

ORIGINAL

RECEIVED

MAY 07 2013

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

13-022

Facility/Project Identification

Facility Name:	Franciscan St. James Health-Chicago Heights		
Street Address:	1423 Chicago Road		
City and Zip Code:	Chicago Heights, IL 60411		
County:	Cook	Health Service Area	VII
Health Planning Area:	A-04		

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Franciscan Alliance, Inc. d/b/a Franciscan St. James Health		
Address:	1423 Chicago Road Chicago Heights, IL 60411		
Name of Registered Agent:			
Name of Chief Executive Officer:	Seth Warren		
CEO Address:	1423 Chicago Road Chicago Heights, IL 60411		
Telephone Number:	708/756-1000		

Type of Ownership of Applicant/Co-Applicant

<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

- 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.

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 during the review period]

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:	847/776-7004

Additional Contact

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

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

### Post Permit Contact

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

Name:	Thomas W. Senesac
Title:	Regional Chief Financial Officer
Company Name:	Franciscan Alliance, Inc.
Address:	1423 Chicago Road Chicago Heights, IL 60411
Telephone Number:	708/756-1000
E-mail Address:	Tom.Senesac@franciscanalliance.org
Fax Number:	708/756-6863

### Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Franciscan Alliance, Inc.
Address of Site Owner:	1515 Dragoon Trail Mishawaka, IN 46545
Street Address or Legal Description of Site:	1423 Chicago Road Chicago Heights, IL 60411
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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:	Franciscan Alliance, Inc. d/b/a Franciscan St. James Health		
Address:	1423 Chicago Road Chicago Heights, IL 60411		
<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>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>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.</li><li>o <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 co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Flood Plain Requirements not applicable**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org). **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

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

**Historic Resources Preservation Act Requirements not applicable**

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

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

**DESCRIPTION OF PROJECT**

**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- Substantive
- Non-substantive

Part 1120 Applicability or Classification:  
[Check one only.]

- Part 1120 Not Applicable
- Category A Project
- Category B Project
- DHS or DVA Project

## 2. Narrative Description

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

The applicant proposes to discontinue the cardiac catheterization category of service at Franciscan St. James Health-Chicago Heights. The service shares equipment and a location with the hospital's interventional radiology service, which will continue in operation.

This is a substantive project by virtue of the proposed discontinuation of an IDPH-designated category of service.

## Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>	\$0	\$0	\$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	\$0	\$0	\$0
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

### Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project  Yes  No  
Purchase Price: \$ \_\_\_\_\_  
Fair Market Value: \$ \_\_\_\_\_

The project involves the establishment of a new facility or a new category of service  
 Yes  No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ \_\_\_\_\_.

### Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable  Preliminary  
 Schematics  Final Working

Anticipated project completion date (refer to Part 1130.140): \_\_\_\_\_

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

- Purchase orders, leases or contracts pertaining to the project have been executed.
- Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
- Project obligation will occur after permit issuance.

**APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

### State Agency Submittals

Are the following submittals up to date as applicable:

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

**Cost Space Requirements not applicable**

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							

**APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

## Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

<b>FACILITY NAME:</b> Franciscan St. James Health-Chicago Heights		<b>CITY:</b> Chicago Heights			
<b>REPORTING PERIOD DATES:</b> From: January 1, 2012 to: December 31, 2012					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	230	8,146	35,525	none	230
Obstetrics	22	1,268	3,136	none	22
Pediatrics	10	387	959	none	10
Intensive Care	20	705	3,893	none	20
Comprehensive Physical Rehabilitation	30	370	5,335	none	30
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
<b>TOTALS:</b>	<b>312</b>	<b>10,876</b>	<b>48,848</b>	<b>none</b>	<b>312</b>

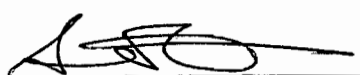


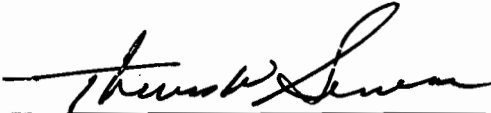
**CERTIFICATION**

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

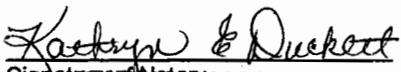

This Application for Permit is filed on the behalf of Franciscan Alliance, Inc. \* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of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

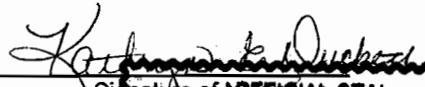
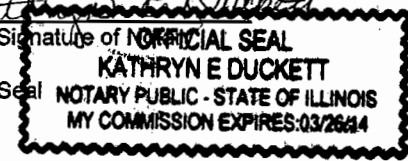
  
\_\_\_\_\_  
SIGNATURE  
SETH C.R. WARREN  
\_\_\_\_\_  
PRINTED NAME  
PRESIDENT & REGIONAL CEO  
\_\_\_\_\_  
PRINTED TITLE

  
\_\_\_\_\_  
SIGNATURE  
THOMAS W. SESESE  
\_\_\_\_\_  
PRINTED NAME  
REGIONAL CFO  
\_\_\_\_\_  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 1st day of May 2013

Notarization:  
Subscribed and sworn to before me  
this 1st day of May 2013

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


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


\*Insert EXHIBIT legal marks of the applicant

## SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

### Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

#### REASONS FOR DISCONTINUATION

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

#### IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

**VIII. - 1120.120 - Availability of Funds**

**not applicable, no capitalized costs**

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

<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and</li> <li>2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;</li> </ol> <p>b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.</p> <p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p> <p>d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:</p> <ol style="list-style-type: none"> <li>1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;</li> <li>4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol> <p>e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;</p> <p>f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;</p> <p>g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.</p>
<b>TOTAL FUNDS AVAILABLE</b>	

**APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**IX. 1120.130 - Financial Viability**

not applicable, no capitalized project costs

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

**Financial Viability Waiver**

The applicant is not required to submit financial viability ratios if:

1. All of the projects capital expenditures are completely funded through internal sources
2. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
3. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

**APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

**2. Variance**

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

**APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**X. 1120.140 - Economic Feasibility not applicable, no capitalized project costs**

This section is applicable to all projects subject to Part 1120.

**A. Reasonableness of Financing Arrangements**

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
  - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
  - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

**B. Conditions of Debt Financing**

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

**C. Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
<b>TOTALS</b>									

\* include the percentage (%) of space for circulation

**D. Projected Operating Costs**

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

**E. Total Effect of the Project on Capital Costs**

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**XI. Safety Net Impact Statement**

**SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:**

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

**Safety Net Impact Statements shall also include all of the following:**

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

**A table in the following format must be provided as part of Attachment 43.**

<b>Safety Net Information per PA 96-0031</b>			
<b>CHARITY CARE</b>			
<b>Charity (# of patients)</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Inpatient	2,310	2,158	2,002
Outpatient	10,101	8,828	8,447
<b>Total</b>	<b>12,411</b>	<b>10,986</b>	<b>10,449</b>
<b>Charity (cost in dollars)</b>			
Inpatient	\$3,513,497	\$2,701,171	\$3,047,468
Outpatient	\$2,815,054	\$3,042,571	3,147,881
<b>Total</b>	<b>\$6,328,551</b>	<b>\$5,753,742</b>	<b>\$6,195,349</b>
<b>MEDICAID</b>			
<b>Medicaid (# of patients)</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Inpatient	2,133	2,495	2,073
Outpatient	21,416	21,357	21,862
<b>Total</b>	<b>23,549</b>	<b>23,852</b>	<b>23,935</b>
<b>Medicaid (revenue)</b>			
Inpatient	\$8,692,704	\$10,191,848	\$8,857,623
Outpatient	\$5,546,646	\$3,028,914	\$3,060,623
<b>Total</b>	<b>\$14,239,350</b>	<b>\$13,220,762</b>	<b>\$11,918,246</b>

**APPEND DOCUMENTATION AS ATTACHMENT 43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**XII. Charity Care Information**

Charity Care information **MUST** be furnished for **ALL** projects.

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.

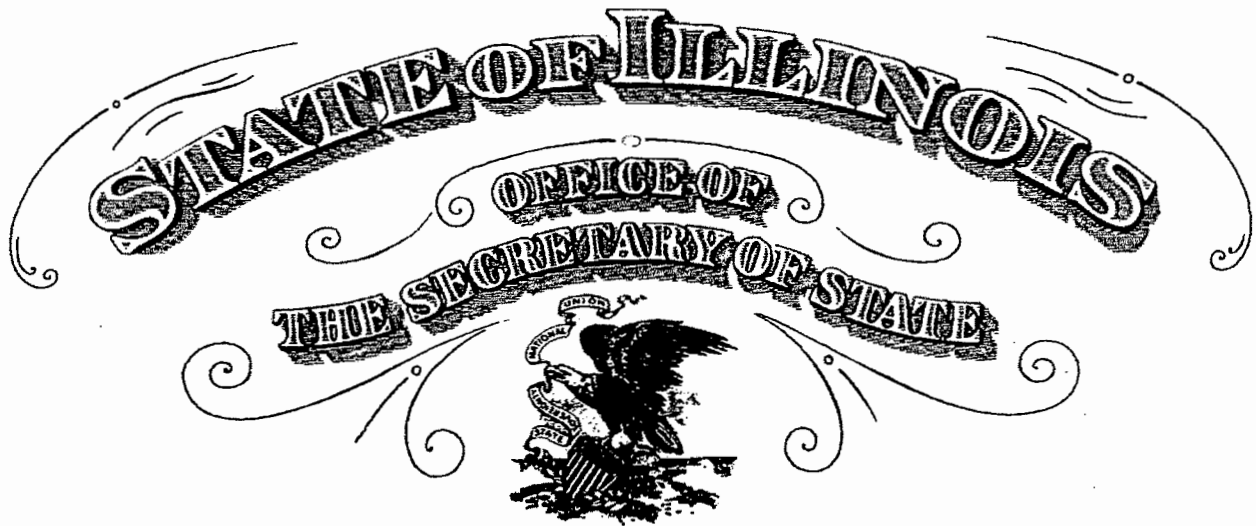
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2009	2010	2011
Net Patient Revenue	\$123,366,082	\$126,484,850	\$129,407,743
Amount of Charity Care (charges)	\$31,416,416	\$19,722,309	\$21,437,193
Cost of Charity Care	\$6,328,551	\$5,753,742	\$6,195,349

**APPEND DOCUMENTATION AS ATTACHMENT 44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**





To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

FRANCISCAN ALLIANCE, INC., INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 15, 1974, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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 1ST day of APRIL A.D. 2013



Jesse White

Authentication #: 1309101450

Authenticate at: <http://www.cyberdriveillinois.com>

SECRETARY OF STATE

ATTACHMENT 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*

FRANCISCAN ALLIANCE, INC., INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 15, 1974, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



Authentication #: 1309101450

Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 1ST day of APRIL A.D. 2013***

*Jesse White*

SECRETARY OF STATE

ATTACHMENT 1



# EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY)  
04/10/2013

THIS EVIDENCE OF PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

AGENCY <b>Gregory &amp; Appel Insurance</b> 1402 N. Capitol Suite 400 Indianapolis, IN 46202 Jeff Webster		PHONE (A/C, No, Ext) <b>317-634-7491</b>		COMPANY <b>Lexington Insurance Co</b> 100 Summer Street Boston, MA 02110-2103	
FAX (A/C, No) <b>317-634-6629</b>		E-MAIL ADDRESS <b>info@gregoryappel.com</b>			
CODE: AGENCY <b>FRANC-3</b>		SUB CODE:			
INSURED <b>Franciscan Alliance, Inc.</b> <b>Rob Hamage</b> <b>3510 Park Place West, #200</b> <b>Mishawaka, IN 46545</b>		LOAN NUMBER		POLICY NUMBER <b>012944968</b>	
		EFFECTIVE DATE <b>09/01/12</b>		EXPIRATION DATE <b>09/01/13</b>	
				<input checked="" type="checkbox"/> CONTINUED UNTIL TERMINATED IF CHECKED	
THIS REPLACES PRIOR EVIDENCE DATED:					

### PROPERTY INFORMATION

LOCATION/DESCRIPTION <b>333 Dixie Highway</b> <b>Chicago HeightsIL</b>	<b>Hospitals</b>
--	------------------

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

### COVERAGE INFORMATION

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Premise 000 Building 000	700000000	100000
BLKT BLDG/BPP	1302640835	100000
BLKT BI/WEE 24 HRS	250000000	100000
Flood SEE SCHEDU	100000000	100000
Flood SEE SCHEDU	100000000	100000
EARTHQUAKE	250000000	100000
Extra Expense	182036337	100,000
1423 Chicago Rd, Chicago Heights, IL - Bldg	53154639	100,000
BPP Limit		

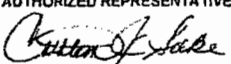
### REMARKS (Including Special Conditions)

REMARKS (Including Special Conditions)

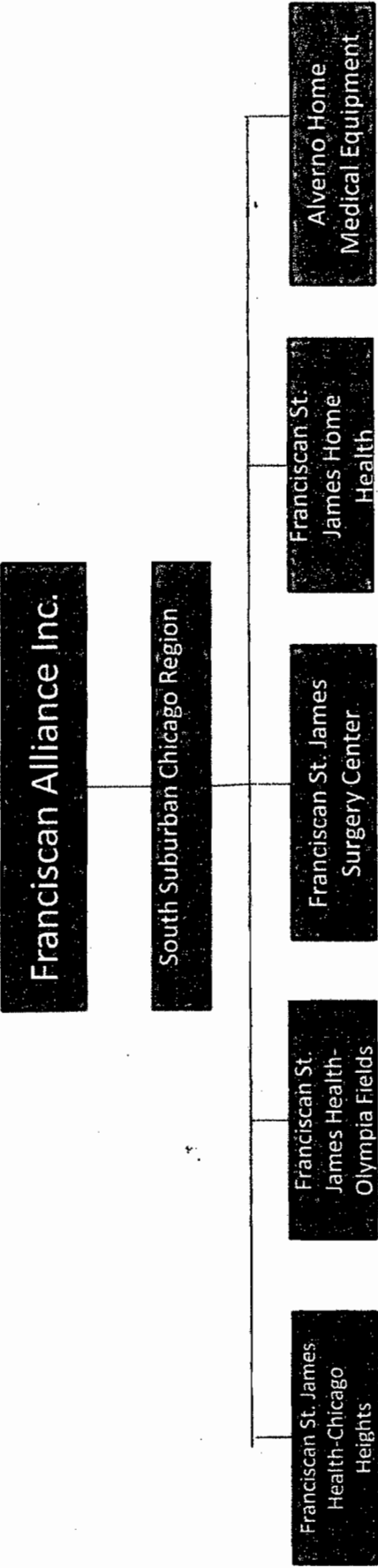
### CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

### ADDITIONAL INTEREST

NAME AND ADDRESS  <b>State of Illinois Health</b> <b>Facilities and Services</b> <b>525 W Jefferson Street</b> <b>Springfield, IL 62761</b>	<input type="checkbox"/> MORTGAGEE <input type="checkbox"/> LOSS PAYEE	<input type="checkbox"/> ADDITIONAL INSURED
	LOAN #	
AUTHORIZED REPRESENTATIVE 		

19



## DISCONTINUATION

The applicants propose the discontinuation of the cardiac catheterization (“cardiac cath”) category of service at Franciscan St. James Health-Chicago Heights. The hospital’s cardiac cath equipment is also used for interventional radiology procedures, and will remain in place for that use. The system’s heart and vascular institute is located at Franciscan St. James Health-Olympia Fields, located approximately 4 ¼ miles from the Chicago Heights hospital; and the vast majority of the system’s cardiology patients are now treated at the Olympia Fields hospital. In 2012, 2,012 cardiac cath procedures were performed at the Olympia Fields hospital. The two hospitals operate with a common medical staff, and it is well known in the region, including by first responders, that the heart and vascular institute is located at the Olympia Fields hospital. While the equipment and staff for performing cardiac cath is available at the Chicago Heights hospital, the intent was to provide the service only on an emergency basis, and no such cases presented themselves over the past two years. As a result, cardiac catheterization has become an unnecessarily duplicative program operated by sister hospitals in close proximity to one another.

The category of service will be discontinued upon proper notification to the IHFSRB and appropriate local legislators, within thirty days of receipt of a Permit to do so.

Medical records are retained by the hospital for ten years.

As identified in the table below, there are five (5) hospitals providing cardiac catheterization services within 45 minutes (MapQuest, adjusted) of Franciscan St. James Health-Chicago Heights, and consistent with IHFSRB requirements, evidence of the driving time to each hospital on the list is also provided.

Hospital	Location
Franciscan St. James Health-Olympia Fields	Olympia Fields
Advocate South Suburban Hospital	Hazel Crest
Ingalls Memorial Hospital	Harvey
MetroSouth Medical Center	Blue Island
Little Company of Mary Hospital	Evergreen Park

The proposed discontinuation will not have an adverse impact on any other hospital. Letters, requesting impact statements, consistent with Section 1110.130, were sent to each of the hospitals in the table above on April 1, 2013. A sample copy of the letter is attached. All responses will be forwarded to IHFSRB staff.

by Certified Mail

April 1, 2013

Name or "Administrator"

Title

Facility name

Street address

City/state/ZIP

Dear :

Franciscan Health Alliance is preparing Certificate of Need applications to be filed with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of the cardiac catheterization category of service at Franciscan St. James Health-Chicago Heights, located at 1423 Chicago Road in Chicago Heights, and the discontinuation/closure of Franciscan St. James Surgery Center, located at 333 Dixie Highway in Chicago Heights. The discontinuations are scheduled to occur following IHFSRB approval, in the third quarter of 2013.

Over the past two years, no cardiac catheterizations have been performed at Franciscan St. James Health-Chicago Heights, and during the 24-month period ending December 31, 2011 6,050 outpatient surgeries were performed at Franciscan St. James Surgery Center.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130.c), you are hereby asked to, within fifteen days, identify what impact, if any, the proposed discontinuations will have on your operations; whether your facility has the available capacity to accommodate a portion or all of caseload noted above, and whether your facility operates with any restrictions or limitations that would preclude providing service to residents of market areas of the two facilities.

Thank you for your prompt attention to this request.

Sincerely,

Seth Warren

ATTACHMENT 10










Notes

Trip to:

**Olympia Fields, IL**

4.28 miles / 9 minutes

**A** **Franciscan St. James Rehabilitative Medicine Center**  
 Rehabilitative Medicine Center  
 1423 Chicago Rd, Chicago Heights, IL 60411  
 (708) 756-6740

- 
 1. Start out going **north** on **Chicago Rd / IL-1** toward **E 14th St / US-30**. [Map](#) **0.03 Mi**  
*0.03 Mi Total*
- 

 2. Take the 1st **left** onto **W 14th St / US-30**. Continue to follow **US-30**. [Map](#) **3.7 Mi**  
*3.8 Mi Total*
- 

 3. Turn **right** onto **Crawford Ave / US-54 / Governors Hwy**. [Map](#) **0.1 Mi**  
*3.9 Mi Total*
- 
 4. Take the 1st **right** onto **Governors Hwy**. [Map](#) **0.4 Mi**  
*4.3 Mi Total*
- 
 5. Welcome to **OLYMPIA FIELDS, IL**. [Map](#)

**B** **Olympia Fields, IL**

Total Travel Estimate: **4.28 miles - about 9 minutes**

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

24





Notes

Trip to:

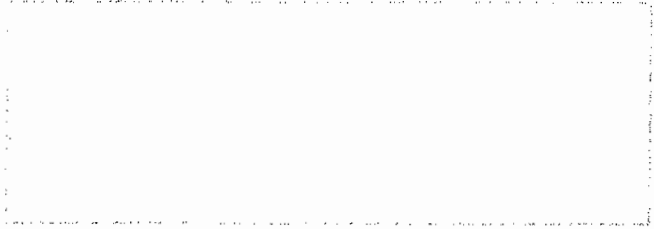
**Little Company of Mary**

**2850 W 95th St**

Evergreen Park, IL 60805

(708) 499-2273

20.79 miles / 37 minutes



**Franciscan St. James Rehabilitative Medicine Center**

Rehabilitative Medicine Center

1423 Chicago Rd, Chicago Heights, IL 60411

(708) 756-6740



1. Start out going **north** on **Chicago Rd / IL-1** toward **E 14th St / US-30**. [Map](#)

**0.4 Mi**

*0.4 Mi Total*



2. Turn **right** onto **IL-1 / Route 1 Cutoff**. [Map](#)

**0.4 Mi**

*0.8 Mi Total*



3. Turn **left** onto **IL-1 / S Halsted St**. Continue to follow **IL-1**. [Map](#)

**4.4 Mi**

*5.2 Mi Total*



4. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). [Map](#)

**9.0 Mi**

*14.3 Mi Total*



5. Take the exit toward **IL-50 S / Cicero Ave / 127th St**. [Map](#)

**0.3 Mi**

*14.6 Mi Total*



6. Turn **right** onto **W 127th St**. [Map](#)

**0.8 Mi**

*15.3 Mi Total*



7. Turn **left** onto **S Pulaski Rd**. [Map](#)

**4.0 Mi**

*19.4 Mi Total*



8. Turn **right** onto **US-20 / US-12 / Ulysses S Grant Memorial Hwy / W 95th St**. [Map](#)

**1.4 Mi**

*20.8 Mi Total*



9. **2850 W 95TH ST** is on the **left**. [Map](#)



**Little Company of Mary**

2850 W 95th St, Evergreen Park, IL 60805

(708) 499-2273

Total Travel Estimate: **20.79 miles - about 37 minutes**

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

25




Notes



Trip to:



**Metrosouth Medical Center**  
**12935 Gregory St**



Blue Island, IL 60406  
 (708) 597-2000  
 20.79 miles / 37 minutes


**A** **Franciscan St. James Rehabilitative Medicine Center**  
 Rehabilitative Medicine Center  
 1423 Chicago Rd, Chicago Heights, IL 60411  
 (708) 756-6740


- 
**0.4 Mi**  
*0.4 Mi Total*


1. Start out going **north** on **Chicago Rd / IL-1** toward **E 14th St / US-30**. [Map](#)
- 

**0.4 Mi**  
*0.8 Mi Total*



2. Turn **right** onto **IL-1 / Route 1 Cutoff**. [Map](#)
- 

**4.4 Mi**  
*5.2 Mi Total*


3. Turn **left** onto **IL-1 / S Halsted St**. Continue to follow **IL-1**. [Map](#)
- 

**9.0 Mi**  
*14.3 Mi Total*

4. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). [Map](#)
- 
**0.3 Mi**  
*14.6 Mi Total*

5. Take the exit toward **IL-50 S / Cicero Ave / 127th St**. [Map](#)
- 
**0.8 Mi**  
*15.3 Mi Total*

6. Turn **right** onto **W 127th St**. [Map](#)
- 
**4.0 Mi**  
*19.4 Mi Total*

7. Turn **left** onto **S Pulaski Rd**. [Map](#)
- 

**1.4 Mi**  
*20.8 Mi Total*

8. Turn **right** onto **US-20 / US-12 / Ulysses S Grant Memorial Hwy / W 95th St**. [Map](#)
- 

9. **2850 W 95TH ST** is on the **left**. [Map](#)

**B** **Metrosouth Medical Center**  
 12935 Gregory St, Blue Island, IL 60406  
 (708) 597-2000

Total Travel Estimate: **20.79 miles - about 37 minutes**

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

26



mapquest

Notes

[Empty dashed box for notes]

Trip to:

**Advocate South Suburban Hospital**

**17800 Kedzie Ave**

Hazel Crest, IL 60429

(773) 264-6800

4.93 miles / 10 minutes



**Franciscan St. James Rehabilitative Medicine Center**

Rehabilitative Medicine Center

1423 Chicago Rd, Chicago Heights, IL 60411

(708) 756-6740



1. Start out going **northwest** on **Dixie Hwy** toward **Ashland Ave.** [Map](#)

**0.3 Mi**

*0.3 Mi Total*



2. Turn **slight left** onto **Vollmer Rd.** [Map](#)

**1.9 Mi**

*2.2 Mi Total*



3. Turn **right** onto **Kedzie Ave.** [Map](#)

**2.6 Mi**

*4.8 Mi Total*



4. Turn **left.** [Map](#)

**0.1 Mi**

*4.9 Mi Total*



5. Turn **right.** [Map](#)

**0.04 Mi**

*4.9 Mi Total*



6. **17800 KEDZIE AVE.** [Map](#)



**Advocate South Suburban Hospital**

Emergency Room

17800 Kedzie Ave, Hazel Crest, IL 60429

(773) 264-6800

Total Travel Estimate: **4.93 miles - about 10 minutes**

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

28

CERTIFIED MAIL

April 1, 2013

Oak Lawn Endoscopy  
9921 Southwest Highway  
Oak Lawn, IL 60453-3767

Attn: Administrator

To Whom It May Concern:

CHICAGO HEIGHTS  
1423 Chicago Road  
Chicago Heights, IL 60411  
PH: 708 756 1000

OLYMPIA FIELDS  
20201 South Crawford Avenue  
Olympia Fields, IL 60461  
PH: 708 747 4000

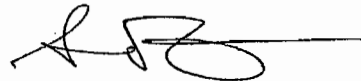
Franciscan Health Alliance is preparing Certificate of Need applications to be filed with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of the cardiac catheterization category of service at Franciscan St. James Health-Chicago Heights, located at 1423 Chicago Road in Chicago Heights, and the discontinuation/closure of Franciscan St. James Surgery Center, located at 333 Dixie Highway in Chicago Heights. The discontinuations are scheduled to occur following IHFSRB approval, in the third quarter of 2013.

Over the past two years, no cardiac catheterizations have been performed at Franciscan St. James Health-Chicago Heights, and during the 24-month period ending December 31, 2011 6,050 outpatient surgeries were performed at Franciscan St. James Surgery Center.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130.c, you are hereby asked to, within fifteen days, identify what impact, if any, the proposed discontinuations will have on your operations; whether your facility has the available capacity to accommodate a portion or all of caseload noted above, and whether your facility operates with any restrictions or limitations that would preclude providing service to residents of market areas of the two facilities.

Thank you for your prompt attention to this request.

Sincerely,



Seth Warren  
President and Regional CEO

kd

**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:

Ms. Bernice Reilly - Resident  
 Little Company of Mary Hospital  
 5660 W. 95th Street  
 Oak Lawn, IL 60453

2. Article Number

(Transfer from service label)

7010 1870 0001 0919 7957

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *Anna Baran*  Agent  
 Addressee

B. Received by (Printed Name)

*Anna Baran*

C. Date of Delivery

*2/13/2013*

D. Is delivery address different from item 1?  Yes

If YES, enter delivery address below:  No

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

**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:

Mr. Seth C.R. Warren, President  
 Franciscan St James Health  
 20201 S. Crawford Ave.  
 Olympia Fields, IL  
 60461

2. Article Number

(Transfer from service label)

7010 1870 0001 0919 7919

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *[Signature]*  Agent  
 Addressee

B. Received by (Printed Name)

*[Signature]*

C. Date of Delivery

*04/05/13*

D. Is delivery address different from item 1?  Yes

If YES, enter delivery address below:  No

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

**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:

MR. SETH WARREN, PRESIDENT &  
 CEO  
 FRANCOISAN ST JAMES HEALTH-CM  
 1423 Chicago Road  
 Chicago Heights, IL  
 60411

2. Article Number

(Transfer from service label)

7010 1870 0001 0919 7902

ATTACHMENT 10

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *MOG*  Agent  
 Addressee

B. Received by (Printed Name)

*MOG*

C. Date of Delivery

*4-3-13*

D. Is delivery address different from item 1?  Yes

If YES, enter delivery address below:  No

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>		A. Signature <input checked="" type="checkbox"/> <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: Mr. Richard Heim, CEO Odessa South Suburban Hospital 1700 South Kelzie Ave. Hazel Crest, IL 60429-0989		B. Received by (Printed Name) <i>MAJOR STEVENS</i> C. Date of Delivery <i>4-3-13</i> D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label) <b>7010 1870 0001 0919 5106</b>		3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>		A. Signature <input checked="" type="checkbox"/> <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: Mr. Kurt E. Johnson, CEO Ingalls Memorial Hospital One Ingalls Drive Harvey, IL 60426-3558		B. Received by (Printed Name) <i>Kurt E Johnson</i> C. Date of Delivery <i>4-4-13</i> D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label) <b>7010 1870 0001 0919 7933</b>		3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>		A. Signature <input checked="" type="checkbox"/> <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: Enrique Beckmann, MD, PhD, CEO MetroSouth Medical Ctr. 12935 South Gregory St. Blue Island, IL 60406-2428		B. Received by (Printed Name) <i>Enrique Beckmann</i> C. Date of Delivery <i>4-3-13</i> D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label) <b>7010 1870 0001 0919 7940 ATTACHMENT 10</b>		3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

## SAFETY NET IMPACT STATEMENT

Franciscan St. James Health-Chicago Heights is one of the region's safety net hospitals, historically serving some of the far southern suburb's most financially-challenged populations. In 2011, 16.5% of the hospital's inpatients were identified as charity care patients, and the hospital's total charity care equaled 4.8% of its net revenue. In addition, during 2011, 17.1% of the patients admitted to the hospital were Medicaid recipients.

Franciscan St. James Health's cardiology services are largely centralized at the Chicago Heights hospital's sister hospital in nearby Olympia Fields; and it has been the practice of the applicants for a number of years to perform all non-emergent cardiac catheterizations at the Olympia Fields hospital. As a result, the proposed discontinuation will not impact patient care services in general, and safety net services in particular.

It is not believed by the applicants that the proposed discontinuation will have any impact on other providers of safety net services.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Coapplicant Identification including Certificate of Good Standing	18
2	Site Ownership	19
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	20
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	21
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	<b>Financial and Economic Feasibility:</b>	
39	Availability of Funds	
40	Financial Waiver	
41	Financial Viability	
42	Economic Feasibility	
43	Safety Net Impact Statement	43
44	Charity Care Information	