ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

RECEIVED
OCT 31 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Schwab Rehabilitation Hospital and Care Network
Street Address: 1401 S. California Avenue
City and Zip Code: Chicago 60608
County: Cook Health Service Area 6 Health Planning Area: A-02

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

Exact Legal Name: Schwab Rehabilitation Hospital and Care Network
Street Address: 1401 S. California Avenue
City and Zip Code: Chicago 60608
Name of Registered Agent: Karen Teitelbaum
Registered Agent Street Address: 1401 S. California Avenue
Registered Agent City and Zip Code: Chicago 60608
Name of Chief Executive Officer: Karen Teitelbaum
CEO Street Address: 1500 S. Fairfield Avenue, Executive Suites
CEO City and Zip Code: Chicago 60608
CEO Telephone Number: 773-257-5322

Type of Ownership of Applicants

X	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.

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: Mary Gollinger
Title: System Vice President Post Acute Care
Company Name: Schwab Rehabilitation Hospital and Care Network
Address: 1401 S. California Avenue
Telephone Number: 773-565-3014
E-mail Address: Mary.Gollinger@sinai.org
Fax Number: 773-257-1709

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

Name: Diane Jacoby
Title: Interim General Counsel
Company: Sinai Health System
Address: 1500 S. Fairfield Avenue, Chicago, IL 60608
Telephone Number: 773-257-5733
E-mail Address: diane.jacoby@sinai.org
Fax Number: 773-257-6190

Post Exemption Contact

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

Name: Mary Gollinger
Title: System Vice President Post Acute Care
Company Name: Schwab Rehabilitation Hospital and Care Network
Address: 1401 S. California Avenue
Telephone Number: 773-565-3014
E-mail Address: Mary.Gollinger@sinai.org
Fax Number: 773-257-1709

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:
Address of Site Owner:
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: Schwab Rehabilitation Hospital and Care Network
Address: 1401 South 00 S. Fairfield Avenue

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

Narrative Description

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

The proposed project is limited to the discontinuation of the 21-bed general long term care category of service at Schwab Rehabilitation Hospital and Care Network ("Schwab") within thirty days following approval of this Certificate of Exemption application. The 21 general long term care beds at Schwab have always been used for the service known as subacute care. Subacute care is a term used to describe inpatient care that focuses on patients regaining functionality to carry out activities of daily living.

While subacute care will no longer occur at the hospital following the formal discontinuation, the rehabilitation hospital is not closing. Comprehensive inpatient acute rehabilitation and outpatient physician and therapy rehabilitation services for adults and children will continue to be provided in Schwab's unique therapeutic environment. Services at Schwab include treatment for brain injury, pediatric rehabilitation, orthotics and prosthetics, pain management, spinal cord injury treatment and stroke.

This is a "substantive" project, because it addresses the discontinuation of a HFSRB-designated category of service.

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No **X**. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): N/A

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the Application being deemed incomplete.

CERTIFICATION

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

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

This Application is filed on the behalf of Schwab Rehabilitation Hospital and 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 on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Karen C. Teitelbaum
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of October 2019

Signature of Notary

Seal

ANNEL HILGEN
Official Seal
Notary Public – State of Illinois
My Commission Expires Feb 19. 2022

SIGNATURE

Mary Gollinger
PRINTED NAME

System Vice President Post Acute Care
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of October 2019

Signature of Notary

Seal

ANNEL HILGEN
Official Seal
Notary Public – State of Illinois
My Commission Expires Feb 19. 2022

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

X	Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the category 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.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide attestation that the facility provided the required notice of the 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.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.

2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. 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 or exemption, 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 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A CATEGORY OF SERVICE [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 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 9.

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 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHARITY CARE INFORMATION

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 10.

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

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

#E-052-19

File Number 1640-927-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 21, 1922, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* OCTOBER *A.D.* 2019 .

Authentication #: 1929802614 verifiable until 10/25/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 30, 2019

Illinois Health Facilities and
Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: Schwab Rehabilitation Hospital and Care Network Site Ownership

To Whom It May Concern:

I hereby attest that the site of Schwab Rehabilitation Hospital and Care Network, located at 1401 South California Avenue, Chicago, Illinois 60608 is owned by Schwab Rehabilitation Hospital and Care Network, Sinai Health System and Mount Sinai Hospital Medical Center of Chicago. The address for all three owners is 1500 South Fairfield Avenue, Chicago, Illinois 60608.

Sincerely,

Mary Gollinger

Mary Gollinger
System Vice President Post-Acute Care Services
and Schwab Rehabilitation Hospital

Subscribed and sworn to before me
this 30 day of October 2019

Signature of Notary

ANNEL HILGEN
Official Seal
Notary Public - State of Illinois
My Commission Expires Feb 19, 2022

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ATTACHMENT 2

File Number 1640-927-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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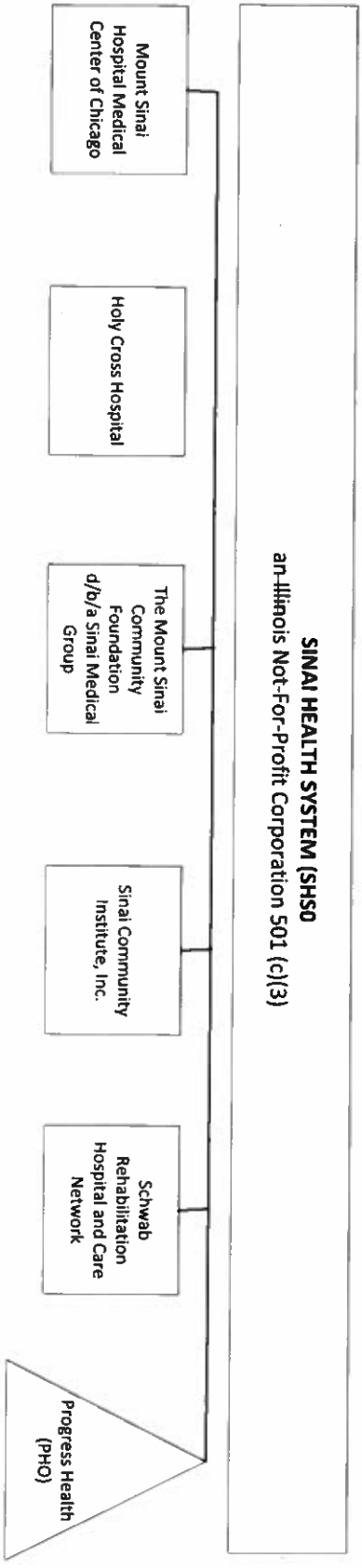
SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 21, 1922, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* OCTOBER *A.D.* 2019 .

Authentication #: 1929802614 verifiable until 10/25/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE


SINAI HEALTH SYSTEM (SHSO
an Illinois Not-For-Profit Corporation 501 (c)(3)
Mount Sinai Hospital Medical Center of Chicago
Holy Cross Hospital
The Mount Sinai Community Foundation d/b/a Sinai Medical Group
Sinai Community Institute, Inc.
Schwab Rehabilitation Hospital and Care Network
Progress Health (PHO)

DISCONTUNATION

1. This Certificate of Exemption ("COE") application addresses the discontinuation of the applicant hospital's general long term care category of service, which includes 21 authorized beds. All rehabilitation services, both inpatient and outpatient services will continue to be provided at the hospital.

2. No other clinical areas/services will also be discontinued.

3. All of the clinical services identified in item one above will be discontinued within 30 days following receipt of the requested COE Permit. Discontinuation will occur via formal notification to the HFSRB and IDPH.

4. The applicants intend to re-designate the 21 beds (11 rooms) into 11 private inpatient rehabilitation rooms. The 21 beds are in rooms identified as:

   302-1, 302-2
   304-1, 304-2
   305-1, 305-2
   307-1, 307-2
   311-1, 311-2, 311-3
   312-1, 312-2
   314-1, 314-2
   316-1
   317-1, 317-2
   320-1, 320-2
   322-1

   The new private rooms will be identified as:

   302
   304
   305
   307
   311
   312
   314
   316
   317
   320
   322

   The medical records of past patients will be retained by the hospital, consistent with licensure and accreditation requirements, as well as contemporary medical records retention practices.

5. The required legal notice was published in the Chicago Sun-Times on October 30, 2019. Proof of publication is attached.

ATTACHMENT 5

#E-052-19

LEGAL NOTICES | FORECLOSURES | TAKE NOTICES

LEGAL NOTICE

Schwab Rehabilitation Hospital and Care Center intends to cease operations of its Sub acute Care Unit following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur before January 30, 2020. This hospital intends to file the Certificate of Exemption application with the IHFSRB by October 31, 2019, after which additional information relating to the proposed discontinuation may be found on the IHFSRB website at hfsrb.illinois.gov.
10/30/2019 6493565

ATTESTATION

I, Diane Jacoby, Interim General Counsel of Sinai Health System do hereby attest that the attached notice was published in the Chicago Tribune and meets all the requirements of 715 ILCS 10/, the Newspaper Legal Notice Act.

Diane Jacoby

Date: 10/30/2019

Subscribed and sworn to before me this 30 day of October 2019

Annel Hilgen

Signature of Notary

ANNEL HILGEN
Official Seal
Notary Public - State of Illinois
My Commission Expires Feb 19, 2022

ATTACHMENT 5

REASONS FOR DISCONTUNATION

The subacute care category of service (general long term care beds) at Schwab Rehabilitation Hospital and Care Network is proposed to be discontinued primarily as the result of low utilization. Due to payment changes by Medicare ("CMS"), the therapy provided as part of "subacute care" is no longer being paid for by CMS; therefore, patients will either be placed in an inpatient rehabilitation facility (such as Schwab) or will receive outpatient therapy while residing at home. Schwab also provides extensive outpatient rehabilitation services. During calendar 2018, the hospital's overage daily census was 4.05 patients, down from 4.88 patients the previous year.

The proposed discontinuation will not result in an unreasonable diminishment of accessibility to the services because Schwab will be able to provide the inpatient or outpatient therapy services needed.

IMPACT ON ACCESS

The proposed discontinuation of "subacute care" general long term care beds at Schwab Rehabilitation Hospital and Care Network will have minimal impact on access to subacute care for residents in the communities and neighborhoods surrounding the hospital because of the availability of inpatient and outpatient rehabilitation services at Schwab and similar programs in the area. Subacute care is a service that is not being prescribed by doctors or paid for by Medicare because patients either are appropriate to go home or to inpatient rehabilitation.

The following providers of inpatient and outpatient care are located within ten (10) miles of the hospital:

- Sinai Health System
- University of Chicago Medical Center
- University of Illinois Health
- Advocate Christ Medical Center
- RUSH University Medical Center
- Kindred Hospital-Chicago North Campus
- Kindred Chicago Central Hospital
- Northwestern Memorial Health Care
- John H. Stroger Jr. Hospital of Cook County
- Holy Cross Hospital
- AMITA Health Saints Mary and Elizabeth Hospital
- Mercy Hospital and Medical Center
- Loretto Hospital
- St. Anthony Hospital
- Provident Hospital of Cook County (Cook County Health)
- Norwegian American
- Jessie Brown VA
- Weiss Memorial Hospital

Notifications of the proposed discontinuation and requests for impact statements have been sent to each of the hospitals listed above. Copies of any responses not included in this attachment will be forwarded to HFSRB Staff.

Attached are the letters used to notify the above-listed hospitals of the proposed discontinuation and request an impact statement, as well as proof of delivery.

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Karen Teitelbaum, President and Chief Executive Officer
Sinai Health System
1500 S. Fairfield Avenue
Chicago, Il 60608-1797

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Karen:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

During a 24-month period, Schwab has seen a change in the average daily census (ADC) from a budgeted 23.9 to an actual 14.72 (8.37) in FY 18 and in FY 19 from a budgeted 16.8 to an actual 10.75 (5.84). FY 20 has begun with trends continuing downward.

If you do elect to provide an impact statement, please include whether your hospital has any restrictions or limitations that would preclude it from providing or obtaining services for patients from our service area. Any impact statement received will be forwarded to the IHFSRB.

If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Sharon O'Keefe
President and Chief Operating Officer
University of Chicago Medical Center
5841 S. Maryland Avenue
Chicago, IL 60637

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Sharon:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

During a 24-month period, Schwab has seen a change in the average daily census (ADC) from a budgeted 23.9 to an actual 14.72 (8.37) in FY 18 and in FY 19 from a budgeted 16.8 to an actual 10.75 (5.84). FY 20 has begun with trends continuing downward.

If you do elect to provide an impact statement, please include whether your hospital has any restrictions or limitations that would preclude it from providing or obtaining services for patients from our service area. Any impact statement received will be forwarded to the IHFSRB.

If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

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#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Timothy L. Killeen, President
University of Illinois Health
President's Office – Chicago
414 Administrative Office Building
1737 W. Polk Street., MC-760

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Timothy:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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If you do elect to provide an impact statement, please include whether your hospital has any restrictions or limitations that would preclude it from providing or obtaining services for patients from our service area. Any impact statement received will be forwarded to the IHFSRB.

If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

23

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Matthew Primack
President
Advocate Christ Medical Center
4440 W. 95th Street
Oak Lawn, IL 60453

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Matthew:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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If you do elect to provide an impact statement, please include whether your hospital has any restrictions or limitations that would preclude it from providing or obtaining services for patients from our service area. Any impact statement received will be forwarded to the IHFSRB.

If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

24

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Michael J. Dandorph
President
RUSH University Medical Center
1653 W. Congress Parkway
Chicago, IL 60612

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Michael:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

During a 24-month period, Schwab has seen a change in the average daily census (ADC) from a budgeted 23.9 to an actual 14.72 (8.37) in FY 18 and in FY 19 from a budgeted 16.8 to an actual 10.75 (5.84). FY 20 has begun with trends continuing downward.

If you do elect to provide an impact statement, please include whether your hospital has any restrictions or limitations that would preclude it from providing or obtaining services for patients from our service area. Any impact statement received will be forwarded to the IHFSRB.

If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

25

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Richard Cercio
Chief Executive Officer
Kindred Hospital – Chicago North Campus
2544 West Montrose Avenue
Chicago, IL 60618

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Richard:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

26

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Timothy Page
Chief executive Officer
Kindred Chicago Central Hospital
4058 W. Melrose Street
Chicago, IL 60641

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Timothy:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

27

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Dean Harrison
President and Chief Executive Officer
Northwestern Memorial Health Care
251 E. Huron Street
Chicago, IL 60611

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Dean:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

28

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Jay Shannon
John H. Stroger Jr. Hospital of Cook County
Chief Executive Officer
1969 W. Ogden Avenue
Chicago, IL 60612

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Jay:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

29

#E-052-19

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BE STRONGER | CARE HARDER | LOVE DEEPER

October 4, 2019

Lori Pacura
President
Holy Cross Hospital
2701 W. 68th Street
Chicago, IL 60629

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Lori:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

30

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October 11, 2019

Bob Zahl
President
AMITA Health Saints Mary and Elizabeth Hospital
1431 N. Western Avenue, Suite 202
Chicago, IL 60622

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Bob:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

31

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October 11, 2019

Carol L. Garikes Schneider
President
Mercy Hospital and Medical Center
2525 S. Michigan Avenue
Chicago, IL 60616

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Carol:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

During a 24-month period, Schwab has seen a change in the average daily census (ADC) from a budgeted 23.9 to an actual 14.72 (8.37) in FY 18 and in FY 19 from a budgeted 16.8 to an actual 10.75 (5.84). FY 20 has begun with trends continuing downward.

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If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

32

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October 11, 2019

George N. Miller Jr.
President and Chief Executive Officer
Loretto Hospital
645 S. Central Avenue
Chicago, IL 60644

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear George:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

33

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October 11, 2019

Guy A. Medaglia
President and Chief Executive Officer
St. Anthony Hospital Chicago
2875 W. 19th Street
Chicago, IL 60623

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Guy:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

34

#E-052-19

SINAI

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October 11, 2019

Jay Shannon
Provident Hospital of Cook County - (Cook County Health)
500 E. 51st Street
Chicago, IL 60615

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Jay:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

35

#E-052-19

SINAI

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October 11, 2019

Jose R. Sanchez
President and CEO
Norwegian American
1044 N. Francisco Avenue
Chicago, IL 60622

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Jose:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

36

#E-052-19

SINAI

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October 11, 2019

Marc A. Magill
Medical Center Director
Jessie Brown VA
820 S. Damen Avenue
Chicago, IL 60612

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Marc:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

Schwab intends to file a Certificate of Exemption ("COE") application within the next thirty (30) days, seeking approval from the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue Schwab's 21 bed Sub-Acute Skilled Category of Service. The formal discontinuation of that service will occur within thirty (30) days following the IHFSRB's approval of the COE application.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

37

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 11, 2019

Mary Shehan
Chief Executive Office
Weiss Memorial Hospital
4646 N. Marine Drive
Chicago, IL 60640

Re: Schwab Rehabilitation Hospital and Care Network (Schwab)
Sub-Acute Skilled Nursing Service
Category of Service

Dear Mary:

This letter regarding Schwab Rehabilitation Hospital and Care Network's Sub-Acute Skilled Unit (Schwab), is being sent to you in order to provide you with the opportunity to submit an impact statement, should you choose to do so.

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Sincerely,

Airica Steed, Ed.D, MBA, RN, CSSMBB, FACHE, IASSC
Executive Vice President/Chief Operating Office
Sinai Health System

38

#E-052-19

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Dean Harrison
Northwestern Mem. Hlth Care
251 E. Huron Street
Chicago IL 60611

9590 9402 3505 7275 9975 15

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2393

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
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Timothy Page
Kindred Chicago Central Hospital
4058 W. Melrose Street
Chicago IL 60641

9590 9402 3505 7275 9975 22

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2386

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 10-8-19

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

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

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Richard Cercio
Kindred Hospital - Chicago North
2544 W. Montrose Avenue
Chicago, IL 60618

9590 9402 3505 7275 9975 39

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2379

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
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
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☐ Signature Confirmation™
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PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Jay Sharon
John H. Stroger Hosp. of Cook County
969 W. Ogden Avenue
Chicago IL 60612

9590 9402 3505 7275 9975 91

COMPLETE THIS SECTION ON DELIVERY

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Karen Tellhaum
Sinai Health System
1500 S. Fairfield Ave.
Chicago IL 60608

9590 9402 3505 7275 9975 84

COMPLETE THIS SECTION ON DELIVERY

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Jay Sharon
John H. Stroger Hosp. of Cook County
969 W. Ogden Avenue
Chicago IL 60612

9590 9402 3505 7275 9975 91

COMPLETE THIS SECTION ON DELIVERY

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☐ Certified Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise

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

29

#E-052-19

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:

Courtney R. Avery, Adm.
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Flr.
Springfield, IL 62761

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X R Martin ☐ Agent ☐ Addressee

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

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

DELIVERED OCT 08 2019

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0000 6272 1154

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:

Karen Senger
Division of Health Care Facilities and Programs
Illinois Dept. of Public Health
525 W Jefferson St. 4th Flr.
Springfield, IL 62761

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X R Martin ☐ Agent ☐ Addressee

B. Received by (Printed Name) R MARTIN C. Date of Deliv

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

DELIVERED OCT 08 2019

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) 7011 1570 0000 6272 1161

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:

JAN Schakowsky
9th District
5533 N. Broadway, Suite 2
Chicago IL 60640

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) Ship Wilson C. Date of Deliver 10/7/19

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 Merchandis
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0000 6272 1178

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

#E-052-19

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Timothy L. Killeen
University of Illinois Health
414 Administrative office Bldg.
1737 W. Polk Street, MC-760
Chicago IL 60612

9590 9402 3505 7275 9975 60

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2348

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Sim Mons C. Date of Delivery 10/7/19

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

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Sharon O'Keefe
University of Chicago Med Ctr.
5841 S. Maryland Ave.
Chicago IL 60637

9590 9402 3505 7275 9975 77

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2331

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 10/7/19

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

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Michael Davdorph
RUSH University Med Ctr.
1653 W. Congress Parkway
Chicago IL 60612

9590 9402 3505 7275 9975 46

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2362

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Priority Mail Expre
☐ Registered Mail™
☐ Registered Mail R Delivery
☐ Return Receipt fo Merchandise
☐ Signature Confirm
☐ Signature Confirm Restricted Deliver

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Lori Pacura
4141 Cross Hospital
2701 W. 68th Street
Chicago IL 60629

9590 9402 3505 7275 9959 00

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2355

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) D. Wheeler C. Date of Delivery 10/10/19

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Matthew Pumack
Advocate Christ Med. Ctr.
4440 W. 95th Street
Oak Lawn, IL 60453

9590 9402 3505 7275 9975 53

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2379

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X ☐ 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
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise

#E-052-19

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Carol L. Garikes - Schneider/Pres.
Mercy Hospital and Med Ctr.
2525 S. Michigan Avenue
Chicago IL 60616

9590 9402 3505 7275 9977 37

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2478

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 10/15/19

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

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

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Guy A. Medaglia, Pres./CED
St. Anthony Hospital - Chicago
2875 W. 19th Street
Chicago IL 60623

9590 9402 3505 7275 9976 83

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2430

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

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

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Jose L. Sanchez - Pres/CED
Norwegian American
1044 N. Francisco Ave.
Chicago IL 60622

9590 9402 3505 7275 9977 20

2. Article Number (Transfer from service label)

7010 2780 0003 4562 2461

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 10/15/19

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

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

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

#E-052-19

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60622
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2485

Sent To: Jose L. Sanchez Norwegian American
Street, Apt. No.; or PO Box No. 1044 N. Francisco Ave.
City, State, ZIP+4 Chicago IL 60622

PS Form 3800, August 2006 See Reverse for Instructions

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60622
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2485

Sent To: Bob Zahl AMLTA Sainte Marie Elizabeth
Street, Apt. No.; or PO Box No. 1431 N. Western Ave., Suite 202
City, State, ZIP+4 Chicago IL 60622

PS Form 3800, August 2006 See Reverse for Instructions

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60623
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2478

Sent To: Guy A. Medaglia/Pres/CEO St. Anthony
Street, Apt. No.; or PO Box No. 2875 W. 19TH Street
City, State, ZIP+4 Chicago IL 60623

PS Form 3800, August 2006 See Reverse for Instructions

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60616
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2478

Sent To: Ann L. Gorikes Schneider Mercy Hosp
Street, Apt. No.; or PO Box No. 2525 S. Michigan Ave
City, State, ZIP+4 Chicago IL 60616

PS Form 3800, August 2006 See Reverse for Instructions

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60612
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2447

Sent To: Marc Magill Jesse Brown VA
Street, Apt. No.; or PO Box No. 820 S. Damen Ave.
City, State, ZIP+4 Chicago IL 60612

PS Form 3800, August 2006 See Reverse for Instructions

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
CHICAGO IL 60640
OFFICIAL USE

Postage	$3.50
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$0.00
	$6.85

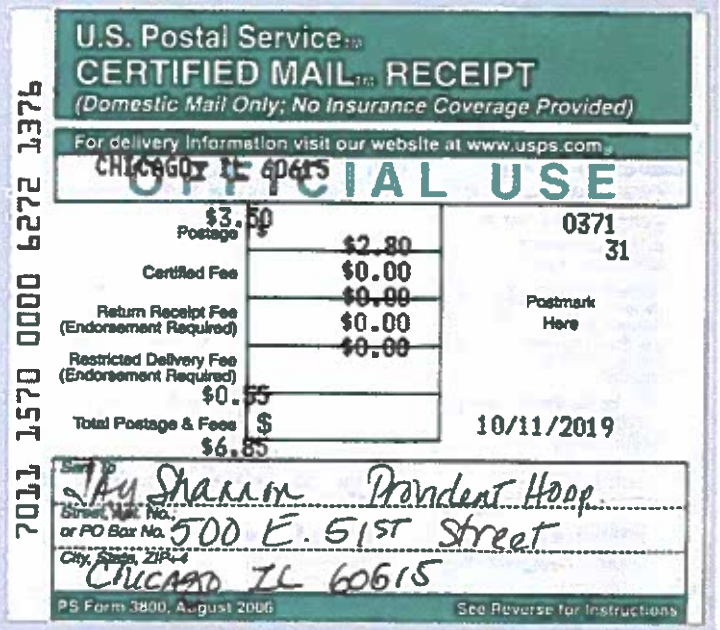
0371 31
Postmark Here
10/11/2019

7010 2780 0003 4562 2447

Sent To: Mary Shehan Weiss Memorial Hosp
Street, Apt. No.; or PO Box No. 4646 N. Marine Drive
City, State, ZIP+4 Chicago IL 60640

PS Form 3800, August 2006 See Reverse for Instructions

44



7011 1570 0000 6272 1376

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

CHICAGO IL 60615

OFFICIAL USE

Postage	$3.50 $2.80
Certified Fee	$0.00
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.85 $

0371
31

Postmark Here

10/11/2019

Sent To: Ty Shannon Provident Hosp.
Street, Apt. No., or PO Box No.: 500 E. 51ST Street
City, State, ZIP+4: CHICAGO IL 60615

PS Form 3800, August 2006 — See Reverse for Instructions

7011 1570 0000 6272 1369

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

CHICAGO IL 60615

OFFICIAL USE

Postage	$3.50 $2.80
Certified Fee	$0.00
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.85 $

0371
31

Postmark Here

10/11/2019

Sent To: George N. Muller Jr. Loretto Hospital
Street, Apt. No., or PO Box No.: 645 S. Central Ave
City, State, ZIP+4: CHICAGO IL 60644

PS Form 3800, August 2006 — See Reverse for Instructions

#E-052-19

BACKGROUND

1. Applicant, Schwab Rehabilitation Hospital and Care Network, owns, operates and/or controls the following Illinois licensed health care facilities:

   Schwab Rehabilitation Health and Care Network

2. See attached letter.

3. See attached letter.

4. There are no other applications for permit in the 2019 calendar year for this applicant.

#E-052-19

SINAI

BE STRONGER | CARE HARDER | LOVE DEEPER

October 30, 2019

Ms. Courtney Avery
Illinois Health Facilities and
Services Review Board
525 W. Jefferson St.
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Schwab Rehabilitation Hospital and Care Network has not had any adverse actions against any facility owned, operated, and/or controlled by the applicant during the three (3) year period prior to the filing of this application; and,

2. Schwab Rehabilitation Hospital and Care Network authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to yoiur staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Mary Gollinger

Mary Gollinger
System Vice President Post-Acute Care Services
and Schwab Rehabilitation Hospital

Date: 10-30, 2019

Subscribed and sworn to before me
this 30 day of October 2019

Signature of Notary

ANNEL HILGEN
Official Seal
Notary Public - State of Illinois
My Commission Expires Feb 19, 2022

46

ATTACHMENT 8

SAFETY NET STATEMENT

Schwab Rehabilitation Hospital, an affiliate of Sinai Health System, is and will continue to be a safety net provider, serving primarily Chicago's West and Southwest Side. Because of the nature of hospital-based sub acute care services, the discontinuation of the service will have no substantial impact on the hospital's commitment to or provision of safety net services.

Section IV. Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
All Patients			
Charity Care (# of patients)	**FY17**	**FY18**	**FY19**
Inpatient	19	19	16
Outpatient	110	256	321
Total	**129**	**275**	**337**
Charity (cost in dollars)			
Inpatient	$481,022	$424,567	$471,446
Outpatient	$195,908	$368,825	$334,417
Total	**$676,929**	**$793,392**	**$805,863**
Medicaid (# of patients)	**FY17**	**FY18**	**FY19**
Inpatient	741	680	634
Outpatient	3,679	5,694	5,606
Total	**4,420**	**6,374**	**6,240**
Medicaid (Net Revenue)			
Inpatient	$12,813,155	$12,755,232	$14,342,838
Outpatient	$3,156,022	$2,151,026	$2,635,437
Total	**$15,969,177**	**$14,906,258**	**$16,978,275**

ATTACHMENT 9

Section V. (Charity Care Information)

CHARITY CARE			
	FY16	**FY17**	**FY18**
Net Patient Revenue	$37,880,000	$36,060,000	$35,446.000
Amount of Charity Care (charges)	$432,178	$1,594,354	$2,153,032
Cost of Charity Care	$167,945	$676,929	$793,392

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	13
2	Site Ownership	14
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	15
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	16
5	Discontinuation General Information Requirements	17-18
6	Reasons for Discontinuation	19
7	Impact on Access	20-44
8	Background of the Applicant	45-46
9	Safety Net Impact Statement	47-48
10	Charity Care Information	49

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Schwab Rehabilitation Hospital and Care Network
Street Address: 1401 S. California Avenue
City and Zip Code: Chicago 60608
County: Cook Health Service Area 6 Health Planning Area: A-02

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

Exact Legal Name: Schwab Rehabilitation Hospital and Care Network
Street Address: 1401 S. California Avenue
City and Zip Code: Chicago 60608
Name of Registered Agent: Karen Teitelbaum
Registered Agent Street Address: 1401 S. California Avenue
Registered Agent City and Zip Code: Chicago 60608
Name of Chief Executive Officer: Karen Teitelbaum
CEO Street Address: 1500 S. Fairfield Avenue, Executive Suites
CEO City and Zip Code: Chicago 60608
CEO Telephone Number: 773-257-5322

Type of Ownership of Applicants

X	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.

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: Mary Gollinger
Title: System Vice President Post Acute Care
Company Name: Schwab Rehabilitation Hospital and Care Network
Address: 1401 S. California Avenue
Telephone Number: 773-565-3014
E-mail Address: Mary.Gollinger@sinai.org
Fax Number: 773-257-1709

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

Name: Diane Jacoby
Title: Interim General Counsel
Company: Sinai Health System
Address: 1500 S. Fairfield Avenue, Chicago, IL 60608
Telephone Number: 773-257-5733
E-mail Address: diane.jacoby@sinai.org
Fax Number: 773-257-6190

Post Exemption Contact

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

Name: Mary Gollinger
Title: System Vice President Post Acute Care
Company Name: Schwab Rehabilitation Hospital and Care Network
Address: 1401 S. California Avenue
Telephone Number: 773-565-3014
E-mail Address: Mary.Gollinger@sinai.org
Fax Number: 773-257-1709

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:
Address of Site Owner:
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: Schwab Rehabilitation Hospital and Care Network
Address: 1401 South 00 S. Fairfield Avenue
X Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each 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.

Narrative Description

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

The proposed project is limited to the discontinuation of the 21-bed general long term care category of service at Schwab Rehabilitation Hospital and Care Network ("Schwab") within thirty days following approval of this Certificate of Exemption application. The 21 general long term care beds at Schwab have always been used for the service known as subacute care. Subacute care is a term used to describe inpatient care that focuses on patients regaining functionality to carry out activities of daily living.

While subacute care will no longer occur at the hospital following the formal discontinuation, the rehabilitation hospital is not closing. Comprehensive inpatient acute rehabilitation and outpatient physician and therapy rehabilitation services for adults and children will continue to be provided in Schwab's unique therapeutic environment. Services at Schwab include treatment for brain injury, pediatric rehabilitation, orthotics and prosthetics, pain management, spinal cord injury treatment and stroke.

This is a "substantive" project, because it addresses the discontinuation of a HFSRB-designated category of service.

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No X. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): N/A

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the Application being deemed incomplete.

CERTIFICATION

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

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

This Application is filed on the behalf of **Schwab Rehabilitation Hospital and 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 on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Karen C. Teitelbaum
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of October 2019

Signature of Notary

Seal

ANNEL HILGEN
Official Seal
Notary Public – State of Illinois
My Commission Expires Feb 19, 2022

SIGNATURE

Mary Gollinger
PRINTED NAME

System Vice President Post Acute Care
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of October 2019

Signature of Notary

Seal

ANNEL HILGEN
Official Seal
Notary Public – State of Illinois
My Commission Expires Feb 19, 2022

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

X	Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the category 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.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide attestation that the facility provided the required notice of the 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.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.

2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. 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 or exemption, 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 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A CATEGORY OF SERVICE [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 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 9.

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 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHARITY CARE INFORMATION

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 10.

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

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

#E-052-19

SINAI

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October 30, 2019

RECEIVED
OCT 31 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

VIA OVERNIGHT MAIL

Ms. Courtney Avery
Administrator
State of Illinois Health Facilities
And Services Review Baord
525 W. Jefferson St.
Springfield, IL 62761

RE: Schwab Rehabilitation Hospital and Care Network
Discontinuation Certificate of Exemption Application

Dear Ms. Avery:

Enclosed please find the original and one copy of the Discontinuation Certification of Exemption Application for Schwab Rehabilitation Hospital and Care Network. Also enclosed please find check number 246242 in the amount of $2,500 for the application processing fee. Finally, we are also including a copy of the application without the attachments and request to have that copy file-stamped as received and returned back to us as proof of filing in the enclosed return receipt labeled envelope. If you have any questions, please do not hesitate to contact me.

Kind Regards,

Annel Hilgen
Executive Assistant to Interim General Counsel

Enclosures