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

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

### Facility/Project Identification

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

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

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

### Type of Ownership of Applicants

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

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

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

### Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

**Post Exemption Contact**

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

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

**Site Ownership**

[Provide this information for each applicable site]

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

**Operating Identity/Licensee**

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

| |
|---|
| Exact Legal Name: Schwab Rehabilitation Hospital and Care Network |
| Address: 1401 South 00 S. Fairfield Avenue |

X Non-profit Corporation
☐ 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 organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

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## Organizational Relationships

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

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

## Narrative Description

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

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

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

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

## Project Status and Completion Schedules

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

_____

_____

_____

_____

_____

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

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

Are the following submittals up to date as applicable:

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

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

## CERTIFICATION

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

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

**This Application is filed on the behalf of Schwab Rehabilitation Hospital and Care Network***

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

SIGNATURE

Karen C. Teitelbaum
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

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

Signature of Notary

Seal

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

SIGNATURE

Mary Gollinger
PRINTED NAME

System Vice President Post Acute Care
PRINTED TITLE

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

Signature of Notary

Seal

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

*Insert the EXACT legal name of the applicant

## SECTION II. DISCONTINUATION

### Type of Discontinuation

| | |
|---|---|
| X | Discontinuation of a single category of service |

### Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

**GENERAL INFORMATION REQUIREMENTS**

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

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

**REASONS FOR DISCONTINUATION**

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

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

**IMPACT ON ACCESS**

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

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

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

## SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

**BACKGROUND OF APPLICANT**

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

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

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

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

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

## SECTION IV. SAFETY NET IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

| | | | |
|---|---|---|---|
| Total | | | |

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

## SECTION V. CHARITY CARE INFORMATION

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

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

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

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

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

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

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

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