

ORIGINAL SIGNATURES

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

E-031-16

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
This Section must be completed for all projects.

AUG 15 2016

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name:	Mercy Hospital and Medical Center		
Street Address:	2525 S Michigan Ave		
City and Zip Code:	Chicago, IL 60616		
County: Cook	Health Service Area	6	Health Planning Area: A-03

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Mercy Hospital and Medical Center		
Address:	2525 S Michigan Ave Chicago, IL 60616		
Name of Registered Agent:			
Name of Chief Executive Officer:	Carol L. Garikes Schneider		
CEO Address:	2525 S Michigan Ave Chicago, IL 60616		
Telephone Number:	312.567.2100		

Type of Ownership of Applicant/Co-Applicant

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

Exact Legal Name:	Mercy Health System of Chicago		
Address:	2525 S Michigan Ave Chicago, IL 60616		
Name of Registered Agent:			
Name of Chief Executive Officer:	Carol L. Garikes Schneider		
CEO Address:	2525 S Michigan Ave Chicago, IL 60616		
Telephone Number:	312.567.2100		

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

Exact Legal Name:	Trinity Health Corporation
Address:	20555 Victor Parkway, Livonia, MI 48152-7018
Name of Registered Agent:	
Name of Chief Executive Officer:	Richard J. Gilfillan, M.D.
CEO Address:	20555 Victor Parkway, Livonia, MI 48152-7018
Telephone Number:	734.343.1000

Type of Ownership of Applicant/Co-Applicant	
<input checked="" type="checkbox"/> Non-profit Corporation	Partnership
<input type="checkbox"/> For-profit Corporation	Governmental
<input type="checkbox"/> Limited Liability Company	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. 	
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:	Jeffrey Mark
Title:	Consultant
Company Name:	JSMA LLC
Address:	1182 S Plymouth Ct., 1SW, Chicago, IL 60605
Telephone Number:	312.804.9401
E-mail Address:	jmark@jsma.com
Fax Number:	

Additional Contact

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

Name:	
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:	Carol L. Garikes Schneider
Title:	President and CEO
Company Name:	Mercy Hospital and Medical Center
Address:	2525 S Michigan Ave, Chicago IL 60616
Telephone Number:	312.567.2100
E-mail Address:	Carol.Schneider@mercy-chicago.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Mercy Hospital and Medical Center
Address of Site Owner:	2525 S Michigan Ave, Chicago IL 60616
Street Address or Legal Description of Site:	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:	Mercy Hospital and Medical Center		
Address:	2525 S Michigan Ave, Chicago IL 60616		
<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"> ○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. ○ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. ○ Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

Flood Plain Requirements**Not Applicable – No Construction**

[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**

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

Substantive

Non-substantive

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 Mercy Hospital and Medical Center's Pediatrics category of service. There is no project cost associated with this project. It is intended that the vacated Pediatrics unit will be used to modernize other services within the Hospital. A request for a CON Permit for that modernization project is to be submitted to the Board for approval for that project.

To assure the continued provision of quality care to the area's Pediatric population, upon discontinuation of the service all Pediatric admissions will be referred to Lurie Children's Hospital with whom Mercy Hospital has an ongoing service relationship. A letter of support from Lurie is included in Attachment 42.

The discontinuation will occur by January 31, 2017 or sooner upon the approval of this request by the Health Facilities and Services Review Board.

This is a substantive project as it proposes the discontinuation of a designated category of service.

Project Costs and Sources of Funds

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

There are no costs associated with this project.

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	\$0.00	\$0.00	\$0.00
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	\$0.00	\$0.00	\$0.00

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): <u>January 31, 2017</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): Not Applicable	
<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 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
<input checked="" type="checkbox"/> All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Not Applicable

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
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: Mercy Hospital & Medical Center		CITY: Chicago			
REPORTING PERIOD DATES: From: Jan. 1, 2015 to: December 31, 2015					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	250	8,699	35,700	0	250
Obstetrics	30	2,495	5,560	0	30
Pediatrics	28	905	4,390	-28	0
Intensive Care	30	1,205	4,390	0	30
Comprehensive Physical Rehabilitation	24	4,229	4,541	0	24
Acute/Chronic Mental Illness	39	921	5,093	0	39
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	401	14,647	61,023	-28	373

CERTIFICATION – Mercy Hospital and Medical Center

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

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

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



SIGNATURE
CAROL SWANSON
PRINTED NAME

PRESIDENT + CEO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 8 day of JUNE 2016

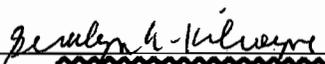


SIGNATURE
ERIC KRUEGER
PRINTED NAME

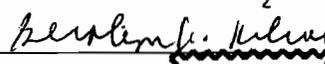
CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 8 day of JUNE 2016



Signature of Notary OFFICIAL SEAL
GERALYN A KILCOYNE
Seal NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18



Signature of Notary OFFICIAL SEAL
GERALYN A KILCOYNE
Seal NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18

*Insert EXACT legal name of the applicant

CERTIFICATION – MERCY HEALTH SYSTEM OF CHICAGO

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

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

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


SIGNATURE

CAROL SCHNEIDER
PRINTED NAME

PRESIDENT & CEO
PRINTED TITLE


SIGNATURE

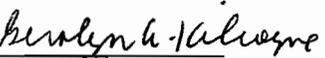
ERIC KRUEGER
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 3 day of AUGUST

Notarization:
Subscribed and sworn to before me
this 3 day of AUGUST


Signature of Notary
Seal
OFFICIAL SEAL
GERALYN A. KILCOYNE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18


Signature of Notary
Seal
OFFICIAL SEAL
GERALYN A. KILCOYNE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18

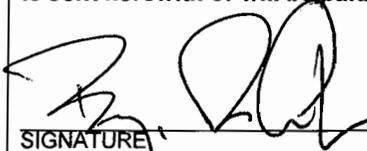
*Insert EXACT legal name of the applicant

CERTIFICATION -- TRINITY HEALTH CORPORATION

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

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

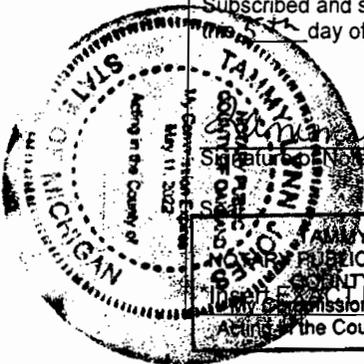
This Application for Permit is filed on the behalf of Trinity Health Corporation* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of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


 SIGNATURE
BENJAMIN R CARTER
 PRINTED NAME
CEO/TREASURER
 PRINTED TITLE


 SIGNATURE
CYNTHIA A CLEMENCE
 PRINTED NAME
SVP FINANCIAL OPERATION & PLANNING
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5th day of August, 2016

Notarization:
Subscribed and sworn to before me
this 5th day of August, 2016




 Signature of Notary
 Seal
 TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne


 Signature of Notary
 Seal
 TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne

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	
<ol style="list-style-type: none"> 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	
<p>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.</p>	
IMPACT ON ACCESS	Not Applicable per Technical Assistance with Board Staff
<ol style="list-style-type: none"> 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. 	
<p>APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</p>	

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. (Dollars are in Fiscal Year)

Safety Net Information per PA 96-0031				
CHARITY CARE				
Charity (# of patients)	2013	2014	2015	
Inpatient				
Outpatient				
Total				
Charity (cost in dollars)				
Inpatient				
Outpatient				
Total				
MEDICAID				
Medicaid (# of patients)				
Inpatient				
Outpatient				
Total				
Medicaid (revenue)				
Inpatient				
Outpatient				
Total				

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

XII. **Charity Care Information**

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE (Fiscal Year)			
	2013	2014	2015
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, 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 attachments included as part of the project's application for permit:

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

File Number 0114-154-6



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

MERCY HOSPITAL AND MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 21, 1852, 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 27TH day of MAY A.D. 2016 .

Jesse White

SECRETARY OF STATE

Authentication #: 1614801634 verifiable until 05/27/2017
Authenticate at: <http://www.cyberdriveillinois.com>

File Number 5257-458-7



To all to whom these Presents Shall Come, Greeting:

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

MERCY HEALTH SYSTEM OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 20, 1981, 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 9TH day of JUNE A.D. 2016 .

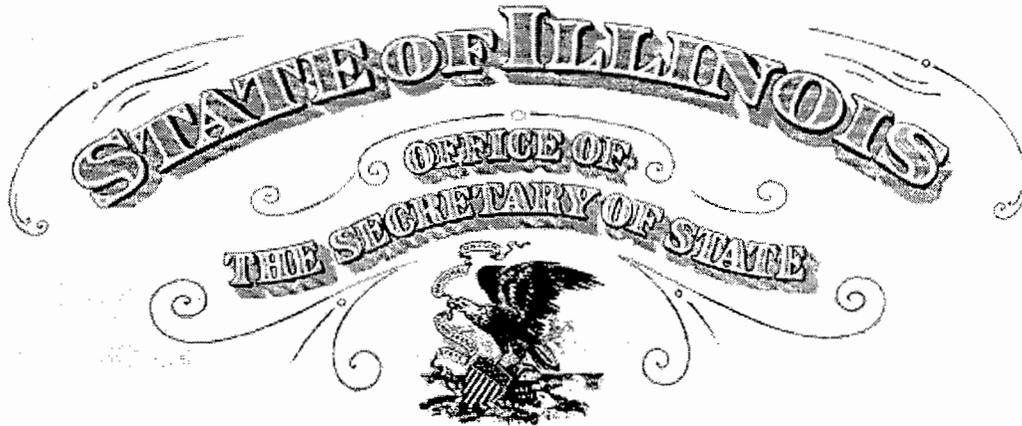
Jesse White

SECRETARY OF STATE

Authentication #: 1616100496 verifiable until 06/09/2017
Authenticate at: <http://www.cyberdriveillinois.com>

File Number

6775-210-4



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

TRINITY HEALTH CORPORATION, INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON MARCH 02, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 27TH day of MAY A.D. 2016 .

Jesse White

SECRETARY OF STATE

Authentication #: 1614801898 verifiable until 05/27/2017
Authenticate at: <http://www.cyberdriveillinois.com>



MERCY HOSPITAL & MEDICAL CENTER
2325 SOUTH AMERICAN AVENUE
CHICAGO, ILLINOIS 60616-2477
112.567.2000 phone

June 8, 2016

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

Dear Ms. Avery:

Mercy Hospital and Medical Center hereby certifies that it is the owner of the site on which Mercy Hospital and Medical Center is located.

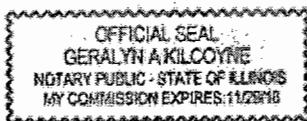
Sincerely,

A handwritten signature in black ink, appearing to read "Carol Schneider".

Carol Schneider
President and CEO

(Notarized Signature)

A handwritten signature in black ink, appearing to read "Geraldyn A. Kilcoyne".



Operating Identity/Licensee

 Illinois Department of PUBLIC HEALTH		HF109511
LICENSE, PERMIT, CERTIFICATION REGISTRATION		
<small>The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes (Chapter 230) and has taken the oath to honestly and lawfully engage in the activity as indicated below.</small>		
Nirav D. Shah, M.D. J.D. Director		
EXPIRES 12/31/2016	CATEGORY General Hospital	LICENSE NUMBER 0001578
Effective: 01/01/2016		
Mercy Hospital & Medical Center 2525 South Michigan Avenue Chicago, IL 60616		

← DISPLAY THIS PART IN A CONSPICUOUS PLACE.

Exp. Date: 12/31/2016
Lic Number: 0001578
Date Printed: 10/28/2015

Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, IL 60616

FEE RECEIPT NO.

File Number 0114-154-6



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

MERCY HOSPITAL AND MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 21, 1852, 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.



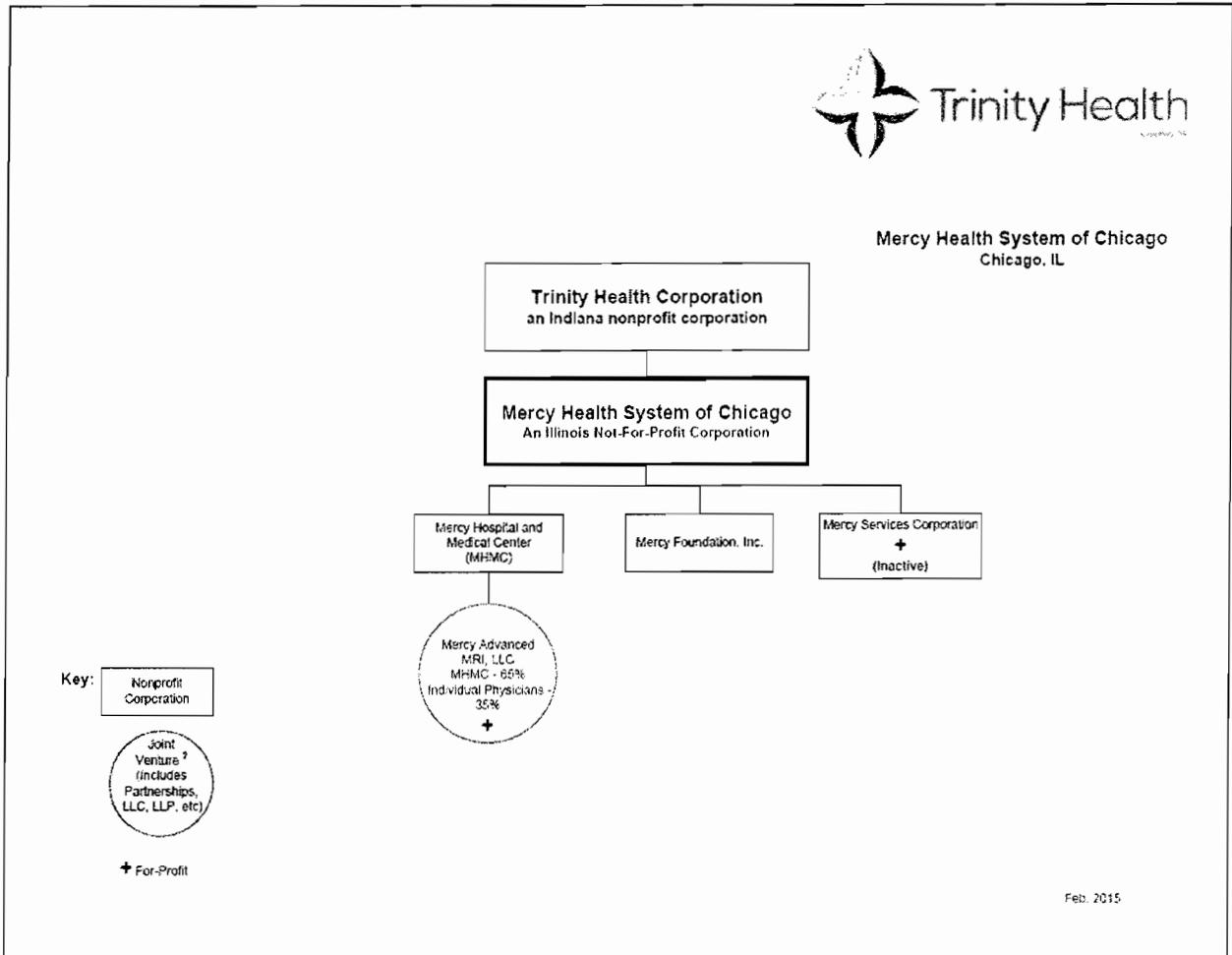
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 27TH day of MAY A.D. 2016 .

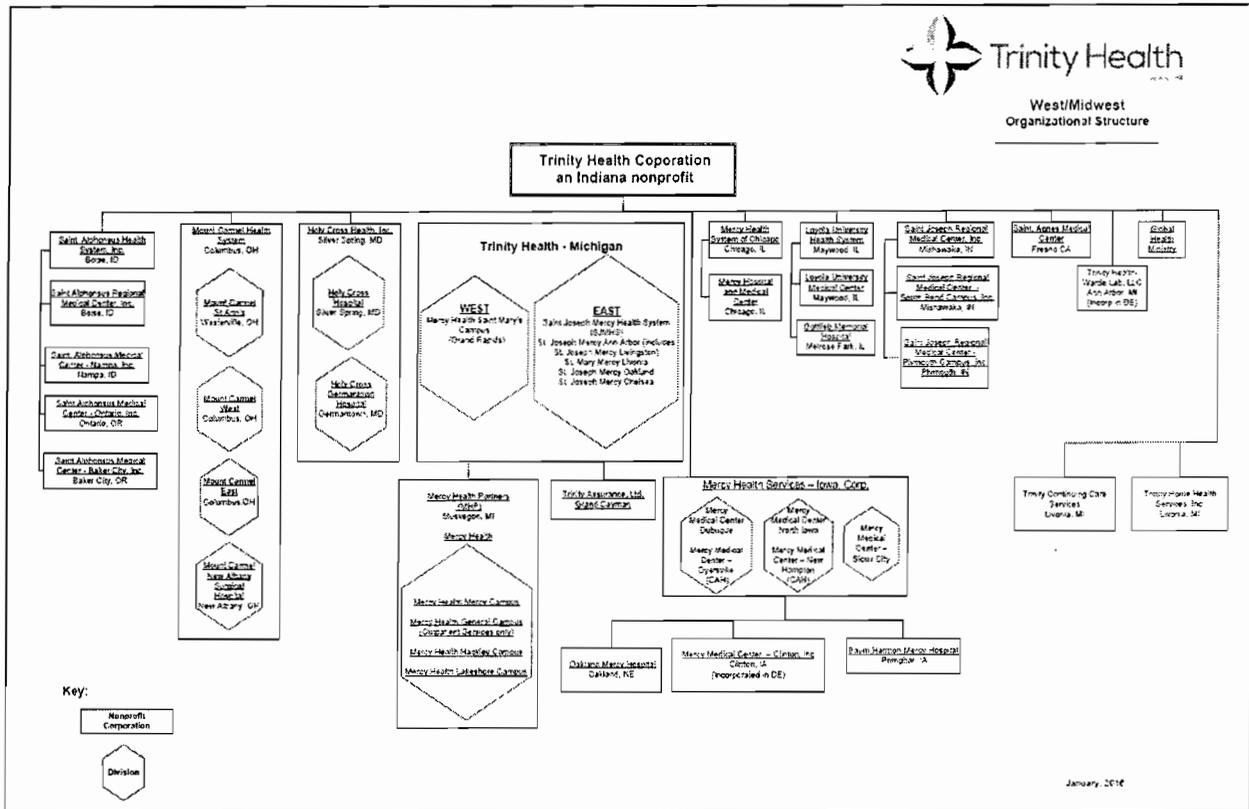
Jesse White

SECRETARY OF STATE

Authentication #: 1614801834 verifiable until 05/27/2017
Authenticate at: <http://www.cyberdriveillinois.com>

Organizational Relationships





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:

1. The applicants propose the Discontinuation of the Pediatrics Category of Service.
2. No other clinical services will be affected.
3. The anticipated dated of Discontinuation is upon approval by the Health Facilities and Services Review Board, or no later than January 31, 2017.
4. The physical space currently occupied by Pediatrics is intended to be used for a major modernization project for the Hospital. An application for CON permit is to be submitted prior to the start of that project.
5. All Pediatric medical records are to be maintained by Mercy Hospital and Medical Center in accordance with its policies and applicable State and Federal regulations.

REASONS FOR DISCONTINUATION

The applicants can no longer maintain a Pediatrics inpatient service for the following reasons:

1. The limited number of admissions, limited average daily census and the increasing clinical complexity of Pediatric admissions, challenges the Hospital's resources financially in maintaining appropriate clinical expertise.
2. An alternative specialized treatment setting for these patients has been identified as Ann & Robert H. Lurie Children's Hospital of Chicago, with whom Mercy Hospital has an ongoing relationship. Lurie Children's Hospital of Chicago is willing to accept pediatric referrals from Mercy Hospital as documented in Attachment 42. The travel time and distance between the two facilities is 13 minutes, or 5 miles.

XIII. Safety Net Impact Statement

1. The applicants maintain that the Discontinuation proposed will have no material impact on essential Safety Net Services in the community due to the limited number of annual admissions affected and the applicants' identification of an alternative site for those admissions at Lurie Children's Hospital, 5 miles from Mercy's campus.
2. The applicants do not see any impact on the ability of another provider or health care system to cross-subsidize safety net services, due to the commitment on part of Lurie Children's Hospital to accept the patients.
3. Given the limited number of patients and the commitment on part of Lurie Children's Hospital to accept the patients, the applicants do not anticipate any negative impact on the remaining safety net providers in the community.

Safety Net Information per PA 96-0031				
CHARITY CARE				
Charity (# of patients)	2013	2014	2015	
Inpatient	39	24	9	
Outpatient	2,348	1,222	1,406	
Total	2,387	1,246	1,415	
Charity (cost in dollars)				
Inpatient	\$2,307,687	\$2,899,512	\$1,141,376	
Outpatient	\$2,209,380	\$2,175,376	\$1,386,431	
Total	\$4,517,067	\$5,074,888	\$2,527,807	
MEDICAID				
Medicaid (# of patients)	2013	2014	2015	
Inpatient	4,623	6,080	6,440	
Outpatient	101,091	148,048	159,314	
Total	105,704	154,128	165,754	
Medicaid (revenue)				
Inpatient	\$58,421,225	\$61,917,548	\$69,803,854	
Outpatient	\$10,369,704	\$10,024,713	\$16,592,065	
Total	\$68,790,929	\$71,942,261	\$86,395,919	

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

XIV. Charity Care Information

Mercy Hospital and Medical Center

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

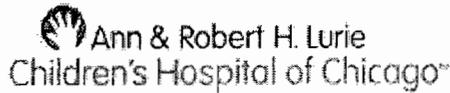
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

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

CHARITY CARE (Fiscal Year)			
	2013	2014	2015
Net Patient Revenue	\$232,199,015	\$232,939,000	\$244,087,374
Amount of Charity Care (charges)	\$13,082,874	\$12,894,275	\$79,845,841
Cost of Charity Care	\$4,517,067	\$5,074,888	\$2,527,807

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Support Letter and Commitment to Treat Referred Patients



June 22, 2016

Kathryn J. Olson, Chair
Health Facilities and Services Review Board
525 West Jefferson St.
Springfield, IL 62761

Dear Chairwoman Olson:

I wish to express our support for Mercy Hospital and Medical Center's application to the Board to discontinue its Pediatric category of service. Given our partnership with Mercy Hospital, Lurie Children's will continue to provide access to our pediatric medical and surgical specialties for patients that require these services. If a higher level of care is needed, patients can be transported to Lurie Children's.

We have an ongoing relationship with Mercy Hospital, providing staff to their Level II+ nursery. The referral of their limited number of pediatric patients to us is a logical extension of this relationship.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick M. Magoon".

Patrick M. Magoon
President & CEO

Patrick M. Magoon
President and CEO

CERTIFICATION – MERCY HEALTH SYSTEM OF CHICAGO

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

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

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


SIGNATURE

CAROL SCHNEIDER
PRINTED NAME

PRESIDENT CEO
PRINTED TITLE

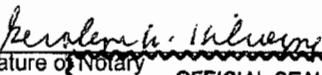

SIGNATURE

ERIC KRUEGER
PRINTED NAME

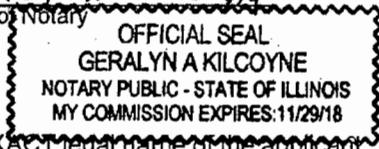
CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 3 day of AUGUST

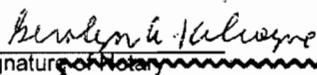
Notarization:
Subscribed and sworn to before me
this 3 day of AUGUST


Signature of Notary

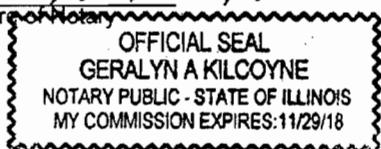
Seal



*Insert EXACT legal name of the applicant


Signature of Notary

Seal

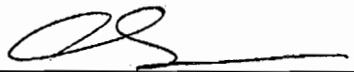


CERTIFICATION – Mercy Hospital and Medical Center

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

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

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



SIGNATURE
CAROL SCHNEIDER
PRINTED NAME

PRESIDENT + CEO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 3 day of AUGUST

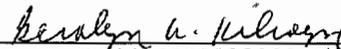


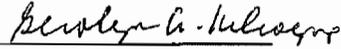
SIGNATURE
ERIC KRUEGER
PRINTED NAME

CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 3 day of AUGUST


Signature of Notary
OFFICIAL SEAL
GERALYN A KILCOYNE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18
Seal


Signature of Notary
OFFICIAL SEAL
GERALYN A KILCOYNE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 11/29/18
Seal

*Insert EXACT legal name of the applicant

CERTIFICATION -- TRINITY HEALTH CORPORATION

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

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

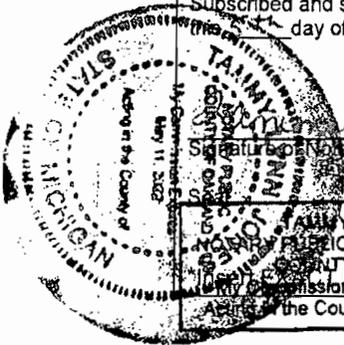
This Application for Permit is filed on the behalf of Trinity Health Corporation* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of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

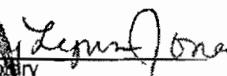

 SIGNATURE
BENJAMIN R CARTER
 PRINTED NAME
EV/PHO/TREASURER
 PRINTED TITLE


 SIGNATURE
Cynthia A. Clemence
 PRINTED NAME
SVP FINANCIAL OPERATION & PLANNING
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4th day of August, 2016

Notarization:
Subscribed and sworn to before me
this 5th day of August, 2016




 Signature of Notary
 TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne


 Signature of Notary
 Seal
 TAMMY LYNN JONES
 NOTARY PUBLIC - STATE OF MICHIGAN
 COUNTY OF OAKLAND
 My Commission Expires May 11, 2022
 Acting in the County of Wayne