

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
DISCONTINUATION APPLICATION FOR EXEMPTION**

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**Facility/Project Identification**

Facility Name:	St. Bernard Hospital and Health Care Center—discontinuation of Obstetrics category of service		
Street Address:	326 West 64 <sup>th</sup> Street		
City and Zip Code:	Chicago, IL 60621		
County:	Cook	Health Service Area	VI Health Planning Area: A-03

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

Exact Legal Name:	St. Bernard Hospital
Street Address:	326 West 64 <sup>th</sup> Street
City and Zip Code:	Chicago, IL 60621
Name of Registered Agent:	Charles Holland
Registered Agent Street Address:	326 West 64 <sup>th</sup> Street
Registered Agent City and Zip Code:	Chicago, IL 60621
Name of Chief Executive Officer:	Charles Holland
CEO Street Address:	326 West 64 <sup>th</sup> Street
CEO City and Zip Code:	Chicago, IL 60621
CEO Telephone Number:	773/962-3900

**Type of Ownership of Applicants**

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7101

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**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:	Charles Holland
Title:	President & CEO
Company Name:	St. Bernard Hospital and Health Care Center
Address:	326 West 64 <sup>th</sup> Street Chicago, IL 60621
Telephone Number:	773/962-3900
E-mail Address:	cholland@stbh.org
Fax Number:	

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	St. Bernard Hospital
Address of Site Owner:	326 West 64 <sup>th</sup> Street Chicago, IL 60621
Street Address or Legal Description of the Site:	326 West 64 <sup>th</sup> Street Chicago, IL 60621
<b>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.</b>	

**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:	St. Bernard Hospital		
Address:	326 West 64 <sup>th</sup> Street Chicago, IL 60621		
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership		
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental		
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other	
<ul style="list-style-type: none"> <li>○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>○ 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.</li> <li>○ <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>			

**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.

St. Bernard Hospital proposes to discontinue its 22-bed obstetrics category of service.

The category of service was suspended on April 20, 2020; and a copy of the letter notifying the Illinois Department of Public Health of the suspension, along with a copy of Emergency Department policies and procedures designed to ensure patient safety are attached.

Because this application addresses the discontinuation of a HFSRB-designated category of service, the project is classified as being substantive.

# ST. BERNARD HOSPITAL

AND HEALTH CARE CENTER

326 WEST 64TH STREET, CHICAGO, ILLINOIS 60621  
TELEPHONE 773.962.3900 FACSIMILE 773.602.3849

**SENT VIA FEDERAL EXPRESS AND EMAIL**

April 17, 2020

Karen Senger, RN, BSN  
Division Chief, Health Care Facilities and Programs  
Illinois Department of Public Health  
Division of Health Systems Development, Program Review Section  
525 W. Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, IL 62761-0001

Dear Ms. Senger:

We would like to inform you that effective April 20, 2020, St. Bernard Hospital will be suspending its Obstetric and Nursery Category of Services in accordance with 77 Illinois Administrative Code 1130.240 -Reporting and Notification requirements, Subsection d) Temporary Suspensions of Facility or Category of Services (See attached).

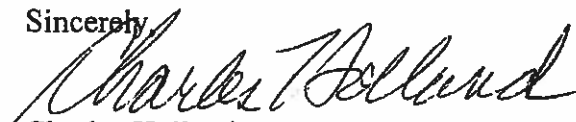
This decision has become necessary to respond more effectively to the increase in the number of patients requiring hospitalization due to COVID-19. Over the last 7 weeks the volume of admitted COVID-19 positive patients and Persons Under Investigation (PUI's) has increased daily. There has been an equal increase in the number of patients requiring isolation. Our ICU is at 100% capacity and approximately 70% of the medical admissions are COVID-19/PUI's.

Our strategy is to convert the existing Obstetrical Nursing unit to a Medical-Surgical nursing unit without increasing or decreasing the total licensed bed count. This change will provide more Medical -Surgical beds and more importantly it will reduce the number of patients holding in the Emergency Room that are waiting for an available bed. We have not determined the time frame for this suspension, and will assess the need on an ongoing basis.

To ensure coordination of care of our existing Obstetric patients we are collaborating with Mercy Hospital, Chicago which has agreed to assist in the transition of patients who are in the queue to deliver at St. Bernard Hospital.

Should you have any questions, do not hesitate to contact Roland Abellera, Chief Operations Officer at 773-962-4100.

Sincerely,



Charles Holland  
President and Chief Executive Officer

cc: Courtney Avery  
Mike Constantino

5



**ST. BERNARD HOSPITAL AND HEALTH CARE CENTER**  
**326 West 64<sup>th</sup> Street Chicago, Illinois 60621**

**DEPARTMENTAL POLICY**

---

**DEPARTMENT:**           **Emergency Department**

**SUBJECT:**           **CARE OF OBSTETRICAL PATIENT IN THE  
EMERGENCY DEPARTMENT**

**Effective Date:**   **4/20**

**Review Date:**

**Revised Date:**   **8/31/2020**

**PAGE 1 OF 3**

**POLICY # 6-1500-148**

---

**POLICY:**

The pregnant patient will be provided evaluation and medically appropriate care when presenting to the Hospital. The Hospital may not transfer or discharge a patient who may be reasonably at risk to deteriorate from, during or after said transfer or discharge. If the patient is at reasonable risk to deteriorate due to the natural process of their medical condition, they are legally unstable as per EMTALA.

Any pregnant patient that presents to the Emergency Department will be assessed initially by the Emergency Department physician, and a subsequent consultation obtained with the on-call Maternal-Fetal Specialist at our Peri-Natal Center; Stroger Hospital of Cook County. The MFM Specialist will determine the disposition of the patient, discharge, transfer or transport.

Patients presenting to the Emergency Department at the St. Bernard Hospital who are pregnant where delivery is imminent will be cared for by the Emergency department staff. After delivery in the Emergency Department and stabilization of mother and infant(s), will be transported to another institution under the direction of the MFM for admission and continuing care.

**PURPOSE:**

To provide guidelines to the Emergency Department staff on the care and management of obstetrical patients in whom delivery is imminent, while in the Emergency Department.

---

**SUBJECT: CARE OF OBSTETRICAL PATIENT IN THE  
EMERGENCY DEPARTMENT**

---

**PAGE 2 OF 3**

---

**DEFINITION:**

**Labor:** The process of childbirth, beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless an obstetrician, or other medical physician acting within his or her scope of practice as defined in hospital medical staff bylaws and state law, certifies that, after a reasonable time of observation, the woman is in false labor.

**PROCEDURE:****Labor indicated patient**

1. Initial examination will be conducted immediately by the ED attending physician
2. The OB department at Mercy Hospital or patient's Obstetrical preference will be notified immediately of the patient and the delivery status
3. After examination ("medical screening examination" per EMTALA) and consultation with the OB attending at transferring hospital /patient's private physician, the patient may be transferred to another facility which provides OB services upon determination that the patient is at a level at which a safe transfer may be executed. The medical record should reflect that the examination included presence of fetal heart tones and status of the membranes. The transfer policy will be followed and consent to transfer completed. (See transfer algorithm in appendix A)

**Procedure for imminent delivery**

1. The patient will be placed in an OB evaluation treatment room
2. Vital signs and fetal heart tones will be taken and documented
3. An IV will be started and oxygen will be readily available
4. Explain all that will be taking place to the patient, prior to treatments, procedures, etc.
5. Place the patient in stirrups.

---

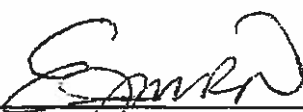
**SUBJECT: CARE OF OBSTETRICAL PATIENT IN THE  
EMERGENCY DEPARTMENT**

---

**PAGE 3 OF 3**

---

6. Cleanse the perineum with betadine and rinse with normal saline
7. Prep as directed by the physician, as time permits
8. Open OB pack
9. Prepare infant warmer
10. Note time of delivery
11. Perform and document A PGAR score at time of delivery and 5 minutes post delivery
12. Obtain and record baby's length and weight
13. Document time delivery of placenta
14. Document any medications given to either mother or baby(ies)
15. Send placenta, properly labeled and in an appropriate container to Pathology
16. Mom and baby(ies) will be properly identified and banded
17. Disposition of Mother and Baby(ies)
18. The baby(ies) will be registered using the time of delivery as the time admitted to the Emergency Department
19. ED nursing staff will complete the delivery case record and defer the birth certificate to receiving hospital.
20. An Emergency Department medical record will then be completed on mother and baby(ies) and provided to receiving hospital.
21. After delivery and stabilization of mother and baby (ies) they will be transferred to the accepting hospital with Obstetrical Services. (transfer algorithm in appendix A).
22. All Maternal and Neonatal transfers are to be document in Maternal transfer log.

  
\_\_\_\_\_  
Vice President of Nursing

  
\_\_\_\_\_  
Emergency Department Medical Director



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

Charles Holland  
SIGNATURE

CHARLES HOLLAND  
PRINTED NAME

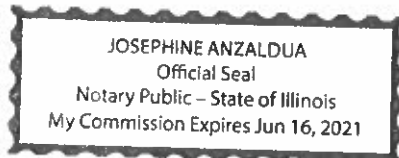
PRES/CFO  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 2nd day of November 2020

Josephine Anzaldúa  
Signature of Notary

Seal



\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary

Seal

\*Insert the EXACT legal name of the applicant

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary

Seal

Robert Springer  
SIGNATURE

Robert Springer  
PRINTED NAME

CFO  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this 6th day of November 2020

Michele Zielinsky  
Signature of Notary

Seal



\*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.**

**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 ☒. 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): 30 days following receipt of COE\_\_

**State Agency Submittals [Section 1130.620(c)]**

Are the following submittals up to date as applicable:

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

**Failure to be up to date with these requirements will result in the Application being deemed incomplete.**

## 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.**

<b>Safety Net Information per PA 96-0031</b>			
<b>CHARITY CARE</b>			
<b>Charity (# of patients)</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Inpatient	633	890	550
Outpatient	14938	18947	18973
<b>Total</b>	<b>15571</b>	<b>19837</b>	<b>19523</b>
<b>Charity (cost in dollars)</b>			
Inpatient	\$941,954	\$1,188,361	\$858,276
Outpatient	\$2,325,717	\$3,591,885	\$2,664,475
<b>Total</b>	<b>\$3,267,671</b>	<b>\$4,780,246</b>	<b>\$3,522,751</b>
<b>MEDICAID</b>			
<b>Medicaid (# of patients)</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Inpatient	4078	3977	3920
Outpatient	42051	39574	36042
<b>Total</b>	<b>46129</b>	<b>43551</b>	<b>39962</b>
<b>Medicaid (revenue)</b>			
Inpatient	\$46,689,574	\$44,567,628	\$41,000,953
Outpatient	\$12,488,528	\$19,570,620	\$25,894,501
<b>Total</b>	<b>\$59,178,12</b>	<b>\$64,181,799</b>	<b>\$66,895,454</b>

**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			
	2017	2018	2019
<b>Net Patient Revenue</b>	<b>\$85,054,120</b>	<b>\$85,502,171</b>	<b>\$90,696,707</b>
Amount of Charity Care (charges)	\$3,267,671	\$4,780,246	\$3,522,751
Cost of Charity Care	\$6,899,644	\$9,422,917	\$7,858,021

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

File Number

0925-506-1



**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*

ST. BERNARD HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1904, 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 29TH*  
*day of OCTOBER A.D. 2020 .*

Authentication #: 2030302760 verifiable until 10/29/2021  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*  
17

SECRETARY OF STATE ATTACHMENT 1

# ST. BERNARD HOSPITAL AND HEALTH CARE CENTER

326 WEST 64TH STREET, CHICAGO, ILLINOIS 60621  
TELEPHONE 773.962.3900 FACSIMILE 773.602.3849

November 2, 2020

Illinois Health Facilities and Services Review Board  
Springfield, IL 62761

To Whom It May Concern:

Please be advised that site occupied by St. Bernard Hospital, that being 326 West 64<sup>th</sup> Street in Chicago, is owned by St. Bernard Hospital and Health Care Center.

Sincerely,



Charles Holland  
President & CEO

Notarized:

*State of Illinois*  
*County of Cook*  
*On this 2nd day of November, 2020*  
*Josephine Anzaldúa*



File Number

0925-506-1



***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***

ST. BERNARD HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1904, 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 29TH  
day of OCTOBER A.D. 2020 .***

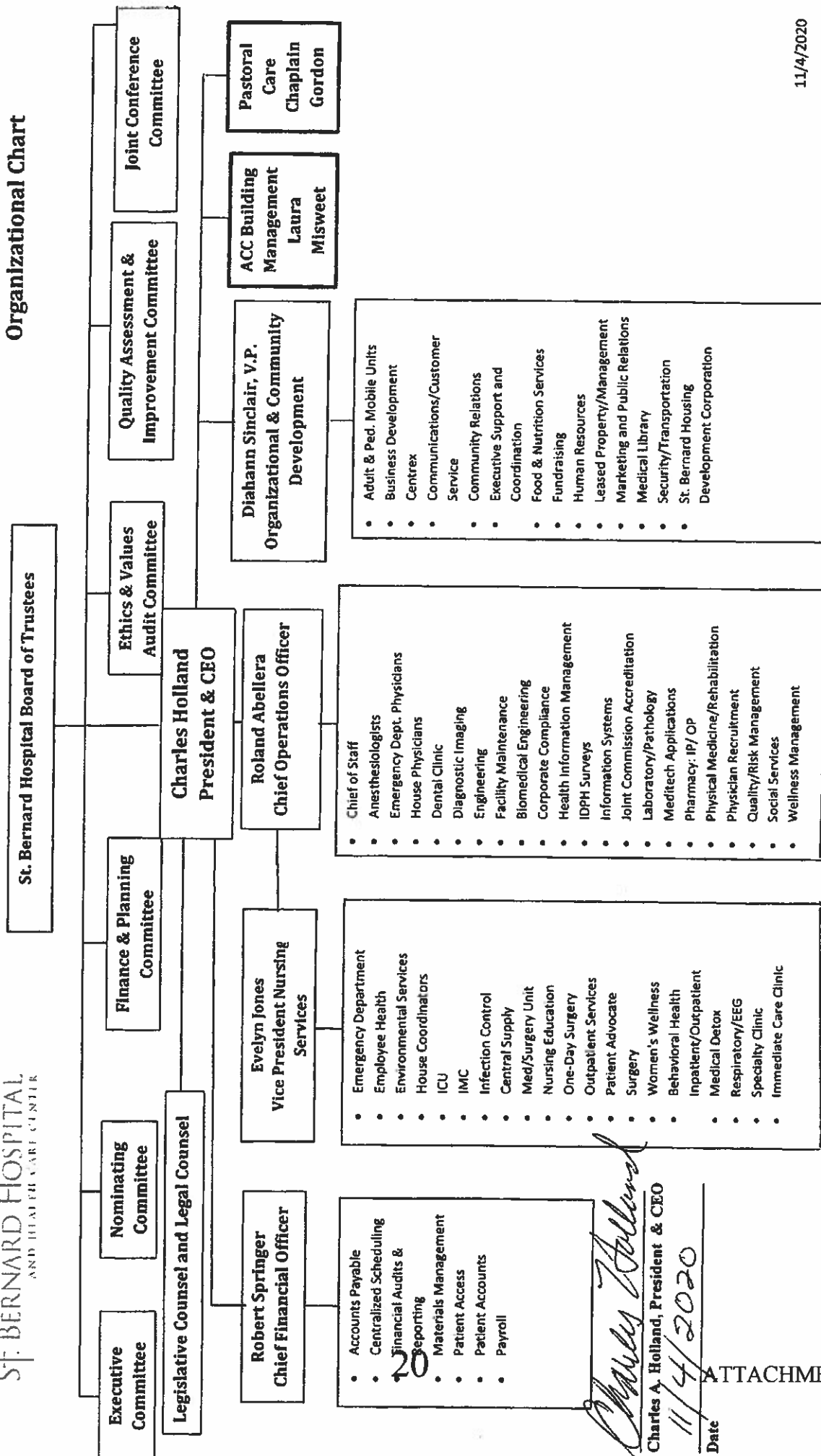
Authentication #: 2030302760 verifiable until 10/29/2021  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*  
19

SECRETARY OF STATE ATTACHMENT 3

# ST. BERNARD HOSPITAL AND HEALTH CARE CENTER

## Organizational Chart



11/4/2020

*Charles A. Holland*  
Charles A. Holland, President & CEO  
11/4/2020  
Date

ATTACHMENT 4

## DISCONTINUATION

1. This Certificate of Exemption ("COE") application addresses the discontinuation of the applicant hospital's obstetrics category of service, which includes twenty-two authorized beds.
2. Those clinical areas/functions directly associated with an obstetrics program, including labor/delivery/recovery, C-Section, and the hospital's nursery will also be discontinued.
3. It is anticipated that the obstetrics unit will be discontinued within 30 days following receipt of the request COE Permit; with the receipt of that Permit anticipated to take place no later than February 1, 2021. Discontinuation will occur via formal notification to the HFSRB.
4. As of the filing of this Certificate of Exemption application, a final decision has not been made relating to the future use of the unit. However, in the event of a surge in the demand for medical beds as a result of the Covid-19 pandemic, the unit could temporarily be converted into a medical/surgical unit. The unit's equipment will be used in other areas of the hospital, donated to not-for-profit organizations, or discarded. Last, the unit's employees have or will be offered other positions at the hospital or affiliated programs.
5. The medical records of patients receiving obstetrical or newborn services at the hospital will be maintained by the hospital, consistent with all retention-related regulatory requirements.

6. The required legal notice was published in the *Chicago Sun Times* in October 30, 2020  
The notice and proof of publication are attached.

#### LEGAL NOTICE

St. Bernard Hospital, located at 326 West 64<sup>th</sup> Street in Chicago, intends to cease the operations of its obstetrics inpatient 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 March 1, 2021. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by November 30, 2020; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at [hfsrb.illinois.gov](http://hfsrb.illinois.gov).

## ST BERNARD HOSPITAL

LEGAL NOTICE St. Bernard Hospital, located at 326 West 64th :

ADORDERNUMBER: 0001116201-01

PO NUMBER: Obstetrics Inpatient Unit

AMOUNT: 240.00

NO OF AFFIDAVITS: 1

## LEGAL NOTICE

St. Bernard Hospital, located at 326 West 64th Street in Chicago, intends to cease the operations of its obstetrics inpatient 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 March 1, 2021. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by November 30, 2020; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at [hfsrb.illinois.gov](http://hfsrb.illinois.gov).  
10/30/2020 #1116201

# Chicago Sun-Times

## Certificate of Publication

State of Illinois - County of Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisements in the following secular newspapers. All newspapers meet Illinois Compiled Statute requirements for publication of Notices per Chapter 715 ILCS 5/0.01 et seq. R.S. 1874, P728 Sec 1, EFF. July 1, 1874. Amended by Laws 1959, P1494, EFF. July 17, 1959. Formerly Ill. Rev. Stat. 1991, CH100, PI.


Note: Notice appeared in the following checked positions.

PUBLICATION DATE(S): 10/30/2020

Chicago Sun-Times

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

by



Susan Quinn

Manager | Recruitment &amp; Legals

This 30th Day of October 2020 A.D.

ST BERNARD HOSPITAL  
326 W 64TH ST  
ATTN: JOSEPHINE ANZALDUA  
CHICAGO, IL 60621



## REASONS FOR DISCONTINUATION

The proposed discontinuation of obstetrics and related services at St. Bernard Hospital is a direct result of a rapidly diminishing utilization of the service, rendering the continued staffing of the labor/delivery/recovery, post-partum, c-section, and nursery functions impractical.

The obstetrics category of service was suspended on April 20, 2020. Prior to the suspension, the hospital experienced a 35% decrease in deliveries and a 29% decrease in obstetrical patient days from 2015 through 2019. Reductions of this magnitude are somewhat greater than the geographic cohort hospitals as a whole; however, a clear downward trend exists in the area. The seven area (A-03) hospitals providing obstetrical services in 2018 (the last year for which data is available), experienced an 11% decrease in deliveries and a 21% decrease in obstetrical patient days between 2015 and 2018. The 2018 area-wide obstetrical occupancy rate was only 26.1%, based on HFSRB data.

In 2019, on average, St. Bernard Hospital experienced only 1.6 deliveries a day (a total of 575 babies), and an average obstetrical census of only 3.68 patients.

## IMPACT ON ACCESS

The proposed discontinuation of obstetrics services at St. Bernard Hospital will have minimal impact on access to services.

St. Bernard Hospital is located in HFSRB-designated Hospital Planning Area A-03, and is one of six hospitals in HPA A-03 currently providing obstetrical services. (The applicant acknowledges that Mercy Hospital, which is approved to provide 30 obstetrics beds, has proposed the closure of the hospital and Holy Cross Hospital has filed a COE application addressing the discontinuation of its 16-bed obstetrics unit.)

During 2019, the average daily census on St. Bernard Hospital's obstetrics unit was only 3.68 patients, resulting from fewer than two admissions per day. Per HFSRB data, HPA A-03 is "over-bedded" by 80 obstetrics beds, with the providing hospitals being approved for 154 beds, and the HFSRB-calculated "bed need" being 74 beds. The 2018 obstetrics occupancy rates of the hospitals in HPA A-03 ranged from 8% to 43%, with the area-wide average being 30%.

Among the hospital providers in HPA A-03 is The University of Chicago Medical Center ("UCMC"), located approximately two miles to the northeast of St. Bernard Hospital. Per HFSRB 2018 data (the most current data available), UCMC is approved to operate 46 obstetrics beds, and in 2018 experienced an average daily census of 17.6 patients (38.3% occupancy). Citing UCMC as an example of the area's "over-bedding", the minimal number of obstetrics patients admitted to St. Bernard Hospital during 2019, and given that area residents will continue to have reasonable access to obstetrical services at other hospitals, the proposed discontinuation will have minimal impact on access to obstetrics services.

Letters, consistent with the requirements of Section 1110.290, have been sent to all area hospitals providing obstetrics services, and a sample of that letter and a listing of those hospitals is attached. Any responses to the letter, received by the applicant, will be forwarded to HFSRB staff.

October 28, 2020

name  
title  
hospital  
street address  
city/state/ZIP code

RE: St. Bernard Hospital  
Proposed Discontinuation of Obstetrics  
Category of Service

Dear \_\_\_\_\_ :

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

St. Bernard Hospital intends to file a Certificate of Exemption application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board to discontinue St. Bernard Hospital's 22-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2019, a total of 1,263 patients were admitted to the obstetrics unit 3,238 patient days of care were provided on the obstetrics unit and 1,333 deliveries were performed at the hospital.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing inpatient obstetrical services to residents 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,

Charles Holland  
President & CEO

Notification letters were sent to the following hospitals:

1. MacNeal Hospital
2. Advocate Christ Medical Center
3. Mount Sinai Hospital
4. John H. Stroger, Jr. Hospital of Cook County
5. Rush University Medical Center
6. Norwegian American Hospital
7. AMITA Health Saint Mary's Hospital
8. Saint Anthony Hospital
9. University of Chicago Medical Center
10. Little Company of Mary Hospital and Health Care Centers
11. Mercy Hospital & Medical Center
12. Northwestern Memorial Hospital
13. Advocate Trinity Hospital
14. Roseland Community Hospital

# ST. BERNARD HOSPITAL AND HEALTH CARE CENTER

326 WEST 64TH STREET, CHICAGO, ILLINOIS 60621  
TELEPHONE 773.962.3900 FACSIMILE 773.602.3849

November 4, 2020

Illinois Health Facilities and Services review Board  
Springfield, IL 62761

To Whom It May Concern:

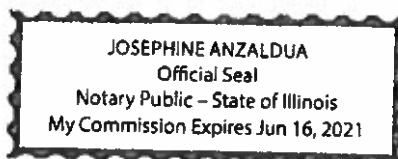
In accordance with Review Criterion 1110.110, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. St. Bernard Hospital and Health Care Center has not had any adverse actions against any facility owned and operated by the applicant during the three (3) year period prior to the filing of this application, and
2. St. Bernard Hospital and Health Care Center authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.110 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 your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

*Charles Holland*  
Charles Holland  
President & CEO



Notarized: *State of Illinois*  
*County of Cook*

*on this 4th day of November 2020*

*Josephine Anzaldúa*



### BACKGROUND OF APPLICANT

The applicant does not own and/or operate any other licensed health care facilities, other than the applicant hospital.

Attached is a letter, providing the required authorizations addressing adverse actions and access to verification documents, as required by Section 1110.110.

Also attached is a photocopy of the hospital's IDPH license and confirmation of accreditation by The Joint Commission.



# Illinois Department of PUBLIC HEALTH

HF 119675

## LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

**Ngozi O. Ezike, M.D.**  
**Director**

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/2020		0002303
<b>General Hospital</b>		
<b>Effective: 01/01/2020</b>		

**St. Bernard Hospital**  
**326 W 64th Street**  
**Chicago, IL 60621**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 1/0M 9/18

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

Exp. Date 12/31/2020

Lic Number 0002303

Date Printed 1/9/2020

**St. Bernard Hospital**  
**326 W 64th Street**  
**Chicago, IL 60621**

**FEE RECEIPT NO.**



# St Bernard Hospital

Chicago, IL

has been Accredited by



## The Joint Commission


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

**January 9, 2019**

Accreditation is customarily valid for up to 36 months.

  
Craig W. Jones, FACHE  
Chair, Board of Commissioners

ID #7304  
Print/Reprint Date: 04/09/2019

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

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

## SAFETY NET IMPACT STATEMENT

St. Bernard Hospital has a long history of being a safety net provider, and because of the low utilization of obstetrics services at the hospital in recent years, the proposed discontinuation will have no material impact on the hospital's commitment to being a safety net provider; nor will the proposed discontinuation have a material impact on other safety net providers.

As one measure of the hospital's standing as a safety net provider, during 2019, charity care (per the IDPH definition) was equal to 8.7% of the hospital's net revenue, compared to 5.1% for all Chicago hospitals and 2.3% state-wide in 2018.

Additionally, St. Bernard Hospital is, and will continue to be an active sponsor of and participant in a broad range of community programming. Examples include:

- Annual Community Health Fair located in the parking lot of the Ambulatory Care Center
- Englewood Back to School Parade
- Adopt a Family Christmas, providing food, clothing, and gifts
- Health Task Force of Englewood Quality of Life Plan, focusing on initiative to improve the quality of life in the community
- Pediatric Mobile Health Units that provide immunizations, screenings, physicals and health education programs throughout the south side of Chicago
- African Festival of the Arts Chicago
- Community Baby Shower, providing educational programming and gifts for expectant and new mothers.

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	17
2	Site Ownership	18
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	19
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	20
5	Discontinuation General Information Requirements	21
6	Reasons for Discontinuation	24
7	Impact on Access	24
8	Background of the Applicant	30
9	Safety Net Impact Statement	33
10	Charity Care Information	15