

[ORIGINAL]

E-008-16

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR CERTIFICATE OF EXEMPTION

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

JAN 08 2016

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Franciscan Alliance, Inc.		
Address:	1515 Dragoon Trail Mishawaka, IN 46544		
Name of Registered Agent:			
Name of Chief Executive Officer:	Kevin Leahy		
CEO Address:	1515 Dragoon Trail Mishawaka, IN 46544		
Telephone Number:	574/273-3844		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other

- 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.

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR CERTIFICATE OF EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Franciscan Alliance, Inc. d/b/a Franciscan St. James Health-Chicago Heights		
Address:	1515 Dragoon Trail Mishawaka, IN 46544		
Name of Registered Agent:	Sister M. Petra Nielsen OSF		
Name of Chief Executive Officer:	Kevin Leahy		
CEO Address:	1515 Dragoon Trail Mishawaka, IN 46544		
Telephone Number:	574/273-3844		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership		
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental		
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/>	Other

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.

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact

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

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

Post Permit Contact

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

Name:	Arnold Kimmel
Title:	CEO
Company Name:	Franciscan St. James Health
Address:	20201 South Crawford Avenue Olympia Fields, IL 60461
Telephone Number:	708/756-1000
E-mail Address:	arnie.kimmel@franciscanalliance.org
Fax Number:	708/756-6869

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Franciscan Alliance, Inc.
Address of Site Owner:	1515 Dragoon Trail Mishawaka, IN 46544
Street Address or Legal Description of Site:	1423 Chicago Road Chicago Heights, IL 60411
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Franciscan Alliance, Inc.				
Address:	1515 Dragoon Trail Mishawaka, IN 46544				
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership		
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental		
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/>	Other
<ul style="list-style-type: none">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.					

Organizational Relationships

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

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

Not Applicable—COE

Flood Plain Requirements

Not Applicable--COE

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

Not Applicable--COE

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

Not Applicable--COE

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

Part 1110 Classification:

Substantive

Non-substantive

2. Narrative Description

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

The applicants propose to discontinue Franciscan St. James Health-Chicago Heights (FSJ-CH), located at 1423 Chicago Heights, Illinois.

FSJ-CH is approved to offer the following IDPH-designated categories of services:

- Medical/Surgical beds
- ICU beds
- Obstetrics beds
- Pediatrics beds
- Comprehensive Physical Rehabilitation beds.

Franciscan Alliance, Inc. also operates Franciscan St. James Health-Olympia Fields (FSJ-OF), located approximately 4½ miles from FSJ-CH. Concurrent to the filing of this Certificate of Exemption application addressing the discontinuation of FSJ-CH, the applicant is filing a Certificate of Need application to modernize and expand FSJ-OF to accommodate many of those historical FSJ-CH inpatients desiring admission to or outpatients desiring services at the Olympia Fields hospital. The two hospitals operate with a common medical staff, and as a result, it is believed by the applicants that difficulties typically associated with consolidations will be minimized.

In addition, Franciscan Alliance, Inc. is expanding its Chicago Heights outpatient center (located approximately 1½ miles to the northwest of the hospital) to accommodate a portion of FSJ-CH's historical outpatient caseload. As a result of the close proximity of FSJ-OF, FSJ-CH and the Chicago Heights outpatient center to one another, accessibility issues will be greatly diminished, and in many cases eliminated all-together.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$0	\$0	\$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$0	\$0	\$0

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Purchase Price: \$ _____
Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.
Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): _____ October 31, 2019 _____
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies <input checked="" type="checkbox"/> Project obligation will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable: <input checked="" type="checkbox"/> Cancer Registry <input checked="" type="checkbox"/> APORS <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Not Applicable—COE

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

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Franciscan St. James Health		CITY: Chicago Heights			
REPORTING PERIOD DATES:		From:	to:		
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	230	4,796	21,184	(230)	0
Obstetrics	22	1,809	4,544	(22)	0
Pediatrics	10	70	176	(10)	0
Intensive Care	20	464	2,823	(20)	0
Comprehensive Physical Rehabilitation	30	317	3,959	(30)	0
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	312	7,456	32,686	(312)	0

CERTIFICATION

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

Kevin D. Leahy
SIGNATURE
Kevin D. Leahy
PRINTED NAME
President/CEO
PRINTED TITLE

Sister Lethia Marie Leveille O.S.F
SIGNATURE
Sister Lethia Marie Leveille O.S.F
PRINTED NAME
Secretary, Franciscan Alliance Inc.
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December

Notarization:
Subscribed and sworn to before me
this 21st day of December

Alison M. Orozco
Signature of Notary
ALISON M OROZCO
NOTARY PUBLIC
Seal
ST. JOSEPH COUNTY, STATE OF INDIANA
COMMISSION NO. 632583
MY COMMISSION EXPIRES 01/23/2020

Alison M. Orozco
Signature of Notary
ALISON M OROZCO
NOTARY PUBLIC
Seal
ST. JOSEPH COUNTY, STATE OF INDIANA
COMMISSION NO. 632583
MY COMMISSION EXPIRES 01/23/2020

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Franciscan Alliance, Inc. d/b/a Franciscan St. James Health-Chicago Heights * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Kevin D. Leahy
SIGNATURE
Kevin D. Leahy
PRINTED NAME
President/CEO
PRINTED TITLE

Sister Lethia Marie Leveille OSF
SIGNATURE
Sister Lethia Marie Leveille O.S.F
PRINTED NAME
Secretary, Franciscan Alliance Inc.
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December

Notarization:
Subscribed and sworn to before me
this 21st day of December

Alison M. Orozco
Signature of Notary
Seal
ALISON M OROZCO
NOTARY PUBLIC
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*Insert EXEMPTED FROM THE APPLICATION FEE

SECTION II. DISCONTINUATION

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

NOT APPLICABLE—COE

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

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

DISCONTINUATION

The applicants propose the discontinuation of Franciscan St. James Health-Chicago Heights (FSJ-CH), all of the inpatient-related clinical services currently provided through that facility, including 312 beds, and many of the outpatient services currently provided in the hospital. The IDPH-designated categories of service to be discontinued are: Medical/Surgical beds (230), Pediatric beds (10), ICU beds (20), Obstetrics beds (22), and Comprehensive Physical Rehabilitation beds (30). The other "clinical services" anticipated to be discontinued include: LDRs, C-Section rooms, newborn nursery, laboratory, surgery, recovery, endoscopy, emergency department, imaging, respiratory therapy, physical therapy, occupational therapy, and EKG.

Discontinuation is anticipated to occur within 45 days following the completion of the proposed modernization of Franciscan St. James Health-Olympia Fields (FSJ-OF). That project is scheduled to be completed on October 31, 2018.

Franciscan Alliance, Inc. also operates Franciscan St. James Health-Olympia Fields (FSJ-OF), located approximately 4½ miles from FSJ-CH. Concurrent to the filing of this Certificate of Exemption application addressing the discontinuation of FSJ-CH, the applicant is filing a Certificate of Need application to modernize and expand FSJ-OF to accommodate many of those historical FSJ-CH inpatients desiring admission to or outpatients desiring services at the Olympia Fields hospital. The two hospitals operate with a common medical staff, and as a result, it is believed by the applicants that difficulties typically associated with consolidations will be minimized.

In addition, Franciscan Alliance, Inc. is expanding its Chicago Heights outpatient center to accommodate a portion of FSJ-CH's historical outpatient caseload. As a result of the close proximity of FSJ-OF, FSJ-CH and the Chicago Heights outpatient center to one another, accessibility issues will be greatly diminished, and in some cases eliminated all-together.

The future use/disposition of the FSJ-CH physical plant has not yet been fully determined, and the applicants will continue to investigate the potential re-use of the facility and site as the FSJ-OF project proceeds. Due to the age of the building, it is anticipated that, at minimum, portions of the physical plant will be demolished. Selected non-clinical/administrative functions currently located at FSJ-OF will be moved to the Chicago Heights campus, and administrative functions currently occupying space in FSJ-CH's Medical Office Building will be moved to the vacated hospital building to facilitate Franciscan Health, Inc.'s physician recruitment initiatives. As appropriate, a limited amount of equipment currently in use at FSJ-CH will be relocated to FSJ-OF, particularly beds and furniture. Other equipment will be sold, donated, or discarded.

All medical records will be maintained by and accessible through FSJ-OF, consistent with all applicable laws, licensure and accreditation requirements, and industry standards.

January 6, 2016

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

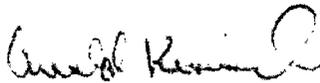
Illinois Health Facilities and
Services Review Board
Springfield, Illinois

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

To Whom It May Concern:

I hereby certify that all questionnaires and data required by the HFSRB or the IDPH will be provided, and will include applicable data through the date of discontinuation. I further certify that the required information will be submitted no later than sixty days following the discontinuation of Franciscan St. James Health-Chicago Heights.

Sincerely,



Arnold Kimmel
CEO



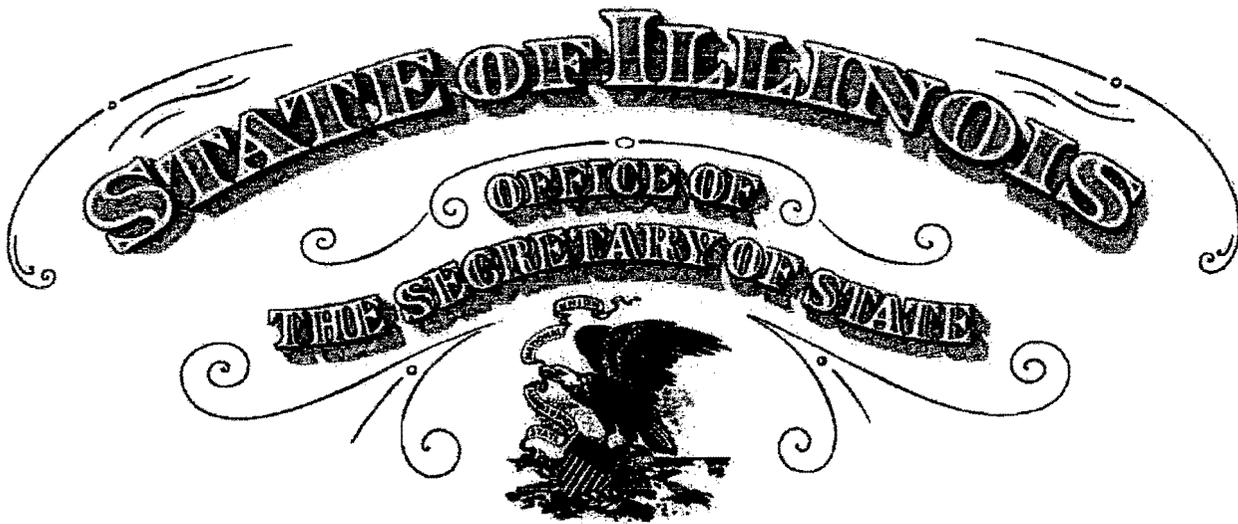
Notarized:

Kathryn E Duckett
State of Illinois
County of Cook

1/6/16

File Number

5053-312-3



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

FRANCISCAN ALLIANCE, INC., INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 15, 1974, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



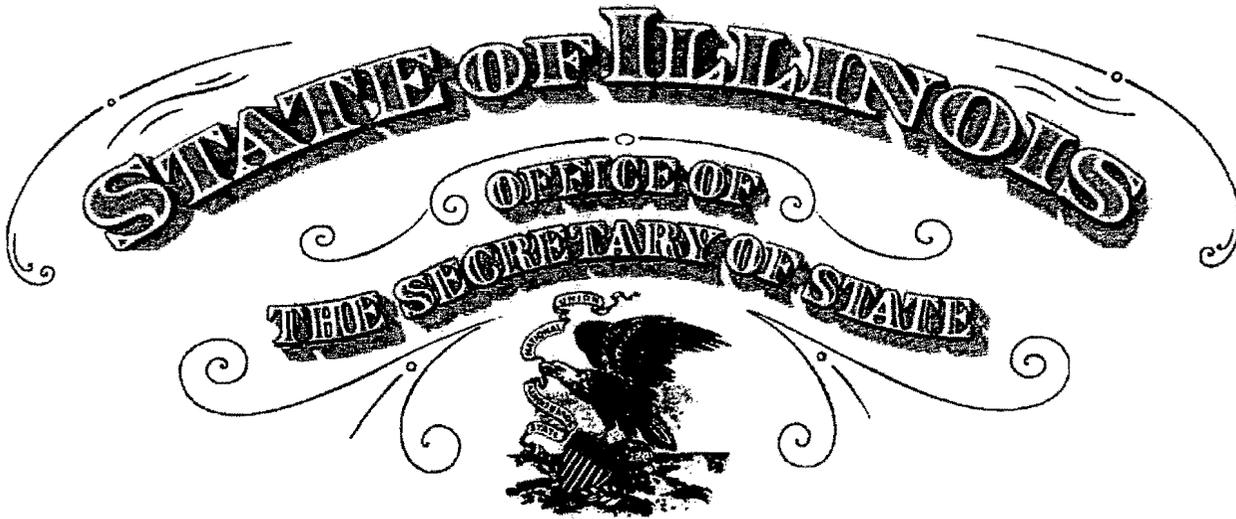
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of NOVEMBER A.D. 2015 .

Jesse White

SECRETARY OF STATE

Authentication #: 1532801766 verifiable until 11/24/2016
Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

FRANCISCAN ALLIANCE, INC., INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 15, 1974, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of NOVEMBER A.D. 2015 .



Authentication #: 1532801766 verifiable until 11/24/2016

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1



OP ID: CK

EVIDENCE OF PROPERTY INSURANCEDATE (MM/DD/YYYY)
04/10/2013

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

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

PROPERTY INFORMATION

LOCATION/DESCRIPTION 333 Dixie Highway Chicago Heights, IL	Hospitals
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THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

COVERAGE INFORMATION

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Premise 000 Building 000	700000000	100000
BLKT BLDG/BPP	1302640835	
BLKT BI W/EE 24 HRS	25000000	100000
Flood SEE SCHEDU	10000000	100000
Flood SEE SCHEDU	100000000	100000
EARTHQUAKE	250000000	
Extra Expense	182036337	100,000
1423 Chicago Rd, Chicago Heights, IL - Bldg	53154639	100,000
BPP Limit		

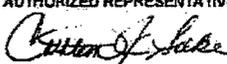
REMARKS (Including Special Conditions)

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CANCELLATION

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

ADDITIONAL INTEREST

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

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January 6, 2016

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

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

**Illinois Health Facilities and
Services Review Board**
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

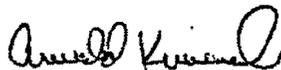
In accordance with Review Criterion 1130.520.b.3, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

Franciscan Alliance, Inc. owns and Franciscan St. James Health operates IDPH-licensed hospitals in Chicago Heights and Olympia Fields, Illinois. Franciscan St. James Health has not had any adverse actions against any Illinois health care facility owned or operated by it during the three (3) year period prior to the filing of this application.

Franciscan St. James Health authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520.b.3 or to obtain any documentation or information which the State Board or Agency finds pertinent to this CON/COE application.

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

Sincerely,



Arnold Kimmel
CEO
Franciscan St. James Health

BACKGROUND OF APPLICANT

Franciscan Alliance, Inc. owns and operates the following licensed health care facilities:

- Franciscan St. Anthony Health-Crown Point; Crown Point, Indiana
- Franciscan St. Anthony Health-Michigan City; Michigan City, Indiana
- Franciscan St. Elizabeth Health-Lafayette Central; Lafayette, Indiana
- Franciscan St. Elizabeth Health-Lafayette East; Lafayette, Indiana
- Franciscan St. Elizabeth Health-Crawfordsville; Crawfordsville, Indiana
- Franciscan St. Francis Health-Carmel; Carmel, Indiana
- Franciscan St. Francis Health-Indianapolis; Indianapolis, Indiana
- Franciscan St. Francis Health-Mooresville; Mooresville, Indiana
- Franciscan St. James Health-Chicago Heights; Chicago Heights, Illinois
- Franciscan St. James Health-Olympia Fields; Olympia Fields, Illinois
- Franciscan St. Margaret Health-Dyer; Dyer, Indiana
- Franciscan St. Margaret Health-Hammond; Hammond, Indiana
- Franciscan Healthcare-Munster; Munster, Indiana

SAFETY NET STATEMENT

Franciscan St. James Health is one of the largest providers of safety net services in the southern suburbs. In 2014 in excess of \$19M (cost) in charity care was provided through the two hospitals, representing a 150% increase over 2012. Similarly, \$27.7M in Medicaid services were provided in 2014, representing a 130% increase over 2012.

Care to the financially-disadvantaged segments of the community are provided consistent with a 100 year history of doing so, and remaining true to the mission of “Continuing Christ’s ministry in the Franciscan tradition,” reflecting values of respect for life, compassionate concern, and joyful service.

Every three years, Franciscan St. James Health, in cooperation with other community resources, leads a community needs assessment that provides a framework for community-based health care programming. Franciscan St. James is currently working under a needs assessment conducted in late 2012/early 2013, and which identified three areas of focus: diabetes health and awareness, cardiovascular disease awareness and education, and access to care. Addressing these issues, during 2014:

- Approximately 580 individuals with previously undiagnosed diabetes were identified and referred to the St. James Diabetes Center or to another provider for education, nutritional counseling, and follow-up care.
- A process for identifying patients suffering from Chronic Obstructive Pulmonary Disease (COPD) or Chronic Heart Failure (CHF), and at risk of being readmitted was developed. A multi-disciplinary team was established to develop plans of care and discharge plans, and to transition patients to appropriate treatment settings.

- The Franciscan Primary Care Clinic was established to provide post-discharge care and immediate follow-up visits to patients without a primary care provider. This clinic, which provides services at a reduced cost, is designed to serve as a bridge between hospitalization and the establishment of a relationship with a primary care provider. Approximately 3,400 patients benefited from this program last year. In addition, Franciscan St. James developed a program to link area residents needing transportation to health care services with providers, and also developed a program to transport area residents to its hospitals, without any cost to the patient.

Of a more general nature, Franciscan St. James is a sponsor of and participant in numerous community-based health fairs throughout the region, and provides direct monetary support to 45-50 not-for-profit agencies and groups annually. Those groups and agencies provide improved education, housing, social support, and health care services to the communities in the south suburbs.

The proposed project will improve access to those services most often used by area residents, including urgent care services, imaging, outpatient mental health services, and laboratory services through Franciscan Health's Chicago Heights outpatient center. Through the proposed expansion of the outpatient center, as well as through the expansion of Franciscan St. James Health-Olympia Fields, access to all services, including safety net services will be maintained and expanded.

XI. Safety Net Impact Statement

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

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

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

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

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

FRANCISCAN ST. JAMES HEALTH

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2012	2013	2014
Inpatient	3,318	1,296	1,582
Outpatient	17,976	10,757	14,190
Total	21,294	12,053	15,772
Charity (cost in dollars)			
Inpatient	\$3,597,608	\$6,165,780	\$8,786,258
Outpatient	\$4,018,443	\$8,016,617	\$10,249,538
Total	\$7,616,051	\$14,182,329	\$19,035,796
MEDICAID			
Medicaid (# of patients)	2012	2013	2014
Inpatient	1,787	1,571	2,132
Outpatient	32,200	17,424	25,882
Total	33,987	18,995	28,014
Medicaid (revenue)			
Inpatient	\$7,442,170	\$12,426,923	\$10,394,352
Outpatient	\$4,474,901	\$5,974,701	\$17,327,847
Total	\$11,917,071	\$18,401,624	\$27,722,199

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