E-018-19

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

RECEIVED

MAY 13 2019

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago				
Street Address:	2900 North Lake Shore Drive				
City and Zip Code:	Chicago, IL 60657				
County:	Cook	Health Service Area	VI	Health Planning Area	A-04

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

Exact Legal Name:	Presence Chicago Hospitals Network d/b/a Presence Saint Joseph Hospital-Chicago
Street Address:	200 S. Wacker Drive, 11th Floor
City and Zip Code:	Chicago, IL 60606
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Mark A. Frey
CEO Street Address:	2601 Navistar Drive
CEO City and Zip Code:	Lisle, IL 60532
CEO Telephone Number:	224/273-4121

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	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:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago
Street Address:	2900 North Lake Shore Drive
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area VI Health Planning Area: A-01

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

Exact Legal Name:	Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health
Street Address:	2601 Navistar Drive Lisle
City and Zip Code:	IL 60532
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Mark A. Frey
CEO Street Address:	2601 Navistar Drive
CEO City and Zip Code:	Lisle, IL 60532
CEO Telephone Number:	224/273-4121

Type of Ownership of Applicants

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☐ For-profit Corporation
☐ Limited Liability Company
☐ Partnership
☐ Governmental
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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:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Presence Saint Joseph Hospital-Chicago
Street Address:	2900 North Lake Shore Drive
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area VI Health Planning Area: A-01

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

Exact Legal Name:	Ascension Health
Street Address:	4600 Edmunson Road
City and Zip Code:	St. Louis, MO 63134
Name of Registered Agent:	Illinois Corporation Service C
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Patricia Maryland, Dr. PH
CEO Street Address:	4600 Edmunson Road
CEO City and Zip Code:	St. Louis, MO 63134
CEO Telephone Number:	314/733-8000

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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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:	Peg Wendell, Esq.
Title:	Executive Vice President, Chief Legal Officer
Company Name:	AMITA Health
Address:	2601 Navistar Drive Lisle, IL 60532
Telephone Number:	224/273-2333
E-mail Address:	peg.wendell@amitahealth.org
Fax Number:	224/273-4121

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Presence Chicago Hospitals Network
Address of Site Owner:	200 South Wacker Drive, 11th Fl. Chicago, IL 60606

Street Address or Legal Description of the Site: 2900 North Lake Shore Drive Chicago, IL 60657

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name:	Presence Chicago Hospitals Network d/b/a Presence saint Joseph Hospital-Chicago
Address:	2900 North Lake Shore Drive Chicago, IL 60657

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

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

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

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

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

Narrative Description

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

The proposed project is limited to the discontinuation of the comprehensive physical rehabilitation ("rehabilitation") category of service at Presence Saint Joseph Hospital-Chicago, within thirty days following approval of this Certificate of exemption application.

The service was suspended via a letter dated March 22, 2019, and sent to the Administrator of the Illinois Health Facilities and Services Review Board and the Division Chief of IDPH's Division of Health Care Facilities and Programs. All of the rehabilitation unit's former staff have been offered and accepted positions within the AMITA Health system.

Project Status and Completion Schedules

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

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): 30 days from Board Approval

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

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

CERTIFICATION

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

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

This Application is filed on the behalf of Presence Chicago Hospitals Network d/b/a Presence Saint Joseph Hospital-Chicago*

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.

Martin Judd	Julie P. Roknich
SIGNATURE	SIGNATURE
MARTIN JUDD	Julie P. Roknich
PRINTED NAME	PRINTED NAME
President	Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 2nd day of May 2019	Notarization: Subscribed and sworn to before me this 6th day of May 2019
Signature of Notary	Melissa Kulik
Seal	Signature of Notary
"OFFICIAL SEAL" A LISA PEREZ Notary Public, State of Illinois My Commission Expires 10/20/2021	Seal
	OFFICIAL SEAL MELISSA KULIK NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:06/13/22

*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 _Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health 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	SIGNATURE
MARK A. FREY	PAUL E. BELTER
PRINTED NAME	PRINTED NAME
PRESIDENT, CEO	EVP, CHIEF FINANCIAL OFFICER
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 6th day of May	Notarization: Subscribed and sworn to before me this 6th day of May 2019
Signature of Notary	Signature of Notary
Seal OFFICIAL SEAL MELISSA KULIK NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:06/13/22	Seal OFFICIAL SEAL MELISSA KULIK NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:06/13/22

*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 Ascension Health*
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

Christine McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of May, 2019

Signature of Notary

Seal

ELFRIEDE M. ROHE
Notary Public - Notary Seal
STATE OF MISSOURI
Comm. Number 01505902
St. Louis County
My Commission Expires: July 13, 2020

SIGNATURE

Rhonda Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6 day of MAY 2019

Signature of Notary

Seal

BARBARA FLICK
Notary Public, Notary Seal
State of Missouri
St. Louis County
Commission # 17739069
My Commission Expires 06-19-2021

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

☐ Discontinuation of an Existing Health Care Facility

X Discontinuation of a 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 categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

REASONS FOR DISCONTINUATION

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

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

IMPACT ON ACCESS

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

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

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

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A HEALTH CARE FACILITY OR 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 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 9.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2016**	**2017**	**2018***
Inpatient	723	42	255
Outpatient	4,445	452	1,376
Total	**5,168**	**496**	**1,631**
Charity (cost in dollars)			
Inpatient	727,799	354,365	763,794
Outpatient	1,520,340	454,772	633,862
Total	**2,248,139**	**809,137**	**1,397,656**
MEDICAID			
Medicaid (# of patients)	**2016**	**2017**	**2018***
Inpatient	464	427	993
Outpatient	3,000	10,536	3,447
Total	3,464	10,963	4,440
Medicaid (revenue)			
Inpatient	20,516,947	33,379,547	12,089,906
Outpatient	7,584,914	18,530,768	1,242,421
Total	28,101,861	51,910,315	13,332,327

*six months

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			
	2016	**2017**	**2018**
Net Patient Revenue	**207,300,397**	**218,077,373**	**105,592,218**
Amount of Charity Care (charges)	9,569,562	4,321,924	6,554,629
Cost of Charity Care	2,248,139	809,137	1,397,656

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

File Number 3128-198-9

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, 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* 5TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1830901492 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

1C

File Number 6964-462-7

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

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, 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* 8TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1831202022 verifiable until 11/08/2019

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

Jesse White

SECRETARY OF STATE ATTACHMENT 1

File Number 6783-860-2

To all to whom these Presents Shall Come, Greeting:

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

ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, 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* 5TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1830901614 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

Presence
Saint Joseph Hospital

James L. Robinson III, PsyD.
President

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site of Presence Saint Joseph Hospital-Chicago, that being 2900 North Lake Shore Drive, is owned by Presence Chicago Hospitals Network.

Sincerely,

James L. Robinson III, PsyD
President

Notarized:

GERALDINE ESCAMILLA
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 11, 2019

ATTACHMENT 2

File Number 3128-198-9

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

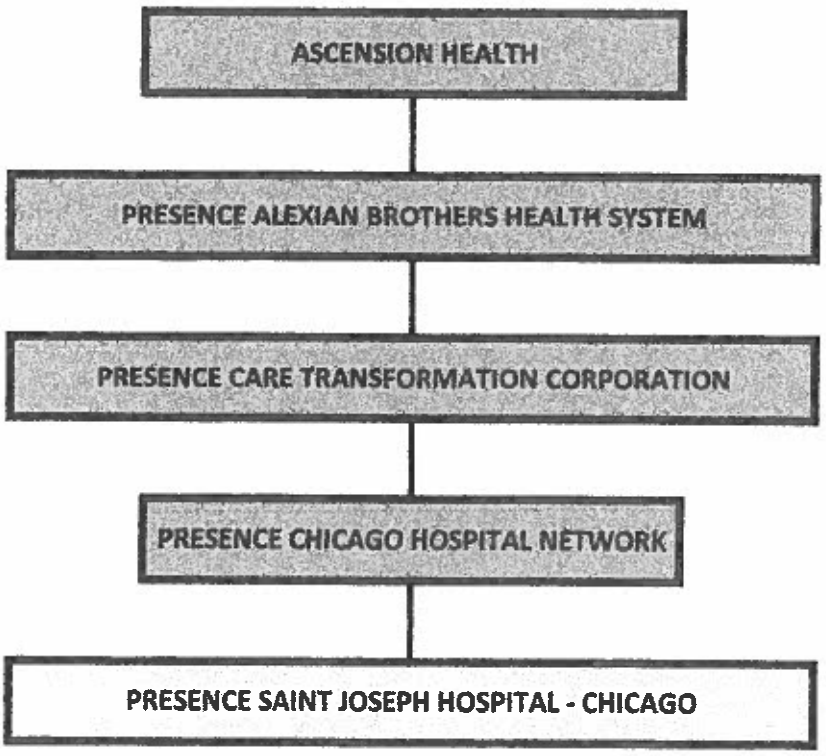
PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN 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* 5TH *day of* NOVEMBER *A.D.* 2018 .

Authentication #: 1830901492 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 3



ATTACHMENT 4

DISCONTINUATION

1. Only the hospital's comprehensive physical rehabilitation ("rehabilitation") category of service is proposed to be discontinued through this Certificate of Exemption ("COE") application. The hospital is approved to operate twenty-three rehabilitation beds.

2. No non-category of service clinical services are proposed to be discontinued as a result of the approval of this COE application.

3. The rehabilitation category of service will be formally discontinued within thirty days following the approval of the COE application addressing the discontinuation.

4. The hospital's rehabilitation unit is located on the eighth floor of the hospital. As of the filing of this Certificate of Exemption application, no decision on the future use of the space occupied by the rehabilitation unit has been made.

5. Medical records will be retained by the hospital, consistent with all licensure and accreditation standards and requirements.

6. Not applicable, applies only to the discontinuation of an entire facility.

7. With the signatures on the Certification pages of this COE application, the applicants attest that notice of the category of service was published in the *Chicago Sun Times* on April 1, 2019. As of the filing of this COE application, the applicants are not aware of any responses to that notice. A copy of the notice is attached.

ATTACHMENT 5

AMITA HEALTH PRESENCE HEALTH
Presence Saint Francis Hosp

ADORDERNUMBER: 0001082208-01
PO NUMBER: Presence Saint Francis Ho
AMOUNT: 188.00
NO OF AFFIDAVITS: 1

LEGAL NOTICE

Presence Saint Joseph Hospital-Chicago intends to cease the operations of its comprehensive physical rehabilitation category of service 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 September 1, 2019. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by May 1, 2019; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hfsrb.illinois.gov.
4/1/19 #1082208

Chicago Sun-Times
Certificate of Publication

State of Illinois - County of Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisments in the following secular newspapers. All newspapers meet Illinois Compiled Statue requirements for publication of Notices per Chapter 715 ILCS 5/0.01 et seq. R.S. 1874, P728 Sec 1, EFF. July 1, 1874. Amended by Laws 1959, P1494, EFF. July 17, 1959. Formerly Ill. Rev. Stat. 1991, CH100, Pl.
Note: Notice appeared in the following checked positions.
PUBLICATION DATE(S): 04/01/2019

Chicago Sun-Times

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

by

Mary Lou Davis
Account Manager - Public Legal Notices

This 1st Day of April 2019 A.D.

AMITA HEALTH PRESENCE HEALTH
200 S WACKER DR
ATTN: OLGA SOLARES
CHICAGO, IL 60606

ATTACHMENT 5

REASONS FOR DISCONTINUATION

The proposed discontinuation is a result of low utilization of the hospital's comprehensive physical rehabilitation ("rehabilitation") unit, a downward trend in admissions, and no anticipated reversal of that trend. As identified in the table below, between 2014 and 2018, admissions to the unit decreased by 111%. The resultant 2018 average daily census was only 2.7 patients.

Year	Admissions
2014	203
2015	188
2016	183
2017	154
2018	92

ATTACHMENT 6

IMPACT ON ACCESS

The discontinuation of comprehensive rehabilitation services ("rehabilitation") at the applicant hospital will not have an adverse effect on area residents' ability to access rehabilitation services.

There are fourteen hospital providers of rehabilitation services located within the HFSRB-identified geographic service area, including:

Advocate Illinois Masonic Medical Center
Evanston Hospital
Holy Cross Hospital
Mercy Hospital & Medical center
Presence Resurrection Medical Center
Presence Saint Mary of Nazareth Hospital
Rush Oak Park Hospital
Rush University Medical Center
Schwab Rehabilitation Center
Shirley Ryan AbilityLab
Shriners Hospital for Children
Swedish Covenant Hospital
University of Illinois Hospital at Chicago
Weiss Memorial Hospital

Each of the hospital providers identified above has been sent a notification of the impending discontinuation (template attached), and has been invited to provide an impact statement. As of the filing of this Certificate of Exemption application, no responses have been received. Should any responses be received post filing, they will be forwarded to HFSRB staff.

ATTACHMENT 7

March 28, 2019

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

name
title
hospital
street address
city/state/ZIP code

RE: Proposed Discontinuation of Comprehensive
Physical Rehabilitation 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.

Presence Saint Joseph Hospital-Chicago has suspended its comprehensive physical rehabilitation ("rehabilitation") category of service, and anticipates the formal discontinuation of that service to occur within thirty days following the Illinois Health Facilities and Services Review Board's ("IHFSRB's") approval of the hospital's Certificate of Exemption application to discontinue the category of service. That application will be filed by mid-April.

During the 24-month period ending December 31, 2018, a total of 246 patients were admitted to te hospital's rehabilitation unit, and 2,759 patient days of care were provided.

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 rehabilitation 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,

Aaron Hazzard
Interim CEO

ATTACHMENT 7

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

University of Illinois Hospital at Chicago

1740 W Taylor St

Chicago, IL 60612

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

B. Received by (Printed Name)

C. Date of

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 Merc

☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5647

PS Form 3811, February 2004 Domestic Return Receipt 102595-0

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:

Schwab Rehabilitation Center

1401 S California Ave

Chicago, IL 60608

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

B. Received by (Printed Name)

4-5-19

C. Date of

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 Merc

☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5609

PS Form 3811, February 2004 Domestic Return Receipt 102595-0

ATTACHMENT 7

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:

Shirley Ryan AbilityLab

355 E Erie St

Chicago, IL 60611

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Ag
☐ Ad

B. Received by (Printed Name)

C. Date of

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 Merch
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number
(Transfer from service label) 7017 2680 0000 6944 5616

PS Form 3811, February 2004 Domestic Return Receipt 102595-0

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:

Shriners Hospital for Children

2211 N Oak Park Ave

Chicago, IL 60707

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X V. Young

☐ Ag
☐ Ad

B. Received by (Printed Name)

C. Date of

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 Merch
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number
(Transfer from service label) 7017 2680 0000 6944 5623

PS Form 3811, February 2004 Domestic Return Receipt 102595-0

ATTACHMENT 7

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Rush Oak Park Hospital
520 S Maple Ave
Oak Park, IL 60304

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Cynthia J. Vs
☐ Ag
☐ Ad

B. Received by (Printed Name) Cyn
C. Date of 04-0

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5586

PS Form 3811, February 2004 Domestic Return Receipt 102595-

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:

Holy Cross Hospital
2701 W 68th St
Chicago, IL 60629

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature]
☐ Ag
☐ Ad

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5548

PS Form 3811, February 2004 Domestic Return Receipt 102595-

ATTACHMENT 7

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Advocate Illinois Masonic Medical Center

836 W Wellington Ave

Chicago, IL 60657

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

B. Received by (Printed Name) Tammie

C. Date of 4/1/19

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number 7017 2680 0000 6944 5654

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:

Weiss Memorial Hospital

4646 N Marine Dr

Chicago, IL 60640

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

B. Received by (Printed Name) GFloyd

C. Date of 4-2-

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5654

PS Form 3811, February 2004 Domestic Return Receipt 102595-

ATTACHMENT 7

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Presence Saint Mary of Nazareth Hospital

2233 West Division St

Chicago, IL 60622

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5555

PS Form 3811, February 2004 Domestic Return Receipt 102595-

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Swedish Covenant Hospital

5140 N California Ave

Chicago, IL 60625

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X Laura Weiss

B. Received by (Printed Name) LAURA WEISS | C. Date of 4-2-

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

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

4. Restricted Delivery? (Extra Fee) ☐ Ye

2. Article Number (Transfer from service label) 7017 2680 0000 6944 5630

PS Form 3811, February 2004 Domestic Return Receipt 102595-

ATTACHMENT 7

BACKGROUND

The following Illinois licensed health care facilities are owned or operated by applicant Ascension Health, or a related entity thereof:

Alexian Brothers Medical Center
Elk Grove Village

St. Alexius Medical Center
Hoffman Estates

Alexian Brothers Behavioral Health Hospital
Hoffman Estates

Adventist Midwest Health d/b/a Adventist Hinsdale Hospital
Hinsdale

Adventist Midwest Health d/b/a Adventist La Grange Memorial Hospital
La Grange

Adventist Bolingbrook Hospital
Bolingbrook

Adventist Glen Oaks Hospital
Glendale Heights

Presence Chicago Hospitals Network d/b/a Presence Saints Mary and Elizabeth Medical Center
Chicago

Presence Chicago Hospitals Network d/b/a Presence Saint Joseph Hospital-Chicago
Chicago

Presence Chicago Hospitals Network d/b/a Presence Saint Francis Hospital
Evanston

ATTACHMENT 8

Presence Chicago Hospitals Network d/b/a Presence Resurrection Medical Center
Chicago

Presence Chicago Hospitals Network d/b/a Presence Holy Family Medical Center
Des Plaines

Presence Central and Suburban Hospitals Network d/b/a/ Mercy Medical Center
Aurora

Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Hospital-Elgin
Elgin

Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center
Joliet

Presence Central and Suburban Hospitals Network d/b/a Presence St. Mary's Hospital
Kankakee

Presence Lakeshore Gastroenterology
Des Plaines

Belmont/Harlem Surgery Center
Chicago

ATTACHMENT 8

AMITA HEALTH

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

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

1. AMITA Health has not had any adverse actions against any facility owned, operated, and/or controlled by the applicant during the three (3) year period prior to the filing of this application, and
2. AMITA Health authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

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

Sincerely,

Mark A. Frey
President and
Chief Executive Officer

Date: 4/3, 2019

Notarized:

OFFICIAL SEAL
DONNA GAUTHIER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/02/22

Donna Gauthier 4-3-19

AMITA Health System Office
2601 Navistar Dr.
Lisle, IL 60532

The Joint Commission

March 7, 2018

Mike Murrill
Chief Executive Officer

Adventist Midwest Health
5101 South Willow Springs Road
La Grange, IL 60525

Joint Commission ID #: 7370
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 03/07/2018

Dear Mr. Murrill:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospitals**

This accreditation cycle is effective beginning December 16, 2017 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

ATTACHMENT 8

Presence Saint Joseph 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

July 2, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #7307
Print/Reprint Date: 09/15/2016

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.

ATTACHMENT 8

SAFETY NET IMPACT STATEMENT

Presence Saint Joseph Hospital-Chicago has a long history of being a safety net provider, both in terms of services provided directly at or by the hospital, as well as its role in the community. The proposed discontinuation of comprehensive rehabilitation services will have no impact on that commitment, nor will it have any impact on any other providers of safety net services.

ATTACHMENT 9

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	16
2	Site Ownership	19
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	20
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	21
5	Discontinuation General Information Requirements	22
6	Reasons for Discontinuation	24
7	Impact on Access	25
8	Background of the Applicant	32
9	Safety Net Impact Statement	37
10	Charity Care Information	15

E-018-19

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

May 10, 2019

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

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Exemption ("COE") application addressing the discontinuation of the comprehensive physical rehabilitation category of service at Presence saint Joseph Hospital-Chicago.

The application is accompanied by a check, in the amount of $2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004