

E-014-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

FEB 17 2017

This Section must be completed for all projects.

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name: St. Mary's Hospital Decatur – Discontinue Long Term Care Category of Service		
Street Address: 1800 E. Lakeshore Drive		
City and Zip Code: Decatur 62521		
County: Macon	Health Service Area 4	Health Planning Area: D-04

Applicant /Co-Applicant Identification

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

Exact Legal Name: St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis	
Address: 1800 E. Lakeshore Drive	
Name of Registered Agent: Amy K. Bulpitt	
Name of Chief Executive Officer: Dan Perryman	
CEO Address: 1800 E. Lakeshore Drive, Decatur, IL 62521	
Telephone Number: (217) 464-2473	

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<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: Clare Connor Ranalli
Title: Partner
Company Name: McDermott Will & Emery
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

Additional Contact

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

Name: Amy K. Bulpitt
Title: Vice President and General Counsel
Company Name: Hospital Sisters Health System
Address: 800 E. Carpenter Street, Springfield, IL 62769
Telephone Number: (217) 544-6464, X 48336
E-mail Address: amy.bulpitt@hshs.org
Fax Number: (217) 535-3989

Applicant /Co-Applicant Identification

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

Exact Legal Name: Hospital Sisters Health System
Address: 4936 LaVerna Road, Springfield, IL 62707
Name of Registered Agent: Amy K. Bulpitt
Name of Chief Executive Officer: Mary Starmann-Harrison, RN, FACHE
CEO Address: 4936 LaVerna Road, Springfield, IL 62707
Telephone Number: (217) 523-4747

Type of Ownership of Applicant/Co-Applicant

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

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- 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.

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Telephone Number: (217) 544-6464 X48336
E-mail Address: amy.bulpitt@hshs.org
Fax Number: (217) 535-3989

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: Amy K. Bulpitt
Title: Vice President and General Counsel
Company Name: Hospital Sisters Health System
Address: 4936 LaVerna Road, Springfield, IL 62707
Telephone Number: (217) 492-9167
E-mail Address: amy.bulpitt@hshs.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Hospital Sisters Services, Inc.
Address of Site Owner: P.O. Box 19456, Springfield, IL 62794
Street Address or Legal Description of Site: 1800 E. Lakeshore Drive, Decatur, IL 62521
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: St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis
Address: 1800 E. Lakeshore Drive, Decatur, IL 62521
<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 the 14-bed Long Term Care/Skilled Unit located on the 7th floor east corridor of St. Mary's Hospital Decatur. St. Mary's has not yet determined the use of the space that will be vacated as a result of the discontinuation. The discontinuation will occur immediately after issuance of an exemption by the Illinois Health Facilities and Services Review Board.

This project does not include the construction, demolition, or modernization of any existing buildings, and there are no project costs.

This is a substantive project because 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.

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

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

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	

The project involves the establishment of a new facility or a new category of service
 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 \$ **N/A**.

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:

None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): September 30, 2015

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):
Not Applicable – No Costs

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

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

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			N	IA			
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: St. Mary's Hospital Decatur			CITY: Decatur		
REPORTING PERIOD DATES:			From: 01/01/2015 to 12/31/2015:		
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	108	4,791	15,569	N/A	108
Obstetrics	18	789	1,848	N/A	18
Pediatrics	14	108	238	N/A	14
Intensive Care	14	412	2,340	N/A	14
Comprehensive Physical Rehabilitation	20	340	4,242	N/A	20
Acute/Chronic Mental Illness	56	1,620	14,767	N/A	56
Neonatal Intensive Care	0			N/A	0
General Long Term Care	14	0	0	-14	0
Specialized Long Term Care	0			N/A	0
Long Term Acute Care	0			N/A	0
Other ((identify))	0			N/A	0
TOTALS:	244	8,010	39,004	-14	230

CERTIFICATION

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 St. Mary's Hospital, Decatur, of the Hospital Sisters of the Third Order of St. Francis* 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.



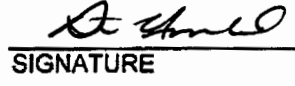
 SIGNATURE

Daniel Peryman

 PRINTED NAME

President and CEO, St. Mary's

 PRINTED TITLE



 SIGNATURE

Steve Umland

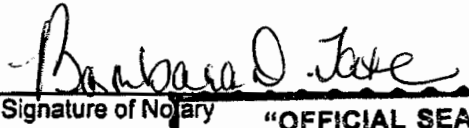
 PRINTED NAME

Chief Financial Officer, St. Mary's

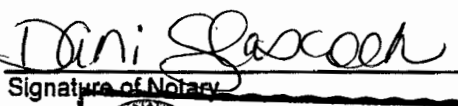
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 8th day of February 2017

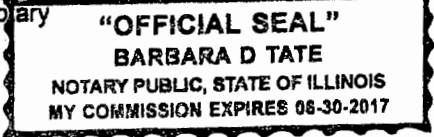
Notarization:
 Subscribed and sworn to before me
 this 10th day of February

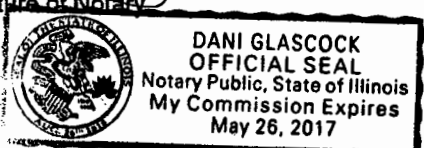


 Signature of Notary



 Signature of Notary

Seal 

Seal 

*Insert EXACT legal name of the applicant

CERTIFICATION

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

- 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);
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Amy K. Bulpitt

 SIGNATURE

Amy K. Bulpitt

 PRINTED NAME

HSHS Vice President General Counsel

 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 9th day of February, 2017

Mary Starmann-Harrison

 SIGNATURE

Mary Starmann-Harrison

 PRINTED NAME


CEO, HSHS

 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 1st day of February, 2017

Dani Glascock

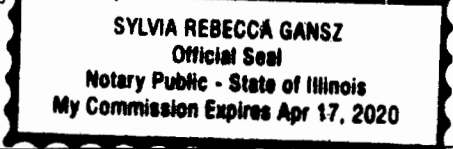
 Signature of Notary

Seal 

*Insert EXACT legal name of the applicant

Sylvia Rebecca Gansz

 Signature of Notary

Seal 

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.

XI. Safety Net Impact Statement

(See Attachment 40)

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 40.

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

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

XII. Charity Care Information**(See Attachment 41)****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	15(a) - 17
2	Site Ownership	18
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	19-20
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
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10	Discontinuation	21 – 23
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12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
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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	24 – 25
41	Charity Care Information	26

See attached certificates of good standing for applicants St. Mary's Hospital Decatur and Hospital Sisters Health System.



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

ST. MARY'S HOSPITAL, DECATUR, OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, 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.

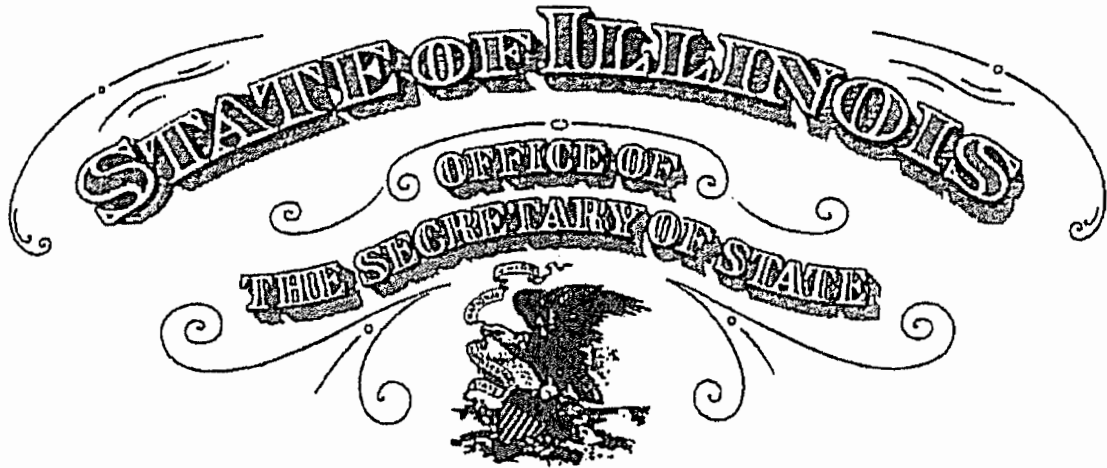
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 16TH day of FEBRUARY A.D. 2017 .



Jesse White

SECRETARY OF STATE

Authentication #: 1704702162 verifiable until 02/16/2018
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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

HOSPITAL SISTERS HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 26, 1978, 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 3RD day of AUGUST A.D. 2016 .



Authentication #: 1621602346 verifiable until 08/03/2017
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Jesse White

SECRETARY OF STATE

February 9, 2017

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson
Second Floor
Springfield, IL 62761

Dear Ms. Avery:

Hospital Sisters of the Third Order of St. Francis hereby certifies that Hospital Sisters Services, Inc. is the owner of the site on which the hospital is located.

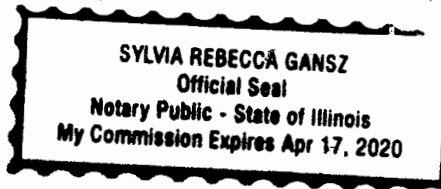
Sincerely,

Amy K. Bulpitt

Amy K. Bulpitt
Senior Vice President and General Counsel

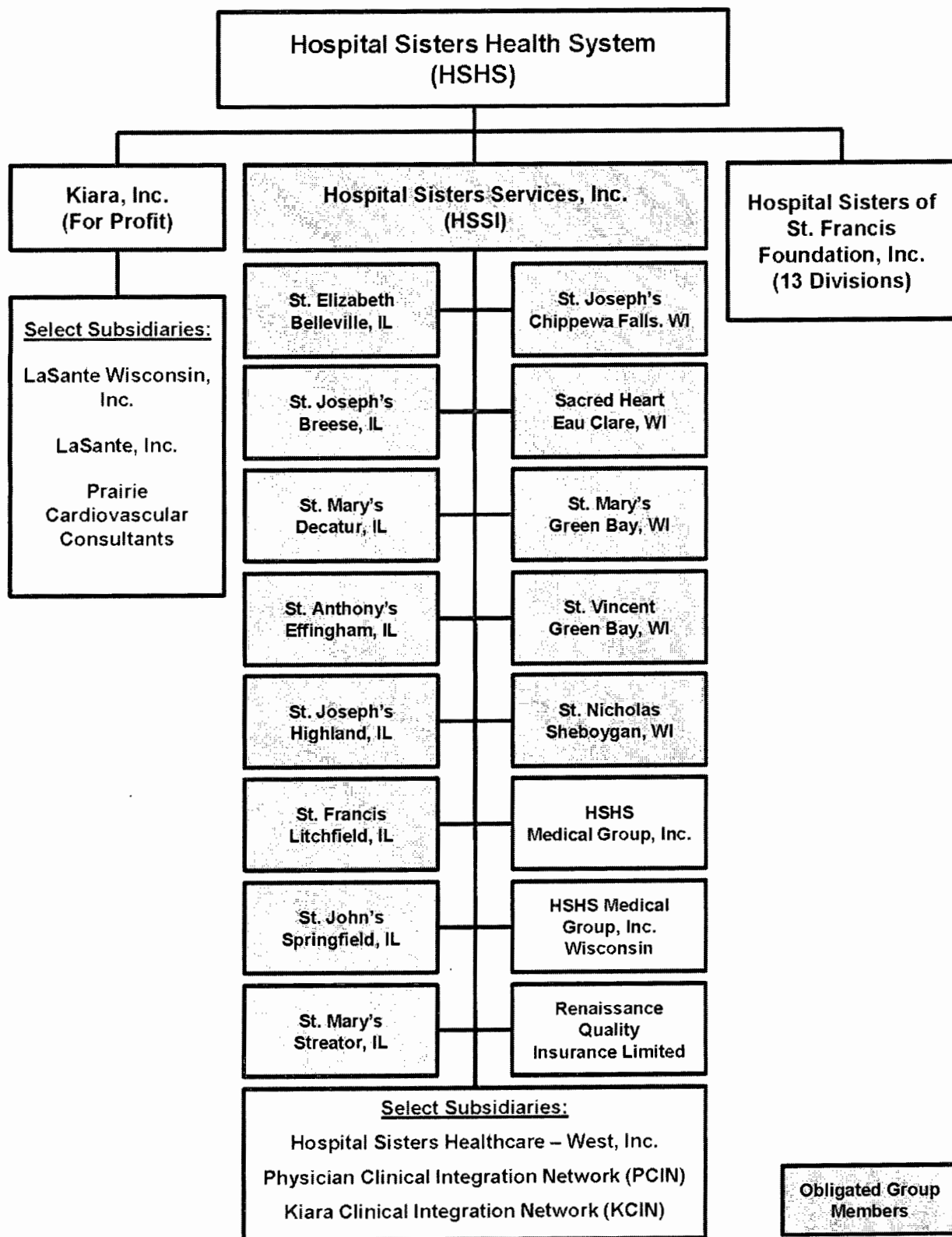
Subscribed and sworn to before me this
9th day of February, 2017

Sylvia Rebecca Gansz
Notary Public



See attached organization chart.

HSHS Organization Chart



ATTACHMENT 10

Discontinuation

General Information Requirements

1. Identify the categories of service and the number of beds, if any, that is to be discontinued.

St. Mary's Hospital Decatur is proposing to discontinue its Long Term/Skilled Unit. This category of service has fourteen (14) beds.

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

No other clinical services will be discontinued as part of this project.

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

The discontinuation will occur immediately after permit issuance.

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

St. Mary's Hospital Decatur is evaluating the future use of the physical space and equipment utilized for the Long Term Care unit, but has not yet made a determination.

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.

All medical records will be maintained at St. Mary's Hospital Decatur in accordance with its standard health information policies, and in accordance with all applicable legal and regulatory requirements

6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB of 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.

Not applicable.

Reasons for Discontinuation

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. Criterion 110.130(b)

St. Mary's Hospital Decatur has provided quality long term care services to its patients for many years. However, utilization of those services has declined over the past several years to the point that it no longer appears the unit is necessary. There are many new facilities offering long term care services in the area, and the overall trend is for hospitals to focus on acute services, versus general skilled nursing beds. The service had no utilization in 2015 and the hospital was considering re-purposing the long term care beds for transition services, but decided the best course of action was to monitor need in 2016 and determine a course of action. There has been no utilization in 2016 and it is clear discontinuation is appropriate and will have no impact on access to LTC services within the area. With the discontinuation of its long term care unit, St. Mary's will be better able to focus its resources on its core services of acute care hospital services, and will allow those long term care facilities in the area with capacity to serve area residents. There is an excess of long term care beds in the community (138 in Macon County and 1,364 in HSA 4). Based on the HFSRB Inventory of Health Care Facilities and Services and Need Determinations for the General Long-Term Care Category of Service (the "Inventory"), in Decatur, Illinois alone there are 984 general nursing care beds at facilities other than St. Mary's Hospital Decatur.

The discontinuation of the Long Term Care/Skilled Unit at St. Mary's Decatur will help reduce this excess over-bedding, which is consistent with the goals of both the HFSRB and the Long Term Care Advisory Subcommittee.

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.

As stated above, according to the most recent HFSRB Inventory, there is a significant excess of beds (138 in Macon County and 1,364 in the HSA). Furthermore, more detailed data in the inventory indicates that St. Mary's Hospital Decatur accounted for only zero to one percent (1%) of the total patient days from 2010 – 2015 among long term care providers in the city of Decatur. From that information and data, it is apparent that sufficient long term care services are available in St. Mary's market area and that the discontinuation of the Long Term Care/Skilled Unit at St. Mary's Hospital Decatur will not materially or adversely affect the ability of residents of Decatur, Illinois or the broader St. Mary's market area to obtain long term care services.

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.

This requirement is no longer applicable to the exemption process for discontinuation of a category of service.

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.

N/A.

ATTACHMENT 40

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.

St. Mary's Hospital Decatur believes that the abundant supply of long term care beds in Decatur, Illinois, the Macon County Planning Area, and Health Service Area 4 are sufficient to ensure that this project will not have a material impact on essential safety net services in the community.

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.

Given that St. Mary's Hospital Decatur served no residents of Decatur, Illinois and the Macon County Planning in 2015 and 2016, and in light of the amount of charity care and Medicaid revenue relating to the specific Long Term Care/Skilled Unit that is the subject of this project historically, St. Mary's believes that this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

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

We believe given the excess of beds in the area, other providers of LTC will be positively impacted, as the service will be less diluted.

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.

See safety net chart below. Note that the chart in this Attachment 40 indicates the amount of charity care provided by St. Mary's Hospital Decatur relating to the Long Term Care/Skilled Unit that is the subject of this discontinuation project. Charity care information pertaining to St. Mary's Hospital Decatur and Hospital Sisters Health System as a whole are included in Attachment 41.

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.

See chart below. Note that the chart in this Attachment 40 indicates the amount of Medicaid care provided by St. Mary's Hospital Decatur relating to the Long Term Care/Skilled Unit that is the subject of this discontinuation project.

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

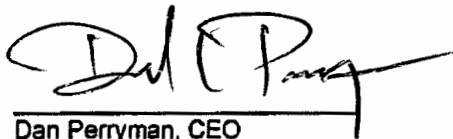
St. Mary's Hospital Decatur believes that the abundant supply of long term care beds in Decatur, Illinois, the Macon County Planning Area, and Health Service Area 4 are sufficient to ensure that residents of these areas will continue to have access to long term care services.

ATTACHMENT 40

The following is HSHS safety net information for St. Mary's Decatur.*

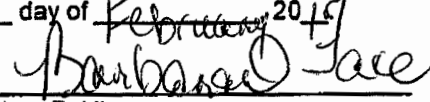
Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	FY2015	FY2014	FY2013
Inpatient	417	583	716
Outpatient	5,981	7,072	7,817
Total	6,398	7,655	8,533
Charity (cost in dollars)			
Inpatient	\$ 166,943	\$ 278,991	\$ 1,394,878
Outpatient	\$ 2,393,527	\$3,382,308	\$ 3,519,291
Total	\$ 2,560,470	\$3,661,299	\$ 4,914,169
MEDICAID			
Medicaid (# of patients)	FY2015	FY2014	FY2013
Inpatient	2,467	2,005	1,882
Outpatient	21,172	17,243	14,802
Total	23,639	19,248	16,684
Medicaid (revenue)			
Inpatient	\$ 1,889,157	\$ 2,000,644	\$ 5,430,581
Outpatient	\$ 16,212,900	\$17,205,539	\$ 8,157,970
Total	\$ 18,102,057	\$19,206,183	\$ 13,588,551

*long term care unit only



Dan Perryman, CEO
St. Mary's Decatur

Subscribed and sworn to before me this

8 day of February 2015


Notary Public



ATTACHMENT 41

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.

See chart below. Please note that this chart reflects charity care provided by St. Mary's Hospital Decatur only and not co-applicant Hospital Sisters Health System, which would necessarily include other facilities that are neither involved in nor relevant to this project.

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.

See chart below. Please note that this chart reflects charity care provided by St. Mary's Hospital Decatur only and not co-applicant Hospital Sisters Health System, which would necessarily include other facilities that are neither involved in nor relevant to this project.

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.

Not applicable.

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.

The following is HSHS Illinois Hospital Information.

CHARITY CARE			
	FY2015	FY2014	FY2013
Net Patient Revenue	972,240,195	1,021,229,534	1,262,757,958
Amount of Charity Care	79,693,832	76,826,472	49,555,376
Cost of Charity Care	25,376,255	21,820,899	20,025,778

Ratio of Costs to Charges
(RCC)