ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Swedish Covenant Health d/b/a Swedish Hospital			
Street Address:5145 N. California Avenue			
City and Zip Code: Chicago 60625			
County: Cook	Health Service Area	6	Health Planning Area: 01

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

Exact Legal Name: Swedish Covenant Health
Street Address: 5145 N. California Avenue
City and Zip Code: Chicago 60625
Name of Registered Agent: Anthony Guaccio
Registered Agent Street Address: 5145 N. California Avenue
Registered Agent City and Zip Code: Chicago 60625
Name of Chief Executive Officer: Anthony Guaccio
CEO Street Address: 5145 N. California Avenue
CEO City and Zip Code: Chicago 60625
CEO Telephone Number:773-878-5370

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Saliba Kokaly
Title: Vice President - Operations
Company Name: Swedish Covenant Health
Address: 5145 N. California Avenue Chicago, Illinois 60625
Telephone Number:773-293-4000 / Cell 773-203-9710
E-mail Address: skokaly@schosp.org
Fax Number: 773-728-6066

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Swedish Covenant Health d/b/a Swedish Hospital			
Street Address:5145 N. California Avenue			
City and Zip Code: Chicago 60625			
County: Cook	Health Service Area	6	Health Planning Area: 01

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

Exact Legal Name: NorthShore University HealthSystem
Street Address: 1301 Central Street
City and Zip Code: Evanston 60201
Name of Registered Agent: Kristen Murtos
Registered Agent Street Address: 1301 Central Street
Registered Agent City and Zip Code: Evanston 60201
Name of Chief Executive Officer: Gerald "J.P." Gallagher
CEO Street Address: 1301 Central Street
CEO City and Zip Code: Evanston 60201
CEO Telephone Number: (847) 570-2000

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
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Telephone Number:773-293-4000 / Cell 773-203-9710
E-mail Address: skokaly@schosp.org
Fax Number: 773-728-6066

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

Name: Janet Scheuerman
Title: Consultant
Company Name: PRISM Healthcare Consulting
Address: 1808 Woodmere Drive Valparaiso, IN
Telephone Number:219-464-3969
E-mail Address: Janet.Scheuerman@outlook.com
Fax Number: 219-464-0027

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: Saliba Kokaly
Title: Vice President - Operations
Company Name: Swedish Covenant Health
Address: 5145 N. California Avenue Chicago, Illinois 60625
Telephone Number:773-293-4000 / Cell 773-203-9710
E-mail Address: skokaly@schosp.org
Fax Number: 773-728-6066

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Swedish Covenant Health
Address of Site Owner: 5145 N. California Avenue Chicago, Illinois 60625
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease**.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Swedish Covenant Health
Address: 5145 N. California Avenue Chicago, Illinois 60625
☒ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Name: Janet Scheuerman
Title: Consultant
Company Name: PRISM Healthcare Consulting
Address: 1808 Woodmere Drive Valparaiso, IN
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APPEND DOCUMENTATION AS <u>ATTACHMENT 3,</u> 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.

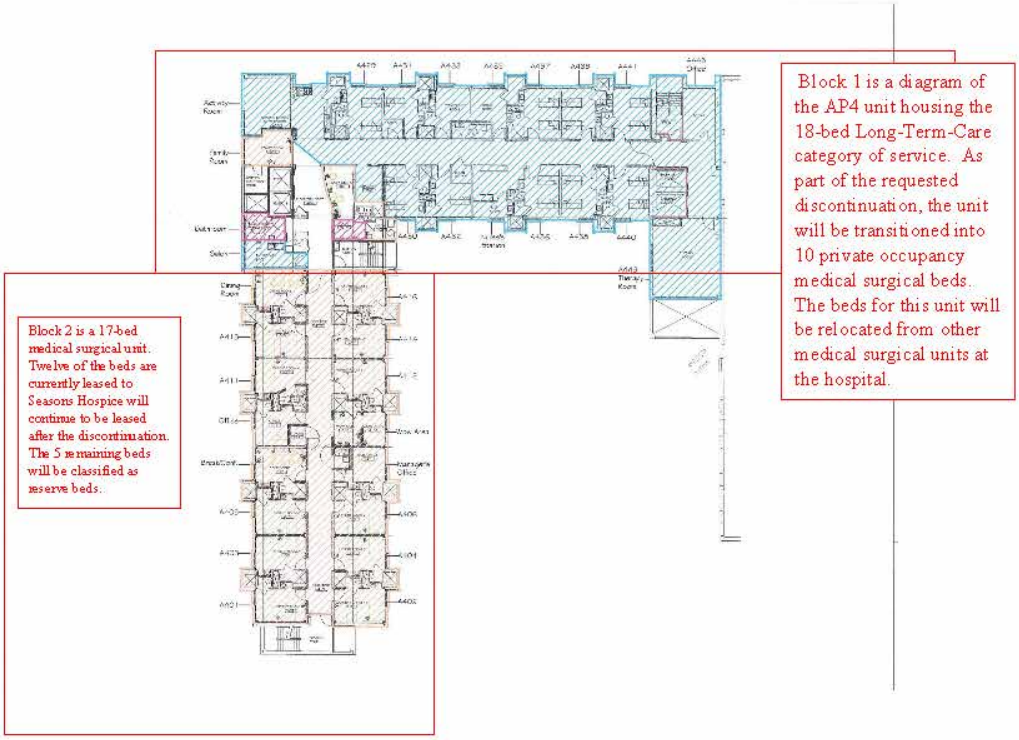
Swedish Covenant Health d/b/a Swedish Hospital (the "Hospital") plans to discontinue the existing 10-room/18-bed Long-Term Care (LTC) category of service and the 18 LTC designated beds located therein.

The diagram on the following page outlines the relative locations of the transitioned Long-Term Care unit (Block 1) and the unchanged, adjacent 17- bed medical surgical unit. (Block 2). The number of license medical-surgical beds at Swedish Hospital will remain at 188 at the conclusion of this project.

According to Section 1110.20 (c) (1) (B) (ii) of the HFSRB rules, the proposed project is classified as a substantive project because it involves "the discontinuation of a category of service within an existing facility."

The total filing fee for this application was mailed to the IHFSRB on August 12, 2020.

Units Affected by the Discontinuation of the LTC Beds
and Rearrangement of Medical Surgical Beds



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): ___October 31, 2020_____

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

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

All of the above listed submittals are as up to date as possible.

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 Swedish Covenant Health d/b/a Swedish Hospital

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

SIGNATURE

Anthony Guaccio
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of SEPT., 2020

Laura D. Weiss
Signature of Notary

Seal

LAURA D WEISS
Official Seal
Notary Public – State of Illinois
My Commission Expires Oct 27, 2021

SIGNATURE

Tom Garvey
PRINTED NAME

Senior Vice President and CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14TH day of SEPT., 2020

Laura D. Weiss
Signature of Notary

Seal

LAURA D WEISS
Official Seal
Notary Public – State of Illinois
My Commission Expires Oct 27, 2021

*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 NorthShore University HealthSystem

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

Kristen Murtos
PRINTED NAME

Chief Administrative & Strategy Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September

Barbara M. Holland
Signature of Notary

Seal
OFFICIAL SEAL
BARBARA M HOLLAND
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/04/23

SIGNATURE

Sean T. O'Grady
PRINTED NAME

Chief Clinical Operations Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of September

Barbara M. Holland
Signature of Notary

Seal
OFFICIAL SEAL
BARBARA M HOLLAND
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/04/23

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

☒ Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the category of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide attestation that the facility provided the required notice of the category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

REASONS FOR DISCONTINUATION

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

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

IMPACT ON ACCESS

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

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

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

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A CATEGORY OF SERVICE [20 ILCS 3960/5.4]:

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

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

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

A table in the following format must be provided as part of Attachment 9.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

SECTION V. CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 10.

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

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

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	15 – 18
2	Site Ownership	19 – 20
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	21 – 22
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	23 – 24
5	Discontinuation General Information Requirements	25 – 28
6	Reasons for Discontinuation	29 – 30
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9	Safety Net Impact Statement	46 – 49
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Appendix 1	Return Receipt Notifications	52 – 75

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

Exact Legal Name: Swedish Covenant Health
Street Address: 5145 N. California Avenue
City and Zip Code: Chicago 60625
Name of Registered Agent: Anthony Guaccio
Registered Agent Street Address: 5145 N. California Avenue
Registered Agent City and Zip Code: Chicago 60625
Name of Chief Executive Officer: Anthony Guaccio
CEO Street Address: 5145 N. California Avenue
CEO City and Zip Code: Chicago 60625
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Exact Legal Name: NorthShore University HealthSystem
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Name of Registered Agent: Kristen Murtos
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APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

A 2020 Certificate of Good Standing for each applicant is located on the following pages.

File Number 1024-301-7

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SWEDISH COVENANT HEALTH, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 06, 1907, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* AUGUST *A.D.* 2020 .

SEAL OF THE STATE OF ILLINOIS — AUG. 26TH 1818

Authentication #: 2023802930 verifiable until 08/25/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

File Number 0567-540-5

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

NORTHSHORE UNIVERSITY HEALTHSYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 04, 1891, 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* 12TH *day of* SEPTEMBER *A.D.* 2020 .

SEAL OF THE STATE OF ILLINOIS — AUG. 26TH 1818

Authentication #: 2025600592 verifiable until 09/12/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Swedish Covenant Health
Address of Site Owner: 5145 N. California Avenue Chicago, Illinois 60625
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease**.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Exhibit 1, Attachment 2 is the first page of the commitment to provide Title Insurance for Swedish Covenant Health.

The complete Proof of Site Ownership document has been sent to file at the offices of the Health Facilities and Services Review Board.

stewart title

ALTA COMMITMENT FOR TITLE INSURANCE

ISSUED BY
STEWART TITLE GUARANTY COMPANY

NOTICE

IMPORTANT - READ CAREFULLY: THIS COMMITMENT IS AN OFFER TO ISSUE ONE OR MORE TITLE INSURANCE POLICIES. ALL CLAIMS OR REMEDIES SOUGHT AGAINST THE COMPANY INVOLVING THE CONTENT OF THIS COMMITMENT OR THE POLICY MUST BE BASED SOLELY IN CONTRACT.

THIS COMMITMENT IS NOT AN ABSTRACT OF TITLE, REPORT OF THE CONDITION OF TITLE, LEGAL OPINION, OPINION OF TITLE, OR OTHER REPRESENTATION OF THE STATUS OF TITLE. THE PROCEDURES USED BY THE COMPANY TO DETERMINE INSURABILITY OF THE TITLE, INCLUDING ANY SEARCH AND EXAMINATION, ARE PROPRIETARY TO THE COMPANY, WERE PERFORMED SOLELY FOR THE BENEFIT OF THE COMPANY, AND CREATE NO EXTRACONTRACTUAL LIABILITY TO ANY PERSON, INCLUDING A PROPOSED INSURED.

THE COMPANY'S OBLIGATION UNDER THIS COMMITMENT IS TO ISSUE A POLICY TO A PROPOSED INSURED IDENTIFIED IN SCHEDULE A IN ACCORDANCE WITH THE TERMS AND PROVISIONS OF THIS COMMITMENT. THE COMPANY HAS NO LIABILITY OR OBLIGATION INVOLVING THE CONTENT OF THIS COMMITMENT TO ANY OTHER PERSON.

COMMITMENT TO ISSUE POLICY

Subject to the Notice; Schedule B, Part I - Requirements; Schedule B, Part II - Exceptions; and the Commitment Conditions, STEWART TITLE GUARANTY COMPANY, a Texas corporation (the "Company"), commits to issue the Policy according to the terms and provisions of this Commitment. This Commitment is effective as of the Commitment Date shown in Schedule A for each Policy described in Schedule A, only when the Company has entered in Schedule A both the specified dollar amount as the Proposed Policy Amount and the name of the Proposed Insured.

If all of the Schedule B, Part I - Requirements have not been met within six months after the Commitment Date, this Commitment terminates and the Company's liability and obligation end.

Countersigned by:

Authorized Countersignature

STEWART TITLE GUARANTY COMPANY INCORPORATED 1908 TEXAS

Matt Morris
President and CEO

Denise Carraux
Secretary

Stewart Title Guaranty Company
10 South Riverside Plaza, Suite 1450
Chicago , IL 60606
(800) 261-9800
Prepared by: George Kintz
For purposes of this form the "Stewart Title" logo featured above is the represented logo for the underwriter, Stewart Title Guaranty Company.

This page is only a part of a 2016 ALTA® Commitment for Title Insurance. This Commitment is not valid without the Notice; the Commitment to Issue Policy; the Commitment Conditions; Schedule A; Schedule B, Part I - Requirements; and Schedule B, Part II - Exceptions; and a countersignature by the Company or its issuing agent that may be in electronic form.

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AMERICAN LAND TITLE ASSOCIATION

File No. 19000033585
ALTA Commitment For Title Insurance 8-1-16 (4-2-18)
Page 1 of 3

Operating Identity/Licensee

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

Exact Legal Name: Swedish Covenant Health			
Address: 5145 N. California Avenue, Chicago, Illinois 60625			
☒	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 <u>ATTACHMENT 3,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

There are no persons with 5 percent or greater interest in the license.

File Number 1024-301-7

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SWEDISH COVENANT HEALTH, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 06, 1907, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 25TH *day of* AUGUST *A.D.* 2020 .

SEAL OF THE STATE OF ILLINOIS — AUG. 26TH 1818

Authentication #: 2023802930 verifiable until 08/25/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

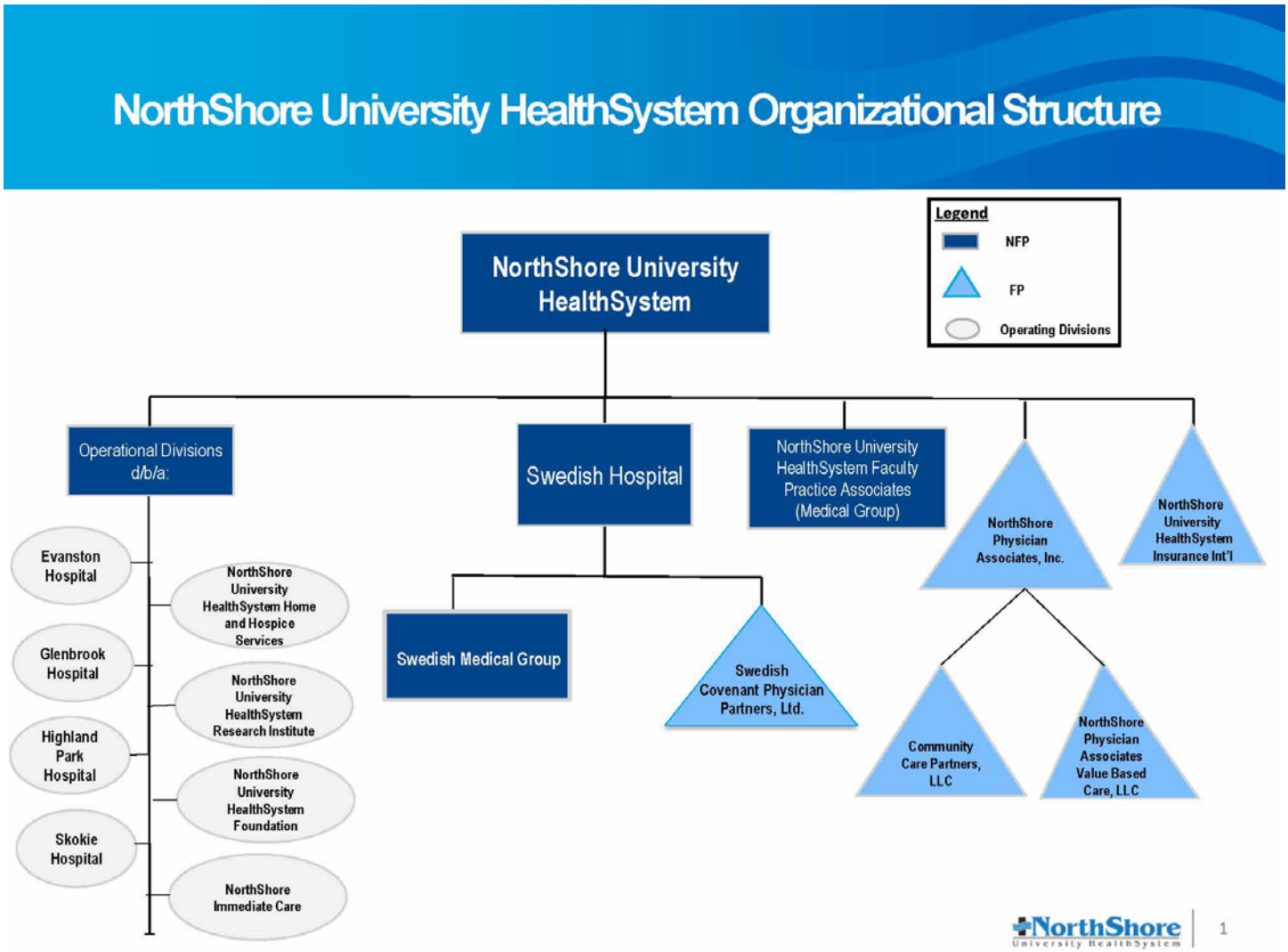
Organizational Relationships

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

Attachment 4 is an organizational chart for North Shore University HealthSystem including Swedish Covenant Health containing the name and relationship of any person or entity who is related (as in Part 1130.140).

There is no capital cost for this project.

Swedish Hospital
Part of NorthShore



SECTION II. DISCONTINUATION

Type of Discontinuation

☒ Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the category of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service.
4. Provide the anticipated use of physical plant and equipment after the discontinuation occurs.
5. Provide attestation that the facility provided the required notice of the category of 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, the number of times broadcasted, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

1. **Identify the category of service and the number of beds, if any that are to be discontinued**.

   Upon approval of the Certificate of Exemption application by the IHFSRB, Swedish Covenant Health d/b/a Swedish Hospital will discontinue its Long-Term Care Category of Service and 18 long-term care beds.

2. **Identify all of the other clinical services that are to be discontinued.**

   No other clinical services will be discontinued at the time the Long-Term Care category of service is discontinued.

3. **Provide the anticipated date of discontinuation.**

   The anticipated date of discontinuation of the Long-Term care category of service and 18 beds is October 31, 2020.

4. **Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.**

   The discontinued Long-Term Care unit and the 18 Long-Term care beds will be transitioned into a 10-bed medical surgical unit. Ten beds for the unit will be moved from multi-bed rooms situated on other medical-surgical units at the Hospital. As a result of this transition, Swedish Hospital will not have increased the number of medical surgical beds, it will have increased the number of private medical surgical rooms by 20.

5. **Provide attestation that the facility provided the required notice of the category of 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, the number of times broadcasted, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.**

   A copy of the notice from the Chicago Tribune and an affidavit attesting to the date the notice was published, August 22, 2020, is attached as Attachment 5, Exhibit 1.

#E-044-20

Chicago Tribune

Sold To:
Corporate Communications Swedish Hospital - CU80091577
5145 N California Ave
Chicago,IL 60625-3661

Bill To:
Corporate Communications Swedish Hospital - CU80091577
5145 N California Ave
Chicago,IL 60625-3661

Classified Advertising: 6746655
Purchase Order:

Certificate of Publication:

State of Illinois - Cook

Chicago Tribune Media Group does hereby certify that it is the publisher of the Chicago Tribune. The Chicago Tribune is a secular newspaper, has been continuously published Daily for more than fifty (50) weeks prior to the first publication of the attached notice, is published in the City of Chicago, State of Illinois, is of general circulation throughout that county and surrounding area, and is a newspaper as defined by 715 IL CS 5/5.

This is to certify that a notice, a true copy of which is attached, was published 1 time(s) in the Chicago Tribune, namely one time per week or on 1 successive weeks. The first publication of the notice was made in the newspaper, dated and published on 8/22/2020, and the last publication of the notice was made in the newspaper dated and published on 8/22/2020.

This notice was also placed on a statewide public notice website as required by 715 ILCS 5/2. 1.

On the following days, to-wit: **Aug 22, 2020.**

Executed at Chicago, Illinois on this

10th Day of September, 2020, by

Chicago Tribune Company

Jeremy Gates

Chicago Tribune - chicagotribune.com
160 N Stetson Avenue, Chicago, IL 60601
(312) 222-2222 - Fax: (312) 222-4014

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.

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.

In making decisions for Swedish Covenant Health d/b/a Swedish Hospital (Hospital), the Hospital's leadership uses its vision/mission statement as their guide. Some of the key tenants in the mission statement include "comprehensive range of health and wellness services – to serve diverse north and northwest sides with an acute hospital." Decisions are made with great care.

According to records, Hospital leadership routinely monitors healthcare trends, many related to population change and others to improved methods of patient care. Just as there has been a substantial increase in the aging in the population in the US, the Hospital's service area has experienced similar percentage growth. Concurrently there have been substantial changes in care for the aging patients – changes focused on aggressive rehabilitation and socialization. It has become increasingly apparent to the Hospital leadership that the development of a "new" model senior rehab facility was unrealistic – it was not feasible for the Hospital to adequately provide aggressive, comprehensive rehabilitation services for a small patient population and compete with the newer models that were increasingly the preferred choice of most seniors and their families.

Realizing that a traditional Long-Term Care model was becoming increasingly outdated and difficult to staff, and aware of the expectations of most long-term care patients, the Hospital staff worked closely with area nursing homes to form a Long-Term Care Council and currently has more than 20 nursing homes participating. Through the work of the Council, communication has been enhanced and the discharge process streamlined. A user-friendly physician, family and patient tool has been developed to assist in the decision-making process of nursing home placement when they leave Swedish Covenant.

Today, Swedish Covenant serves effectively as a "bridge" from the hospital to the appropriate nursing home or rehabilitation facility.

For the longer term, however, Hospital leadership concluded that resources should be focused on acute care (the priority noted in the vision/mission statement) and the Long-Term Care unit should be discontinued.

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.

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

   Swedish Hospital is located in Hospital Planning Area A-06. According to the "Inventory of Health Care Facilities and Services and Need Determination by Planning Area" (Long-Term Nursing Care Beds) Area A-06 has 6,513 existing beds and a projected 2022 bed need of 5,423 beds, which is an excess of 1,090 beds. The planned discontinuation will have a minimal impact on the planning area but will reduce the bed excess by a small fraction.

   During the first 6 months of 2020, the average daily census of the Swedish Hospital long-term care unit was 7.7. With a large planning area excess of LTC beds there is capacity in the area to accommodate the Hospital's LTC census of 7.7 without having an adverse effect upon access to care for residents of the planning 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.**

Notification Letter for Area Hospitals

August (date), 2020
Name of Recipient/Address

Dear (insert name):

In accordance with the Illinois Health Facilities and Services Review Board's (IHFSRB's) Discontinuation Certificate of Exemption Application (COE), Attachment 7, the purpose of this letter is to notify your organization that Swedish Covenant Health (d/b/a Swedish Hospital) in Chicago, Illinois will be filing a COE permit application to discontinue its 18- bed Long-Term Care Category of Service. The anticipated discontinuation is planned to occur by October 31,2020, pending receipt IHFSRB necessary approvals. The space currently housing the Long-Term Care Category of Service will become medical/surgical beds.

As required by the IHFSRB requirements for discontinuation, we are sending you this intent to discontinue notice. The following table includes the last two and a half years of utilization of the Hospital long-term care category of service. As detailed below, the service has been experiencing declining utilization recently.

Swedish Hospital Utilization 2018 and 2019

Year	Beds	Admissions	Total Patient Days	Average Daily Census	Percent Occupancy
2018	37	430	5,220	14.3	38.7
2019	37	390	5,007	13.7	37.0
2020 (6 mo)	18	80	1397	7.7	42.8

We believe this modest Swedish Hospital volume can be appropriately accommodated in the geographic service area's (GSA's) available long-term care beds and that patients and families that have relied on Swedish for long-term care will be very satisfied with the programs that continue to provide care to the community.

We will be happy to answer any questions you may have about our plans. Please call Kathy Donofrio at **773-878-8200, Ext. 7330** with your questions. Further, please share with us any impact the proposed discontinuation of long-term care beds will have on your facility or programs. We request your comments by September 4th via fax to **219-464-0027**.

Thank you for your thoughtful consideration of our plans to discontinue our long-term care category of service.

Sincerely,

Swedish Hospital
Part of NorthShore

Miles From SCH	Facility Name	Facility Type	Facility Address	Facility City	Facility State	Facility Zip Code	Licensed Beds	Contact Telephone	Administrator Name
0.1	Foster Health & Rehabilitation Center	Multiple-Level	2840 W Foster Ave	Chicago	IL	60625	46	847-933-1274	Michael Donovan
0.8	Continental Nursing and Rehabilitation Center	Multiple-Level	5336 N Western Ave	Chicago	IL	60625	208	773-271-5600	Monica Winkleman
1.1	Balmoral Home Inc	Multiple-Level	2055 W Balmoral Ave	Chicago	IL	60625	213	773-561-8661	Yonathan Stern
1.4	Ambassador Nursing And Rehabilitation	Multiple-Level	4900 N. Bernard St.	Chicago	IL	60712	190	773-583-7130	Raphael Nudell
1.4	Astoria Place Living and Rehab Center	Multiple-Level	6300 N. California Avenue	Chicago	IL	60659	164	773-973-1900	Patricia Davis
1.5	Harmony Nursing & Rehabilitation	Multiple-Level	3919 W. Foster Ave.	Chicago	IL	60625	180	773-588-9500	Allen Hollander
1.7	Fairmont Care	Multiple-Level	5061 N. Pulaski Road	Chicago	IL	60630	186	773-604-8112	Sandra Bernett
1.8	Wesley Place	Multiple-Level	1415 W Foster	Chicago	IL	60640	108	773-769-5500	Jay Evans
2.0	St Pauls House	Multiple-Level	3800 N California Ave.	Chicago	IL	60618	110	773-596-5113	Marie Carpanzano
2.4	The Admiral at the Lake	Multiple-Level	933 W Foster Ave	Chicago	IL	60640	36	773-654-5121	Chaim Dubovick
2.5	Peterson Park Healthcare Center	Multiple-Level	6141 N Pulaski Ave	Chicago	IL	60646	196	773-478-2000	Jonathan (Yoni) Dauber
2.6	Beacon Health Center	Multiple-Level	4538 N Beacon Street	Chicago	IL	60640	143	773-275-7200	Orlando Arjona
2.6	Park View Rehabilitation Center	Multiple-Level	5888 N. Ridge Avenue	Chicago	IL	60660	128	773-769-2626 x20	David J. Zaruba
2.6	Uptown Health Center	Multiple-Level	4920 N. Kenmore	Chicago	IL	60640	310	773-769-2700	Aaron Yehuda Gruman
2.6	The Selfhelp Home	Multiple-Level	908 W. Argyle Street	Chicago	IL	60640	72	773-619-1176	Liza Steinfeld
2.7	All American Nursing Home	Multiple-Level	5448 N. Broadway	Chicago	IL	60640	144	773-334-2224	Mary Claussen
2.7	Buckingham Pavilion	Multiple-Level	2625 W Touhy Ave	Chicago	IL	60645	247	773-973-5333	Eric Stern
2.8	Glen Elston Nursing and Rehabilitation Center	Multiple-Level	4340 N Keystone Ave	Chicago	IL	60641	117	773-545-8700	Laquanta Jordan
2.8	MADO Uptown	Multiple-Level	4621 North Racine Avenue	Chicago	IL	60640	132	773-784-2300 x409	Mardelle Gibbs
2.8	Lincolnwood Place	Multiple-Level	7000 N McCormick Blvd	Lincolnwood	IL	60712	40	847-982-3413	Andrew Burke
3.0	Alden Lakeland Healthcare and Rehabilitation	Multiple-Level	820 W. Lawrence Ave	Chicago	IL	60640	300	773-286-3883	Solomon Mizrahi
3.1	Westwood Manor, The	Multiple-Level	2444 W Touhy Ave	Chicago	IL	60645	115	773-274-7705	Dr. Joseph Liberman, Phd
3.2	GlenCrest Healthcare and Rehab Center	Multiple-Level	2451 W. Touhy Ave	Chicago	IL	60645	312	773-338-6800	Yekusiel Field
3.3	Warren Park Health & Living Center	Multiple-Level	6700 N Damen Ave	Chicago	IL	60645	127	773-465-5000	Joshua Williams
3.6	Carlton at the Lake	Multiple-Level	725 W Montrose Ave	Chicago	IL	60645	244	773-929-1700	Joanne Ventrella
3.6	Sheridan Shores Care & Rehabilitation	Multiple-Level	5838 North Sheridan Road	Chicago	IL	60660	191	773-769-2230	Erina Wittrock
3.8	Dobson Plaza Nursing & Rehab Center, LLC	Multiple-Level	120 Dodge Ave	Evanston	IL	60202	97	847-869-7744	Charlotte Kohn
4.0	Clark Manor	Multiple-Level	7433 N Clark Street	Chicago	IL	60626	267	773-338-8778	Michael Kaplan
4.0	The Grove of Evanston	Multiple-Level	500 Asbury	Evanston	IL	60202	124	847-316-3320	Shilpi Chona
4.1	atrium rehab and nursing	Multiple-Level	1425 w estes ave	Chicago	IL	60626	160	773-973-480	Ahahrondiena
4.1	St. Joseph Village of Chicago	Multiple-Level	4021 West Belmont Avenue	Chicago	IL	60641	54	773-328-5501	Brian R. Celerio
4.2	Woodbridge Nursing Pavilion	Multiple-Level	2242 N. Kedzie blvd	Chicago	IL	60647	222	773-486-7700	Patricica Correa
4.4	Birchwood Plaza Inc.	Multiple-Level	1426 W. Birchwood Ave.	Chicago	IL	60626	200	773-274-4405	Abraham Schiffman
4.4	Arbour Healthcare	Multiple-Level	1512 W Fargo Ave	Chicago	IL	60626	99	773-465-7751	Michael Jacobson
4.5	Lakefront Nursing	Multiple-Level	7618 N Sheridan Road	Chicago	IL	60626	99	773-743-7711	Eli Barnett

Miles From SCH	Facility Name	Facility Type	Facility Address	Facility City	Facility State	Facility Zip Code	Licensed Beds	Contact Telephone	Administrator Name
4.5	The Mosaic of LakeShore	Multiple-Level	7200 N. Sheridan Rd	Chicago	IL	60626	313	773-973-7200	Shannon Jones
4.5	Chalet Living & Rehab	Multiple-Level	7350 N Sheridan Road	Chicago	IL	60626	219	773-274-1000	Laurie Daugherty
4.8	Symphony of Lincoln Park	Multiple-Level	1366 W. Fullerton Avenue	Chicago	IL	60614	248	773-248-9300	Moshe Pretter
5.0	Center Home For Hispanic Elderly	Multiple-Level	1401 N. California Ave	Chicago	IL	60622	156	773-782-8700	Juvenal Jay Gonzalez
5.0	Little Sisters of the Poor, Chicago/St. Mary's Home	Multiple-Level	2325 N. Lakewood Ave.	Chicago	IL	60614	76	773-935-9600	Sr. Carolyn Martin, L.S.P.
5.0	Alden Northmoor Rehabiliation and Healthcare Center	Multiple-Level	5831 N Northwest Hwy	Chicago	IL	60631	198	773-286-3883	Allison Pease
5.3	Aperion Care Evanston	Multiple-Level	1300 Oak Ave.	Evanston	IL	60201	57	847-869-1300	Meir Katzenstein
5.4	Winston Manor Conv & Nursing	Multiple-Level	2155 West Pierce AVe	Chicago	IL	60622	180	773-252-2066	Arleen D Batorek
5.5	Alden North Shore Rehabilitation & Health Care Center	Multiple-Level	5050 West Touhy Avenue	Skokie	IL	60077	93	773-286-3883	Angela Ditangco
5.6	Amita Saint Joseph Hospital Skilled Unit	Hospital-Owned	2900 N Lake Shore Drive	Chicago	IL	60614	26	773-665-9142	Mary F Von Goeben
5.8	Alden Lincoln Park Rehabilitation and Healthcare Center	Multiple-Level	504 W Wellington	Chicago	IL	60657	96	773-724-6534	Mary Saleh
5.9	Generations at Regency	Multiple-Level	6631 N Milwaukee Ave	Niles	IL	60714	300	847-647-7444	Joseph Javier
6.0	Warren Barr Lincoln Park	Multiple-Level	2732 N Hampden Ct	Chicago	IL	60614	109	773-248-6000	Jennifer Labella
6.1	Lakeview Rehab and Nursing	Multiple-Level	735 W Diversey Parkway	Chicago	IL	60614	178	773-348-4055	Melody Decollo
6.1	The Danish Home of Chicago	Multiple-Level	5656 N. Newcastle Ave.	Chicago	IL	60631	17	773 775-7383 x2231	Scott Swanson
6.1	The Mather	Multiple-Level	425 Davis Street	Evanston	IL	60201	37	847-492-7582	Brandon Davidson
6.3	Three Crowns Park	Multiple-Level	2323 McDaniel Ave.	Evanston	IL	60201	49	224-420-3024	Mary Beth Dentzer
6.3	Symphony Evanston Healthcare LLC	Multiple-Level	820 Foster	Evanston	IL	60201	158	847-492-7700	Philip Stone
6.5	Grosse Pointe Manor	Multiple-Level	6601 W Touhy Ave	Niles	IL	60714	99	847-647-9875	Jonathan Burstyn
6.6	Norridge Gardens	Multiple-Level	7001 W Cullom	Norridge	IL	60706	292	708-457-0700	Shully Lichtman
6.6	Norwood Crossing	Multiple-Level	6016-20 N. Nina Ave.	Chicago	IL	60631	131	773-577-5327	Jon Ragsdale
6.6	Chicago-Read Mental Health Center	Hospital-Owned	4200 N. Oak Park Avenue	Chicago	IL	60634	0	773-794-4010	Ellen Otomo
6.7	Avanti Wellness and Rehabilitation	Multiple-Level	6840 W Touhy Ave	Niles	IL	60714	212	847-647-6400	Jared Carr
6.9	Presence Saint Benedict Nursing and Rehab	Multiple-Level	6930 W Touhy Ave	Niles	IL	60714	99	847-647-0003	Kristen Felker
7.0	Central Nursing Home	Multiple-Level	2450 N. Central Av.	Chicago	IL	60639	245	773-889-1333	Philip Morgenstein
7.0	Westminster Place	Multiple-Level	3200 Grant Street	Evanston	IL	60602	204	847-866-1650	William Casper
7.0	Glen Saint Andrew Living Community	Multiple-Level	7000 N. Newark Ave	Niles	IL	60714	55	847-647-9824	Miron Tabic
7.0	Alden Estates of Evanston	Multiple-Level	2520 Gross Point Road	Evanston	IL	60201	99	773-286-3883	Joseph Rusinak
7.0	Presence Resurrection Life Center	Multiple-Level	7370 West Talcott	Chicago	IL	60631	157	773-594-7400	Nancy Razo
7.1	Cambridge Nursing & Rehab Center	Multiple-Level	9615 N Knox Ave	Skokie	IL	60076	113	847-679-4161	Margaret O Brien
7.3	Central Baptist Village	Multiple-Level	4747 N. Canfield Ave.	Norridge	IL	60706	120	708-583-8539	Anna-Liisa Lacroix
8.3	Warren Barr Gold Coast	Multiple-Level	66 W Oak St	Chicago	IL	60610	271	312-705-5100	Crystal Shelby
8.4	The Terraces at The Clare	Multiple-Level	55 E Pearson St	Chicago	IL	60611	50	312-784-8316	Ashleigh Guerin
8.5	Bethesda Rehab and Senior Care	Multiple-Level	2833 North Nordica Ave	Chicago	IL	60634	96	773-577-5327	Erin Conley
9.2	Park Ridge Care Center	Multiple-Level	665 Busse Hwy	Park Ridge	IL	60068	46	847-825-5517	Rob Weisz

Miles From SCH	Facility Name	Facility Type	Facility Address	Facility City	Facility State	Facility Zip Code	Licensed Beds	Contact Telephone	Administrator Name
9.2	Presence Resurrection Nursing and Rehab	Multiple-Level	1001 N. Greenwood Ave	Park Ridge	IL	60068	298	847-685-2805	Lisa Orzada
9.4	Lieberman Center for Health & Rehabilitation	Multiple-Level	9700 Gross Point Road	Skokie	IL	60076	240	773-508-1072	Scott Hochstadt
9.7	Alden Estates of Skokie	Multiple-Level	4626 Old Orchard Road	Skokie	IL	60076	56	773-724-6534	Alexis Effert
9.9	West Suburban Medical Center	Hospital-Owned	3 Erie Court	Oak Park	IL	60302	50	708-763-6018	Sherry Worman
10	Bella Terra	Multiple-Level	8425 Waukegan Rd.	Morton Grove	IL	60053	211	847-965-8100	Alicia Wildermuth
10.0	Berkeley Nursing and Rehabilitation Center	Multiple-Level	6909 West North Ave	Oak Park	IL	60302	72	708-386-1112	Chandra Crawford
10.3	California Gardens	Multiple-Level	2829 S. California Ave.	Chicago	IL	60608	297	773-847-2019	Prentice Dixon
10.3	Generations at Elmwood Park	Multiple-Level	7733 West Grand Avenue	Elmwood Park	IL	60707	245	708-452-9200	Marie Rosete

WESTMINSTER PLACE

3200 GRANT STREET • EVANSTON, ILLINOIS 60201

September 3, 2020

Swedish Hospital
5140 California Ave.
Chicago, IL 60625
By Fax to 219-464-0027

I am writing regarding the application by Swedish Hospital for Certificate of Exemption to discontinue its 18-bed Long Term Care Category of Service. We agree with the assessment by Swedish Hospital that the volume of long term care service that has been provided at the hospital can be appropriately accommodated in available long term care beds in the area.

As a member of the Long Term Care Subcommittee of the Illinois Health Facilities and Services Review Board, I fully understand the changing dynamics of the long term care sector of our health care system. It would not be necessary nor fiscally responsible for the hospital to continue these services with the current occupancy and the breadth of services that are readily available in the community.

Westminster Place has a long standing relationship with Swedish Hospital and the NorthShore University Health System in serving the needs of persons requiring services in long term care beds in the Evanston community. We will continue that relationship and work with the hospital to address any unmet need that may be identified in the future.

Sincerely,

William Casper
Health Services Administrator
bcasper@presbyterianhomes.org
847-866-1650

WWW.WESTMINSTERPLACE.ORG

Return Receipt Notifications

Return Receipts for Facilities Notified are provided in

Appendix One

Pages 53 – 75

Located following Attachment 10

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.

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

Swedish Covenant Hospital

The current operator of Swedish Hospital (the "Hospital") is Swedish Covenant Health d/b/a Swedish Hospital. The Hospital is the only Illinois health care facility (as that term is defined under the Illinois Health Facilities Planning Act, 20 LCS 3960 et seq, (the "Act")) owned and operated by Swedish Covenant Health. The Hospital is located at 5145 N. California Avenue in Chicago, Illinois.

Copies of the Hospital's general acute care hospital license and accreditation by the Healthcare Facilities Accreditation Program ("HFAP") are attached as Exhibits 1, 2, and 3, Attachment 8. The Hospital's CMS Certification Number ("CCN") is 14-0114.

NorthShore University HealthSystem

- Evanston Hospital, located at 2650 Ridge Avenue, Evanston, IL 60201 ("Evanston Hospital")
- Highland Park Hospital, located at 777 Park Avenue West, Highland Park, IL 60035 ("Highland Park Hospital")
- Glenbrook Hospital, located at 2100 Pfingsten Road, Glenview, IL 60225 ("Glenbrook Hospital"), and
- Skokie Hospital, located at 9600 Gross Point Road, Skokie, IL 60076 ("Skokie Hospital")

Copies of facilities owned by NorthShore University HealthSystem were previously provided in the Membership Substitution Agreement Application.

NorthShore also has a five percent (5%) or greater indirect, partial ownership interest in the following Illinois health care facilities:

- North Shore Surgical Center, located at 3725 West Touhy Avenue, Lincolnwood, IL 60712
- Raven Way Surgery Center, located at 2350 Ravine Way, #500, Glenview, IL 60025;

- River North Same Day Surgery Center, located at 1 East Street, #300, Chicago, IL 60611; and
- 25 East Same Day Surgery, located at 25 East Washington Street #300, Chicago, IL 60602.

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.**

   In signing this Certificate of Exemption (COE) application, the Applicants attest that, in the last three years prior to the filing of this application, there has been no "adverse action" (as that term is defined in 77 IAC ("1130.140) against any Illinois facility owned and/or operated by the Applicants.

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 any 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.**

   Copies of the Hospital's general acute hospital license and accreditation by the Healthcare Facilities Accreditation Program ("HFAP") are attached as Attachment 8; Exhibits 1, 2, and 3.

   The Illinois Health Facilities and Services Review Board (IHFSRB) and the Illinois Department of Public Health (IDPH) are hereby authorized by the Applicants to access any documents necessary to verify the information submitted with this application pertaining to Swedish Hospital, including, but not limited to: official records of IDPH or other State Agencies; the licensing or certification records of other states, when applicable ; and the records of nationally recognized accreditation organization.

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.**

   Copies of licenses and certification for facilities owned by NorthShore University HealthSystem were previously provided in the Membership Substitution Agreement Application.

Illinois Department of PUBLIC HEALTH HF 119194

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2020		0002717

General Hospital

Effective: 01/01/2020

Swedish Covenant Health
dba Swedish Covenant Hospital
5145 N California Avenue

Chicago, IL 60625

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/18

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2020

Lic Number 0002717

Date Printed 10/29/2019

Swedish Covenant Health
dba Swedish Covenant Hospital
5145 N California Avenue
Chicago, IL 60625

FEE RECEIPT NO.

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 ph 312 202 8258 | 800- 621 -1773 X 8258

February 28, 2018

Anthony Guaccio
Chief Executive Officer
Swedish Covenant Hospital
5145 N California Ave
Chicago, IL 60625

Dear Mr. Guaccio:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation (BHFA) reviewed the triennial Deficiency Assessment Report for your Acute Care Hospital and granted Full Accreditation with resurvey within 3 years and does recommend that the Centers for Medicare and Medicaid Services Regional Office (CMS, RO) approve continued deemed status for:

Swedish Covenant Hospital
5145 N California Ave
Chicago, IL 60625

Program: Acute Care Hospital
CCN # 140114
HFAP ID: 119094
Triennial Survey Dates: 12/11/2017 – 12/14/2017
Plan(s) of Correction Received: 01/12/2018
Effective Date of Accreditation: 01/29/2018 – 01/29/2021

Center for Ambulatory Surgery
Foster Medical Pavilion
5215 North California, Suite #800
Chicago, IL 60625

Outpatient Cardiac and Pulmonary Rehab
Galter LifeCenter
5157 N. Francisco, 2nd Floor
Chicago, IL 60625

Wound Care/Hyperbaric Treatment
Winona Building
2751 W. Winona, 3rd Floor
Chicago, IL 60625

CyberKnife Cancer Institute
160 E Illinois St.
Chicago, IL 60611

Outpatient Rehab Services
Galter LifeCenter, 1st and 2nd Floors
5157 N. Francisco
Chicago, IL 60625

Pain Management
Foster Medical Pavilion
5215 N. California, Suite #600
Chicago, IL 60625

Foster Medical Pavilion Lab and X-ray
5215 N. California, Suite #713
Chicago, IL 60625

Condition Level Deficiencies: ☒ None
(Use crosswalk and CFR citiations, if applicable):

Swedish Covenant Hospital does not have Swing Beds and was not surveyed under those standards.

Swedish Covenant Hospital has a DPU Rehab Unit and a DPU Psych Unit and was surveyed under those standards. The facility met the requirements for both units.

This accreditation decision was reached on February 21, 2018 by the BHFA's Executive Committee.

In reviewing your report, the Bureau of Healthcare Facilities Accreditation (BHFA) made the observations that are contained on the enclosed Bureau Progress Report and requires that an Interim Progress Report be received in the AOA Division of Healthcare Facilities Accreditation prior to **December 10, 2018.**

Sincerely,

Lawrence U. Haspel

Lawrence U. Haspel, D.O.
Chairman, Bureau of Healthcare Facilities Accreditation
The Healthcare Facilities Accreditation Program
LUH/CDC

c: CMS Central Office
Region V, CMS

Healthcare Facilities Accreditation Program

HFAP

grants this

CERTIFICATE OF ACCREDITATION

to

Swedish Covenant Hospital

Chicago, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2018-2021

Executive Director
American Osteopathic Association

President
American Osteopathic Association

Chairman
Bureau Healthcare Facilities Accreditation

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A CATEGORY OF SERVICE [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

A table in the following format must be provided as part of Attachment 9.

1, 2, and 3

Swedish Hospital has no special knowledge related to the impact of the proposed discontinuation of other area hospitals. However, the area's excess of nursing long-term care beds will be only slightly affected by the discontinuation of 18 beds at Swedish Hospital; a substantial excess of beds will continue to exist in the area.

Swedish Hospital recently joined NorthShore University HealthSystem. The Membership Substitution Agreement documents filed with the Illinois Health Facilities and Services Review Board identify how Swedish Hospital will be integrated into the system to further the charitable missions of NorthShore and Swedish Hospital to meet the needs of their communities with a commitment to care for the vulnerable and underserved. The following summarizes how NorthShore will work to define and implement the integration of Swedish Hospital in a manner that:

- Furthers the charitable missions of NorthShore and Swedish Hospital in meeting the needs of their communities with a commitment to care for the vulnerable and underserved;
- Continues to improve patient access to comprehensive, convenient, high quality impatient and outpatient healthcare throughout the communities;
- Continues to improve and manage health status of the population of the communities served by the combined system;
- Promotes community health and well-being through enhanced patient care, research, and educational efforts;
- Preserves the Swedish Hospital charitable community programs through commitment to the local Swedish Foundation;
- Builds the medical community through strongly-aligned relationships and enhanced education and developmental opportunities among primary care, core specialist, subspecialist group practice physicians and other members of the staff;
- Enhances sound stewardship through the efficient delivery of all services, resulting in favorable financial performance for the System entities;

- Develops a comprehensive delivery system, resulting in improved outcomes and quality of life for patients;
- Enhances physician, payor and patient preference; and
- Enhances community benefit and public policy advocacy.

The parties believe this transaction will result in delivering superior value and quality to patients, physicians and payers, and will also be in the best interests of the community at large. The transaction presents significant opportunities to improve health care delivery and access to services provided in the combined system's service area in a manner that results in cost savings and other efficiencies that will ensure that NorthShore and Swedish Hospital can more effectively continue their shared charitable mission and purposes. Such opportunities will likely include initiatives for integration of information technology and system-wide support functions, with the goal of enhancing operational uniformity, efficiency, quality, outcomes and performance, as well as access to in-house resources of the combined system where Swedish Hospital has currently had to rely on outside vendors or providers for certain services.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2016**	**2017**	**2018 Per AHQ**
Inpatient	271	179	372
Outpatient	6,831	5,059	6,934
Total	**6,831**	**5,059**	**6,934**
Charity (cost In dollars)			
Inpatient	$2,279,427	$1,858,111	$3,277,178
Outpatient	$3,680,573	$4,354,459	$5,346,975
Total	**$5,960,000**	**$6,212,570**	**$8,624,153**
MEDICAID			
Medicaid (# of patients)	**2016**	**2017**	**2018**
Inpatient	4,396	4,392	3,662
Outpatient	69,864	64,574	71,023
Total	74,260	68,966	74.685
Medicaid (revenue)			
Inpatient	$32,605,779	$29,744,718	$32,201,455
Outpatient	$20,544,457	$20,526,803	$20,206,497
Total	$53,150,236	$50,271,521	$52,407,952

SECTION V. CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 10.

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

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

1. Charity Care Information – Swedish Hospital

CHARITY CARE			
	2016	**2017**	**2018**
Net Patient Revenue	231,496,644	224,102,810	235,549,332
Amount of Charity Care (charges)	36,349,619	35,383,812	47,260,443
Cost of Charity Care	5,960,000	6,212,570	10,436,594

1. Charity Care Information – NorthShore University HealthSystem

CHARITY CARE			
	FY 2016	**FY 2017**	**FY 2018**
Net Patient Revenue	$1,267,824,773	**$1,270,483,123**	**$1,295,160,316**
Amount of Charity Care (charges)	$ 61,854,365	$ 62,776,737	$ 70,231,298
Cost of Charity Care	$ 15,696,721	$15,967,076	$ 17,190,094

Appendix 1

Return Receipt Notifications

Pages 53 - 75

#E-044-20

SENDER: COMPLETE THIS SECTION

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

1

Sherry Worman
West Suburban Medical Center
3 Erie Court
Oak Park, Illinois 60302

9590 9402 5919 0049 5526 54

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Marcelo
C. Date of Delivery 8-27

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

1. Article Addressed to:

Eli Barnett
Lakefront Nursing
7618 N Sheridan Road
Chicago, Illinois 60626

9590 9402 5919 0049 5527 77

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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- 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.

Andrew Burke
Lincolnwood Place
7000 N McCormick Blvd
Lincolnwood, Illinois 60712

9590 9402 5919 0049 5528 90

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M. Zimmer ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* M ZIMMERMAN
C. Date of Delivery 8 19 20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
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- Attach this card to the back of the mailpiece, or on the front if space permits.

Anna Lisa LaCroix
Central Baptist Village
4747 N Canfield Ave
Norridge, Illinois 60706

9590 9402 5919 0049 5525 79

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X A.G R422 ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
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☐ Registered Mail™
☐ Registered Mail Restricted Delivery
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- 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:

Alexis Effert
Alden Estates of Skokie
4626 Old Orchard Road
Skokie, Illinois 60076

9590 9402 5919 0049 5526 47

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
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☐ Signature Confirmation Restricted Delivery

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

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SENDER: COMPLETE THIS SECTION

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

1.

Joseph Javier
Generations at Regency
6631 N Milwaukee Ave
Niles, Illinois 60714

9590 9402 5919 0049 5533 85

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C/19 ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* | C. Date of Delivery 8/20/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
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☐ Registered Mail™
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☐ Signature Confirmation Restricted Delivery

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

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

1. Article Addressed to:

Ashleigh Guerin
The Terrace at The Clare
55 E Pearson Street
Chicago, Illinois 60611

9590 9402 5919 0049 5525 93

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C-19 Guerin ☐ Agent ☐ Addressee

B. Received by (Printed Name) C-19
C. Date of Delivery 8-20-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
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- 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:

Jonathan Burstyn
Grosse Pointe Manor
6601 W Touhy Ave
Niles, Illinois 60714

9590 9402 5919 0049 5533 16

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [illegible] ☐ Agent ☐ Addressee

B. Received by (Printed Name)
C. Date of Delivery 8-20-20

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

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

1. Article Addressed to:

Mardelle Gibbs
MADO Uptown
4621 N Racine Ave
Chicago, Illinois 60640

9590 9402 5919 0049 5528 83

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Per Instructions ☒ Agent ☐ Addressee

B. Received by (Printed Name) COVID 19
C. Date of Delivery 8/20/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
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☐ Insured Mail
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☐ Priority Mail Express®
☐ Registered Mail™
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PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

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- 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.

Patricia Davis
Astoria Place Living & Rehab Center
6300 N California Ave
Chicago, Illinois 60659

9590 9402 5422 9189 6772 33

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
8/20/20

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

3. Service Type
☐ Adult Signature
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PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

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

1

Joseph Rusinak
Alden Estates of Evanston
2520 Gross Point Road
Evanston, Illinois 60201

9590 9402 5919 0049 5525 48

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
8-20-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
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☐ Collect on Delivery Restricted Delivery
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☐ Registered Mail™
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☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

SENDER: COMPLETE THIS SECTION

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

1.

Ellen Otomo
Chicago-Read Mental Health Center
4200 N Oak Park Ave
Chicago, Illinois 60634

9590 9402 5919 0049 5532 86

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
8/20/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

SENDER: COMPLETE THIS SECTION

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

1.

Jon Ragsdale
Norwood Crossing
6016-20 N Nina Ave
Chicago, Illinois 60631

9590 9402 5919 0049 5532 93

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

AUG 26 2020

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

---

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

1.

David J Zaruba
Park View Rehabilitation Center
5888 N Ridge Ave
Chicago, Illinois 60660

9590 9402 5919 0049 5525 24

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X MC97 TI COVI9 ☑ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

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

1.

Brian R Celerio
St Joseph Village of Chicago
4021 W Belmont Ave
Chicago, Illinois 60641

9590 9402 5919 0049 5528 14

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☑ Agent ☐ Addressee

B. Received by *(Printed Name)* M. AZZOYO | C. Date of Delivery 8-21-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

1.

Dr. Joseph Liberman, PhD
Westwood Manor
2444 W Touhy Ave
Chicago, Illinois 60645

9590 9402 5919 0049 5529 13

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C-A ☑ Agent ☐ Addressee

B. Received by *(Printed Name)* E.L. #94
C. Date of Delivery 08-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

Chaim Dubovick
The Admiral at the Lake
933 W Foster Ave
Chicago, Illinois 60640

9590 9402 5422 9189 6771 89

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X delivered Front desk ☑ Agent ☐ Addressee

B. Received by *(Printed Name)* delivered Front desk
C. Date of Delivery 8/22/2020

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

1.

Charlotte Kohn
Dobson Plaza Nursing & Rehab Ctr
120 Dodge Ave
Evanston, Illinois 60202

9590 9402 5919 0049 5529 68

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X AL Rt 52 ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Covid 19
C. Date of Delivery 8/21/2020

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

SENDER: COMPLETE THIS SECTION

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

1.

Philip Stone
Symphony Evanston Healthcare LLC
820 Foster
Evanston, Illinois 60201

9590 9402 5919 0049 5533 23

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X DL 849 ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* C - 19 | C. Date of Delivery 8-20-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

Jennifer LaBella
Warren Barr Lincoln Park
2732 N Hampden Ct
Chicago, Illinois 60614

9590 9402 5919 0049 5533 78

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* X Jennifer LaBella | C. Date of Delivery 8/20/20

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

LINCOLN PARK POST OFFICE
AUG
CHICAGO IL 60614

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

Mary F Von Goeben
Amita Saint Joseph Hospital Skilled Unit
2900 N Lake Shore Drive
Chicago, Illinois 60614

9590 9402 5919 0049 5534 08

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

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

1. Article Addressed to:

Shannon Jones
The Mosaic of LakeShore
7200 N Sheridan Road
Chicago, Illinois 60626

9590 9402 5919 0049 5527 60

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X LC Pt 38C.18 ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 8/24/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

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

1. Article Addressed to:

Scott Swanson
The Danish Home of Chicago
5656 N Newcastle Ave
Chicago, Illinois 60631

9590 9402 5919 0049 5533 54

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Debi Lathom | C. Date of Delivery 8-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

1.

Lisa Orzada
Presence Resurrection Nursing & Rehab
1001 N Greenwood Ave
Park Ridge, Illinois 60068

9590 9402 5919 0049 5526 23

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X L. Orzada ☐ Agent ☒ Addressee

B. Received by (Printed Name) JB#31C19 | C. Date of Delivery 8/20/19

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

#E-044-20

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Yekusiel Field
GlenCrest Healthcare & Rehab Center
2451 W Touhy Ave
Chicago, Illinois 60645

9590 9402 5919 0049 5529 20

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C-9 ☐ Agent ☐ Addressee

B. Received by (Printed Name): E.L. #94
C. Date of Delivery: 08.20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

1. Article Addressed to:

Nancy Razo
Presence Resurrection Life Center
7370 W Talcott
Chicago, Illinois 60631

9590 9402 5919 0049 5525 55

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

AUG 24 2020

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

1. Article Addressed to:

Ahahrondiena
Atrium Rehab & Nursing
1425 W Estes Ave
Chicago, Illinois 60626

9590 9402 5919 0049 5529 99

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
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☐ Signature Confirmation™
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- 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.

Alicia Wildermuth
Bella Terra
8425 Waukegan Road
Morton Grove, Illinois 60053

9590 9402 5919 0049 5526 61

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [illegible] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery 8/20/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

1

Jay Evans
Wesley Place
1415 W Foster
Chicago, Illinois 60640

9590 9402 5422 9189 6772 02

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Karen Claros ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* KAREN CLAROS C. Date of Delivery 8/21/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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- 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

Angela Ditangco
Alden North Shore Rehabilitation Healthcare
5050 W Touhy Ave
Skokie, Illinois 60077

9590 9402 5919 0049 5534 15

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X PLRT5C19 ☒ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery 8-20-20

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

AUG 2020

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

#E-044-20

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

1. Article Addressed to:

Meir Katzenstein
Aperion Care Evanston
1300 Oak Ave
Evanston, Illinois 60201

9590 9402 5919 0049 5528 21

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X COVID19 ☐ Agent ☐ Addressee

B. Received by (Printed Name) E L RECEPTIONIST C. Date of Delivery 8/2

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

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

1. Article Addressed to:

Michael Jacobson
Arbour Healthcare
1512 W Fargo Ave
Chicago, Illinois 60626

9590 9402 5919 0049 5527 84

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M. Jacobson ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

1

Carolyn Martin
Little Sisters of the Poor/St Mary's Home
2325 N Lakewood Ave
Chicago, Illinois 60614

9590 9402 5919 0049 5527 22

2. Article Number (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmatic
☐ Signature Confirmatic Restricted Delivery

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

#E-044-20

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

1

William Casper
Westminster Place
3200 Grant Street
Evanston, Illinois 60602

9590 9402 5919 0049 5532 48

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery 8-21-20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

1.

Jared Carr
Avanti Wellness & Rehabilitation
6840 W Touhy Ave
Niles, Illinois 60714

9590 9402 5919 0049 5532 79

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

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

1

Miron Tabic
Glen Saint Andrew Living Community
7000 N Newark Ave
Niles, Illinois 60714

9590 9402 5919 0049 5525 31

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

#E-044-20

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Mary Claussen
All American Nursing Home
5448 N Broadway
Chicago, Illinois 60640

9590 9402 5919 0049 5528 52

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C 19 [illegible] ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

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

1.

Zev Brody
Atrium Rehab & Nursing
1425 W Estes Avenue
Chicago, IL 60626

9590 9402 5919 0049 5530 02

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [illegible] ☑ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery
8/21

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

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

1

Brandon Davidson
The Mather
425 Davis Street
Evanston, Illinois 60201

9590 9402 5919 0049 5533 47

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Aria Coccorese ☐ Agent ☑ Addressee

B. Received by *(Printed Name)* C. Date of Delivery
[illegible] 8/2013

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: *COMPLETE THIS SECTION*

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

Kristen Felker
Presence Saint Benedict Nursing & Rehab
6930 W Touhy Ave
Niles, Illinois 60714

9590 9402 5919 0049 5532 62

2. Article Numl

COMPLETE THIS SECTION ON DELIVERY

#E-044-20

A. Signature
X
☐ Agent
☐ Addressee

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

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

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

PS Form 381 1, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

#E-044-20

SENDER: *COMPLETE THIS SECTION*

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

1.

Marie Rosete
Generations at Elmwood Park
7733 W Grand Avenue
Elmwood Park, Illinois 60707

9590 9402 5919 0049 5526 92

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☒ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
8/26/2020

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

ELMWOOD PARK BRANCH
AUG 26 2020
60707
ELMWOOD PARK IL

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

Arleen D Batorek
Winston Manor Conv & Nursing
2155 W Pierce Ave
Chicago, Illinois 60622

9590 9402 5919 0049 5527 08

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* A Batorek
C. Date of Delivery 6-27-20

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

3. Service Type
- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☐ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Insured Mail
- ☐ Insured Mail Restricted Delivery (over $500)
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

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

#E-044-20

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

Laurie Daugherty
Chalet Living & Rehab
7350 N Sheridan Road
Chicago, Illinois 60626

9590 9402 5919 0049 5527 53

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X LC Rt38 C.19 ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery 8/25/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
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☐ Signature Confirmation Restricted Delivery

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

SENDER: *COMPLETE THIS SECTION*

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

Joshua Williams
Warren Park Health & Living Center
6700 N Damen Ave
Chicago, Illinois 60645

9590 9402 5919 0049 5529 37

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

#E-044-20

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
8-27-20

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

3. Service Type
- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☐ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Insured Mail
- ☐ Insured Mail Restricted Delivery (over $500)
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

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

#E 044 20

SENDER: *COMPLETE THIS SECTION*

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

1.

Chandra Crawford
Berkeley Nursing & Rehabilitation Center
6909 W North Ave
Oak Park, Illinois 60302

9590 9402 5919 0049 5526 78

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jenn Epley
☐ Agent
☐ Addressee

B. Received by *(Printed Name)* Jennifer Epley
C. Date of Delivery 8/21/20

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
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☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

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

1

Scott Hochstadt
Lieberman Center for Health & Rehabilitation
9700 Gross Point Road
Skokie, Illinois 60076

9590 9402 5919 0049 5526 30

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery

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

3. Service Type

☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
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PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

#E-044-20

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- 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

Crystal Shelby
Warren Barr Gold Coast
66 W Oak Street
Chicago, Illinois 60610

9590 9402 5919 0049 5525 86

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery

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

3. Service Type

☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

ENVELOPE TO THE RIGHT
FOLD AT DOTTED LINE

D MAIL®

12 1256 1974

Refused

Melody DeCollo
Lakeview Rehab & Nursing
735 W Diversey Parkway
Chicago, Illinois 60614

TE THIS SECTION

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rn the card to you.
the back of the mailpiece,
ace permits.

& Nursing
arkway
0614

5919 0049 5533 61

fer from service label)

2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

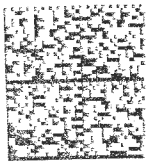
Domestic Return Receipt

NIXIE 601 C0 1 0109/12/20
RETURN TO SENDER
REFUSED
UNABLE TO FORWARD
BC: 60625368799 0121N256035-00107

#E-044-20

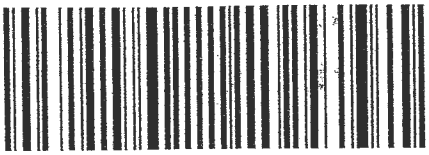
Swedish Hos
5145 N Calif
Chicago, IL 60625

FIRST CLASS



PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL®



7019 2280 0002 1256 1974

Refused

Melody DeCollo
Lakeview Rehab
735 W Diversey P
Chicago, Illinois 6

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

Melody DeCollo
Lakeview Rehab & Nursing
735 W Diversey Parkway
Chicago, Illinois 60614

9590 9402 5919 0049 5533 61

2. Article Number (Transfer from service label)

7019 2280 0002 1256 1974

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
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☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

NIXIE

BC: 60

SENDER: *COMPLETE THIS SECTION*

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

Michael Donovan
Foster Health & Rehabilitation Center
2840 W Foster Ave
Chicago, Illinois 60625

9590 9402 5422 9189 6772 71

2. Article Number *(Transfer from service label)*

COMPLETE THIS SECTION ON DELIVERY

#E-044-20

A. Signature
X Frederick Brown ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Frederick Brown
C. Date of Delivery 9/16/2020

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

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

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

#E-044-20

Certificate of Exemption
For
Discontinuation of
Long-Term Care Category of Service
At
Swedish Hospital
Chicago, Illinois

For Applicants

Swedish Covenant Health d/b/a Swedish Hospital

And

NorthShore University HealthCare System

Submitted by Electronic Mail

Date of Submission: September 19, 2020

#E-044-20

Swedish Hospital
Part of NorthShore

September 18, 2020

Ms. Courtney R. Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Swedish Hospital LTC Discontinuation COE Application

Dear Ms. Avery:

This COE Discontinuation Permit is being submitted by Swedish Covenant Health to the Illinois Health Facilities and Services Review Board requesting approval to discontinue its Long-Term Care Category of Service and 18 long-term care beds. This project is substantive under Section 1110.20 of the Review Board's rules because it discontinues a bed category of service. A check for the application processing fee of $2,500 has already been sent to the Illinois Health Facilities and Services Review Board offices.

Should you have any questions about this discontinuation application, please do not hesitate to contact me directly at 773-293-4000.

Sincerely,

Saliba M. Kokaly

Saliba Kokaly
Vice President, Operations
Swedish Covenant Health

CC: Mike Constantino, Supervisor, Project Review Section
Janet Scheuerman, PRISM Healthcare Consulting