E-012-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
JAN 30 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Iroquois Memorial Hospital and Resident Home		
Street Address: 200 Fairman		
City and Zip Code: Watseka 60970		
County: Iroquois	Health Service Area 4	Health Planning Area: D-03

Applicant /Co-Applicant Identification

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

Exact Legal Name: N/A - no co-applicant
Address:
Name of Registered Agent:
Name of Chief Executive Officer:
CEO Address:
Telephone Number:

Type of Ownership of Applicant/Co-Applicant

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

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

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: Timothy Smith
Title: Chief Operating Officer
Company Name: Iroquois Memorial Hospital and Resident home
Address: 200 Fairman, Watseka, IL 60970
Telephone Number: 815-432-7967
E-mail Address: tim.smith@iroquoismemorial.com
Fax Number: 815-432-7821

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: Timothy Smith
Title: Chief Operating Officer
Company Name: Iroquois Memorial Hospital and Resident Home
Address: 200 Fairman, Watseka, IL 60970
Telephone Number: 815-432-7967
E-mail Address:
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Iroquois Memorial Hospital and Resident Home
Address of Site Owner: 200 Fairman, Watseka, IL 60970
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: Iroquois Memorial Hospital and Resident Home
Address: 200 Fairman, Watseka, IL 60970

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

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

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

Organizational Relationships

N/A - no co-applicant

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 N/A - discontinuation of service
[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 N/A discontinuation of service
[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.

Iroquois Memorial Hospital and Resident Home, located at 200 Fairman in Watseka 60970, has a non-substantive project to close the Obstetrics Unit, which includes maternal and neonatal services effective July 31, 2017. We anticipate using the four rooms currently used for maternal and neonatal services, for medical/surgical beds. The use of these rooms for medical/surgical beds will allow us to continue to have 25 inpatient beds available.

Project Costs and Sources of Funds N/A - discontinuation of services

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			
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			

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 N/A - discontinuation of services

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 ☐ Yes ☐ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☐ 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 N/A - discontinuation of services

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _____

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☐ 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 N/A - discontinuation of services

Are the following submittals up to date as applicable:

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

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

Cost Space Requirements N/A - discontinuation of services

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.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**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: Iroquois Memorial Hospital and Resident Home		**CITY:** Watseka			
REPORTING PERIOD DATES:		**From:** Jan. 1, 2015	**to:** Dec. 31, 2015		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	15	621	2,542	+4	19
Obstetrics	4	111	222	- 4	0
Pediatrics	0	0	0	0	0
Intensive Care	6	34	61	0	6
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	0	0	0	0	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	25	766	2,825	0	25

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 Iroquois Mem. Hospital and Resident Home * **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

Timothy L. Smith
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26 day of January 2017

Signature of Notary

Seal

OFFICIAL SEAL
LAURA L. SUCHOR
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 08-02-2018

SIGNATURE

Roger Dittrich
PRINTED NAME

Chairman, Board of Trustees
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26 day of January 2017

Signature of Notary

Seal

OFFICIAL SEAL
LAURA L. SUCHOR
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 08-02-2018

*Insert EXACT legal name of the applicant

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

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.

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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.

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

	Medicaid (revenue)				
	Inpatient				
	Outpatient				
	Total				

APPEND DOCUMENTATION AS ATTACHMENT-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			
	Year	**Year**	**Year**
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	14
2	Site Ownership	15
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	16
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
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	17-18
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	19
41	Charity Care Information	20

File Number 1620-858-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

THE IROQUOIS MEMORIAL HOSPITAL AND RESIDENT HOME, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 20, 1921, 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* 20TH *day of* JANUARY *A.D.* 2017 .

Authentication #: 1702001308 verifiable until 01/20/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

ORIGINAL

Certificate of Status of Exempt Property

For owners of exempt parcels in Iroquois County

In accordance with ILCS-35, Section 15-10, this Certification is hereby submitted. As title holder or as the beneficial owner of the rights to the properties identified below, it is hereby declared that as of January 1, 2017, there has not been a change in the ownership or use of the properties since the initial issuance of the Certification of Exemption by the Illinois Department of Revenue, except as noted.

Owner: IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME,

Owner's Address: 200 E FAIRMAN AVE

WATSEKA IL 60970-1644

Permanent Parcel #	Street Addresses of Properties	Permanent Parcel #	Street Addresses of Properties
26-05-278-017			

Describe change in ownership and property affected (use attachment if necessary): _____

Date ownership changed: _____
Month/ Day/ Year

Describe change in use and property affected: (Be specific) _____

Date use changed: _____
Month/ Day/ Year

Is any of the property leased? (yes or no) NO
If yes, Attach copies of any lease agreements not previously submitted.

____ If marked, this office is requesting you to provide a copy of each of your original Certificates of Exemption issued by the Department of Revenue. Attach and return a copy with this document.

I hereby certify this to be a true and correct reporting of the facts concerning these properties.

Signature: x Joni Uplinch — Owner or Authorized Representative

CFO — Title

815-432-7929 — Phone Number

12-21-16 — Date

IMPORTANT: This should be completed and returned to the Iroquois County Board of Review prior to January 31st. Failure to file shall constitute cause to terminate the exemption.

Ptax-328 (R-9/01) approved by the Forms Management Center

ATTACHMENT 2

File Number 1620-858-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

THE IROQUOIS MEMORIAL HOSPITAL AND RESIDENT HOME, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 20, 1921, 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* 20TH *day of* JANUARY *A.D.* 2017 .

Authentication #: 1702001308 verifiable until 01/20/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

SECTION II. DISCONTINUATION

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
   Answer: Maternal and Neonatal Services

2. Identify all of the other clinical services that are to be discontinued.
   Answer: None

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
   Answer: Maternal and Neonatal Services will be discontinued effective July 31, 2017.

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
   Answer: The space currently utilized for providing maternal and neonatal services is located on the 3rd floor of the facility. The space is separated from Medical/Surgical/Intensive Care Units by double doors which serve as fire doors between the maternal and neonate unit and medical/surgical/intensive care units. The four beds will be moved to our medical/surgical unit and the patient rooms in the unit will be used for outpatient infusion services. The nurses' station will be used for coordination of those services, monitoring and charting. The labor and delivery room, staff lounge, physician lounge, nursery, and nursery work rooms will be decommissioned. These areas will be evaluated for use as office space for Care Coordination for all patient care services from discharge planning to post discharge follow-up.

   We will maintain a bassinet, infant warmer and delivery supplies in the event there is an urgent delivery in the Emergency Department. We will also continue to stock resuscitation supplies in the Emergency Department for infants and moms. Emergency Department staff and physicians will receive regular and recurrent training on emergency delivery procedures.

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.
   Answer: Medical Records will be maintained on site for the length of time as specified by 210 ILCS 85/6.17 that is not less than 10 years after discharge or 12 years if there is litigation.

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.
   Answer: N/A as we are not discontinuing an entire facility.

REASONS FOR DISCONTINUATION

In our service area, the number of births remain stable however Iroquois Memorial's number of births has declined. Over the past 3 years births have been below 100 births per year 2013 - 97, 2014 - 89, 2015-78. During this 3 year period Iroquois Memorial lost 3 Family Practitioners who did Obstetrics. Despite significant efforts and investment to recruit replacements we were only able to replace 2. Both of these physicians have informed us they will be leaving in 2017 at the end of their contracts – one in April and one in August. Both have stated that are leaving because volumes do not provide sufficient activity to sustain skills necessary for the safety of our obstetrics patients. Recruitment and retention of OB staff is difficult as this concern for declination of skills also applies to our OB nursing staff.

Our payor mix for Obstetrics services is greater than 60%. The State of Illinois historically is significantly behind in payments of claims and when the State of Illinois does pay, they pay our hospital an average of $0.11 cents for every dollar's worth of care provided.

The result is that our Maternity department (OB, Labor & delivery and Nursery) is unable to support itself. Over the last 3 years Iroquois Memorial has seen a total loss from OB services in excess of $2.5 Million and just last year lost $873,997. This requires other revenue generating departments in the Hospital to cover the losses and we can no longer do that. Operational losses for the Hospital have been substantial. 2013 losses - $1.9 Million, 2014 losses - $2.0 Million and 2015 losses $2.4 Million. These losses put our entire Hospital system in jeopardy.

IMPACT ON ACCESS

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.

Response: Our market share change for all Obstetric services declined 19% from 2014 to 2015 as more patients chose to go elsewhere for Obstetric services. We have been below 100 births per year over the last 3 years.

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.

Response: There are two hospitals providing OB services within 45 minutes of Iroquois Memorial. The written requests along with certification of receipt and MapQuest Maps are included in Appendices 1

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.

Response: The letters received from the two hospitals providing OB services within 45 minutes of Iroquois Memorial are included in Appendices 2

SECTION XI. Safety Net Impact Statement

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.
   Response: Iroquois Memorial Hospital is not a Safety Net Hospital and it is believed that there would be no material impact on essential safety net services.

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.
   Response: Iroquois Memorial Hospital is not a Safety Net Hospital and it is believed that there would be no impact on the ability of another provider or health care system to cross-subsidize safety net services if necessary.

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.
   Response: Iroquois Memorial Hospital is not a Safety Net Hospital. Other providers in the community are not safety net providers so it is believed there would be no impact on essential safety net services.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2015**	**2014**	**2013**
Inpatient	94	92	56
Outpatient	1,055	1,402	1,318
Total	**1,149**	**1,494**	**1,374**
Charity (cost in dollars)			
Inpatient	$ 99,376	$ 41,157	$ 81,654
Outpatient	$ 362,624	$ 376,843	$ 357,346
Total	**$ 462,000**	**$ 418,000**	**$ 439,000**
MEDICAID			
Medicaid (# of patients)	**2015**	**2014**	**2013**
Inpatient	140	191	218
Outpatient	9033	8450	7893
Total	**9,173**	**8,641**	**8,111**
Medicaid (revenue)			
Inpatient	$ 1,201,274	$ 991,687	$ 931,467
Outpatient	$ 4,765,910	$ 3,446,697	$ 3,412,806
Total	*$ 5,967,184*	*$ 4,438,384*	*$ 4,344,273*

CHARITY CARE			
	2015	2014	2013
Net Patient Revenue	$ 33,664,975	$ 32,303,484	$ 31,612,415
Amount of Charity Charges	$ 953,000	$ 868,000	$ 898,000
Cost of Charity Care	$ 462,000	$ 418,000	$ 439,000

IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME

Now an independent partner of Presence Health
Today counts.

December 13, 2016

Mr. Chris Shride
Presence St. Mary's Hospital
500 West Court St.
Kankakee, IL 60901

Dear Mr. Shride,

In accordance with the requirements of 77 Ill. Adm Code 1110.130 C) 3) Iroquois Memorial Hospital and Resident Home is requesting an impact statement from your organization regarding the closure of the Hospital's obstetric services effective July 31, 2017. The code requires contact with all existing or approved health care facilities, providing the same services as those proposed for discontinuation, which are located with 45 minutes travel time of the requesting facility.

For your reference, included below is a table of the birth statistics for the last three years at Iroquois Memorial Hospital:

- 2013 - 97
- 2014 - 89
- 2015 - 78

Please provide, as applicable, the following information with your impact statement:

Capacity to accommodate a portion or all of Iroquois Memorial hospital's experienced caseload.
Explanation of any restrictions or limitations precluding providing services to the residents of Iroquois Memorial Hospital's market area.
If a response is not received within 15 days from the date of delivery, the Hospital will assume that the discontinuation will not have an adverse impact on your organization.

Please direct your response to the following

Iroquois Memorial Hospital
Tim Smith, COO
200 Fairman
Watseka, IL 60970

I greatly appreciate your assistance with this and the continuation of obstetrics care in our area. If you have any questions please direct them to my attention at 815-432-7967 or email tim.smith@iroquoismemorial.com

Sincerely,

Tim Smith,
Chief Operating Officer

7014 2120 0003 7309 3981

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.
KANKAKEE IL 60901
OFFICIAL USE

Postage	$2.70
Certified Fee	$0.00
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$

$3.30
$0.47
$3.17

0970
05

Postmark Here

01/04/2017

Sent To: Mr. Chris Shride
Street and Apt. No., or PO Box No.: Presence St. Mary's Hospital
City, State, ZIP+4®: 500 West Court Street
Kankakee, Illinois 60901

PS Form 3800, July 2014 — See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Mr. Chris Shride
Presence St. Mary's Hospital
500 West Court Street
Kankakee, Illinois 60901

9590 9402 1615 6053 1634 27

2. Article Number (Transfer from service label)
7014 2120 0003 7309 3981

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Debra Dunlavey ☒ Agent ☐ Addressee

B. Received by (Printed Name): Debra Dunlavey
C. Date of Delivery: 1-5-17

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

USPS

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

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

YOUR TRIP TO:

Saint Mary's Hospital

45 MIN | 32.6 MI

Est. fuel cost: $2.13

Trip time based on traffic conditions as of 1:46 PM on January 24, 2017. Current Traffic: Light

Start of next leg of route

1. Start out going east on E Fairman Ave toward S 5th St.

Then 0.00 miles — 0.00 total miles

2. Take the 1st left onto S 5th St.

If you reach S Belmont Ave you've gone about 0.1 miles too far.

Then 0.74 miles — 0.75 total miles

3. Turn left onto E Walnut St/US-24 W/IL-1. Continue to follow US-24 W.

US-24 W is just past E Cherry St.

If you are on N 5th St and reach E Oak St you've gone a little too far.

Then 7.18 miles — 7.93 total miles

4. Turn right onto IL-49/N State Route 49.

IL-49 is 0.1 miles past Cherry St.

If you are on Main St and reach N State Route 49 you've gone a little too far.

Then 8.10 miles — 16.02 total miles

5. IL-49/N State Route 49 becomes US-45 N/US-52 W.

Then 14.99 miles — 31.01 total miles

6. Turn slight right onto S Schuyler Ave.

Then 1.18 miles — 32.19 total miles

7. Turn left onto E Court St/IL-17.

E Court St is just past E Merchant St.

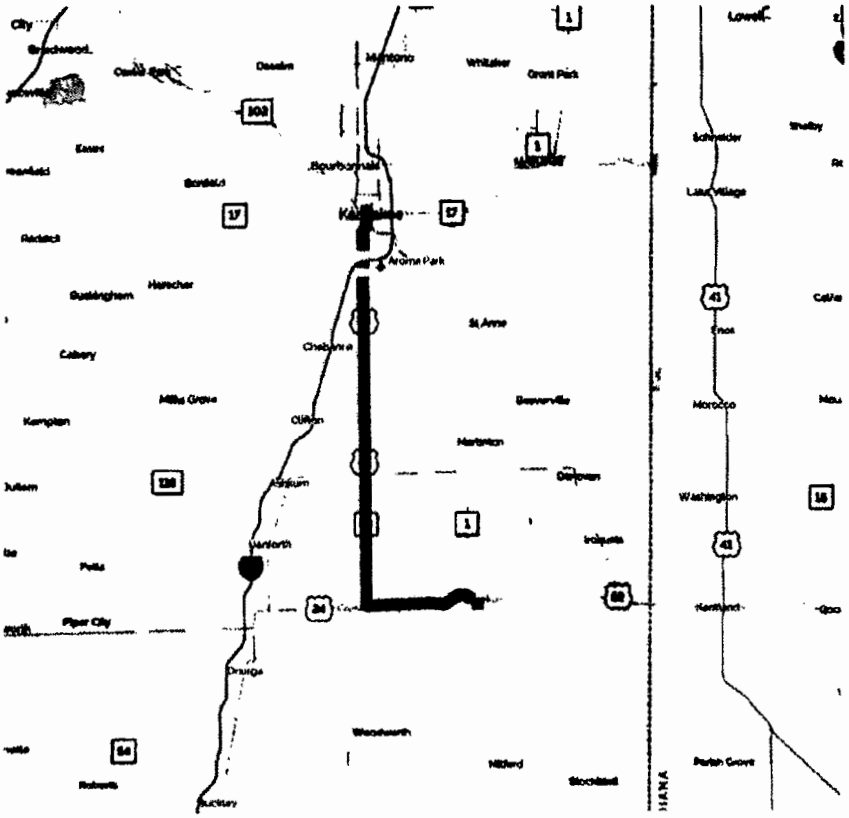
If you reach E Oak St you've gone a little too far.

Then 0.40 miles — 32.59 total miles

8. Saint Mary's Hospital, 500 W Court St, IL, 60901, 500 W COURT ST.

Your destination is just past S 4th Ave.

If you reach N 5th Ave you've gone a little too far.


Saint Mary's Hospital
200 E Fairman Ave

IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME

Now an independent partner of Presence Health™
Today counts.

December 13, 2016

Mr. Phil Kambic
Riverside Medical Center
350 North Wall St.
Kankakee, IL 60901

Dear Mr. Kambic,

In accordance with the requirements of 77 Ill. Adm Code 1110.130 C) 3) Iroquois Memorial Hospital and Resident Home is requesting an impact statement from your organization regarding the closure of the Hospital's obstetric services effective July 28, 2017. The code requires contact with all existing or approved health care facilities, providing the same services as those proposed for discontinuation, which are located with 45 minutes travel time of the requesting facility.

For your reference, included below is a table of the birth statistics for the last three years at Iroquois Memorial Hospital:

- 2013 - 97
- 2014 - 89
- 2015 - 78

Please provide, as applicable, the following information with your impact statement:

Capacity to accommodate a portion or all of Iroquois Memorial hospital's experienced caseload.
Explanation of any restrictions or limitations precluding providing services to the residents of Iroquois Memorial Hospital's market area.
If a response is not received within 15 days from the date of delivery, the Hospital will assume that the discontinuation will not have an adverse impact on your organization.

Please direct your response to the following:
Iroquois Memorial Hospital
Tim Smith, COO
200 Fairman
Watseka, IL 60970

I greatly appreciate your assistance with this and the continuation of obstetrics care in our area. If you have any questions please direct them to my attention at 815-432-7967 or email tim.smith@iroquoismemorial.com

Sincerely,

Tim Smith,
Chief Operating Officer

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Mr. Phil Kambic
Riverside Medical Center
350 North Wall Street
Kankakee, Illinois 60901

9590 9402 1615 6053 1634 10

2. Article Number (Transfer from service label)
7014 2120 0003 7309 3974

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

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

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

U.S. Postal Service
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com

KANKAKEE IL 60901

OFFICIAL USE

Postage	$3.30 $2.70
Certified Fee	$0.00
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$6.47

0970 05

Postmark Here

01/04/2017

Sent To: Mr. Phil Kambic
Street or PO: Riverside Medical Center
City: 350 North Wall Street
Kankakee, Illinois 60901

PS Form 3800, July 2014

7014 2120 0003 7309 3974

YOUR TRIP TO:

mapquest

Riverside Medical Ctr

44 MIN | 32.6 MI

Est. fuel cost: $2.13

Trip time based on traffic conditions as of 1:48 PM on January 24, 2017. Current Traffic: Light

Start of next leg of route

1. Start out going east on E Fairman Ave toward S 5th St.

Then 0.00 miles — 0.00 total miles

2. Take the 1st left onto S 5th St.

If you reach S Belmont Ave you've gone about 0.1 miles too far.

Then 0.74 miles — 0.74 total miles

3. Turn left onto E Walnut St/US-24 W/IL-1. Continue to follow US-24 W.

US-24 W is just past E Cherry St.

If you are on N 5th St and reach E Oak St you've gone a little too far.

Then 7.18 miles — 7.93 total miles

4. Turn right onto IL-49/N State Route 49.

IL-49 is 0.1 miles past Cherry St.

If you are on Main St and reach N State Route 49 you've gone a little too far.

Then 6.10 miles — 18.02 total miles

5. IL-49/N State Route 49 becomes US-45 N/US-52 W.

Then 14.99 miles — 31.01 total miles

6. Turn slight right onto S Schuyler Ave.

Then 0.73 miles — 31.74 total miles

7. Turn right onto E River St/IL-50.

E River St is 0.1 miles past E Water St.

If you reach E Beaubonnais St you've gone a little too far.

Then 0.22 miles — 31.96 total miles

8. Turn left onto S Harrison Ave/IL-50.

S Harrison Ave is just past S Indiana Ave.

If you reach S Chicago Ave you've gone a little too far.

Then 0.45 miles — 32.41 total miles

9. Turn left onto E Court St/IL-17.

E Court St is just past E Merchant St.

If you reach E Oak St you've gone a little too far.

Then 0.07 miles — 32.48 total miles

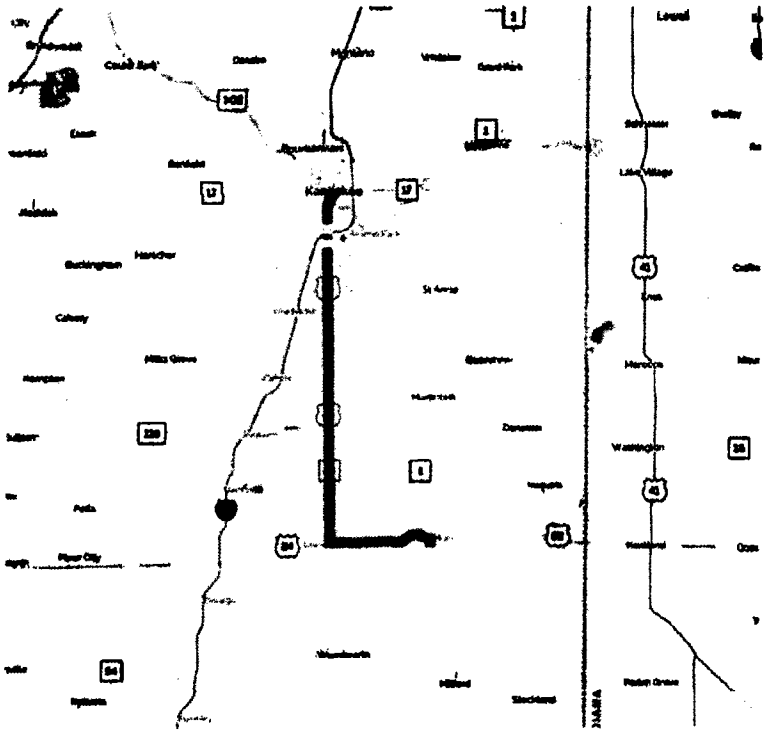
10. Turn left onto N Indiana Ave/IL-50.

If you reach N Dearborn Ave you've gone a little too far.

Then 0.00 miles — 32.48 total miles

11. Riverside Medical Ctr, 350 N WALL ST 350 N WA.

If you are on S Indiana Ave and reach E Merchant St you've gone a little too far.



Presence
St. Mary's Hospital

January 10, 2017

Mr. Tim Smith, COO
Iroquois Memorial Hospital & Resident Home
200 Fairman
Watseka, IL 60970

Dear Mr. Smith:

I have received your request for an impact statement pursuant to section 77 Illinois Administrative Code 1110.130 (c), regarding the proposed closure of Iroquois Memorial Hospital's obstetric services.

Presence St. Mary's Hospital has the capacity to accommodate a caseload equal to the birth statistics provided in your letter. I would be happy to meet with you or your physicians regarding our service line.

If you have any questions, please feel free to contact me at (815) 937-2401.

Sincerely,

Christopher Shride
President

500 West Court Street, Kankakee, Illinois 60901 815.937.2400 presencehealth.org

RIVERSIDE HEALTHCARE

January 5, 2017

Mr. Tim Smith
Chief Operating Officer
Iroquois Memorial Hospital
200 Fairman
Watseka, IL 60970

Re: Obstetric Service Closure

Dear Mr. Smith:

In response to your letter of December 13, 2016 regarding the proposed discontinuation of the Obstetric Service at Iroquois Memorial Hospital, please be advised that Riverside Medical Center would have the capacity in its current Obstetrics Department to accommodate the annual deliveries from your facility.

If we can be of assistance in any way to facilitate the transition of your obstetric patients to our hospital as you plan for the discontinuation, please feel free to contact me at any time.

Sincerely,

Phillip Kambic
President & CEO