E-047-18 [ORIGINAL]

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
AUG 31 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: OSF Saint Anthony's Health Center – Discontinuation of Obstetric Category of Service		
Street Address: 1 Saint Anthony's Way		
City and Zip Code: Alton 62002		
County: Madison	Health Service Area 11	Health Planning Area: F-01

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

Exact Legal Name: OSF Healthcare System d/b/a OSF Saint Anthony's Health Center
Street Address: 800 N.E. Glen Oak Avenue
City and Zip Code: Peoria, IL 61603
Name of Registered Agent: Sister Theresa Ann Brazeau, OSF
Registered Agent Street Address: 1175 Saint Francis Lane
Registered Agent City and Zip Code: East Peoria 61611
Name of Chief Executive Officer: Robert Sehring
CEO Street Address: 800 N.E. Glen Oak Avenue
CEO City and Zip Code: Peoria 61603
CEO Telephone Number: 309-655-2850

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Mark Hohulin
Title: Senior Vice President, Healthcare Analytics
Company Name: OSF Healthcare System
Address: 800 N.E. Glen Oak Avenue Peoria, IL 61603
Telephone Number: 309-308-9656
E-mail Address: mark.e.hohulin@osfhealthcare.org
Fax Number: 309-308-0530

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

Name: Michael Henderson
Title: Corporate Counsel
Company Name: OSF Healthcare System
Address: 800 N.E. Glen Oak Avenue Peoria, IL 61603
Telephone Number: 309-655-2590
E-mail Address: michael.b.henderson@osfhealthcare.org
Fax Number: 309-655-4847

Post Exemption 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: Mark Hohulin
Title: Senior Vice President, Healthcare Analytics
Company Name: OSF Healthcare System
Address: 800 N.E. Glen Oak Avenue Peoria, IL 61603
Telephone Number: 309-308-9656
E-mail Address: mark.e.hohulin@osfhealthcare.org
Fax Number: 309-308-0530

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: OSF Healthcare System
Address of Site Owner: 800 N.E. Glen Oak Avenue Peoria, IL 61603
Street Address or Legal Description of the Site: 1 Saint Anthony's Way, Alton, IL 62002 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: OSF Healthcare System d/b/a OSF Saint Anthony's Health Center
Address: 800 N.E. Glen Oak Avenue Peoria, IL 61603

☒ 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

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

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

Flood Plain Requirements – Not Applicable, No Construction

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 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 #2006-5 (**http:// www.illinois.gov/sites/hfsrb**).

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:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

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

OSF Saint Anthony's Health Center proposes to discontinue the twenty (20) bed Obstetric Unit. OSF Saint Anthony's Health Center will undertake an analysis of the space vacated by this discontinuation to determine the most appropriate use for the benefit of the communities served by the hospital.

Upon closure of the Obstetric Unit Beds, OSF Saint Anthony's Health Center will continue to provide gynecological surgical procedures, lactation consultation, and overall women's health, including 3D mammography, bone density, and wellness screenings.

The ability to provide continued obstetrical services is being impacted by clinical and operational challenges. Based upon these circumstances, OB services at OSF Saint Anthony's Health Center will not be available beyond September 7, 2018.

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 be equal. **Not applicable. There are no project costs.**

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 ☐ 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 $ 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): on or before December 31, 2018.

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): **Not applicable. There are no project costs.**

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☐ Financial Commitment 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 [Section 1130.620(c)]

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.

CERTIFICATION

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

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

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

Robert Sehring
SIGNATURE

Robert Sehring
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of August 2018

Tonda L. Stewart
Signature of Notary

Seal

OFFICIAL SEAL
TONDA L. STEWART
Notary Public - State of Illinois
My Commission Expires 8/26/2020

Roxanna Crosser
SIGNATURE

Roxanna Crosser
PRINTED NAME

CEO, Western Region
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of August 2018

Tonda L. Stewart
Signature of Notary

Seal

OFFICIAL SEAL
TONDA L. STEWART
Notary Public - State of Illinois
My Commission Expires 8/26/2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of OSF Saint Anthony's Health 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 on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

Roxanna Crosser
SIGNATURE

Roxanna Crosser
PRINTED NAME

CEO, Western Region
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of August 2018

Tonda L. Stewart
Signature of Notary

Seal

OFFICIAL SEAL
TONDA L. STEWART
Notary Public - State of Illinois
My Commission Expires 8/26/2020

SIGNATURE

Ajay Pathak
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of August 2018

Tonda L. Stewart
Signature of Notary

Seal

OFFICIAL SEAL
TONDA L. STEWART
Notary Public - State of Illinois
My Commission Expires 8/26/2020

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency.
NOTE: If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

☐ Discontinuation of an Existing Health Care Facility

☒ Discontinuation of a category of service

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 are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service 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, provide 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 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will 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.

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

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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

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

3. How the discontinuation of a 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:

4. 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.

5. 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.

6. 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)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20has].

7. 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.

8. 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.

9. 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 41.

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

APPEND DOCUMENTATION AS ATTACHMENT 21, 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 included attachments:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	14-15
2	Site Ownership	16-17
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.	18
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	19-22
11	Background of the Applicant	
12	Purpose of the Project	
+13	Alternatives to the Project	
	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
18	Financial Viability	
19	Economic Feasibility	
20	Safety Net Impact Statement	23-24
21	Charity Care Information	25

SEE ATTACHED CERTIFICATE OF GOOD STANDING FOR OSF HEALTHCARE SYSTEM

ATTACHMENT 1

File Number 0107-414-8

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

OSF HEALTHCARE SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 02, 1880, 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* 25TH *day of* JUNE *A.D.* 2018 .

Authentication #: 1817601890 verifiable until 06/25/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

PROOF OF SITE OWNERSHIP – SEE ATTCHED

ATTACHMENT 2

I, Robert Sehring, do hereby attest the site of the OSF Saint Anthony's Health Center, which is located at 1 Saint Anthony's Way in Alton, Illinois is owned by OSF Healthcare System.

Robert Sehring, CEO
OSF Healthcare System

Subscribed and sworn to before me this
30th day of August, 2018

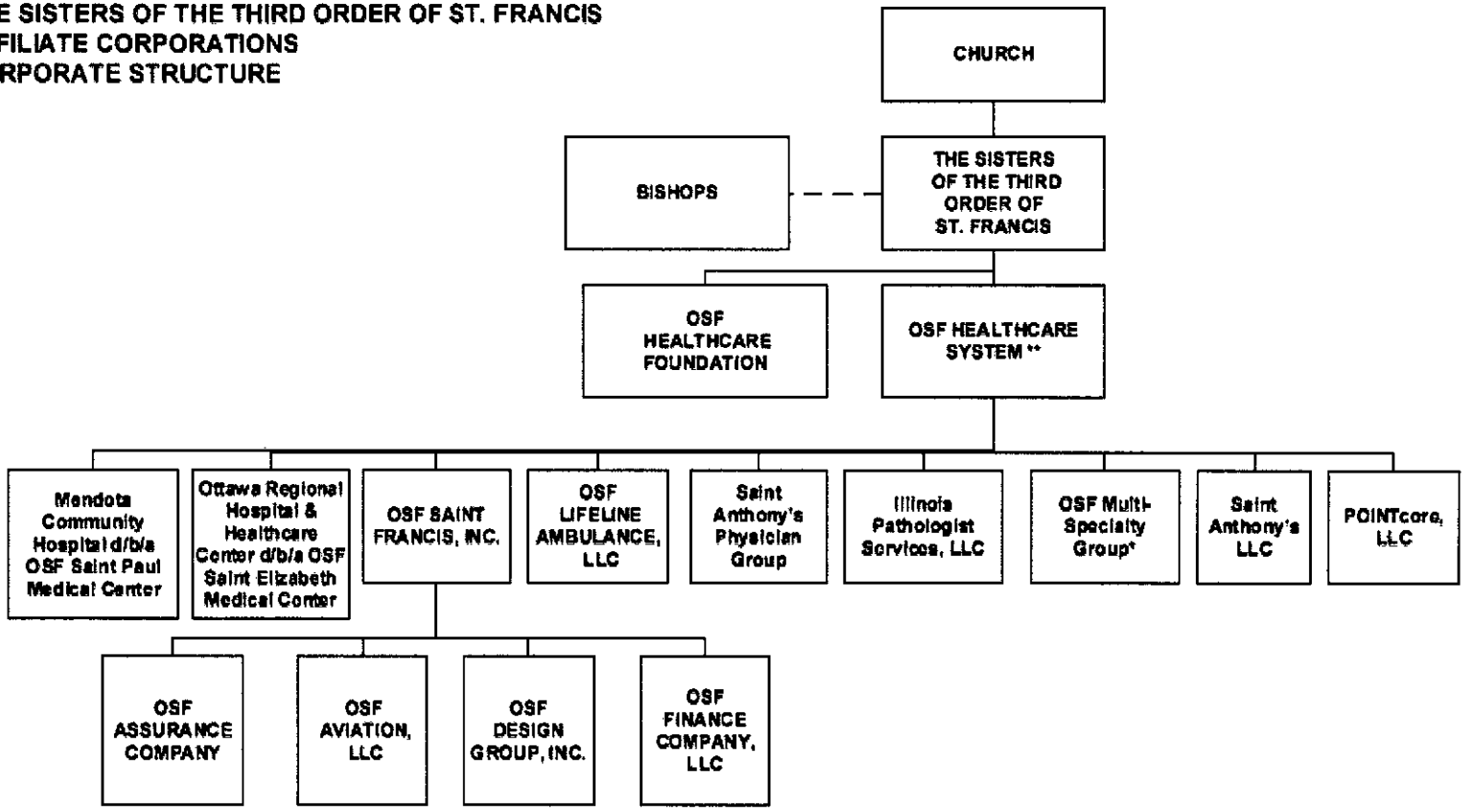
Notary Public

<seal>

OFFICIAL SEAL
TONDA L. STEWART
Notary Public - State of Illinois
My Commission Expires 8/26/2020

ATTACHMENT 2

THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS
AFFILIATE CORPORATIONS
CORPORATE STRUCTURE



** OSF Healthcare System

OSF Saint Francis Medical Center - Peoria
OSF Saint Anthony Medical Center – Rockford
OSF St. Joseph Medical Center – Bloomington
OSF Saint James-John W. Albrecht Medical Center - Pontiac
OSF St. Mary Medical Center - Galesburg
OSF Holy Family Medical Center - Monmouth
OSF St. Francis Hospital – Escanaba, Michigan
OSF Saint Luke Medical Center - Kewanee
OSF Saint Anthony's Health Center - Alton
OSF Heart of Mary Medical Center - Urbana
OSF Sacred Heart Medical Center - Danville
OSF Home Care Services

*OSF Multi-Specialty Group

OSF Medical Group
Cardiovascular Services
Neuroscience Services
Children's Services
Ambulatory Services

Legend:

——— Direct Responsibility

- — — — Advisory

DISCONTINUATION

GENERAL INFORMATION REQUIREMENTS

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

   OSF Saint Anthony's Health Center proposes to discontinue the twenty (20) bed Obstetric Unit.

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 ability to provide continued obstetrical services is being impacted by clinical and operational challenges. Based upon these circumstances, OB services at OSF Saint Anthony's Health Center will not be available beyond September 7, 2018.

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

   OSF Saint Anthony's Health Center will undertake an analysis of the space vacated by this discontinuation to determine the most appropriate use for the benefit of the communities served by the hospital. Upon closure of the Obstetric Unit Beds, OSF Saint Anthony's Health Center will continue to provide gynecological surgical procedures, lactation consultation, and overall women's health, including 3D mammography, bone density, and wellness screenings.

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 OSF Saint Anthony's Health Center 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, provide 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 90 days following the date of discontinuation. .

   Not applicable.

7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.

   Not applicable.

DISCONTINUATION CONTINUED

8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

   OSF Saint Anthony's Health Center distributed a classified ad to the Alton Telegraph on August 17-19 2018. A copy of the notice is provided in Attachment 10.

REASONS FOR DISCONTINUATION

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

OSF Saint Anthony's Health Center has provided quality Obstetric care services to the community and its patients for over 30 years. However, utilization of those services has declined over the past several years to the point that it no longer appears the services are necessary for a separate Obstetric Unit, and are being provided elsewhere in the community. Given the decline in census it has been increasingly difficult to retain and recruit Obstetric staff for the unit.

The Obstetric unit has had relatively low and declining average daily census (ADC) and occupancy for the last several years. The last five years, the Obstetric Unit has seen an ADC and occupancy % as follows:

2013: ADC 2.6 , Occ% 12.9 %
2014: ADC 2.5 , Occ% 12.3 %
2015: ADC 2.3 , Occ% 11.6 %
2016: ADC 1.9 , Occ% 9.7 %
2017: ADC 1.6 , Occ% 7.9 %

Based on the HFSRB Inventory of Healthcare Facilities and Services and Needs Determinations, there are available 156 Obstetric Beds in the community in Hospital Planning Area F-01 which is estimated 126 excess beds. With the availability of ~~other~~ these Obstetric service providers in the area, it is clear the discontinuation of the Obstetric unit will have no impact on access to Obstetric services within the market.

The discontinuation of the Obstetric Unit at OSF Saint Anthony's Health Center will help reduce the excess beds, which is consistent with the goals of the Health Facilities Services Review Board.

ATTACHMENT 10

Classified Ad

18-0451

OSF Saint Anthony's Health Center (OSF SAHC) in Alton, Illinois intends to discontinue the obstetric licensed bed "category of service" for its twenty (20) bed OB Unit after approval to do so is issued by the Illinois Health Facilities and Services Review Board (IHFSRB). OSF intends to submit the required Certificate of Exemption application to the IHFSRB on or around September 1, 2018 and a copy of it can be found after the application is deemed complete on the IHFSRB website at https://www2.illinois.gov/sites/hfsrb/Projects/Pages/CompApps.aspx. For further information, please contact Ajay Pathak at (618)-474-4690 at OSF Saint Anthony's Health Center.

ATTACHMENT 10

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will 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 are available Obstetric Beds in Madison County and HSA 11. Furthermore, more detailed data in the inventory indicates that OSF Saint Anthony's Health Center's Obstetric unit accounted for only 4.7% of the total patient days in 2015 among Obstetric providers in the Hospital Planning Area F-01.

   From that information and data, it is apparent that sufficient Obstetric services are available in the OSF Saint Anthony's Health Center market area and that the discontinuation of the Obstetric Beds will not materially or adversely affect the ability of the residents of Alton, Illinois or broader Madison county area to obtain Obstetric 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. See Appendices 1-8.

   Impact statement requests were sent to facilities, with obstetric beds, within a 45 minute travel time from OSF Saint Anthony's Health Center, on August 17, 2018 (see Appendices). We will send the signed, return receipts and returned impact letters once they are made available.

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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

   OSF Saint Anthony's Health Center believes that the availability of Obstetric beds in Alton Illinois, the Madison County Planning Area, and Health Service Area 11 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 OSF Saint Anthony's Health Center served a relatively small number of Obstetric inpatients in Alton, Illinois and the Madison County Planning Area for the past several years, OSF Saint Anthony's Health Center 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 the applicant.

   We believe given the excess of beds in the area, other providers of Inpatient Obstetric services will be positively impacted, as the services will be more effectively utilized.

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 20 indicates the amount of charity care provided by OSF Saint Anthony's Health Center relating to Obstetrics that is the subject of this discontinuation project. Charity care information pertaining to OSF Saint Anthony's Health Center and OSF Healthcare System as a whole are included in Attachment 21.

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 safety net chart below. Note that the chart in this Attachment 20 indicates the amount of Medicaid care provided by OSF Saint Anthony's Health Center relating to Obstetrics 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.

   OSF Saint Anthony's Health Center believes that the available supply of Obstetric Beds in Alton, Illinois, the Madison County Planning Area, and the Health Service Area 11 are sufficient to ensure that residents of these areas will continue to have access to these services.

ATTACHMENT 20

Obstetrics

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**FY15***	**FY16**	**FY17**
Inpatient	2	2	1
Outpatient	-	1	-
Total	2	3	1
Charity (cost in dollars)			
Inpatient	7,556	19,779	11,212
Outpatient	-	2,396	-
Total	7,556	22,175	11,212
MEDICAID			
Medicaid (# of patients)	**FY15**	**FY16**	**FY17**
Inpatient	210	167	171
Outpatient	20	10	9
Total	230	177	180
Medicaid (revenue)			
Inpatient	371,623	775,829	930,466
Outpatient	7,873	15,897	21,357
Total	379,496	791,727	951,823

* Not part of OSF Healthcare System in FY15
FY15 is based on EMR & calculations prior to joining OSF. Does not include Medicaid Assessment or other add-on payments.

ATTACHMENT 20

Charity Care

OSF SAINT ANTHONY'S HEALTH CENTER CHARITY CARE			
	2015	2016	2017
Net Patient Revenue	71,846,989	72,856,853	75,954,537
Amount of Charity Care (charges)	9,045,839	5,302,094	5,725,917
Cost of Charity Care	2,045,264	1,161,505	1,198,253

OSF HEALTHCARE SYSTEM CHARITY CARE			
	2015	2016	2017
Net Patient Revenue	1,917,020,581	1,970,497,456	2,057,383,657
Amount of Charity Care (charges)	123,694,713	121,815,596	123,255,304
Cost of Charity Care	24,351,000	25,170,596	26,127,456

ATTACHMENT 21

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Anderson Hospital
Attention: Keith Page, President/CEO
6800 State Route 162
Maryville, IL 62062

Dear Mr. Page:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

OSF HealthCare Saint Anthony's Health Center | 1 Saint Anthony's Way, Alton, IL 62002 | (618) 474-4690

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:

Anderson Hospital
Attention: Keith Page, President/CEO
6800 State Route 162
Maryville, IL 62062

9590 9402 3331 7227 0009 56

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5697

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

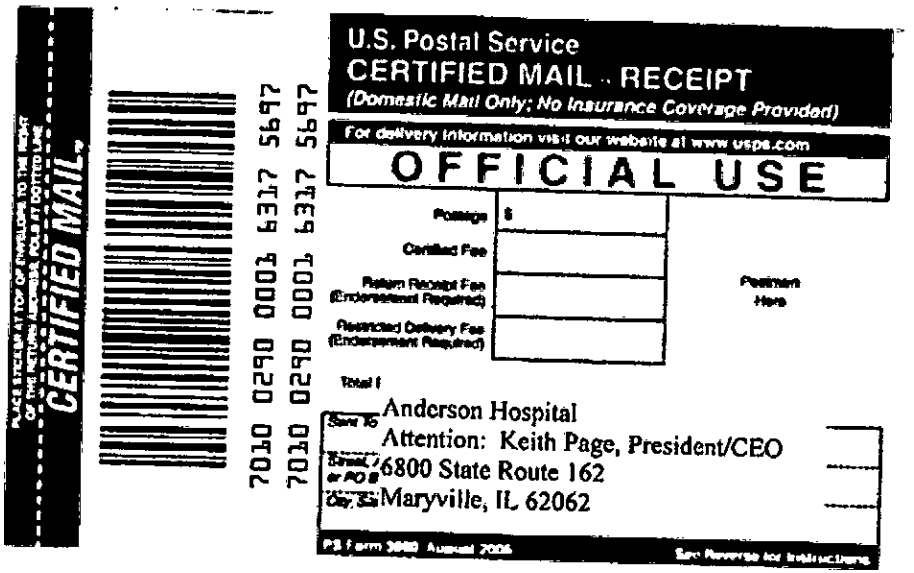
COMPLETE THIS SECTION ON DELIVERY

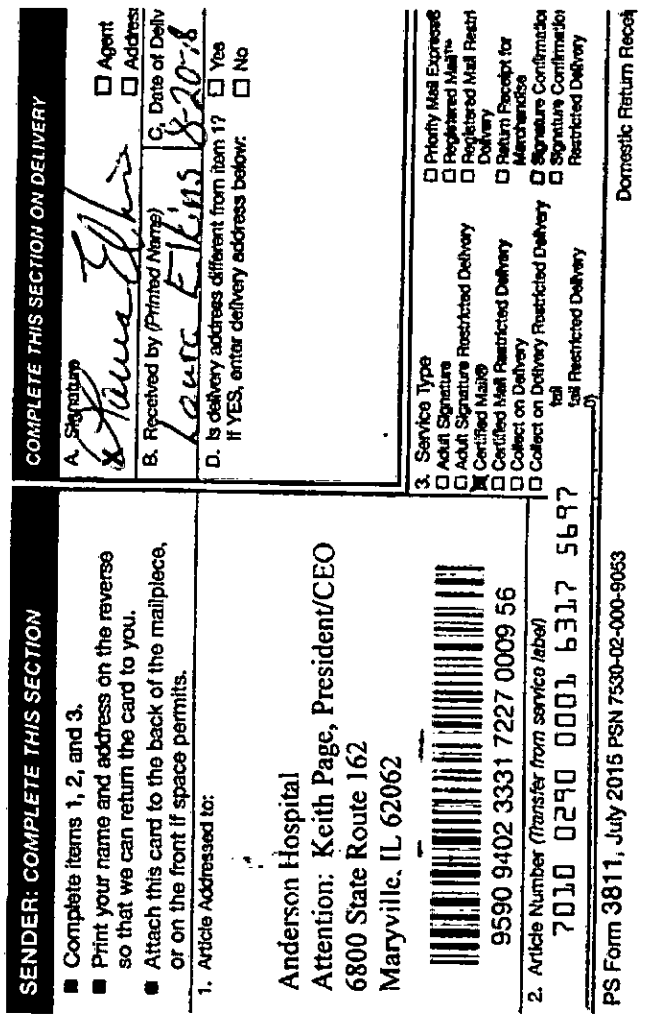
A. Signature
X ☐ Agent ☐ Addressee

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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery





OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

BJC Alton Memorial Hospital
Attention: David Braasch, President
One Memorial Drive
Alton, IL 62002

Dear Mr. Braasch:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

OSF HealthCare Saint Anthony's Health Center | 1 Saint Anthony's Way, Alton, IL 62002 | (618) 474-4690

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:

BJC Alton Memorial Hospital
Attention: David Braasch, President
One Memorial Drive
Alton, IL 62002

9590 9402 3331 7227 0009 63

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5703

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery
Mail
Mail Restricted Delivery

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

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL

7010 0290 0001 6317 5703

7010 0290 0001 6317 5703

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total P

Postmark Here

Sent To BJC Alton Memorial Hospital
Attention: David Braasch, President
Street, Apt. or PO Box One Memorial Drive
City, State Alton, IL 62002

PS Form 3800, August 2006 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:

BJC Alton Memorial Hospital
Attention: David Braasch, President
One Memorial Drive
Alton, IL 62002

9590 9402 3331 7227 0009 63

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5703

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
Paul J Kelle | 8-20-1

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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery
Mail
Mail Restricted Delivery

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

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

BJC Memorial Hospital Belleville
Attention: Mark Turner, President/CEO
4500 Memorial Drive
Belleville, IL 62226

Dear Mr. Turner:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

OSF HealthCare Saint Anthony's Health Center | 1 Saint Anthony's Way, Alton, IL 62002 | (618) 474-4690

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

CERTIFIED MAIL.

7010 0290 0001 6317 5673

7010 0290 0001 6317 5673

U.S. Postal Service
CERTIFIED MAIL.. RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total P
Postmark Here

Sent To BJC Memorial Hospital Belleville
Attention: Mark Turner, President/CEO
Street, Apt. No.; or PO Box No. 4500 Memorial Drive
City, State, ZIP+4 Belleville, IL 62226

PS Form 3800, August 2006 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:

BJC Memorial Hospital Belleville
Attention: Mark Turner, President/CEO
4500 Memorial Drive
Belleville, IL 62226

9590 9402 3331 7227 0009 32

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5673

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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 ☐ Priority Mail Express®
☐ Adult Signature Restricted Delivery ☐ Registered Mail™
☐ Certified Mail® ☐ Registered Mail Restricted Delivery
☐ Certified Mail Restricted Delivery ☐ Return Receipt for Merchandise
☐ Collect on Delivery ☐ Signature Confirmation™
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmation Restricted Delivery
☐ Restricted Delivery

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:

BJC Memorial Hospital Belleville
Attention: Mark Turner, President/CEO
4500 Memorial Drive
Belleville, IL 62226

9590 9402 3331 7227 0009 32

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5673

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

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

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

3. Service Type
☐ Adult Signature ☐ Priority Mail Express®
☐ Adult Signature Restricted Delivery ☐ Registered Mail™
☐ Certified Mail® ☐ Registered Mail Restri Delivery
☐ Certified Mail Restricted Delivery ☐ Return Receipt for Merchandise
☐ Collect on Delivery ☐ Signature Confirmatio
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmatio Restricted Delivery
☐ Restricted Delivery

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

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

BJC Memorial Hospital East
Attention: Mark Turner, President/CEO
1404 Cross Street
Shiloh, IL 62269

Dear Mr. Turner:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

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:

BJC Memorial Hospital East
Attention: Mark Turner, President/CEO
1404 Cross Street
Shiloh, IL 62269

9590 9402 3331 7227 0009 25

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5666

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ 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

7010 0290 0001 6317 5666
7010 0290 0001 6317 5666

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Postmark Here
Total Pr

Sent To BJC Memorial Hospital East
Attention: Mark Turner, President/CEO
Street, Ap or PO Box 1404 Cross Street
City, State Shiloh, IL 62269

PS Form 3800 August 2006 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:

BJC Memorial Hospital East
Attention: Mark Turner, President/CEO
1404 Cross Street
Shiloh, IL 62269

9590 9402 3331 7227 0009 25

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5666

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Gateway Regional Medical Center
Attention: Ed Cunningham, CEO
2100 Madison Avenue
Granite City, IL 62040

Dear Mr. Cunningham:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

OSF HealthCare Saint Anthony's Health Center | 1 Saint Anthony's Way, Alton, IL 62002 | (618) 474-4690

Appendices 5

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:

Gateway Regional Medical Center
Attention: Ed Cunningham, CEO
2100 Madison Avenue
Granite City, IL 62040

9590 9402 3331 7227 0009 49

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5680

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

7010 0290 0001 6317 5680
7010 0290 0001 6317 5680

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com.
OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Postmark Here
Total P

Sent To Gateway Regional Medical Center
Attention: Ed Cunningham, CEO
Street, Apt. or PO Box 2100 Madison Avenue
City, State Granite City, IL 62040

PS Form 3800, August 2006 — 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:

Gateway Regional Medical Center
Attention: Ed Cunningham, CEO
2100 Madison Avenue
Granite City, IL 62040

9590 9402 3331 7227 0009 49

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5680

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

HSHS St. Elizabeth's Hospital
Patti Fischer, President/CEO
1 St. Elizabeth's Boulevard
O'Fallon, IL 62269

Dear Ms. Fischer:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

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:

HSHS St. Elizabeth's Hospital
Patti Fischer, President/CEO
1 St. Elizabeth's Boulevard
O'Fallon, IL 62269

9590 9402 3331 7227 0009 01

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5659

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ 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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

CERTIFIED MAIL

7010 0290 0001 6317 5659
7010 0290 0001 6317 5659

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com.
OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Postmark Here
Total
Sent To HSHS St. Elizabeth's Hospital
Patti Fischer, President/CEO
1 St. Elizabeth's Boulevard
O'Fallon, IL 62269

PS Form 3800, August 2006 — 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:

HSHS St. Elizabeth's Hospital
Patti Fischer, President/CEO
1 St. Elizabeth's Boulevard
O'Fallon, IL 62269

9590 9402 3331 7227 0009 01

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5659

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Address

B. Received by (Printed Name) | C. Date of Deliv

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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restri Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmatio
☐ Signature Confirmatio Restricted Delivery

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

HSHS St. Joseph's Hospital Breese
Attention: Chris Klay, President/CEO
9515 Holy Cross Lane
Breese, IL 62230

Dear Mr. Klay:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:
OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

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:

HSHS St. Joseph's Hospital Breese
Attention: Chris Klay, President/CEO
9515 Holy Cross Lane
Breese, IL 62230

9590 9402 3331 7227 0028 44

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5642

COMPLETE THIS SECTION ON DELIVERY

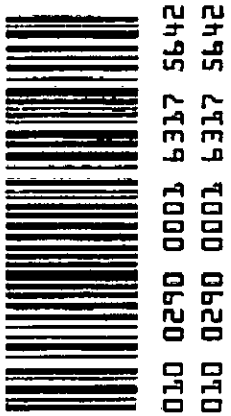
A. Signature
X ☐ Agent ☐ Addressee

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
☐ 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; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Total
Postmark Here

Sent To HSHS St. Joseph's Hospital Breese
Attention: Chris Klay, President/CEO
Street and Apt. No. 9515 Holy Cross Lane
City, State Breese, IL 62230

PS Form 3800, August 2006 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:

HSHS St. Joseph's Hospital Breese
Attention: Chris Klay, President/CEO
9515 Holy Cross Lane
Breese, IL 62230

9590 9402 3331 7227 0028 44

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5642

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
8-20-1

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
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation
☐ Signature Confirmation Restricted Delivery

OSF HEALTHCARE

August 16, 2018

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Touchette Regional Hospital
Attention: Larry McCulley, CEO
5900 Bond Avenue
Centreville, IL 62207

Dear Mr. McCulley:

Per Section 1110.110 of Title 77 of the Illinois Administrative Code, we are sending this impact letter to inform you that OSF Saint Anthony's Health Center plans to file a Certificate of Exemption (COE) with the Illinois Health Facilities and Review Board (IHFSRB) for discontinuation of our 20-bed obstetric category of service. OSF intends to submit the required COE application to the IHFSRB on or around September 1, 2018. The discontinuation will occur after the approval is granted by the IHFSRB.

For your reference, OSF Saint Anthony's Health Center reported the following admissions on the IDPH Annual Hospital Questionnaire:

	2015	2016	2017
Obstetric	339	318	255

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

- Capacity to accommodate a portion or all of OSF Saint Anthony's Health Center's obstetric caseload.
- Explanation of any restrictions or limitations precluding providing obstetric services to the residents of OSF Saint Anthony's Health Center's market area.

If a response is not received within 15 days from the date of delivery, the Health Center will assume that the discontinuation of obstetric beds will not have an adverse impact on your organization.

Please direct your response to the following:

OSF Saint Anthony's Health Center
Ajay Pathak, President
1 Saint Anthony's Way
Alton, IL 62002

I greatly appreciate your assistance regarding this requirement and the continuation of Obstetric services in our area. If you have any questions, please direct them to my attention at 618-474-4690 or email ajay.pathak@osfhealthcare.org.

Sincerely,

Ajay Pathak, President

OSF HealthCare Saint Anthony's Health Center | 1 Saint Anthony's Way, Alton, IL 62002 | (618) 474-4690

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:

Touchette Regional Hospital
Attention: Larry McCulley, CEO
5900 Bond Avenue
Centreville, IL 62207

9590 9402 3331 7227 0028 37

2. Article Number (Transfer from service label)
7010 0290 0001 6317 5635

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ 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
☐ Restricted Delivery
☐ 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

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE
CERTIFIED MAIL™

7010 0290 0001 6317 5635
7010 0290 0001 6317 5635

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)
Postmark Here

Total P

Sent To Touchette Regional Hospital
Attention: Larry McCulley, CEO
Street, Apt. or PO Box 5900 Bond Avenue
City, State Centreville, IL 62207

PS Form 3800 August 2006 See Reverse for Instructions

OSF
HEALTHCARE SYSTEM

E-047-18

original

August 30, 2018

Ms. Courtney Avery, Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

RE: OSF Saint Anthony's Health Center, Alton
Discontinuation of Obstetric Category of Service

Dear Ms. Avery:

Enclosed is a certificate of exemption for discontinuation of obstetric category of service for OSF Saint Anthony's Health Center. Also enclosed is the application filing fee.

We submit this application with our respectful request that it be expedited and heard at the October meeting of the IHFSRB. The ability to provide continued obstetrical services is being impacted by clinical and operational challenges. Based upon these circumstances, OB services at OSF Saint Anthony's Health Center will not be available beyond September 7, 2018.

If you have any questions, please contact me at 309-308-9656 or mark.e.hohulin@osfhealthcare.org.

Sincerely,

Mark Hohulin

Mark E. Hohulin, Senior Vice President
OSF Healthcare System

c: Mike Constantino
Ajay Pathak