL	74

No nursing homes reported any expected adverse impact. Rather, five of the facilities listed above indicated they could accommodate patients from Advocate South Suburban Hospital. See the following letters. In addition, a letter was received from St. James Manor, 1251 E. Richton Rd, Crete, IL 60417 after they learned of the proposed discontinuation, expressing a willingness to take patient referrals.

Sabrina Garth, Nurse
Director of Business Development

Cell
708 646.8368

Fax
708 589 1381

Address
16300 Wausau Avenue
South Holland, IL 60473

E-mail
sgarth@villahc.com

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Mr. Richard Heim

Advocate South Suburban Hospital

17800 South Kedzie Ave.

Hazel Crest, Illinois 60429

RE: Impact Statement

Dear Mr. Heim,

As the Administrator of the Villa at South Holland, I have always enjoyed sharing a warm collegial relationship with you and your organization. Several physicians from your medical staff are also members of my medical staff which has allowed us to create a seamless transition of care from your hospital to our skilled care facility. Also as a proud member of your Post-Acute Care Network I have enjoyed working collaboratively with your team to improve our joint patient outcomes.

We are ready, willing, and able to accept your patients in to our facility as you close your skilled care unit. I promise to continue to provide exceptional care and outstanding service to those patients because everything we do is rooted in making people better. Please let me know how we can be of assistance to you during this transition.

I wish you continued success in your future endeavors!

Sincerely,

Susan Ahlgren RN/MSN/LNHA

Executive Administrator

Phone: (708) 225-6130

Email: Sahlgren@villahc.com

PROVIDENCE
Healthcare &
Rehabilitation Center

August 21, 2017

Richard Heim
Advocate South Suburban Hospital
17800 South Kedzie Avenue
Hazel Crest, IL 60429

Response to Letter

Dear Richard:

This letter is in response to the letter we received on August 9, 2017 titled "Request for Impact Statement". We here at Providence of Palos Heights are able to accept a portion of your caseload. We are a licensed 193 bed Skilled Nursing Facility. We do offer Marianjoy Rehabilitation. Dr. Asad Zaman is our Medical Director and we have his IMMPACT team managing patients here. We have had great success with reducing our Re-admission rate with Dr. Zaman and his team managing patients. We do have admission criteria and would look forward to having our Hospital Nurse Liaison screen any potential patients.
Please contact me to arrange that at 708-597-1000. Thank you.

Megan Tengerstrom
Administrator
Providence of Palos Heights
13259 S. Central Ave
Palos Heights, IL 60463

13259 S. Central Avenue · Palos Heights, Illinois 60463
708.597.1000 · 708.389.9990 · providencelifeservices
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HEALTH SERVICES
of Chicago Heights

www.briahs.com

Richard Heim, President

Advocate South Suburban Hospital

17800 South Kedzie Ave.

Hazel Crest, IL 60429

August 16, 2017

Dear Mr. Heim,

I am writing in response to your letter to notify you that Bria of Chicago Heights has the available capacity to accommodate a portion of the caseload. There are currently no limitations or restrictions to report, each referral is reviewed on the case by case basis. If you have any further questions you may contact me at 708-756-5200 or mcarter@briahs.com.

Sincerely,

Marcita Carter,

Administrator

BRIA Health Services 120 West 26th Street Chicago Heights, Illinois 60411 p: 708.756.5200 fax: 708.709.3142

HCR ManorCare Health Services
940 Maple Avenue
Homewood, Illinois 60430
708.799.0244
708.799.1505 fax

ManorCare Health Services

August 24, 2017

Advocate South Suburban Hospital

17800 South Kedzie Avenue

Hazel Crest, IL 60429

To: Richard Heim

Re: Impact Statement

Thank you for the information provided regarding the discontinuation of Advocate South Suburban Hospital's long term care unit. Manor Care of Homewood does have the ability to accommodate the caseload outlined in your letter. While all admissions are reviewed on a case by case basis, there are some patient services that the facility does not provide. Those patients that need: ventilators, peritoneal dialysis, hemodialysis and epidurals with external pumps.

Manor Care of Homewood would not be adversely impacted by the closure of the LTC unit. Again, thank you for the opportunity to work with you and the community to provide the needed services for our population.

Please contact me if I can provide further information.

Sincerely,

Frank P. Troha

Administrator

Manor Care of Homewood

19000 S. Halsted
Homewood, IL 60430
t: 708.957.9200
f: 708.957.7828

Accessible 24/7 365

South Suburban

NURSING & REHABILITATION CENTER

August 22, 2017

Certified Mail

Richard Heim- President
Advocate South Suburban Hospital
17800 South Kedzie
Hazel Crest, Ill 60429

Dear President:

This letter is to inform you that South Suburban Nursing and Rehab, has the available capacity to accommodate a portion or all of the experienced caseload. We do not accept patient's on ventilators.

Thank you for your consideration.

Sincerely,

Nichole Cole

Nichole Cole
Administrator

www.southsuburbannursing.com

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August 23, 2017

Mr. Richard Heim
President
Advocate South Suburban Hospital
17800 South Kedzie Avenue
Hazel Crest, Illinois 60429

Dear Mr. Heim:

This letter is in response to the certified letter received regarding the interest in receiving those persons on your Rehabilitation / LTC caseload. St. James Manor and Villas (St. James Wellness Rehab and Villas) can accommodate those persons in need of such services. Our facility is a Skilled Nursing Facility and services both short term and long term service needs with the value of excellent care and customer service emphasis. St. James Manor and Villas provides all skilled service needs with the exception of vent services and in house dialysis. In addition, we will set up transportation services to various appointments necessary to meet the needs of those we serve. A final note is that we have an in- house cardiology program and outpatient therapy availability to the community.

St. James Manor and Villas serves the community as a Continuum Care Retirement Community with an added component of Assisted Living and Memory Care unit. St. James Manor and Villas is able to provide a multiple set of services within the St. James Manor and Villas Community. Continuity of care is maintained with the variety of services we have to offer.

Please feel free to contact me at any time with any questions or concerns at 708-672-6700.

We look forward to working with you and your organization.

Sincerely,

Sandra L. Erickson

Administrator

1251 E. RICHTON ROAD. CRETE. IL 60417 TEL. 708-367-4410

Advocate South Suburban Hospital
17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799 8000 || advocatehealth.com

August 9, 2017

Certified Mail

Administrator
Hospital
Address
City, State

Request for Impact Statement

Dear Administrator:

This letter is to inform you that Advocate South Suburban Hospital is seeking a Certificate of Exemption from the Illinois Health Facilities and Services Review Board to discontinue its pediatric category of service with its 10 pediatric beds. The anticipated date of closure is September 30, 2017.

In 2015 Advocate South Suburban Hospital admitted 99 pediatric patients and had 423 days of inpatient and observation care. In 2016 there were 27 pediatric patients admitted and 108 days of inpatient and observation care. There have been no admissions in 2017.

The purpose of this letter is to inquire whether your hospital has or will have available capacity to accommodate a portion or all of the experienced caseload. In addition, please indicate whether any restrictions or limitations preclude providing service to the residents of Advocate South Suburban Hospital's market area.

Please respond within 15 days of receiving this letter. Failure to respond within the prescribed 15-day response period shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact for your facility.

Thank you for your consideration of this request.

Sincerely,

Richard Heim
President

Facilities with Pediatric Category of Service	Street	City	St	Receipt Page
Adventist Hinsdale Hospital	120 North Oak Street	Hinsdale	IL	71
Advocate Christ Hospital and Medical Center	9500 South Kenneth Ave	Oak Lawn	IL	73
Advocate Good Samaritan Hospital	3815 Highland Avenue	Downers Grove	IL	70
Advocate Illinois Masonic Medical Center	836 West Wellington	Chicago	IL	75
Ann & Robert Lurie Children's Hospital of Chicago	2300 Childrens Plaza	Chicago	IL	78
Elmhurst Memorial Hospital	York Rd & Roosevelt Rd	Elmhurst	IL	72
Ingalls Memorial Hospital	One Ingalls Drive	Harvey	IL	73
Jackson Park Hosp. Foundation	7531 Stony Island Avenue	Chicago	IL	72
John H. Stroger Hospital of Cook County	1901 West Harrison Street	Chicago	IL	61
LaRabida Children's Hospital	6501 S. Promontory Drive	Chicago	IL	62
Little Company of Mary Hospital and Health Care Cntr	2800 West 95th Street	Evergreen Park	IL	74
Loyola Health System at Gottlieb	701 West North Avenue	Melrose Park	IL	77
Loyola University Medical Center/Foster G. McGaw	2160 South 1st Avenue	Maywood	IL	58
MacNeal Memorial Hospital	3249 South Oak Park Avenue	Berwyn	IL	58
Morris Hospital & Healthcare Centers	150 West High Street	Morris	IL	70
Mount Sinai Hospital Medical Center	1501 S California Ave	Chicago	IL	77
Norwegian American Hospital	1044 North Francisco Avenue	Chicago	IL	59
Palos Community Hospital	12251 South 80th Avenue	Palos Heights	IL	73
Presence Resurrection Medical Center	7435 West Talcott Avenue	Chicago	IL	76
Presence Saint Joseph Hospital	2900 North Lake Shore W	Chicago	IL	75
Presence Saint Joseph Medical Center	333 North Madison Street	Joliet	IL	76
Presence Saint Mary's Hospital	500 West Court Street	Kankakee	IL	71
Rush University Medical Center	1653 West Congress Parkway	Chicago	IL	74
Saint Mary Of Nazareth Hospital	2233 West Divison Street	Chicago	IL	60
Shriner's Hospitals for Children	2211 North Oak Park	Elmwood Park	IL	76
Silver Cross Hospital	1900 Silver Cross Boulevard	New Lenox	IL	69
St. Anthony Hospital	2875 West 19th Street	Chicago	IL	69
St. Bernard Hospital	326 West 64th Street	Chicago	IL	71
Swedish Covenant Hospital	5145 North California Avenue	Chicago	IL	76
University Of Chicago Medical Center	5841 South Maryland	Chicago	IL	69
University of Illinois Hospital	1740 West Taylor Avenue	Chicago	IL	72
VHS West Suburban Medical Center	622 North Austin Ave	Oak Park	IL	69
VHS Westlake Hospital	1225 W Lake St	Melrose Park	IL	77

No hospitals reported any expected adverse impact from Advocate South Suburban Hospital discontinuing pediatrics category of service. Rather, two of the facilities listed above indicated they could accommodate pediatric patients from Advocate South Suburban Hospital. See the following two letters.

Presence
Saint Joseph Medical Center

August 16, 2017

Mr. Richard Heim
President
Advocate South Suburban Hospital
17800 South Kedzie Avenue
Hazel Crest, IL 60429

Dear Mr. Heim:

In response to your request for impact statement dated August 9, 2017, please accept this letter as notification that Presence Saint Joseph Medical Center has the capacity to accommodate and serve your pediatric population in our emergency department and our 13-bed pediatric unit.

There are no known restrictions or limitations that we are aware of for the residents in the said market area. Presence Saint Joseph Medical Center has a skilled and competent group of pediatric hospitalists that serve our patients, and we welcome your residents during their time of need.

Please feel frea to contact me directly, if there are any other questions.

Sincerely,

Lynn Watson, RN, MSN

Lynn Watson, RN
Interim Chief Nursing Officer

LW:bcp

333 North Madison Street, Joliet, Illinois 60435 815.725.7133
presencehealth.org

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Healthy Driven
Edward-Elmhurst
HEALTH

August 25, 2017

Richard Heim
President
Advocate South Suburban Hospital
17800 South Kedzie Avenue
Hazel Crest, IL 60429

Dear Mr. Heim:

We received your letter notifying Elmhurst Memorial Hospital of Advocate South Suburban Hospital's intent to file a Certificate of Exemption with the Illinois Health Facilities and Services Review Board to discontinue its pediatric category of service with its 10 pediatric beds. Given the 30 mile distance between South Suburban and Elmhurst Hospitals, and small number of pediatric patients seeking care at South Suburban in the last several years with no pediatric admissions to the hospital in 2017, we do not anticipate any impact, adverse or otherwise, to Elmhurst Memorial Hospital. Elmhurst Hospital currently has excess inpatient pediatric capacity to handle additional pediatric cases if needed.

We hope this information proves to be useful as you pursue this project. If you have any further questions, please contact Cheryl Eck, Associate Vice President, Strategy & Planning, at 331-221-3478.

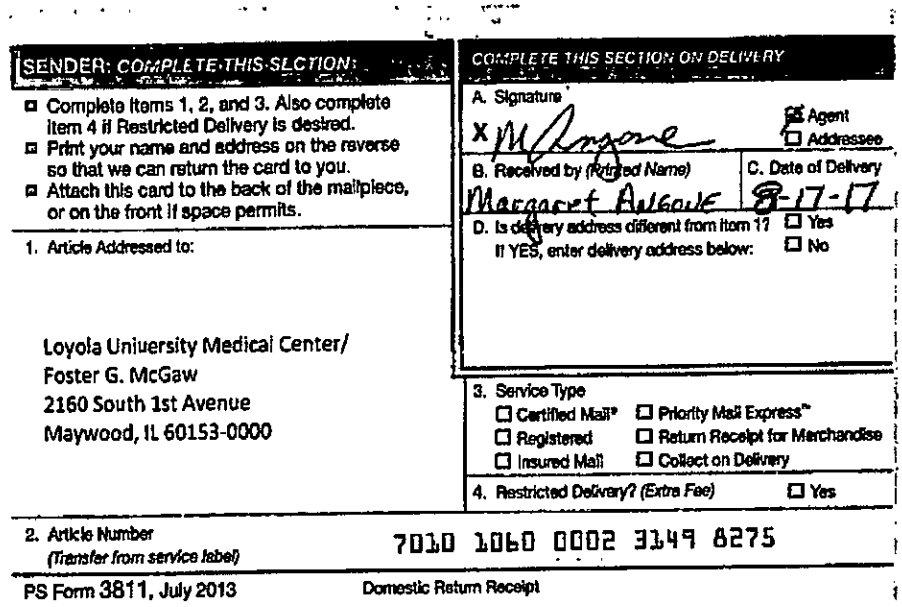
Sincerely,

Pamela L Dunley

Pamela Dunley
President/CEO

Elmhurst Memorial Hospital
155 E. Brush Hill Road
Elmhurst, IL 60126

Pages 58-78 of this application contain copies of postal service documentation showing receipt by all of the healthcare entities listed on pages 46 and 54 of this application of Advocate South Suburban Hospital's intent to discontinue its skilled nursing and pediatric categories of service.



SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Loyola Uniuersity Medical Center/
Foster G. McGaw
2160 South 1st Avenue
Maywood, IL 60153-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Margaret Aulgoue C. Date of Delivery 8-17-17

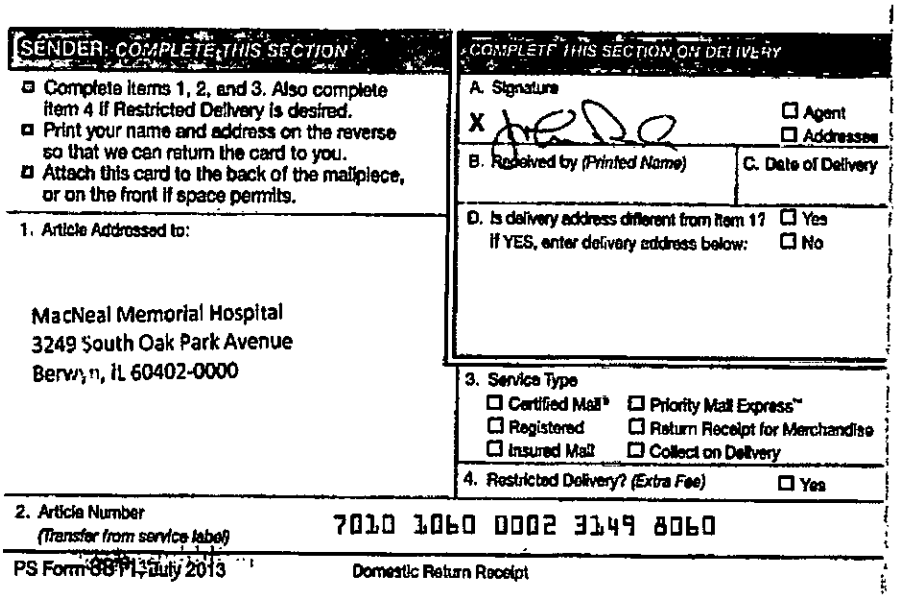
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8275

PS Form 3811, July 2013 Domestic Return Receipt



SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

MacNeal Memorial Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
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2. Article Number (Transfer from service label) 7010 1060 0002 3149 8060

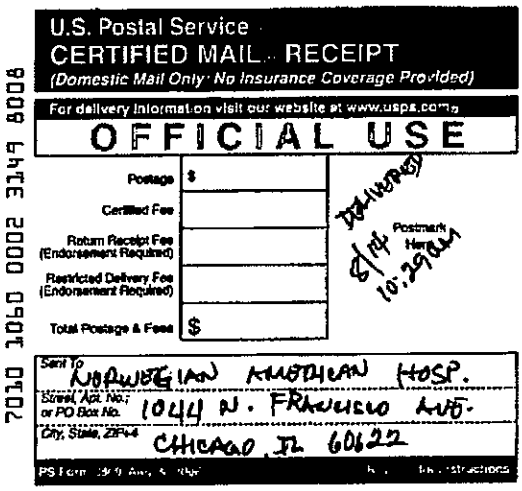
PS Form 3811, July 2013 Domestic Return Receipt

USPS Tracking® Results

FAQs

Track Another Pac

Tracking Number: 70101060000231498008



Delivered

Updated Delivery Day: Monday, August 14, 2017 ⓘ

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
August 14, 2017, 10:29 am	**Delivered, Left with Individual**	**CHICAGO, IL 60622**

Your item was delivered to an individual at the address at 10:29 am on August 14, 2017 in CHICAGO, IL 60622.

August 14, 2017, 9:18 am	In Transit to Destination	ON ITS WAY TO CHICAGO, IL 60622
August 14, 2017, 7:18 am	Arrived at Unit	CHICAGO, IL 60622

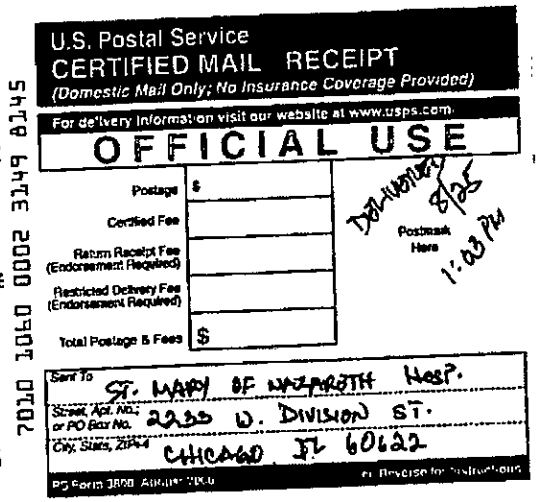
sds

USPS Tracking® Results

FAQ

Track Another Pa

Tracking Number: 70101060000231498145



Delivered

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
August 25, 2017, 1:03 pm	**Delivered, Individual Picked Up at Postal Facility**	**CHICAGO, IL 60622**
August 25, 2017, 8:12 am	Out for Delivery	CHICAGO, IL 60622
August 25, 2017, 8:02 am	Sorting Complete	CHICAGO, IL 60622
August 24, 2017, 7:35 am	Arrived at Unit	CHICAGO, IL 60622

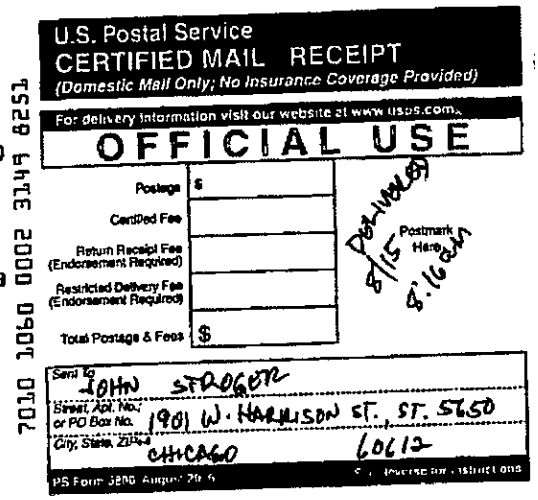
Your item was picked up at a postal facility at 1:03 pm on August 25, 2017 in CHICAGO, IL 60622.

USPS Tracking® Results

FAQ

Track Another Pa

Tracking Number: 70101060000231498251


U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com.
OFFICIAL USE
Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $
Postmark Here
8/15
8:16 am
Sent To JOHN STROGER
Street, Apt. No.; or PO Box No. 1901 W. HARRISON ST., ST. 5650
City, State, ZIP+4 CHICAGO 60612
PS Form 3800, August 2006
7010 1060 0000 3149 8251

Delivered

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

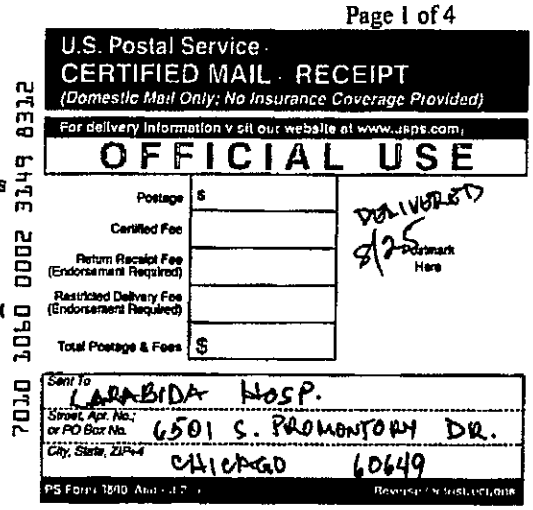
DATE & TIME	STATUS OF ITEM	LOCATION
August 15, 2017, 8:16 am	**Delivered, Left with Individual**	**CHICAGO, IL 60612**
	Your item was delivered to an individual at the address at 8:16 am on August 15, 2017 in CHICAGO, IL 60612.	
August 14, 2017, 12:08 pm	Business Closed	CHICAGO, IL 60612
August 14, 2017, 9:36 am	In Transit to Destination	ON ITS WAY TO CHICAGO, IL 60612
August 14, 2017, 8:43 am	Out for Delivery	CHICAGO, IL 60612

USPS Tracking® Results

FAQs

Track Another Pac

Tracking Number: 70101060000231498312



Delivered

Updated Delivery Day: Friday, August 25, 2017 ⓘ

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

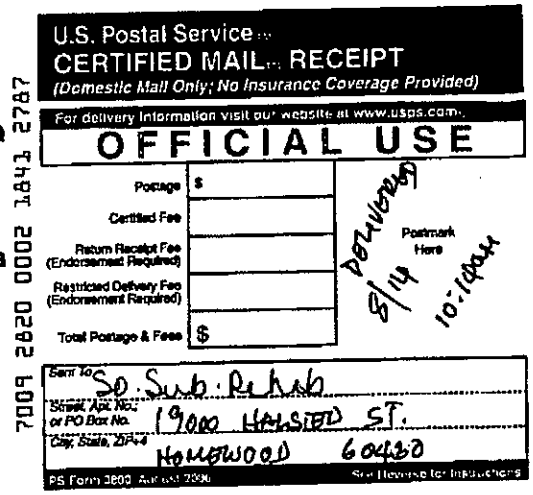
DATE & TIME	STATUS OF ITEM	LOCATION
August 25, 2017, 10:44 am	**Delivered, To Agent**	**HAZEL CREST, IL 60429**
	Your item has been delivered to an agent at 10:44 am on August 25, 2017 in HAZEL CREST, IL 60429.	
August 25, 2017, 8:32 am	Out for Delivery	HAZEL CREST, IL 60429
August 25, 2017, 8:22 am	Sorting Complete	HAZEL CREST, IL 60429
August 25, 2017, 8:02 am	Arrived at Unit	HAZEL CREST, IL 60429

USPS Tracking® Results

FAQ

Track Another Pa

Tracking Number: 70092820000218412787



Delivered

Updated Delivery Day: Monday, August 14, 2017 ⓘ

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
August 14, 2017, 10:14 am	**Delivered, Left with Individual**	**HOMEWOOD, IL 60430**

Your Item was delivered to an individual at the address at 10:14 am on August 14, 2017 in HOMEWOOD, IL 60430.

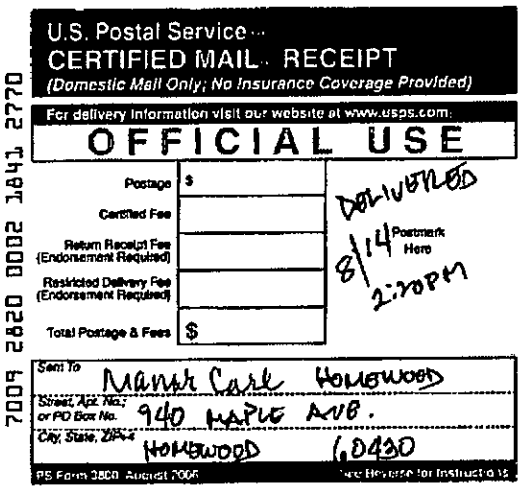
August 14, 2017, 8:58 am	Out for Delivery	GLENWOOD, IL 60425
August 14, 2017, 8:48 am	Sorting Complete	GLENWOOD, IL 60425
August 14, 2017, 8:19 am	Arrived at Unit	GLENWOOD, IL 60425

USPS Tracking® Results

FAQs

Track Another Pac

Tracking Number: 70092820000218412770



Delivered

Updated Delivery Day: Monday, August 14, 2017 ⓘ

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

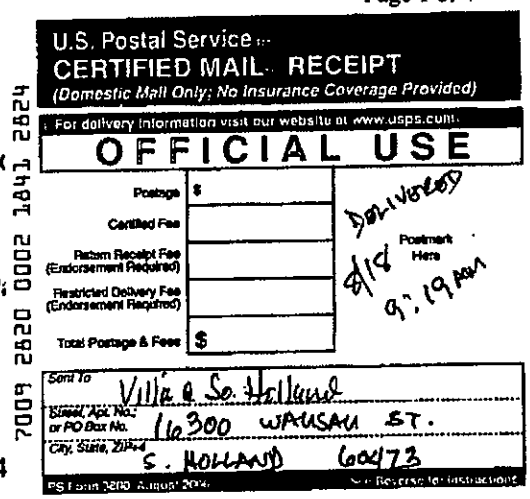
DATE & TIME	STATUS OF ITEM	LOCATION
August 14, 2017, 2:20 pm	**Delivered, Left with Individual**	**HOMEWOOD, IL 60430**
	Your item was delivered to an individual at the eddress at 2:20 pm on August 14, 2017 in HOMEWOOD, IL 60430.	
August 14, 2017, 8:58 am	Out for Delivery	GLENWOOD, IL 60425
August 14, 2017, 8:48 am	Sorting Complete	GLENWOOD, IL 60425
August 14, 2017, 8:19 am	Arrived at Unit	GLENWOOD, IL 60425

USPS Tracking® Results

FA(

Track Another P;

Tracking Number: 70092820000218412824



Delivered

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

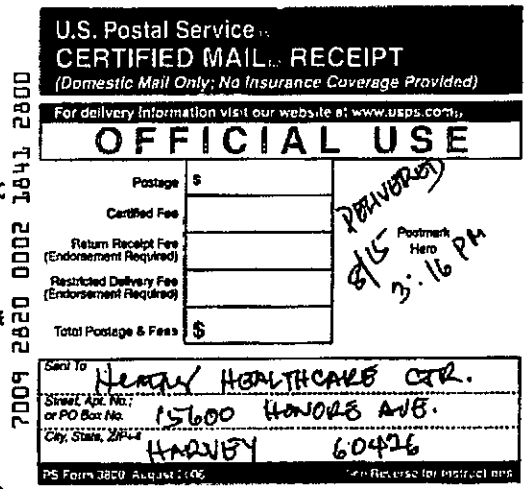
DATE & TIME	STATUS OF ITEM	LOCATION
August 18, 2017, 9:19 am	**Delivered, Left with Individual**	**SOUTH HOLLAND, IL 60473**
	Your item was delivered to an individual at the address at 9:19 am on August 18, 2017 in SOUTH HOLLAND, IL 60473.	
August 14, 2017, 8:48 am	Out for Delivery	SOUTH HOLLAND, IL 60473
August 14, 2017, 8:38 am	Sorting Complete	SOUTH HOLLAND, IL 60473

USPS.com® - USPS Tracking® Results

USPS Tracking® Results

FAC

Track Another P



Tracking Number: 70092820000218412800

Delivered

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
August 15, 2017, 3:16 pm	**Delivered, Left with Individual**	**HARVEY, IL 60426**

Your item was delivered to an individual at the address at 3:16 pm on August 15, 2017 in HARVEY, IL 60426.

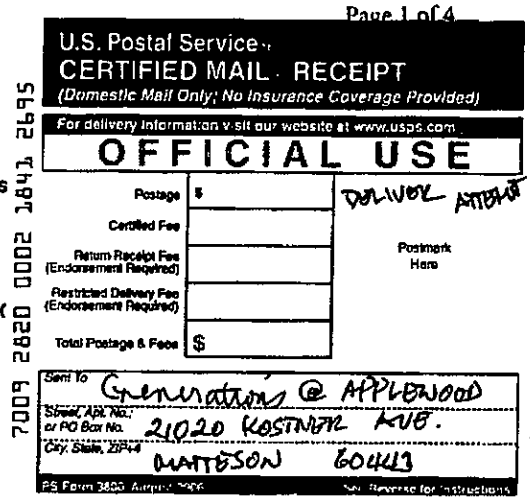
August 14, 2017, 4:05 pm	Notice Left (No Secure Location Available)	HARVEY, IL 60426
August 14, 2017, 9:10 am	Out for Delivery	HARVEY, IL 60426
August 14, 2017, 9:00 am	Sorting Complete	HARVEY, IL 60426

https://tools.usps.com/go/TrackConfirmAction?tRef=fullpage&tLc=2&text28777=&tLabe... 8/29/2017

USPS Tracking® Results

FAQs

Track Another Pac



Tracking Number: 70092820000218412695

Delivery Attempt: Action Needed

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
	Reminder to Schedule Redelivery of your Item	

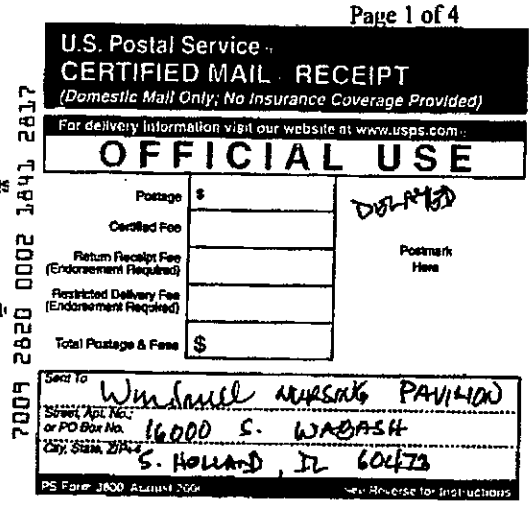
This is a reminder to arrange for redelivery of your item or your item will be returned to sender. You may arrange redelivery by using the Schedule a Redelivery feature on this page or calling 800-ASK-USPS, or may pick up the item at the Post Office indicated on the notice.

August 14, 2017, 3:54 pm	Notice Left (No Secure Location Available)	MATTESON, IL 60443
August 14, 2017, 5:27 am	Arrived at Unit	MATTESON, IL 60443

USPS Tracking® Results

FAQs

Track Another Pa



Tracking Number: 70092820000218412817

Alert

Your item has been subject to a delivery delay at 10:47 am on August 18, 2017 in SOUTH HOLLAND, IL 60473. Your item will go out for delivery on the next business day.

Product & Tracking Information

See Available Actions

Postal Product: **Features:** Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
August 18, 2017, 10:47 am	**Delivery Delay**	**SOUTH HOLLAND, IL 60473**
	Your item has been subject to a delivery delay at 10:47 am on August 18, 2017 in SOUTH HOLLAND, IL 60473. Your item will go out for delivery on the next business day.	
August 14, 2017, 8:48 am	Out for Delivery	SOUTH HOLLAND, IL 60473

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

University Of Chicago Medical Center
5841 South Maryland
Chicago, IL 60637-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
8/15/17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0002 5253 9921

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

VHS West Suburban Medical Center
622 North Austin Ave
Oak Park, IL 60302-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
[illegible] 8.17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 7995

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Silver Cross Hospital
1900 Silver Cross Boulevard
New Lenox, IL 60451

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8046

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

St. Anthony Hospital
2875 West 19th Street
Chicago, IL 60623-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) L. Jones | C. Date of Delivery 8-14-17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8091

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Providence Palos Heights
13259 South Central Avenue
Palos Heights, IL 60463-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Amber Lacy ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2725

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Morris Hospital & Healthcare Centers
150 West High Street
Morris, IL 60450-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
8-15

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 7957

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-15

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Pine Crest Health Care
3300 West 175th Street
Hazel Crest, IL 60429-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
8-14

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2732

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Advocate Good Samaritan Hospital
3815 Highland Avenue
Downers Grove, IL 60515-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
8/15/17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8039

PS Form 3811, July 2013 Domestic Return Receipt

ENDER: COMPLETE THIS SECTION

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

. Article Addressed to:

Presence Saint Mary's Hospital
500 West Court Street
Kankakee, IL 60901-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X B. [illegible] ☒ Agent ☐ Addressee

B. Received by (Printed Name) B. Franks C. Date of Delivery 8-4-17

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

AUG 7

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

. Article Number (Transfer from service label) 7010 1060 0002 3149 8114

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

St. Bernard Hospital
326 West 64th Street
Chicago, IL 60621-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature [illegible] ☐ Agent ☐ Address

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandi
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8084

PS Form 3811, July 2013 Domestic Return Receipt

ENDER: COMPLETE THIS SECTION

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

. Article Addressed to:

enshire Nsg & Rehab Centre
)660 South Cicero Avenue
chton Park, IL 60472-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature X [illegible] ☒ Agent ☐ Addressee

B. Received by (Printed Name) DANIELANTIN C. Date of Delivery 8/4/17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

. Article Number (Transfer from service label) 7009 2820 0002 1841 2688

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Adventist Hinsdale Hospital
120 North Oak Street
Hinsdale, IL 60521-0000

AUG 15 2017

COMPLETE THIS SECTION ON DELIVERY

A. Signature X [illegible] ☐ Agent ☐ Address

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandi
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8206

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Elmhurst Memorial Hospital
York Rd & Roosevelt Rd
Elmhurst, IL 60126-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8015

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Prairie Manor Nsg & Rehab Ctr
345 Dixie Highway
Chicago Heights, IL 60411-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Chastellar Stubbs C. Date of Deliv

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2756

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

University of Illinois Hospital
1740 West Taylor Avenue
Chicago, IL 60612-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 3/14/17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8282

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Jackson Park Hosp. Foundation
7531 Stony Island Avenue
Chicago, IL 60649-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

7531 Stony Island 6

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 3460 0003 2412 5833

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Ingalls Memorial Hospital
One Ingalls Drive
Harvey, IL 60426-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 5-16-17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8183

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Palos Community Hospital
12251 South 80th Avenue
Palos Heights, IL 60463-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) William Gitmer C. Date of Delivery 5-17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8176

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Advocate Christ Hospital & Medical Center
9500 South Kenneth Ave
Oak Lawn, IL 60453 [illegible]

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 5-16

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8299

S Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Bria of Chicago Heights
120 West 26th Street
S Chicago Hts, IL 60411-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 5/16

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2763

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-15

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Windsor Estates Nursing & Rehab
18300 South Lavergne Ave
Country Club Hills, IL 60478

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 8/14/17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2701

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Rush University Medical Center
1653 West Congress Parkway
Chicago, IL 60612-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Age ☐ Add

B. Received by (Printed Name) C. Date of D 8/14

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merch
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8213

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Little Company of Mary Hospital and
Health Care Center
2800 West 95th Street
Evergreen Park, IL 60642-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8220

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Aperion Care Midlothian
3249 West 147 Street
Midlothian, IL 60445-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addr

B. Received by (Printed Name) C. Date of Del 8/14/17

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2794

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

nphony of Crestwood
255 South Cicero Ave
dlothian, IL 60445-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Nancy McDonald C. Date of Delivery 8-14-17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2718

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Advocate Illinois Masonic Medical Center
836 West Wellington
Chicago, IL 60657-5193

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addr

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

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

CHICAGO, IL 606
AUG 14 2017

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Mercha
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8152

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

outh Suburban Rehab Center
3000 Halsted Street
omewood, IL 60430-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Debbie C. Date of Delivery 8-15-17

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2787

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Presence Saint Joseph Hospital
2900 North Lake Shore W
Chicago, IL 60657-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agen ☐ Addr

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

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

CHICAGO, IL 6065
AUG 14 2017

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchs
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8077

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Swedish Covenant Hospital
5145 North California Avenue
Chicago, IL 60625-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8022

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Shriner's Hospitals for Children
2211 North Oak Park
Elmwood Park, IL 60707

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X N. Young ☐ Agent ☐ Addres

B. Received by (Printed Name) V. Young | C. Date of Deli

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchand
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8305

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Presence Resurrection Medical Center
7435 West Talcott Avenue
Chicago, IL 60631-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] | C. Date of Delivery

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8190

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Presence Saint Joseph Medical Center
333 North Madison Street
Joliet, IL 60435-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addres

B. Received by (Printed Name) | C. Date of Deli

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchan
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8107

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Aperion Care Chicago Heights
490 West 16th Place
Chicago Heights, IL 60411-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Samantha Jones ☐ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7009 2820 0002 1841 2749

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Mount Sinai Hospital Medical Center
1501 S California Ave
Chicago, IL 60608-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 8-14-17

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

3. Service Type
☐ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 8268

PS Form 3811, July 2013 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Loyola Health System at Gottlieb
701 West North Avenue
Melrose Park, IL 60160-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 8-14-17

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 7964

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

VHS Westlake Hospital
1225 W Lake St
Melrose Park, IL 60160-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) Mauricio C. Date of Delivery 8-17

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 1060 0002 3149 7988

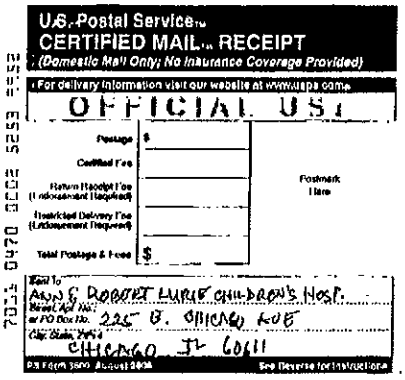
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-

USPS Tracking® Results

FAQs

Track Another Pa

Tracking Number: 70110470000252539952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For delivery information visit our website at www.usps.com®
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Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $
Postmark Here
Sent To
ANN & ROBERT H LURIE CHILDREN'S HOSP.
Street, Apt. No.; or PO Box No. 225 E. CHICAGO AVE
City, State, ZIP+4 CHICAGO IL 60611
PS Form 3800, August 2006 See Reverse for Instructions
7011 0470 0000 2525 3952

Alert

The delivery status for this item has not been updated as of September 7, 2017, 12:59 am.

Product & Tracking Information

See Available Actions

Postal Product: Features: Certified Mail™

DATE & TIME	STATUS OF ITEM	LOCATION
September 7, 2017, 12:59 am	Delivery status not updated	
The delivery status for this item has not been updated as of September 7, 2017, 12:59 am.		
September 6, 2017, 10:59 am	Out for Delivery	CHICAGO, IL 60610

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.

The hospitals and nursing homes in the service area have not indicated that the closure of the long term care and pediatrics services will pose a hardship for any of them.

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.

Other providers have not expressed any reservation about this planned closure that might impact their ability to cross-subsidize their safety net services.

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.

The other providers of long term care will have the opportunity to increase their patient volume. The pediatrics providers have already experienced any impact on their admissions.

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.

See table below.

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.

See table below. (The report for 2016 has been submitted but not published.)

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

In addition to the Charity Care and provision of services classified as Bad Debt, Advocate South Suburban Hospital has been a significant provider of safety net services. In 2016, the following are some of the ways the hospital has helped the community.

Language Assistant Services	$47,387
Donations	$145,342
Volunteer Services	$389,048
Education	$2,354,508
Subsidized Health Services	$2,082,576

Safety Net Information per PA 96-0031			
CHARITY CARE			
	2013	2014	2015
Charity (# of patients)			
Inpatient	536	165	106
Outpatient	7,111	5,252	4,796
Total	**7,647**	**5,417**	**4,902**
Charity (cost In dollars)			
Inpatient	$ 3,642,000	$ 1,568,000	$ 1,029,000
Outpatient	$ 2,854,000	$ 2,203,000	$ 2,027,000
Total	**$ 6,496,000**	**$ 3,771,000**	**$ 3,056,000**
MEDICAID			
Medicaid (# of patients)			
Inpatient	1,312	1,654	2,411
Outpatient	28,530	38,403	44,003
Total	**29,842**	**40,057**	**46,414**
Medicaid (revenue)			
Inpatient	$ 5,033,929	$ 11,058,545	$ 11,834,689
Outpatient	$ 3,868,439	$ 4,610,931	$ 8,279,584
Total	**$ 8,902,368**	**$ 15,669,476**	**$ 20,114,273**