

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT

FEB 22 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION IN FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

ORIGINAL

Facility/Project Identification

Facility Name:	Pekin Hospital / Long Term Care Category of Service Discontinuation				
Street Address:	600 South 13 th Street				
City and Zip Code:	Pekin 61554				
County:	Tazewell	Health Service Area	2	Health Planning Area:	C-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Progressive Health System (Applicant)				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Name of Registered Agent:	Kevin R. Andrews, FACHE				
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE				
CEO Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0756				

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name:	Kevin R. Andrews, FACHE				
Title:	Chief Executive Officer				
Company Name:	Pekin Memorial Hospital				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0700				
E-mail Address:	kandrews@pekinhospital.com				
Fax Number:	309-353-0908				

Additional Contact

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

Name:	Jo Ellen Patterson, RN MS				
Title:	Vice President, Patient Care Services				
Company Name:	Pekin Memorial Hospital				
Address:	600 South 13 th Street, Pekin, Illinois 61554				
Telephone Number:	309-353-0728				
E-mail Address:	jpatterson@pekinhospital.com				
Fax Number:	309-353-0930				

Additional Contact

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

Name:	Edwin W. Parkhurst, Jr.
Title:	Managing Principal
Company Name:	PRISM Healthcare Consulting
Address:	800 Roosevelt Road, Building E, Suite 110, Glen Ellyn, Illinois 60137
Telephone Number:	630-790-5089
E-mail Address:	eparkhurst@consultprism.com
Fax Number:	630-790-2696

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

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Facility Name:	Pekin Hospital / Long Term Care Category of Service Discontinuation				
Street Address:	600 South 13 th Street				
City and Zip Code:	Pekin 61554				
County:	Tazewell	Health Service Area	2	Health Planning Area:	C-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Pekin Memorial Hospital DBA Pekin Hospital (Co-Applicant)				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Name of Registered Agent:	Kevin R. Andrews, FACHE				
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE				
CEO Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0700				

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership		
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o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

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Fax Number:	630-790-2696

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:	Jo Ellen Patterson, RN MS
Title:	Vice President, Patient Care Services
Company Name:	Pekin Memorial Hospital
Address:	600 South 13 th Street, Pekin, Illinois 61554
Telephone Number:	309-353-0728
E-mail Address:	jpatterson@pekinhospital.com
Fax Number:	309-353-0930

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Pekin Memorial Hospital
Address of Site Owner:	600 South 13 th Street, Pekin, Illinois 61554
Street Address or Legal Description of Site:	600 South 13 th Street Pekin, Illinois 61554
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:	Pekin Memorial Hospital		
Address:	600 South 13 th Street Pekin, Illinois 61554		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
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<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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



State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

CRAIG CLINEVER, M.D.
ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CG660	CG01C34

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 19TH STREET
PEKIN IL 61554

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/87 •

← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PEKIN MEMORIAL HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CG660	CG01C34

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/05/11
PEKIN MEMORIAL HOSPITAL
600 SOUTH 19TH STREET
PEKIN IL 61554

FEE RECEIPT NO.

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State of Illinois
Department of Public Health

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CRAIG CONOVER, M.D.
ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CGED	0001034

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 19TH STREET
PEKIN IL 61554

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← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
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State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PEKIN MEMORIAL HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CGED	0001034

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/01/11

PEKIN MEMORIAL HOSPITAL
600 SOUTH 19TH STREET

PEKIN IL 61554

FEE RECEIPT NO.

Flood Plain Requirements Not Applicable. No construction is involved.

[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)]

<p>Part 1110 Classification:</p> <p><input checked="" type="checkbox"/> Substantive</p> <p><input type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input checked="" type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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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.

Progressive Health Systems ("Applicant") and Pekin Memorial Hospital ("Co-Applicant") doing business as Pekin Hospital (DBA), located at 600 South 13th Street, Pekin, Illinois 61554, proposes to discontinue its CON approved 27-bed long term care (LTC) category of service thereby reducing its post-discontinuation bed capacity to 98 beds as shown in the following chart.

<u>Bed Category</u>	<u>Current</u>	<u>Proposed</u>
Medical / Surgical	68	68
Pediatric	10	10
Intensive Care	8	8
OB/Gyn	12	12
Long Term Care	<u>27</u>	<u>0</u>
Total	<u>125</u>	<u>98</u>

After discontinuation, the applicants propose to reconfigure their current mix of private and semi-private rooms to provide more private medical / surgical patient rooms in order to increase patient privacy, better manage infectious disease cases, enhance safety, and improve patient care quality. There will be no vacant patient-room space post-discontinuation as the current LTC bed rooms will be used for medical / surgical patients when the patient care units are reconfigured to provide additional private rooms and private beds.

Over 50 impact letters were sent to nursing home facilities within a 45-minute normal drive time from the Hospital site location, 38 of which have licensed nursing care beds; 14 response letters were received and there were a total of 186 to 196 available LTC beds identified to accommodate the current (2011) average daily LTC census of 8.8 patients; four (4) of the 14 respondents identified the ability to accept 53 to 60 LTC patients without conditions per State Agency rules. Hence, there is no identified impact on access for LTC patients within the defined market area.

There is no cost to the proposed long term care category of service discontinuation.

According to Public Act 095-0031, this is a substantive project in that it proposes to discontinue a designated category of service.

Support Letter



January 23, 2012

Illinois Health Facilities and Services Review Board

To Whom It May Concern:

I am writing this letter in support of Pekin Hospital's decision to discontinue their Skilled Nursing Facility located on the sixth floor of the hospital in order to increase the number of private rooms for acute care patients. As a Hospitalist I have seen the declining usage of the Skilled Nursing Facility for both inpatients from the acute care side of the hospital and for patients being transferred from other acute care hospitals.

The opportunity for Pekin Hospital to increase their private rooms will make it easier to admit patients with infectious conditions that require isolation. My patients prefer being in a private room when they are hospitalized for a variety of reasons, including being able to rest better without having to deal with a roommate's visitor.

Thank you for your support of this decision.

Sincerely,

A handwritten signature in black ink that reads 'Ahsan Usman'.

Ahsan Usman, MD

UNRECORDED
PEKIN HOSPITAL
JAN 23 2012

Project Costs and Sources of Funds

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

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

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

Related Project Costs

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

Land acquisition is related to project Yes No
 Purchase Price: \$ _____
 Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service
 Yes No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

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): Within 45 days of IHFSRB approval which is anticipated to be June 5, 2012; approximate closing date is July 20, 2012 pending notification to all regulatory agencies.

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not applicable. There is no project cost.**

- 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 **(There are no 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							
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: Pekin Memorial Hospital		CITY: Pekin, Illinois			
REPORTING PERIOD DATES: From: January 1, 2010 to: December 31, 2010					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	68	2,750	13,176 *	--	68
Obstetrics	12	486	1,077 **	--	12
Pediatrics	10	202	732 ***	--	10
Intensive Care	8	355	1,325 ****	--	8
Comprehensive Physical Rehabilitation	0				0
Acute/Chronic Mental Illness	0				0
Neonatal Intensive Care	0				0
General Long Term Care	27	426	3,770	--	27
Specialized Long Term Care	0				0
Long Term Acute Care	0				0
Other ((identify))	0				0
TOTALS:	125	4,219	20,080	--	125

- * Includes 1,198 observation days in M/S beds
- ** Includes 65 observation days in OB/Gyn beds
- *** Includes 236 observation days in Pediatric beds
- **** Includes 55 observation days in ICU beds

Note: ICU admissions exclude internal transfers; patient days include 1,554 observation days

Facility Bed Capacity and Utilization (Estimated for 2011)

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: Pekin Memorial Hospital		CITY: Pekin, Illinois			
REPORTING PERIOD DATES: From: January 1, 2011 to: December 31, 2011					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	68	2,477	10,931	--	68
Obstetrics	12	525	1,131	--	12
Pediatrics	10	170	408	--	10
Intensive Care	8	356	1,218	--	8
Comprehensive Physical Rehabilitation	0				0
Acute/Chronic Mental Illness	0				0
Neonatal Intensive Care	0				0
General Long Term Care	27	371	3,220	--	27
Specialized Long Term Care	0				0
Long Term Acute Care	0				0
Other ((Identify))	0				0
TOTALS:	125	4,219	16,908	--	125

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 manger 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 Progressive Health Systems * 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.

A. Richard Kriegsman
SIGNATURE

A. Richard Kriegsman
PRINTED NAME

Chair, Board of Trustees
PRINTED TITLE

Kevin R. Andrews
SIGNATURE

Kevin R Andrews, FACHE
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

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

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

Cheryl Landry
Signature of Notary

Cheryl Landry
Signature of Notary



Insert EX-107 legal name of the applicant

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A. Richard Kriegsman
SIGNATURE

A. Richard Kriegsman
PRINTED NAME

Chair, Board of Trustees
PRINTED TITLE

Kevin R. Andrews
SIGNATURE

Kevin R Andrews, FACHE
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of February

Cheryl Landry
Signature of Notary

Seal OFFICIAL SEAL
CHERYL LANDRY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/26/15
Insert EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 16th day of February

Cheryl Landry
Signature of Notary

Seal OFFICIAL SEAL
CHERYL LANDRY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/26/15

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

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

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

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-44, 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/Co-applicant Identification including Certificate of Good Standing	25 – 27
2	Site Ownership	28 – 31
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	32 – 39
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	40 – 41
5	Flood Plain Requirements	42
6	Historic Preservation Act Requirements	43
7	Project and Sources of Funds Itemization	44
8	Obligation Document if required	45
9	Cost Space Requirements	46
10	Discontinuation	47 – 187
11	Background of the Applicant	NA
12	Purpose of the Project	NA
13	Alternatives to the Project	NA
14	Size of the Project	NA
15	Project Service Utilization	NA
16	Unfinished or Shell Space	NA
17	Assurances for Unfinished/Shell Space	NA
18	Master Design Project	NA
19	Mergers, Consolidations and Acquisitions	NA
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	NA
21	Comprehensive Physical Rehabilitation	NA
22	Acute Mental Illness	NA
23	Neonatal Intensive Care	NA
24	Open Heart Surgery	NA
25	Cardiac Catheterization	NA
26	In-Center Hemodialysis	NA
27	Non-Hospital Based Ambulatory Surgery	NA
28	General Long Term Care	NA
29	Specialized Long Term Care	NA
30	Selected Organ Transplantation	NA
31	Kidney Transplantation	NA
32	Subacute Care Hospital Model	NA
33	Post Surgical Recovery Care Center	NA
34	Children's Community-Based Health Care Center	NA
35	Community-Based Residential Rehabilitation Center	NA
36	Long Term Acute Care Hospital	NA
37	Clinical Service Areas Other than Categories of Service	NA
38	Freestanding Emergency Center Medical Services	NA
	Financial and Economic Feasibility:	
39	Availability of Funds	NA
40	Financial Waiver	NA
41	Financial Viability	NA
42	Economic Feasibility	NA
43	Safety Net Impact Statement	188 – 190
44	Charity Care Information	191 – 192

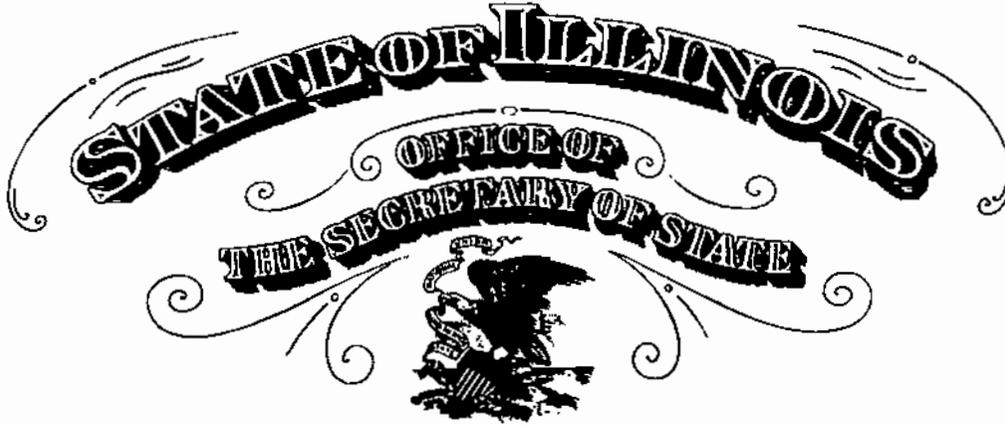
ATTACHMENTS

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Progressive Health Systems (Applicant)
Address:	600 South 13 th Street Pekin, Illinois 61554
Name of Registered Agent:	Kevin R. Andrews, FACHE
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE
CEO Address:	600 South 13 th Street Pekin, Illinois 61554
Telephone Number:	309-353-0756

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Pekin Memorial Hospital DBA Pekin Hospital (Co-Applicant)
Address:	600 South 13 th Street Pekin, Illinois 61554
Name of Registered Agent:	Kevin R. Andrews, FACHE
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE
CEO Address:	600 South 13 th Street Pekin, Illinois 61554
Telephone Number:	309-353-0756



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PROGRESSIVE HEALTH SYSTEMS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 05, 1985, 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.



Authentication #: 1202200166
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PEKIN MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 25, 1913, 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.



Authentication #: 1202200180
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Pekin Memorial Hospital
Address of Site Owner:	600 South 13 th Street, Pekin, Illinois 61554
Street Address or Legal Description of Site:	600 South 13 th Street Pekin, Illinois 61554
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.	

Certificate of Status of Exempt Property
For owners of exempt parcels in Tazewell County

In accordance with Section 15-10 of the Property Tax Code (35 ILCS 200.15/10), this Certification is hereby submitted. As title holder or as the beneficial owner of the rights to the property(s) identified below, it is hereby declared that as of January 1, 2012, there has not been a change in the ownership or use of the property(s) since the initial issuance of the Certification of Exemption by the Illinois Department of Revenue, except as noted.

Owner: PEKIN MEMORIAL HOSPITAL
600 S. 13TH ST.

PEKIN IL 61554-0000

Permanent Parcel #	Street Addresses of Properties	Permanent Parcel #	Street Addresses of Properties
04-10-02-225-015	COURT ST	04-10-02-225-016	
04-10-02-225-017	609 13TH ST	04-10-02-225-018	613 13TH ST
04-10-02-225-020	619 13TH ST	04-10-02-225-022	1225 PARK AVE
04-10-02-225-023	1227 PARK AVE	04-10-02-225-024	1229 PARK AVE
04-10-02-225-025	1231 PARK AVE	04-10-02-226-001	
04-10-02-226-002	616 13TH ST	04-10-02-227-001	COURT ST
04-10-02-227-002	1309 PARK AVE	04-10-02-227-003	PARK AVE
04-10-02-227-004	1314 COURT ST	04-10-02-227-005	S 14TH ST
04-10-02-227-007	13 H ST	04-10-02-229-007	1220 PARK AVE
04-10-02-229-008	1226 PARK AVE	04-10-02-229-016	
04-10-02-233-001	1300 PARK AVE	04-10-02-233-002	1316 PARK AVE
04-10-02-233-004	1320 PARK AVE	04-10-02-233-005	1324 PARK AVE
04-10-02-233-006	1328 PARK AVE	04-10-02-233-007	1332 PARK AVE
04-10-02-233-008	1336 PARK AVE		

Describe change in ownership and property affected (if none, state none)

Date ownership changed: _____
Month/Day/Year

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

Date use changed: _____
Month/Day/Year

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

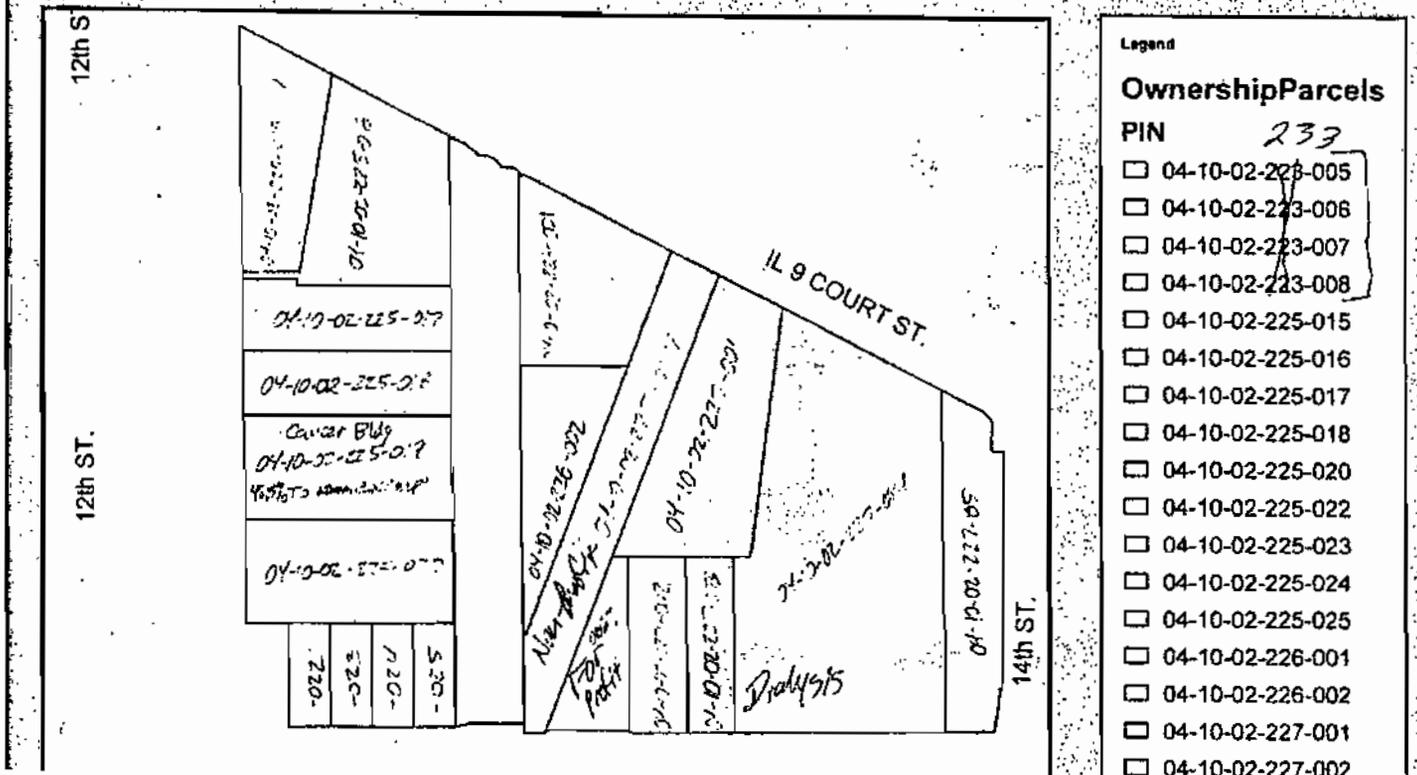
If marked, this office is requesting you to provide a copy of each of your original Certificates of Exemption issued by the Department of Revenue. Attach and return a copy with this document.

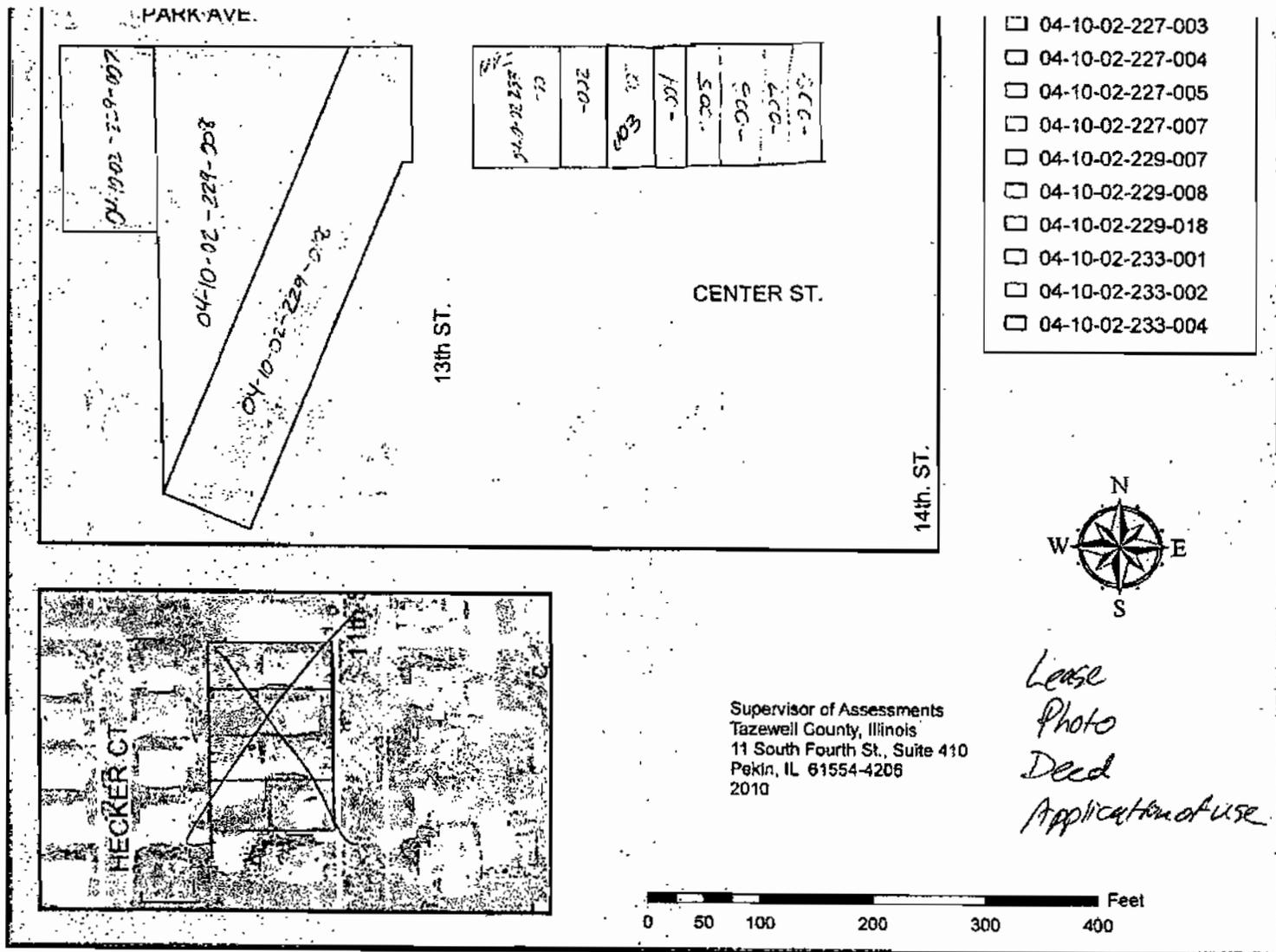
I hereby certify this to be a true and correct reporting of the facts concerning these properties.

Signature: *[Signature]* Title: Controller
Owner or Authorized Representative
309-353-0984 Phone Number
1-3-12 Date

IMPORTANT: This should be completed and returned to the Tazewell County Assessment Office, Room 401, 11 South Fourth Street, Pekin, IL prior to January 31st. Failure to file shall constitute cause to terminate the exemption.

PEKIN MEMORIAL HOSPITAL TAX EXEMPT PROPERTIES





Operating Identity/Licensee

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

Exact Legal Name:	Pekin Memorial Hospital		
Address:	600 South 13 th Street Pekin, Illinois 61554		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

CRAIG CUNOVER, M.D.
ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRES DATE	CATEGORY	ID NUMBER
12/31/12	GGED	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET
PEKIN IL 61554

The face of this license has a colored background. Printed by authority of the State of Illinois - 477 -

← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PEKIN MEMORIAL HOSPITAL

EXPIRES DATE	CATEGORY	ID NUMBER
12/31/12	GGED	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/6/11

PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET

PEKIN IL 61554

FEE RECEIPT NO.

File Number 5380-419-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PROGRESSIVE HEALTH SYSTEMS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 05, 1985, 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.



Authentication #: 1202200166

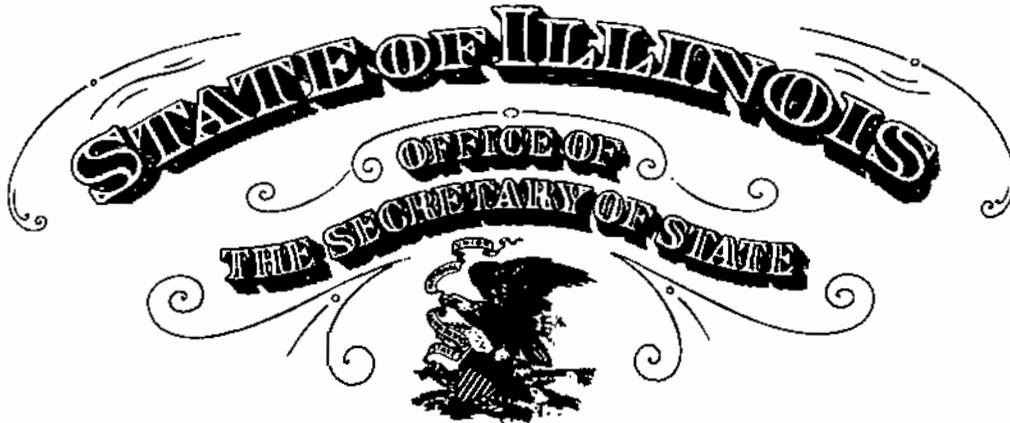
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE

File Number 1250-952-9



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PEKIN MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 25, 1913, 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.



Authentication #: 1202200160

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE



CORPORATION FILE DETAIL REPORT

Entity Name	PROGRESSIVE HEALTH SYSTEMS	File Number	53804195
Status	ACTIVE		
Entity Type	CORPORATION	Type of Corp	NOT-FOR-PROFIT
Incorporation Date (Domestic)	04/05/1965	State	ILLINOIS
Agent Name	KEVIN R ANDREWS	Agent Change Date	05/29/2007
Agent Street Address	600 S 137H ST	President Name & Address	
Agent City	PEKIN	Secretary Name & Address	
Agent Zip	61554	Duration Date	PERPETUAL
Annual Report Filing Date	02/21/2011	For Year	2011
Assumed Name	ACTIVE - PEKIN MEMORIAL HOSPITAL HOME HEALTH		

[Return to the Search Screen](#)

[Purchase Certificate of Good Standing](#)

(One Certificate per Transaction)

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SERVICES PROGRAMS PRESS PUBLICATIONS DEPARTMENTS CONTACT

CORPORATION FILE DETAIL REPORT

Entity Name	PEKIN MEMORIAL HOSPITAL	File Number	12509529
Status	ACTIVE		
Entity Type	CORPORATION	Type of Corp	NOT-FOR-PROFIT
Incorporation Data (Domestic)	06/25/1913	State	ILLINOIS
Agent Name	KEVIN R ANDREWS	Agent Change Date	05/29/2007
Agent Street Address	600 S 13TH ST	President Name & Address	
Agent City	PEKIN	Secretary Name & Address	
Agent Zip	61554	Duration Date	PERPETUAL
Annual Report Filing Date	04/18/2011	For Year	2011
Assumed Name	ACTIVE - PEKIN HOSPITAL #INACTIVE - PEKIN MEMORIAL HOSPITAL HOME HEALTH AGENCY		

[Return to the Search Screen](#)

[Purchase Certificate of Good Standing](#)

(One Certificate per Transaction)

[BACK TO CYBERDRIVEILLINOIS.COM HOME PAGE](http://CYBERDRIVEILLINOIS.COM)

Pekin Memorial Hospital

Pekin, IL

has been Accredited by



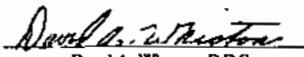
The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

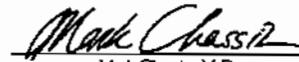
Hospital Accreditation Program

May 5, 2011

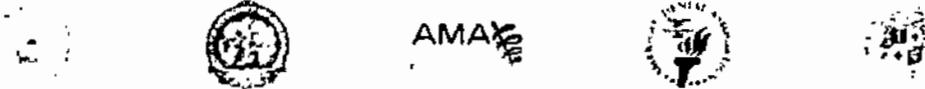
Accreditation is customarily valid for up to 36 months.


David A. Whiston, D.D.S.
Chairman of the Board

Organization ID #: 7407
Print/Reprint Date: 11/17/11


Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Pekin Memorial Hospital
Pekin, IL

has been Accredited by



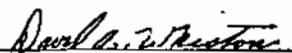
The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

May 7, 2011

Accreditation is customarily valid for up to 36 months.


David A. Whiston, D.D.S.
Chairman of the Board

Organization ID #: 7407
Print/Reprint Date: 11/17/11


Mark Chassin, M.D.
President

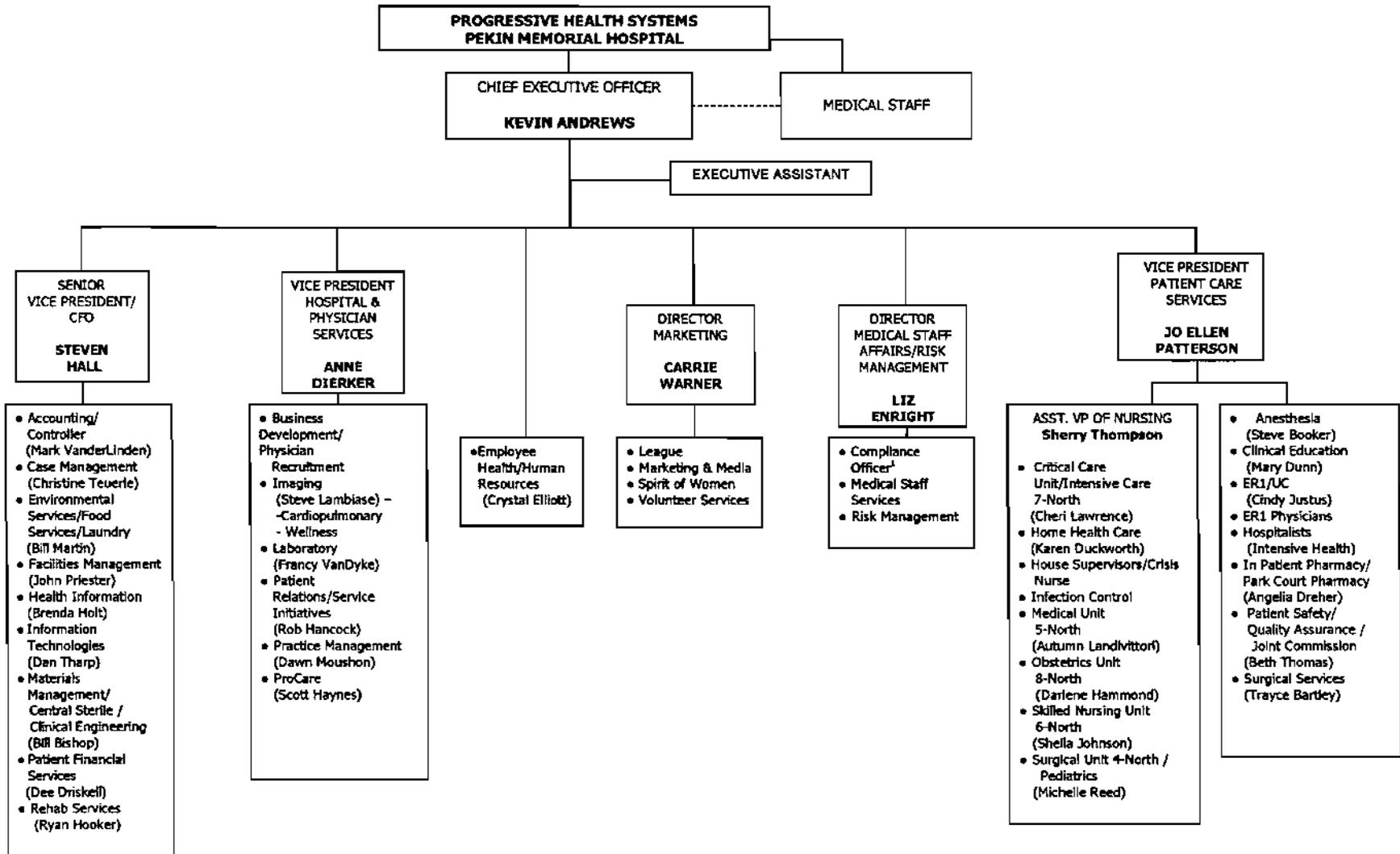
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This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

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.



2-3-2012
Compliance Officer¹

Flood Plain Requirements**Not Applicable. No construction is involved.**

[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>).

Historic Resources Preservation Act Requirements

Not Applicable; this is solely a proposed LTC discontinuation.

[Refer to application instructions.]

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

Project Costs and Sources of Funds

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

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

There is no cost associated with the proposed Long Term Care Category of Service discontinuation.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

- | | |
|--|--|
| <input checked="" type="checkbox"/> None or not applicable | <input type="checkbox"/> Preliminary |
| <input type="checkbox"/> Schematics | <input type="checkbox"/> Final Working |

Anticipated project completion date (refer to Part 1130.140): Within 45 days of IHFSRB approval which is anticipated to be June 5, 2012; approximate closing date is July 20, 2012 pending notification to all regulatory agencies.

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not applicable. There is no project cost.**

- 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.

Cost Space Requirements associated with the LTC bed discontinuation

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	0	22,422	31,046	0	0	31,046	0
LTC	0	8,624	0	0	0	0	0
Diagnostic Radiology							
MRI							
Total Clinical	0	31,046	31,046	0	0	31,046	0
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	0	31,046	31,046	0	0	31,046	0

Note: The vacated LTC unit on 6N will be reassigned to medical / surgical (M/S) beds. The current total Hospital complement of 68 M/S beds will be retained and the current mix of M/S patient rooms will be enhanced by an increase in private room / bed accommodations for M/S patients.

**ILLINOIS HEALTH FACILITIES AND SERVICES
REVIEW BOARD**

**PERMIT APPLICATION
TO
DISCONTINUE THE LONG TERM CARE
CATEGORY OF SERVICE**

Submitted by:

**Progressive Health Systems
And
Pekin Memorial Hospital
(Co-Applicants)
Doing Business as (DBA):**

**Pekin Hospital
600 South 13th Street
Pekin, Illinois 61554**

Dated February 20, 2012



February 20, 2012

Ms. Courtney R. Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Permit Application and Request for Expedited Review
Long Term Care (LTC) Category of Service

Dear Ms. Avery,

Progressive Health Systems ("Applicant") and Pekin Memorial Hospital ("Co-applicant") doing business as Pekin Hospital (DBA) proposes to discontinue its CON approved 27-bed LTC category of service and requests an expedited review of the underlying Permit Application. Barring any unforeseen considerations in the review process, we respectfully request an expedited review of our application and Review Board consideration at the tentatively scheduled April 17th IHFSRB meeting.

Our request for an expedited review is predicated on a decrease in demand for hospital based LTC services and increasing losses from the unit which jeopardizes our financial position and ability to serve acute patients. Over the last 3 years, the LTC unit has incurred operating losses approximating \$5.0 million. The sooner we can discontinue this service while meeting all regulatory compliance requirements, the less money we will lose.

In preparing our Permit Application, we distributed over 50 impact letters and received 14 return responses. Four (4) respondents indicated the ability to accept 53 to 60 additional LTC patients "without conditions" per State Agency rules. Our 2011 LTC ADC approximated 8.8 patients. Hence, there are sufficient LTC beds available in-market and there will be no impact on access post-discontinuation. In addition, the other eleven (11) impact letter responses indicated an additional 133 to 136 LTC bed being available for our patients. Thus, there is a market-based capacity to accommodate our LTC patients post-discontinuation, assuming Review Board approval.

Pekin Memorial Hospital
Expedited Review Letter
February 16, 2012
Page 2 of 2

There is no cost to the discontinuation and no vacant space post discontinuation. We will reduce our current CON approved 125 bed complement to 98 beds. After the LTC discontinuation, we propose to reconfigure the current mix of private and semi-private rooms / beds in order to increase patient privacy, better manage infectious diseases, enhance patient safety, and improve patient care quality.

We believe we have met all applicable State Agency rules in preparing our Permit Application and look forward to working with your staff in the review process.

Enclosed is our check in the amount of \$2,500.00 for the application processing fee.

Please contact Jo Ellen Patterson, VP of Patient Care Services at 309-353-0728 or the main switchboard at 309-347-1151, if you have any questions and look forward to your approval of our expedited review request.

Sincerely,



Kevin R. Andrews, Chief Executive Officer
Pekin Hospital

Pekin Memorial Hospital
Permit Application to Discontinue the Long-Term Care Category of Service
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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Pekin Hospital / Long Term Care Category of Service Discontinuation				
Street Address:	600 South 13 th Street				
City and Zip Code:	Pekin 61554				
County:	Tazewell	Health Service Area	2	Health Planning Area:	C-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Progressive Health System (Applicant)				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Name of Registered Agent:	Kevin R. Andrews, FACHE				
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE				
CEO Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0756				

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

- 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 during the review period]

Name:	Kevin R. Andrews, FACHE				
Title:	Chief Executive Officer				
Company Name:	Pekin Memorial Hospital				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0700				
E-mail Address:	kandrews@pekinhospital.com				
Fax Number:	309-353-0908				

Additional Contact

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

Name:	Jo Ellen Patterson, RN MS				
Title:	Vice President, Patient Care Services				
Company Name:	Pekin Memorial Hospital				
Address:	600 South 13 th Street, Pekin, Illinois 61554				
Telephone Number:	309-353-0728				
E-mail Address:	jpatterson@pekinhospital.com				
Fax Number:	309-353-0930				

Additional Contact

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

Name:	Edwin W. Parkhurst, Jr.
Title:	Managing Principal
Company Name:	PRISM Healthcare Consulting
Address:	800 Roosevelt Road, Building E, Suite 110, Glen Ellyn, Illinois 60137
Telephone Number:	630-790-5089
E-mail Address:	eparkhurst@consultprism.com
Fax Number:	630-790-2696

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

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Facility Name:	Pekin Hospital / Long Term Care Category of Service Discontinuation				
Street Address:	600 South 13 th Street				
City and Zip Code:	Pekin 61554				
County:	Tazewell	Health Service Area	2	Health Planning Area:	C-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Pekin Memorial Hospital DBA Pekin Hospital (Co-Applicant)				
Address:	600 South 13 th Street Pekin, Illinois 61554				
Name of Registered Agent:	Kevin R. Andrews, FACHE				
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE				
CEO Address:	600 South 13 th Street Pekin, Illinois 61554				
Telephone Number:	309-353-0700				

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

- 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.

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Telephone Number:	630-790-5089
E-mail Address:	eparkhurst@consultprism.com
Fax Number:	630-790-2696

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:	Jo Ellen Patterson, RN MS
Title:	Vice President, Patient Care Services
Company Name:	Pekin Memorial Hospital
Address:	600 South 13 th Street, Pekin, Illinois 61554
Telephone Number:	309-353-0728
E-mail Address:	jpatterson@pekinhospital.com
Fax Number:	309-353-0930

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Pekin Memorial Hospital
Address of Site Owner:	600 South 13 th Street, Pekin, Illinois 61554
Street Address or Legal Description of Site:	600 South 13 th Street Pekin, Illinois 61554
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:	Pekin Memorial Hospital		
Address:	600 South 13 th Street Pekin, Illinois 61554		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

CRAIG CONOVER, M.D.
ACTING DIRECTOR

Issued under the authority of
 The State of Illinois
 Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CCED	0001834

FULL LICENSE:
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET
PEKIN IL 61554

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/07 •

← DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION



State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PEKIN MEMORIAL HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	CCED	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/01/11
 PEKIN MEMORIAL HOSPITAL
 600 SOUTH 13TH STREET
 PEKIN IL 61554

FEE RECEIPT NO.

Post Permit Contact

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Name:	Jo Ellen Patterson, RN MS
Title:	Vice President, Patient Care Services
Company Name:	Pekin Memorial Hospital
Address:	600 South 13 th Street, Pekin, Illinois 61554
Telephone Number:	309-353-0728
E-mail Address:	jpatterson@pekinhospital.com
Fax Number:	309-353-0930

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[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Pekin Memorial Hospital
Address of Site Owner:	600 South 13 th Street, Pekin, Illinois 61554
Street Address or Legal Description of Site:	600 South 13 th Street Pekin, Illinois 61554
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.	
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Exact Legal Name:	Pekin Memorial Hospital		
Address:	600 South 13 th Street Pekin, Illinois 61554		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
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<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
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State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

CRAIG CONOVER, M.D.
ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRES DATE	CATEGORY	ID NUMBER
12/31/12	CGRB	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET
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11/01/11
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PEKIN IL 61554

FEE RECEIPT NO.

Flood Plain Requirements Not Applicable. No construction is involved.

[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)]

<p>Part 1110 Classification:</p> <p><input checked="" type="checkbox"/> Substantive</p> <p><input type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input checked="" type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
---	--

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.

Progressive Health Systems (“Applicant”) and Pekin Memorial Hospital (“Co-Applicant”) doing business as Pekin Hospital (DBA), located at 600 South 13th Street, Pekin, Illinois 61554, proposes to discontinue its CON approved 27-bed long term care (LTC) category of service thereby reducing its post-discontinuation bed capacity to 98 beds as shown in the following chart.

<u>Bed Category</u>	<u>Current</u>	<u>Proposed</u>
Medical / Surgical	68	68
Pediatric	10	10
Intensive Care	8	8
OB/Gyn	12	12
Long Term Care	<u>27</u>	<u>0</u>
Total	<u>125</u>	<u>98</u>

After discontinuation, the applicants propose to reconfigure their current mix of private and semi-private rooms to provide more private medical / surgical patient rooms in order to increase patient privacy, better manage infectious disease cases, enhance safety, and improve patient care quality. There will be no vacant patient-room space post-discontinuation as the current LTC bed rooms will be used for medical / surgical patients when the patient care units are reconfigured to provide additional private rooms and private beds.

Over 50 impact letters were sent to nursing home facilities within a 45-minute normal drive time from the Hospital site location, 38 of which have licensed nursing care beds; 14 response letters were received and there were a total of 186 to 196 available LTC beds identified to accommodate the current (2011) average daily LTC census of 8.8 patients; four (4) of the 14 respondents identified the ability to accept 53 to 60 LTC patients without conditions per State Agency rules. Hence, there is no identified impact on access for LTC patients within the defined market area.

There is no cost to the proposed long term care category of service discontinuation.

According to Public Act 095-0031, this is a substantive project in that it proposes to discontinue a designated category of service.

Support Letter

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$ 0	\$ 0	\$ 0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 0	\$ 0	\$ 0
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM			

Related Project Costs

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

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

The project involves the establishment of a new facility or a new category of service
 Yes No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

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): Within 45 days of IHFSRB approval which is anticipated to be June 5, 2012; approximate closing date is July 20, 2012 pending notification to all regulatory agencies.

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not applicable. There is no project cost.**

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 **(There are no 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							
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: Pekin Memorial Hospital		CITY: Pekin, Illinois			
REPORTING PERIOD DATES: From: January 1, 2010 to: December 31, 2010					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	68	2,750	13,176 *	--	68
Obstetrics	12	486	1,077 **	--	12
Pediatrics	10	202	732 ***	--	10
Intensive Care	8	355	1,325 ****	--	8
Comprehensive Physical Rehabilitation	0				0
Acute/Chronic Mental Illness	0				0
Neonatal Intensive Care	0				0
General Long Term Care	27	426	3,770	--	27
Specialized Long Term Care	0				0
Long Term Acute Care	0				0
Other ((Identify))	0				0
TOTALS:	125	4,219	20,080	--	125

- * Includes 1,198 observation days in M/S beds
- ** Includes 65 observation days in OB/Gyn beds
- *** Includes 236 observation days in Pediatric beds
- **** Includes 55 observation days in ICU beds

Note: ICU admissions exclude internal transfers; patient days include 1,554 observation days

Facility Bed Capacity and Utilization (Estimated for 2011)

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: Pekin Memorial Hospital		CITY: Pekin, Illinois			
REPORTING PERIOD DATES: From: January 1, 2011 to: December 31, 2011					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	68	2,477	10,931	--	68
Obstetrics	12	525	1,131	--	12
Pediatrics	10	170	408	--	10
Intensive Care	8	356	1,218	--	8
Comprehensive Physical Rehabilitation	0				0
Acute/Chronic Mental Illness	0				0
Neonatal Intensive Care	0				0
General Long Term Care	27	371	3,220	--	27
Specialized Long Term Care	0				0
Long Term Acute Care	0				0
Other ((identify))	0				0
TOTALS:	125	4,219	16,908	--	125

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

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

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

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-44, 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/Co-applicant Identification including Certificate of Good Standing	25 – 27
2	Site Ownership	28 – 31
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	32 – 39
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	40 – 41
5	Flood Plain Requirements	42
6	Historic Preservation Act Requirements	43
7	Project and Sources of Funds Itemization	44
8	Obligation Document if required	45
9	Cost Space Requirements	46
10	Discontinuation	47 – 187
11	Background of the Applicant	NA
12	Purpose of the Project	NA
13	Alternatives to the Project	NA
14	Size of the Project	NA
15	Project Service Utilization	NA
16	Unfinished or Shell Space	NA
17	Assurances for Unfinished/Shell Space	NA
18	Master Design Project	NA
19	Mergers, Consolidations and Acquisitions	NA
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	NA
21	Comprehensive Physical Rehabilitation	NA
22	Acute Mental Illness	NA
23	Neonatal Intensive Care	NA
24	Open Heart Surgery	NA
25	Cardiac Catheterization	NA
26	In-Center Hemodialysis	NA
27	Non-Hospital Based Ambulatory Surgery	NA
28	General Long Term Care	NA
29	Specialized Long Term Care	NA
30	Selected Organ Transplantation	NA
31	Kidney Transplantation	NA
32	Subacute Care Hospital Model	NA
33	Post Surgical Recovery Care Center	NA
34	Children's Community-Based Health Care Center	NA
35	Community-Based Residential Rehabilitation Center	NA
36	Long Term Acute Care Hospital	NA
37	Clinical Service Areas Other than Categories of Service	NA
38	Freestanding Emergency Center Medical Services	NA
	Financial and Economic Feasibility:	
39	Availability of Funds	NA
40	Financial Waiver	NA
41	Financial Viability	NA
42	Economic Feasibility	NA
43	Safety Net Impact Statement	188 – 190
44	Charity Care Information	191 – 192

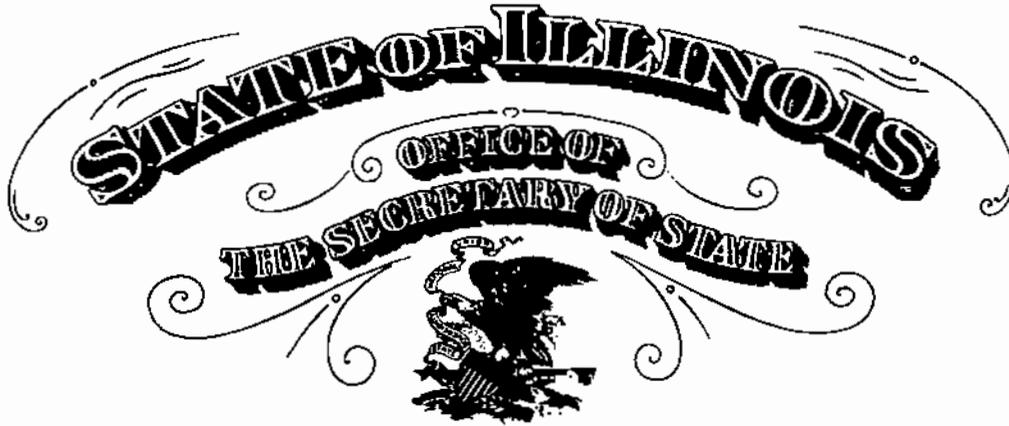
ATTACHMENTS

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Progressive Health Systems (Applicant)
Address:	600 South 13 th Street Pekin, Illinois 61554
Name of Registered Agent:	Kevin R. Andrews, FACHE
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE
CEO Address:	600 South 13 th Street Pekin, Illinois 61554
Telephone Number:	309-353-0756

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Pekin Memorial Hospital DBA Pekin Hospital (Co-Applicant)
Address:	600 South 13 th Street Pekin, Illinois 61554
Name of Registered Agent:	Kevin R. Andrews, FACHE
Name of Chief Executive Officer:	Kevin R. Andrews, FACHE
CEO Address:	600 South 13 th Street Pekin, Illinois 61554
Telephone Number:	309-353-0756



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PROGRESSIVE HEALTH SYSTEMS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 05, 1985, 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.

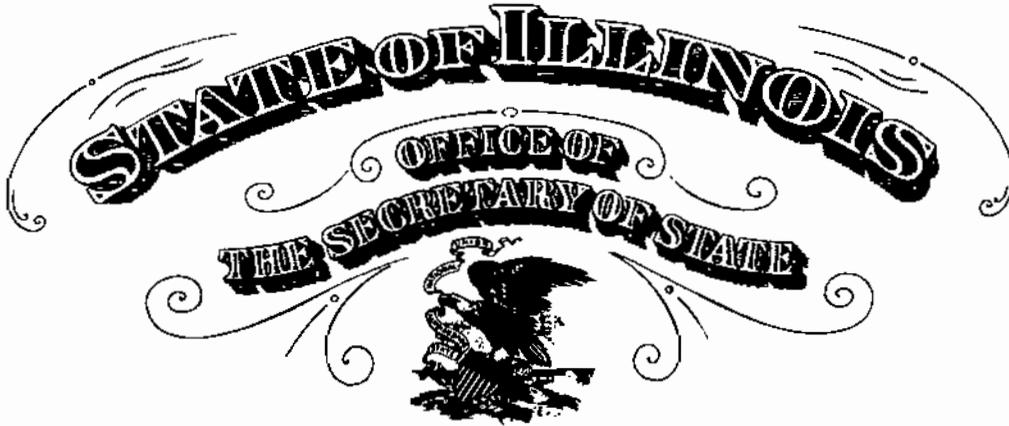


Authentication #: 1202200166
Authenticate at: <http://www.cyberdriveIllinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PEKIN MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 25, 1913, 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.



Authentication #: 1202200160
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Pekin Memorial Hospital
Address of Site Owner:	600 South 13 th Street, Pekin, Illinois 61554
Street Address or Legal Description of Site:	600 South 13 th Street Pekin, Illinois 61554
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.	

Certificate of Status of Exempt Property
For owners of exempt parcels in Tazewell County

In accordance with Section 15-10 of the Property Tax Code (35 ILCS 200-15/10), this Certification is hereby submitted. As title holder or as the beneficial owner of the rights to the property(s) identified below, it is hereby declared that as of January 1, 2012, there has not been a change in the ownership or use of the property(s) since the initial issuance of the Certification of Exemption by the Illinois Department of Revenue, except as noted.

Owner: PEKIN MEMORIAL HOSPITAL
600 S 13TH ST.

PEKIN, IL 61554-0000

Permanent Parcel #	Street Addresses of Properties	Permanent Parcel #	Street Addresses of Properties
04-10-02-225-015	COURT ST.	04-10-02-225-016	613 13TH ST.
04-10-02-225-017	609 13TH ST.	04-10-02-225-022	1226 PARK AVE.
04-10-02-225-020	619 13TH ST.	04-10-02-225-024	1229 PARK AVE.
04-10-02-225-023	1227 PARK AVE.	04-10-02-226-001	
04-10-02-225-025	1231 PARK AVE.	04-10-02-227-001	COURT ST.
04-10-02-226-002	616 13TH ST.	04-10-02-227-003	PARK AVE.
04-10-02-227-002	1309 PARK AVE.	04-10-02-227-005	S 14TH ST.
04-10-02-227-004	1314 COURT ST.	04-10-02-229-007	1220 PARK AVE.
04-10-02-227-007	13 H ST.	04-10-02-229-016	
04-10-02-229-008	1226 PARK AVE.	04-10-02-233-002	1316 PARK AVE.
04-10-02-233-001	1300 PARK AVE.	04-10-02-233-005	1324 PARK AVE.
04-10-02-233-004	1320 PARK AVE.	04-10-02-233-007	1332 PARK AVE.
04-10-02-233-006	1328 PARK AVE.		
04-10-02-233-008	1336 PARK AVE.		

Describe change in ownership and property affected (if none, state none):

Date ownership changed: _____
Month/Day/Year

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

Date use changed: _____
Month/Day/Year

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

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

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

Signature: [Signature]
Owner or Authorized Representative
309-253-0787
Phone Number

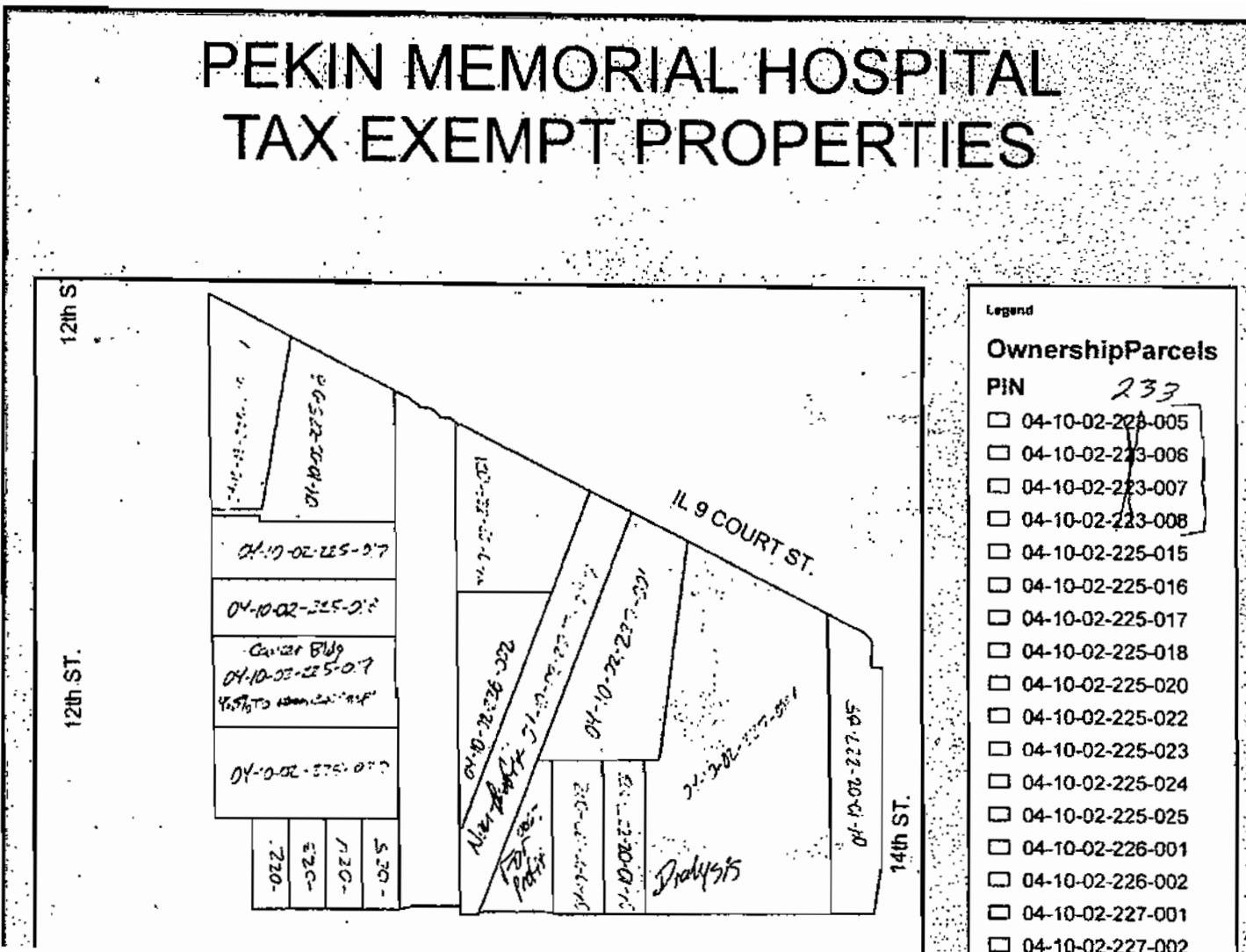
[Signature]
Title
1-3-12
Date

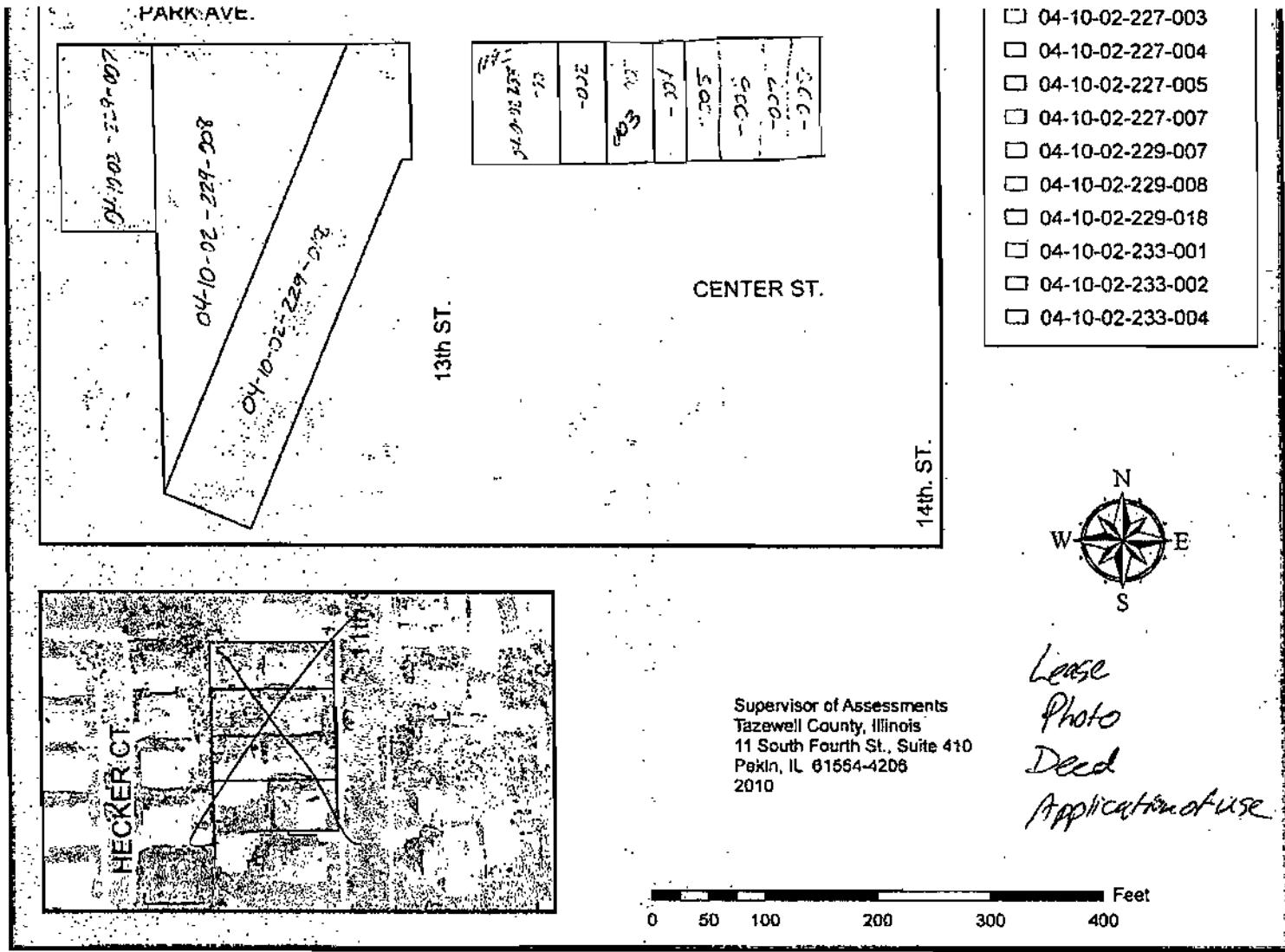
IMPORTANT: This should be completed and returned to the Tazewell County Assessment Office, Room 401 11 South Fourth Street, Pekin, IL prior to January 31st. Failure to file shall constitute cause to terminate the exemption.

Form 328 (R-11/11) Tazewell County

318

PEKIN MEMORIAL HOSPITAL TAX EXEMPT PROPERTIES





Operating Identity/Licensee

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

Exact Legal Name:	Pekin Memorial Hospital		
Address:	600 South 13 th Street Pekin, Illinois 61554		
<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

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

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Issued under the authority of
The State of Illinois
Department of Public Health

CRAIG CONOVER, M.D.
ACTING DIRECTOR

EXPIRES DATE	CATEGORY	ID NUMBER
12/31/12	CGC0	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET
PEKIN IL 61554

The face of this license has a colored background. Printed by Authority of the State of Illinois - 4/07

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

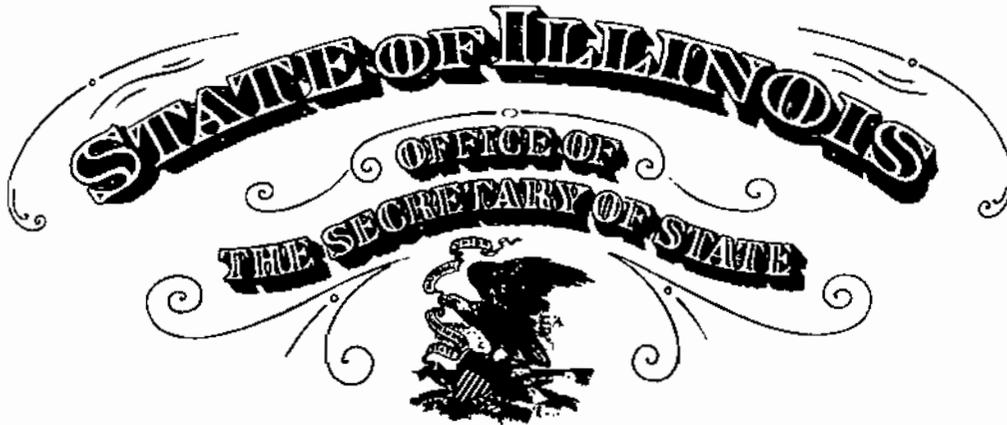
PEKIN MEMORIAL HOSPITAL

EXPIRES DATE	CATEGORY	ID NUMBER
12/31/12	CGC0	0001834

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/06/11
PEKIN MEMORIAL HOSPITAL
600 SOUTH 13TH STREET
PEKIN IL 61554

FEE RECEIPT NO.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PROGRESSIVE HEALTH SYSTEMS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 05, 1985, 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.



Authentication #: 1202200166
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE

File Number 1250-952-9



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

PEKIN MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 25, 1913, 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.



Authentication #: 1202200160

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 22ND day of JANUARY A.D. 2012 .

Jesse White

SECRETARY OF STATE



SERVICES PROGRAMS PRESS PUBLICATIONS DEPARTMENTS CONTACT

CORPORATION FILE DETAIL REPORT

Entity Name	PROGRESSIVE HEALTH SYSTEMS	File Number	53804195
Status	ACTIVE		
Entity Type	CORPORATION	Type of Corp	NOT-FOR-PROFIT
Incorporation Date (Domestic)	04/05/1985	State	ILLINOIS
Agent Name	KEVIN R ANDREWS	Agent Change Date	06/29/2007
Agent Street Address	600 S 13TH ST	President Name & Address	
Agent City	PEKIN	Secretary Name & Address	
Agent Zip	61554	Duration Date	PERPETUAL
Annual Report Filing Date	02/21/2011	For Year	2011
Assumed Name	ACTIVE - PEKIN MEMORIAL HOSPITAL HOME HEALTH		

[Return to the Search Screen](#)

[Purchase Certificate of Good Standing](#)

(One Certificate per Transaction)

[BACK TO CYBERDRIVEILLINOIS.COM HOME PAGE](#)



SERVICES PROGRAMS PRESS PUBLICATIONS DEPARTMENTS CONTACT

CORPORATION FILE DETAIL REPORT

Entity Name	PEKIN MEMORIAL HOSPITAL	File Number	12509529
Status	ACTIVE		
Entity Type	CORPORATION	Type of Corp	NOT-FOR-PROFIT
Incorporation Date (Domestic)	06/25/1913	State	ILLINOIS
Agent Name	KEVIN R ANDREWS	Agent Change Date	05/29/2007
Agent Street Address	600 S 13TH ST	President Name & Address	
Agent City	PEKIN	Secretary Name & Address	
Agent Zip	61554	Duration Date	PERPETUAL
Annual Report Filing Date	04/18/2011	For Year	2011
Assumed Name	ACTIVE - PEKIN HOSPITAL INACTIVE - PEKIN MEMORIAL HOSPITAL HOME HEALTH AGENCY		

[Return to the Search Screen](#)

[Purchase Certificate of Good Standing](#)

(One Certificate per Transaction)

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Pekin Memorial Hospital

Pekin, IL

has been Accredited by



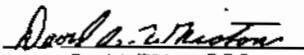
The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

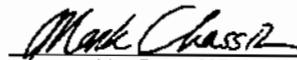
Hospital Accreditation Program

May 5, 2011

Accreditation is customarily valid for up to 36 months.


David A. Whiston, D.D.S.
Chairman of the Board

Organization ID #: 7407
Print/Reprint Date: 11/17/11


Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Pekin Memorial Hospital
Pekin, IL

has been Accredited by



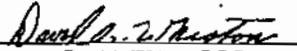
The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

May 7, 2011

Accreditation is customarily valid for up to 36 months.


David A. Whiston, D.D.S.
Chairman of the Board

Organization ID #: 7407
Print/Reprint Date: 11/17/11


Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



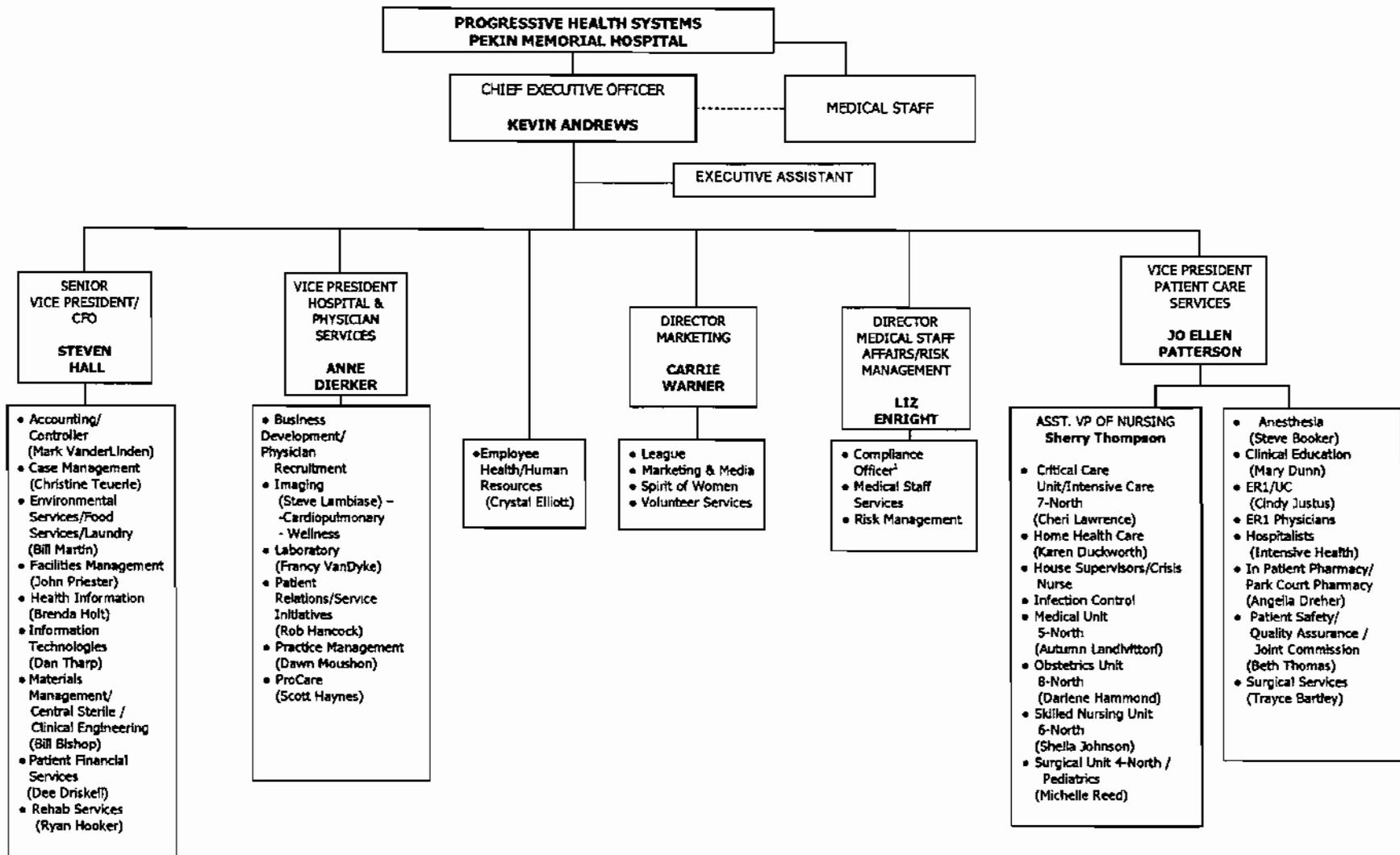
AMA



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

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.



2-3-2012
Compliance Officer¹

Flood Plain Requirements

Not Applicable. No construction is involved.

[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>).

Historic Resources Preservation Act Requirements

Not Applicable; this is solely a proposed LTC discontinuation.

[Refer to application instructions.]

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

Project Costs and Sources of Funds

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

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

There is no cost associated with the proposed Long Term Care Category of Service discontinuation.

Project Status and Completion Schedules

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): Within 45 days of IHFSRB approval which is anticipated to be June 5, 2012; approximate closing date is July 20, 2012 pending notification to all regulatory agencies.

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not applicable. There is no project cost.**

- 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.

Cost Space Requirements associated with the LTC bed discontinuation

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	0	22,422	31,046	0	0	31,046	0
LTC	0	8,624	0	0	0	0	0
Diagnostic Radiology							
MRI							
Total Clinical	0	31,046	31,046	0	0	31,046	0
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	0	31,046	31,046	0	0	31,046	0

Note: The vacated LTC unit on 6N will be reassigned to medical / surgical (M/S) beds. The current total Hospital complement of 68 M/S beds will be retained and the current mix of M/S patient rooms will be enhanced by an increase in private room / bed accommodations for M/S patients.

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.

Executive Overview

General Information (1110.130(a))

Progressive Health Systems and Pekin Memorial Hospital, the co-applicants, DBA Pekin Hospital, propose to discontinue the facility's 27-bed Long Term Care category of service. There are no other associated discontinuations. The Hospital bed complement will be reduced from 125 to 98 beds post-LTC discontinuation.

The anticipated discontinuation date is approximately July 20, 2012, or before, assuming IHFSRB approval at its tentatively schedule June 5, 2012 Board meeting and subsequent applicant compliance with all required regulatory agency notifications.

There will be no vacated space resulting from the proposed discontinuation. The existing long term care unit will be reassigned to medical / surgical (M/S) beds. The M/S bed complement will remain at 68 beds post-discontinuation / project completion. This will be accomplished by increasing the Hospital's complement of private M/S patient rooms.

The existing LTC unit is a component of Pekin Hospital which will remain in operation. Hence, all LTC patient records will remain in its possession and be managed and maintained per Hospital policy which complies with all associated regulatory requirements.

In that this discontinuation pertains solely to the LTC category of service at Pekin Hospital and that the Hospital facility will continue to operate, the certifications identified in 1110.130 a) (6) are not applicable.

Reason for Discontinuation (1110.130 (b))

The Applicants propose to discontinue the Long Term Care category of service at Pekin Hospital in that the service is not economically feasible and continuation impairs the facility's financial viability. The Pekin Hospital LTC unit financial analysis is shown below:

	<u>Calendar Year</u>		
	<u>2009</u>	<u>2010</u>	<u>2011</u>
Patient Days	4,261	3,770	3,220
ADC (Patients)	11.7	10.3	8.8
Net revenue (cash)	\$1,870,169	\$1,737,959	\$1,370,056
Direct operating expense	<u>\$2,333,132</u>	<u>\$1,998,633</u>	<u>\$1,919,648</u>
Direct operating margin	(\$462,963)	(\$260,674)	(\$549,592)
Allocated overhead	<u>\$1,346,468</u>	<u>\$1,214,762</u>	<u>\$1,096,841</u>
Operating income	<u>(\$1,809,431)</u>	<u>(\$1,457,436)</u>	<u>(\$1,646,433)</u>

Source: Hospital financial records and analysis (See also Exhibit E)

The cumulative operating loss over the last 3 years approximates \$5.0 Million (\$4,931,300) which is unsustainable; in particular, with the upcoming health reform initiatives predicated on improving access while reducing cost and Medicare / Medicaid reimbursements.

Impact on Access (1110.130 (c))

The Hospital is within Health Service Area (HSA) 002. The most recent long-term care bed inventory dated January 15, 2012 indicates the HSA has a calculated 2018 LTC bed need of 8,040 beds with 8,013 being approved. Hence, the calculated bed need within the HSA indicates a potential 27 LTC bed shortage within the HSA in 2018 which will increase to a calculated shortage of 54 LTC beds post-discontinuation assuming no other changes in the market. This IDPH / IHFSRB analysis is based on 2008 use rates and projected 2018 population cohorts for those 65 and older and may not fully account for the most recent changes in how the elderly use health services; in particular, LTC services, changing use rates for LTC services as further described herein, nor the most recent population forecasts by age cohort within the planning area, all of which impact on LTC bed need projections. In addition, the respective service areas for various LTC providers may not be constrained by planning area or county designations. An analysis of the LTC providers in the planning area and 45-minute GSA indicates sufficient available LTC beds now and in the future.

By State Agency rules, the facility's market area is defined by a 45-minute travel / drive time from the applicant site. Exhibit A graphically depicts the designated market area. Within this geographic service area there are 56 facilities with nursing home type care programs (Exhibit B), 38 of which have licensed nursing care beds (Exhibit C). These facilities include Pekin Hospital. These 38 facilities have 3,923 licensed nursing care beds, 3,809 set-up beds, and the potential of accommodating additional LTC patients based on the 414 available beds assuming the suggested State Agency 90% occupancy target. Hence, utilizing 2010 IDPH data, as profiled in the Illinois Long Term Care Profiles, there is bed availability and market capacity to accommodate an additional 414 LTC patients. There is no bed shortage.

The Pekin Hospital LTC unit designated 45-minute travel time geographic market area (GSA) is a sub-set of HSA002 and touches on HSA003. HSA002 encompasses 10 counties with all or parts of them within the designated Pekin LTC GSA ... Tazewell, Peoria, Fulton, and Woodward Counties. HSA003 embraces 15 counties, and Pekin's designated GSA touches on Mason County. Thus, the applicants defined GSA is a component of a much larger IDPH designated planning region.

Impact letters were sent to over 50 nursing home type bed providers within the defined GSA on January 9, 2012 according to Section 1130.130(c) review criterion. There were 14 total responses to the impact letter through February 2, 2012. This date allowed for more than 15 days after receipt for an impacted facility to respond and is also more than 30 days prior to filing the Permit Application as required by State Agency rules.

Exhibit D profiles the 14 impact letter responses. Four (4) responders indicated between 53 to 60 LTC beds are available "without conditions, limitations, or discrimination" with an additional 133 to 136 LTC beds also being available in facilities within the GSA willing to accept LTC patients brings the total current LTC bed availability to 186 to 196 beds; however, ten (10) of the responders did not comply with the necessary condition statement as required by Section 1110.130. Thus, based on the responses to the impact letters from providers within the GSA, there are more than sufficient available LTC beds to accommodate Pekin Hospital's LTC 2011 ADC approximating 8.8 patients.

Supporting Narrative / Additional Information (Attachment 10)

The following supporting material is structured as follows:

- Background / History (LTC and acute care hospitals)
- LTC utilization trends
- Situational Overview and Board Resolution (Pekin) (Exhibit E)
- IHFSRB Request
- Access, Impact letters and analysis
- Use of vacated space / Bed relocation plan (Exhibits K and L)
- Outline Closure plan (including stakeholder notification letters and press release material)
- Summary

Background / History

The Social Security Act of 1965 created the Medicare and Medicaid programs to provide health insurance and/or medical assistance for the aged, disabled, and those needing assistance. The initial nursing home regulations under the Act were implemented in 1967 with guidelines based on the Older Americans Act. Subsequently, Congress passed the Omnibus Budget Reconciliation Act of 1987 (OBRA) which established strict minimum standards for nursing homes accepting Medicare and/or Medicaid payments.

Medicare's benefit structure is based on providing services to treat acute illness which includes short-term coverage in Skilled Nursing Facilities (SNF's), but not long term extended stay nursing home (NH) care. The SNF benefit was originally designed to reduce the length of stay in acute care hospitals and was conceived as a post-hospital stay, short-term sub-acute care program Medicare benefit. Many hospitals developed in-hospital nursing care beds, some of which met SNF compliance requirements, in order to better manage the care process and reduce acute care average lengths of stay. The Pekin unit was originally opened in 1993 in response to

the federal Medicare provisions which provided incentives for, and also promoted the LTC concept. At that time, SNF's were paid on a reasonable cost basis or through prospectively determined rates for low volume services. This all changed on July 1, 1998.

The Balanced Budget Act of 1997 (BBA) modified how payment is made for Medicare certified SNF services. Effective with cost reporting periods beginning on or after July 1, 1998, SNF's were now paid on the basis of a national fixed payment prospective payment rate system (PPS). These rates were adjusted for a respective facility's case mix and geographic variation in wages to cover the costs of furnishing covered SNF services. This change in reimbursement was driven by Medicare's spending for SNF care which increased on an average rate of 30 percent from the mid 1980's through 1997. Reimbursement has continued to be constrained and is proposed to be reduced by over 11% in 2012.

With the implementation of the PPS, providers stated SNF payments were inadequate, threatening their financial viability. Congress subsequently modified PPS payments with temporary increases. According to a General Accounting Office (GAO) analysis in 2002, 90 percent of hospital-based SNF's reported negative Medicare margins. This trend has continued, and with proposed health reform initiatives as currently enacted, Medicare has and proposes to make further significant cuts in reimbursement to SNF's. Hence, the need to assess any hospital's ability to provide in-house post-acute care services such as those in a SNF.

Nursing Home Utilization Trends

A key goal in federal and state long-term care policy is to increase the use of home and community-based services and reduce institutional care; more significantly, finding methods to reduce the use of nursing homes. The overall goal is to create a balanced long-term care financing and delivery system.

The Illinois Department on Aging in its FY 2010-2012 State Plan recognizes twenty (20) strategic trends. One indicates that by 2030 over 24% of the states' population will be over 60 years of age many of which will be aged 85 or older. Another recognizes the national rates of residents utilizing nursing homes has declined due to alternative housing options such as home care, assisted living facilities, and in-home services provided by community-based service providers.

Nursing home use has been declining since the mid-1980's. Nationally, in 1985, 220 per 1,000 aged 85 and over resided in nursing homes. In 2004, the latest year for which data is available, this rate was reduced to 139 per 1,000 aged 85 and over (Federal Interagency Forum on Aging-Related Statistics, 2008). According to the US Census Bureau, approximately 7.4% of Americans aged 75 and older living in nursing homes in 2006 compared to 8.1% in 2000 and 10.2% in 1990.

Illinois has a higher ratio of those aged 65 and over residing in nursing homes than the national average. A 2009 AARP report states Illinois has 5.0 nursing facility residents per 100 aged 65 and over. The national rate is 3.8. One goal of the Illinois State Plan on Aging is to expand in-home and community-based services to enable seniors to remain in their own homes. Given this goal, and national trends to utilize non-institutional services for the elderly, demand for nursing home care and SNF services in Illinois is expected to decline.

Despite an aging population, the percentage of elderly living in nursing homes has declined in part due to improved health status and more choices for elderly care. In-home services and assisted-living services are fast growing segments of elder care and are expected to provide a greater proportion in the future.

Pekin Situational Overview

The hospital industry is in transition. Health reform initiatives mandate the hospital must do more with less as access is increased and reimbursement is constrained. In this context, Pekin Hospital has evaluated several alternatives to manage its cost structure one of which is discontinuing its LTC category of service due to its negative financial performance.

Internal analysis (Exhibit E) shows the decline in utilization over the period CY 2009 through CY 2011 from an average 11.7 daily patient census (ADC) to 8.8 ADC in 2011 with a 3-year cumulative loss approximately \$4.931 million. In January, the co-applicants Board approved a resolution to discontinue the LTC service (Exhibit F) which was earlier announced to the organizations stakeholders in December, 2011 (Exhibits G through J, inclusive)

Request to the IHFSRB

Progressive Health Systems (“Applicant”) and Pekin Memorial Hospital (“Co-Applicant”) doing business as Pekin Hospital (DBA), located at 600 South 13th Street, Pekin, Illinois 61554, respectfully requests the IHFSRB approve the discontinuation of the Hospital’s CON approved 27-bed long term care (LTC) category of service thereby reducing its post-discontinuation bed capacity to 98 beds as shown in the following chart.

<u>Bed Category</u>	<u>Current</u>	<u>Proposed</u>
Medical / Surgical	68	68
Pediatric	10	10
Intensive Care	8	8
OB/Gyn	12	12
Long Term Care	<u>27</u>	<u>0</u>
Total	<u>125</u>	<u>98</u>

After discontinuation, the applicants propose to reconfigure their current mix of private and semi-private rooms to provide more private medical / surgical patient rooms in order to increase patient privacy, better manage infectious disease cases, enhance safety, and improve patient care quality. There will be no vacant patient-room space post-discontinuation as the current LTC bed rooms will be used for medical / surgical patients when the patient care units are reconfigured to provide additional private rooms.

Access, Impact Letters, and Analysis

The Hospital is within Health Service Area (HSA) 002. The most recent long-term care bed inventory dated January 15, 2012 indicates the HSA has a calculated 2018 LTC bed need of 8,040 beds with 8,013 being approved. Hence, the calculated bed need within the HSA indicates a potential 27 LTC bed shortage within the HSA in 2018 which will increase to a calculated need of 54 LTC beds post-discontinuation assuming no other changes in the market. This IDPH / IHFSRB analysis is based on 2008 use rates and projected 2018 population cohorts for those 65 and older and may not fully account for the most recent changes in how the elderly use health services; in particular, LTC services, changing use rates for LTC services, nor the most recent population forecasts by age cohort within the planning area. In addition, the respective service areas for various LTC providers may not be constrained by planning area or county designations.

An analysis of the LTC providers in the planning area and 45-minute GSA indicates available beds to accommodate the Hospital's LTC patients post-discontinuation.

By State Agency rules, the facility's market area is defined by a 45-minute travel / drive time from the applicant site. Exhibit A graphically depicts the designated market area. Within this geographic service area there are over 50 facilities with nursing home type care programs (Exhibit B), 38 of which have licensed nursing care beds (Exhibit C). These facilities include Pekin Hospital. These 38 facilities have 3,923 licensed nursing care beds, 3,809 set-up beds, and the potential of accommodating additional LTC patients in the 414 available beds based on the suggested State Agency 90% occupancy target. Hence, utilizing 2010 IDPH data, as profiled in the Illinois Long Term Care Profiles, there is bed availability and market capacity to accommodate additional LTC patients.

The Pekin Hospital LTC unit designated 45-minute travel time geographic market area (GSA) is a sub-set of HSA002 and touches on HSA003. HSA002 encompasses 10 counties with all or parts of them within the designated Pekin LTC GSA ... Tazewell, Peoria, Fulton, and Woodward Counties. HSA003 embraces 15 counties, and Pekin's designated GSA touches on Mason County. Thus, the defined GSA is a component of a much larger planning region.

Impact letters were sent to the 56 nursing home type bed providers within the defined GSA on January 9, 2012 according to Section 1130.130(c) review criterion. There were 14 total responses to the impact letter through February 2, 2012. This date allowed for more than 15 days after receipt for an impacted facility to respond and is also more than 30 days prior to filing the Permit Application.

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Patients using the LTC unit originate from the local geographic market. A zip-code based patient origin analysis of the applicants LTC discharges in 2011 indicates the following distribution.

<u>Municipality</u>	<u>Discharges</u>	<u>% Distribution</u>
Pekin	292	78.7
Manito	14	3.8
Delevan	9	2.4
East Peoria	6	1.6
Morton	5	1.3
Groveland	4	1.1
Other Illinois (21 Zip Codes)	<u>41</u>	<u>11.1</u>
Total	<u>371</u>	<u>100.0</u>

Source: Hospital Records

Compiled by: PRISM Healthcare Consulting

Those LTC providers responding to the required impact letter (Exhibit D) are primarily local and can accommodate Pekin's 2011 ADC of 8.8 patients. In particular Pekin Manor indicated the ability to accept 15 to 20 patients "without conditions".

In addition, the Hospital has a proactive case management process to assist patients and their families with LTC placement. The most recent data for January 2012 indicates the following placements.

<u>Facility</u>	<u>Location</u>	<u>Placements</u>
Hallmark House	Pekin	5
Pekin Manor	Pekin	11
Timbercreek Rehab and Health Center	Pekin	11
Morton Villa Care Center	Morton	5
Heartland of Riverview	East Peoria	1
Manor Court	Peoria	1
Colonial Hall	Princeton	1
Havana Healthcare	Havana	<u>1</u>
Total Placements		36

If this trend is annualized, over 400 LTC placements can be anticipated in 2012.

Use of Vacated Space

Private rooms are the trend in hospital planning and design. In a recent research study commissioned by the American Institute of Architects (AIA) and the Facility Guidelines Institute, it was found that private patient rooms:

1. Reduce operating costs due to reduced transfer costs, higher potential overall bed occupancy levels, and labor cost reductions.
2. Reduce patient ALOS which reduces operating costs.
3. Reduce medication errors which results in higher quality care and enhanced patient safety.
4. Reduce nosocomial infections due to reduced patients ALOS, intra-hospital transfers, and internal vectors – patient, family, caregiver contacts.
5. Increase privacy thereby reducing noise and improving sleep quality and healing. Crowding within multi-occupancy rooms has been correlated with increased blood pressure readings.
6. Provide enhanced opportunity for family caregiving.
7. Increase patient and family privacy which enhances caregiver consultations.
8. Reduce patient and family stress which can reduce anxiety and perception of pain thereby increasing care quality.

The Hospitals current medical / surgical (M/S) and long-term care (LTC) bed distribution is shown on Exhibit K. The proposed bed distribution, post-discontinuation, is shown on Exhibit L. The current 42 M/S rooms will increase to 57 post-discontinuation with 46 being private and 11 being semi-private for an approximate 81% private, 21 semi-private room mix yielding an approximate 68% private bed, 32% semi-private bed complement compared to the current 20% private bed, 80% semi-private bed mix. This new room and bed mix configuration will provide the opportunity to better manage and reduce infections, enhance patient safety, improve patient care quality, and provide a more contemporary healing environment.

Outline Closure Plan

The following outlines key tasks to be completed in effecting an orderly closure (discontinuation) of the LTC unit once approval is secured from the IHFSRB.

1. Confirm basis for closure; i.e. lack of financial viability (complete)
2. Notify internal stakeholders that discontinuation process has been initiated with IHFSRB (complete) (see Exhibits G through J, inclusive)
3. Confirm discontinuation with governing Board(s) (complete) (Exhibit F)
4. Identify LTC providers within 45-minute drive time and send out impact letters per IHFSRB rules (complete) (Exhibits A and B)
5. Develop and submit Permit Application to IHFSRB (in process)
6. Profile LTC staff capabilities and future hospital staffing requirements to appropriately retain and place existing personnel within the organization as is possible. (in process)
7. Develop and distribute news release to notify public regarding the potential discontinuation (complete, Exhibit M).
8. Review and confirm patient transfer agreements with local LTC providers (in process, see Exhibit M, N, and O for examples)
9. Develop a LTC patient case management placement process pre- and post-discontinuation (complete) (current Hospital procedure)
10. Secure Permit Application approval from IHFSRB (in process)
11. 45 days prior to the anticipated IHFSRB approval date, notify all current and future LTC patients that the LTC unit will close 30 days from or sooner than the post-discontinuation approval date; continue notification and placement process as patients are admitted. Similar notifications will be sent to impacted staff.

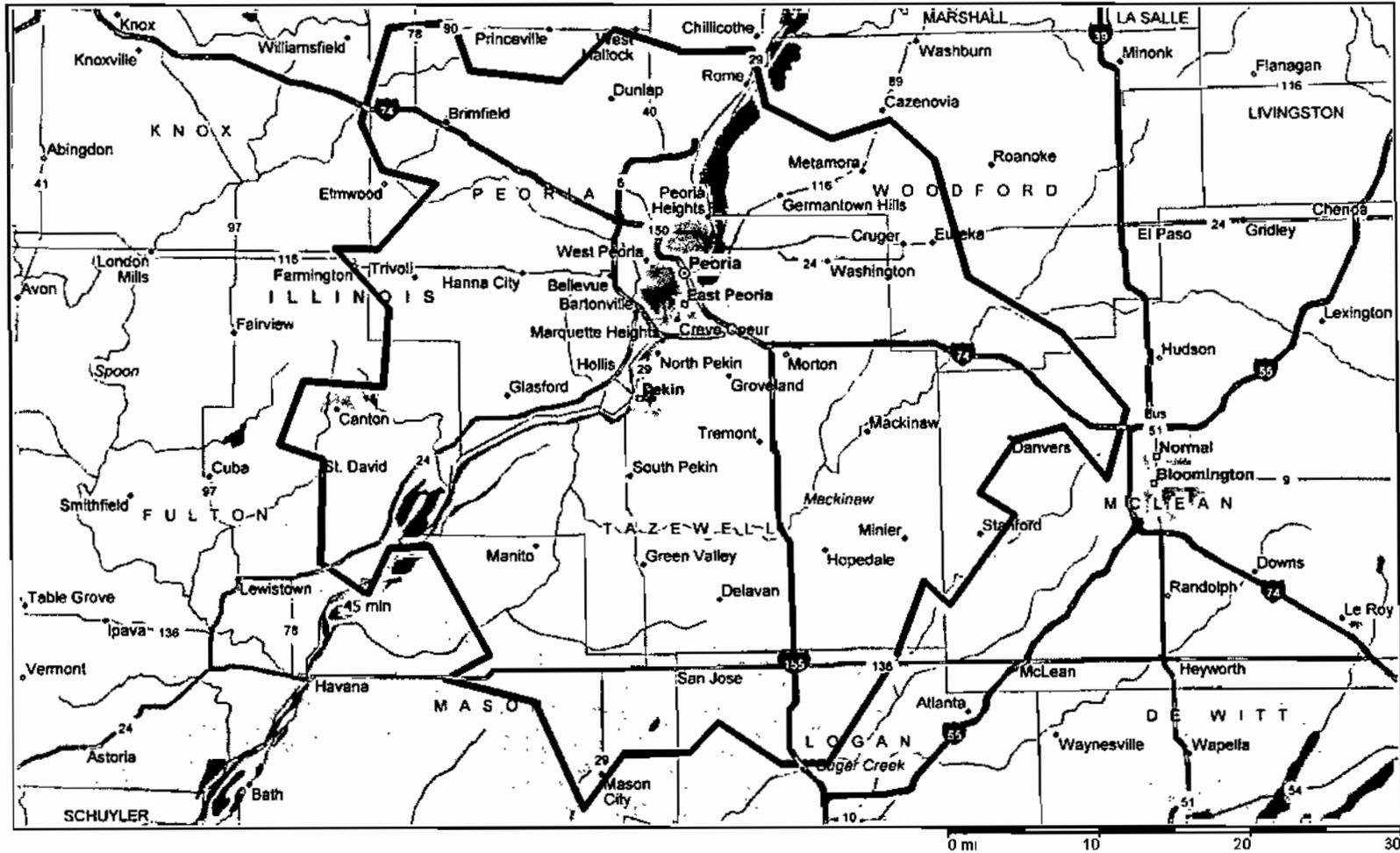
12. Subsequent to IHFSRB approval to discontinue the LTC category of service, provide written notification to the following agencies 30 days prior to the “official” discontinuation date which is the date the last resident is expected to be discharged that the unit will be closed:
 - a. Illinois Department of Public Health Division of Long Term Care Quality Assurance
 - b. Centers for Medicare and Medicaid services
13. Develop and execute final elements of the discontinuation plan including staff relocations.
14. Notify all regulatory bodies of closure date
15. Close Permit with IHFSRB
16. Reconfigure bed units to embrace private room / bed complement.

Summary

Progressive Health Systems and Pekin Memorial Hospital DBA Pekin Hospital will discontinue its LTC category of service through a well planned and thorough process to ensure patient safety, staff retention, and stakeholder communication and understanding. Market-based research indicates there will be no impact on access. There is current and future market capacity for LTC services. Post LTC bed discontinuation, the M/S services will be enhanced through an increased complement of private M/S rooms and associated beds.

Exhibit A

Pekin, Illinois, United States



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Exhibit B

**Nursing Home Type Facilities Within 45-Minute Travel Time
Pekin Memorial Hospital**

Facility	Address	City	County	Distance (miles)	Travel Time (minutes)	Authorized Beds	Administrator	Phone Number	Certified Receipt Number (1/9/12)	Certified Return Receipt Received	Letter Received
Briarbrook Place	228 Briarbrook Drive	East Peoria	Tazewell	10.80	18		Christina Durbin				
Heartland of Riverview	500 Centennial Dr.	East Peoria	Tazewell	12.57	23	61	Candy Moore	694-0022	7011 1570 0001 6445 0013	1/12/12	
Rosewood Care Center	900 Centennial Dr.	East Peoria	Tazewell	19.66	30	120	Becky Wolwode	699-5400	7011 1570 0001 6445 0020	1/12/12	
Fondulac Rehab & Healthcare Center	901 Illini Dr.	East Peoria	Tazewell	11.49	24	98	Renee Gass	694-6446	7011 1570 0001 6445 0037	1/12/12	
OSF Saint Clare Home	5533 N. Galena Rd.	Peoria Heights	Peoria	17.48	31	94	Don Dadds	682-5428	7011 1570 0001 6445 00044	1/12/12	
Apostolic Christian Restmor	1500 Parkside Ave	Morton	Tazewell	11.97	19	116*	John Kelley	284-1400	7011 1570 0001 6445 0051	1/12/12	
Apostolic Christian - Tiberridge	2125 Veteran's Road	Morton	Tazewell	13.86	22		Ron Messner		7011 1570 0001 6445 0068	1/12/12	
Apostolic Christian Skylines	7023 NE Skyline Dr.	Peoria	Peoria	19.02	33	57	Matt Feucht	691-8091	7011 1570 0001 6445 0075	1/12/12	
Apostolic Christian - Eureka	610 W. Cruger Ave.	Eureka	Woodford	26.49	40	109	Tom Hoffman	467-2311	7011 1570 0001 6445 0082	1/12/12	
Belwood Nursing Home	6701 Plank Rd.	Peoria	Peoria	13.78	21	300	Matt Nieu Kirk	697-4541	7011 1570 0001 6445 0099	1/12/12	
Christian Buehler Memorial Home	3415 N. Sheridan Rd.	Peoria	Peoria	19.34	28	78	Stacy Neubert	685-6236	7011 1570 0001 6445 0105	1/12/12	
Hallmark House Nursing Center	2501 Allentown Rd.	Pekin	Tazewell	1.43	4	71	Lynn Brady	347-3121	7011 1570 0001 6445 0112	1/12/12	1/19/2012
Heritage Manor - Chillicothe	1028 W. Hillcrest Dr.	Chillicothe	Peoria	32.02	43	110	Wade Cies	274-2194	7011 1570 0001 6445 0129	1/12/12	1/13/2012
John C. Proctor Endowment Home	272 W. Reservoir Blvd.	Peoria	Peoria	17.33	25	59	Donna Malone	685-6580	7011 1570 0001 6445 0136	1/12/12	
Lutheran Home	7019 N. Galena Rd.	Peoria	Peoria	18.93	33	85	Janelle Clark	692-4600	7011 1570 0001 6445 0143	1/12/12	
Heartland Healthcare	5600 Glen Elm Dr.	Peoria	Peoria	15.53	30	144	Carol Williams	693-8777	7011 1570 0001 6445 0150	1/12/12	1/19/2012
Maple Lawn Health Center	700 N. Main St.	Eureka	Woodford	31.07	42	89	Nyla Krabbenhofp	467-2337	7011 1570 0001 6445 0167	1/12/12	
Morton Terrace	191 E. Queenwood	Morton	Tazewell	10.51	17	166	David McDaniels	266-9741	7011 1570 0001 6445 0174	1/12/12	

Exhibit B

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Pekin Memorial Hospital**

Facility	Address	City	County	Distance (miles)	Travel Time (minutes)	Authorized Beds	Administrator	Phone Number	Certified Receipt Number (1/9/12)	Certified Return Receipt Received	Letter Received
Pekin Manor	1520 El Camino Dr.	Pekin	Tazewell	1.81	5	120	Ben Perkins	353-1099	7011 1570 0001 6445 0181	1/12/12	1/25/2012
Pekin Memorial Hospital	600 S. 13 th	Pekin	Tazewell	0	0	27	Kevin Andrews	347-1151			
Harris Place	209 Harris Rd.	East Peoria	Tazewell	10.84	18		Christina Durbin		7011 1570 0001 6445 0198	1/12/12	
Hopedale Hospital	107 W. Tremont	Hopedale	Tazewell	18.79	28		Mark Rossi		7011 1570 0001 6445 0204	1/12/12	1/12/2012
Bella Vista Care Center	1629 E. Gardner Ln.	Peoria Heights	Peoria	18	32	110	Lorraine Foust	685-1545	7011 1570 0001 6445 0211	1/12/12	1/16/2012
Rosewood Care Center—Peoria	1500 W. Northmoor Rd.	Peoria	Peoria	19.66	30	120	Timothy Wiley	691-2200	7011 1570 0001 6445 0228	1/12/12	
Sharon Health Care Elms	3611 N. Rochelle Ln.	Peoria	Peoria	18.20	27	98	Sharyl Ford	685-8800	7011 1570 0001 6445 0235	1/12/12	
Sharon Health Care Pines	3614 N. Rochelle Ln.	Peoria	Peoria	18.20	27		Randall Bauer		7011 1570 0001 6445 0242	1/12/12	
Sharon Health Care Willows	3520 N. Rochelle Ln.	Peoria	Peoria	18.11	26		Cindy Jones		7011 1570 0001 6445 0259	1/12/12	
Snyder Village	1200 E. Partridge	Metamora	Woodford	24.87	41	105	Thomas Becker	367-4300	7011 1570 0001 6445 0266	1/12/12	1/19/2012
Timbercreek Rehab & Healthcare (2)	2220 State St	Pekin	Tazewell	1.32	4	202	Brent Morgan	347-1110	7011 1570 0001 6445 0273	1/12/12	1/13/2012
Washington Christian Village	1201 Newcastle Rd	Washington	Tazewell	19.70	35	122	Stacy Brenton	444-3161	7011 1570 0001 6445 0280	1/12/12	1/19/2012
Linden Estate	1000 Linden	Morton	Tazewell	14.6	24		Matthew Steffen		7011 1570 0001 6445 0297	1/12/12	
Morton Villa Care Center	190 E. Queenwood Road	Morton	Tazewell	10.51	17		Clinton McDaniel		7011 1570 0001 6445 0303	1/12/12	1/19/2012
Oakwood Estate	2213 Veterans Road	Morton	Tazewell	14.02	22		Matthew Steffen		7011 1570 0001 6445 0310	1/12/12	
Davies Square	1817 Crescent Drive	Pekin	Tazewell	2.02	6		Adam Tabor		7011 1570 0001 6445 0327	1/12/12	
Marigold Estates	3240 Barney Avenue	Pekin	Tazewell	2.46	6		Core Dillman		7011 1570 0001 6445 0334	1/13/12	
Twin Oaks	2011 14 th Street	Pekin	Tazewell	1.28	3		Theresa Appleyard		7011 1570 0001 6445 0341	1/12/12	
Crabel Court	1105 Crabel Court	Chillicothe	Peoria	34.01	47		Sue Wujek		7011 1570 0001 6445 0358	1/12/12	
Andover	4636 W. Andover Dr.	Peoria	Peoria	19.45	30		Edith Morris		7011 1570 0001 6445 0365	1/12/12	

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Pekin Memorial Hospital**

Facility	Address	City	County	Distance (miles)	Travel Time (minutes)	Authorized Beds	Administrator	Phone Number	Certified Receipt Number (1/9/12)	Certified Return Receipt Received	Letter Received
Hart House	905 NE Perry St.	Peoria	Peoria	11.78	23		Marie Dixon		7011 1570 0001 6445 0372	1/12/12	
Hartwick House	702 NE Madison	Peoria	Peoria	11.46	23		Marie Dixon		7011 1570 0001 6445 0389	1/12/12	
Hunter House	605 NE Perry St	Peoria	Peoria	11.54	23		Marie Dixon		7011 1570 0001 6445 0396	1/12/12	
Lyons Court	4505 W. Lyons	Peoria	Peoria	18.85	28		Edith Morris		7011 1570 0001 6445 0402	1/12/12	
Manor Court of Peoria	6900 N. Stalworth Drive	Peoria	Peoria	18.57	27		Linda Patton		7011 1570 0001 6445 0419	1/12/12	
North Frostwood	61116 N. Frostwood Parkway	Peoria	Peoria	18.95	28		Edith Morris		7011 1570 0001 6445 0426	1/12/12	
Proctor Community Hospital	5409 N. Knoxville Ave.	Peoria	Peoria	15.20	29		Paul Macek		7011 1570 0001 6445 0433	1/12/12	
Rochelle	3505A N. Rochelle	Peoria	Peoria	18.10	26		Mona Robinson		7011 1570 0001 6445 0440	1/12/12	
Sharon Healthcare Woods	3223 W. Richwoods Blvd.	Peoria	Peoria	18.03	26		Bobby Ford		7011 1570 0001 6445 0457	1/12/12	
South Frostwood	6101 N. Frostwood	Peoria	Peoria	19.06	28		Edith Morris		7011 1570 0001 63445 0464	Letter Returned Undeliverable	
Eureka Hospital	101 S. Major	Eureka	Woodford	26.95	41		Anna Laible		7011 1570 0001 6445 0471	1/12/12	
Emerald Estates	1577 E. Myrtle	Canton	Fulton	24.39	34		Lora Dillman		7011 1570 0001 6445 0488	1/12/12	
Graham Hospital	210 W. Walnut St.	Canton	Fulton	25.19	35		Robert Senneff		7011 1570 0001 6445 0495	1/12/12	1/23/2012
Heartland of Canton	2081 N. Main	Canton	Fulton	27.82	41		Martha Jones		7011 1570 0001 6445 0501	1/12/12	
Renaissance Care Center	1675 E. Ash St.	Canton	Fulton	23.75	32		Leann Thomas		7011 1570 0001 6445 0518	1/12/12	1/23/2012
Sunset Rehab & Health Center	1295. 1 st Ave	Canton	Fulton	24.95	34		Aaron Anderson		7011 1570 0001 6445 0525	1/12/12	2/2/2012
Farrington Country Manor	701 S. Main St.	Farrington	Fulton	27.57	41		Jenifer Baker		70111570 0001 6445 0532	1/12/12	1/17/2012
Mason City Area Nursing Home	520 N. Price Ave	Mason City	Mason	30.36	42		Joyce Conrady		7011 1570 0001 6445 0549	1/12/12	

Exhibit C

Long Term Care Category of Service Discontinuation
 General Long Term Care Facilities Within 45 Minute Drive Time
 Pekin Memorial Hospital

Facility	Municipality	Distance	Travel Time (Minutes)	Licensed Nursing Care Beds	Set-Up Beds	2010 ADC	Licensed Bed Occupancy	Beds @ 90% Occupancy	Available Beds	Medicare Certified Beds
<u>Tazewell County</u>										
Pekin Memorial Hospital	Pekin	0.00	0	27	27	10.3	38.2	24	13	20
Fondulac Rehab & Healthcare Center	East Peoria	11.49	24	98	98	78.3	75.3	88	14	98
Heartland of Riverview	East Peoria	12.57	23	71	71	64.2	90.5	64	0	71
Rosewood Care Center - East Peoria	East Peoria	13.00	24	120	120	86.9	72.4	108	21	36
Hopedale Nursing Home	Hopedale	18.79	28	74	52	49	66.2	68	18	0
Apostolic Christian - Restnore	Morton	11.99	19	116	116	105.2	90.7	104	0	42
Morton Terrace Care Center	Morton	10.51	17	166	156	121.2	73.0	149	28	46
Morton Villa Care Center	Morton	10.51	17	106	106	69.6	65.7	95	26	106
Hallmark House Nursing Home	Pekin	1.43	4	71	69	62.8	88.4	64	1	71
Pekin Manor	Pekin	1.81	5	120	120	97.6	81.3	108	10	120
Timbercreek Rehab & Health Center	Pekin	1.48	4	202	150	115.0	57	81	66	202
Washington Christian Village	Washington	19.64	34	122	110	97.5	79.9	109	11	122
<u>Peoria County</u>										
Heritage Health - Chillicothe	Chillicothe	32.01	43	110	110	96.4	87.6	99	2	110
Apostolic Christian - Skylines	Peoria	19.02	33	57	57	54.8	96.1	52	0	14
Bel-Wood Nursing Home	Peoria	13.84	21	300	300	230.1	76.7	270	39	50
Christian Buehler Memorial Home	Peoria	14.12	28	78	72	58.9	75.5	70	11	0
Heartland of Peoria	Peoria	15.53	30	144	144	30.4	90.6	130	0	144
John C. Proctor Endowment Home	Peoria	17.31	25	59	59	53.2	90.2	53	0	59
Lutheran Home	Peoria	18.78	33	85	85	77.8	91.5	76	0	85
Manor Court (Hawthorne Manor)	Peoria	18.57	27	50	50	47.5	95.0	45	0	0

Exhibit C

Facility	Municipality	Distance	Travel Time (Minutes)	Licensed Nursing Care Beds	Set-Up Beds	2010 ADC	Licensed Bed Occupancy	Beds @ 90% Occupancy	Available Beds	Medicare Certified Beds
Proctor Community Hospital	Peoria	15.20	29	30	20	12.5	41.8	27	14	36
Rosewood Care of Peoria	Peoria	19.66	30	120	120	86.0	71.7	108	22	52
Sharon Healthcare Elms	Peoria	18.20	27	98	98	78.9	80.5	88	9	98
Sharon Healthcare Pines	Peoria	18.20	27	116	116	93.8	80.9	104	10	0
Sharon Healthcare Willows	Peoria	18.11	26	219	219	191.7	87.5	97	5	0
Sharon Healthcare Woods	Peoria	18.03	26	152	152	147.3	96.9	137	0	0
Bella Vista Care Center	Peoria Heights	18.00	32	110	110	88.0	80.0	99	11	24
Saint Clare Home	Peoria Heights	17.48	31	94	94	67.5	71.9	84	16	94
Woodford County										
Apostolic Christian Home of Eureka	Eureka	26.49	40	102	102	89.2	87.5	92	4	36
Eureka Hospital (Advocate)	Eureka	26.95	41	0	0	Swing Bed Provider				
Maple Lawn Health Center	Eureka	27.52	43	89	89	78.4	88.1	80	1	89
Snyder Village	Metamora	24.87	41	105	105	94.3	89.8	95	0	105
Fulton County										
Graham Hospital Association	Canton	25.19	35	50	50	38.4	76.8	45	7	32
Heartland of Canton	Canton	27.82	41	90	90	71.8	79.8	81	9	90
Renaissance Care Center	Canton	23.75	32	99	99	59.8	59.4	89	30	120
Sunset Rehab & Health Center	Canton	24.95	34	115	115	89.1	77.5	103	13	25
Farmington Country Manor	Farmington	27.57	41	92	92	84.0	91.3	83	0	92
Mason County										
Mason City Area Nursing Home	Mason City	30.36	42	66	66	55.8	84.6	59	3	66
Totals / Average				3,923	3,809	--	--	3,328	414	2,355

Source: IDPH Nursing Homes in Illinois; MapQuest Driving Times; Illinois Long Term Care Profiles (2010), IDPH; Annual Hospital Questionnaire (2010), IDPH
 Compiled by PRISM Healthcare Consulting

Exhibit D

Long Term Care Category of Service Discontinuation
 Impact Letter Response Analysis
 General Long Term Care Facilities Within 45 Minute Drive Time
 Pekin Memorial Hospital

Facility	Location	County	Distance	Travel Time (Minutes)	Licensed Nursing Care Beds*	ADC from Reponse	Available Beds @ 90% of Licensed	Willing to Accept (Patients)	Willing to Accept Without Conditions (Patients)	Comments
Hallmark House Nursing Home	Pekin	Tazewell	1.43	4	71	67	11	63	--	Assumes 20 day ALOS
Heartland of Riverview	East Peoria	Tazewell	12.57	23	71	57	20	Yes	8 - 10	
Hopedale Hospital	Hopedale	Tazewell	18.79	28		Swing Bed Provider				No objections
Morton Villa Care Center	Morton	Tazewell	10.51	17	106	Mid 70's	20	Yes	--	No beds stated
Pekin Manor	Pekin	Tazewell	1.81	5	120	96 - 102	6 - 12	Yes	15 - 20	
Timbercreek Rehab & Health Center	Pekin	Tazewell	1.48	4	202	120	62	40	--	
Washington Christian Village	Washington	Tazewell	19.64	34	122	96	14	10	--	
Bella Vista Care Center	Peoria Heights	Peoria	18.00	32	110	Mid 90's	4	Yes	--	No beds stated
Heritage Health - Chillicothe	Chillicothe	Peoria	32.01	43	110	100	0	5	--	
Snyder Village	Metamora	Woodford	24.87	41	105	--	--	Yes	--	Financial screen
Farmington Country Manor	Farmington	Fulton	27.57	41	92	80	3	Yes	10	
Graham Health System	Canton	Fulton	25.19	35	50	21	24	Yes	Yes	No beds stated
Renaissance Care Center	Canton	Fulton	23.75	32	99	55	26	Yes	20	
Sunset Rehab & Health Center	Canton	Fulton	24.95	34	115	97	11	15 - 18	--	No beds stated
Totals					1,373	768**	201-207**	133-136	53 - 60	

Source: Impact Letter Responses; MapQuest Driving Times; Illinois Long Term Care Profiles, IDPH (2010)
 Compiled by PRISM Healthcare Consulting

* See Exhibit C

** Incomplete Data

Exhibit E

Pekin Hospital
SNF Unit

	Calendar Year		
	2009	2010	2011
Patient Days	4,261	3,770	3,220
Average Daily Census	11.7	10.3	8.8
SNF Unit Revenue	2,466,396	2,239,181	1,947,285
Ancillary Dept Revenue	5,355,244	4,994,625	4,531,395
Total Revenue	7,821,640	7,233,806	6,478,680
Contractual Adjustments	(5,951,471)	(5,495,847)	(5,108,624)
Net Revenue (Cash Collections)	1,870,169	1,737,959	1,370,056
	23.9%	24.0%	21.1%
Salaries & Wages	868,780	735,964	748,527
Employee Benefits	xxx 234,379	230,128	149,339
Other Direct Expenses	65,700	59,043	77,816
Pharmacy	423,591	415,107	378,934
Medical Supplies	428,678	309,339	330,062
Therapy	268,007	218,136	194,093
Other Ancillary Dept Expenses	43,997	30,916	40,877
Total Direct Operating Expenses	2,333,132	1,998,633	1,919,648
Direct Operating Margin	(462,963)	(260,674)	(549,592)
	-24.8%	-15.0%	-40.1%
Capital Related Costs	xxx 86,059	84,818	91,221
Administrative & General	xxx 324,740	259,155	232,994
Operation of Plant	xxx 177,631	159,883	150,481
Laundry	xxx 53,672	51,686	53,746
Houskeeping	xxx 91,099	87,300	83,441
Dietary	xxx 176,596	159,957	141,895
Cafeteria	xxx 40,284	36,048	41,658
Nursing Administration	xxx 376,229	357,562	284,487
Central Supply	xxx 902	738	531
Pharmacy	xxx 734		
Medical Records	xxx 18,522	17,615	16,387
Total - Allocated Overhead Cost	1,346,468	1,214,762	1,096,841
Net Operating Income	(1,809,431)	(1,475,436)	(1,646,433)
	-96.8%	-84.9%	-120.2%

xxx - per Medicare Cost Report - Worksheet B Part I

Exhibit F

Board Resolution
January 24, 2012

Progressive Health Systems
and
Pekin Memorial Hospital
DBA
Pekin Hospital

Discontinuation of 27-bed Long Term Care ("LTC")
Category of Service

WHEREAS, it has been determined that, based on a financial analysis, the LTC service loses money on its operations, and is not therefore economically feasible, and;

WHEREAS, continuation impairs the organizations financial viability, and;

WHEREAS, there are sufficient long term care beds or market capacity in the geographic service area (45-minute travel time) as defined by the Illinois Health Facilities Services Review Board (IHFSRB) criterion, and;

WHEREAS, there are sufficient long term care beds (IHFSRB) criterion to service patients who would otherwise use Pekin Hospital's LTC service.

WHEREAS, access to long term care beds within the defined service area will not be compromised if the LTC discontinuation is approved at Pekin Hospital by the IHFSRB, and;

WHEREAS, the space currently housing the LTC beds is deemed as being better utilized for medical / surgical beds, and;

WHEREAS, the organizations have determined that there is a greater need for private medical / surgical bed accommodations to enhance patient safety, improve quality, and better meet patient / family expectations, and;

WHEREAS, the current LTC unit space will be reassigned to medical / surgical beds, thereby obviating any vacant area if discontinuation is approved, and;

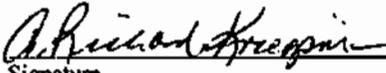
WHEREAS, the IHFSRB must approve discontinuing the organizations LTC beds, and;

WHEREAS, all reasonable attempts will be made to place existing staff into comparable positions within the organization.

Exhibit F

NOW THEREFORE BE IT RESOLVED; that the respective organizations Board of Trustees hereby authorizes its officers and management to develop and execute all necessary papers, documents, and applications to secure approval to discontinue the LTC Category of Service, develop a LTC Category of Service closure plan, and comply with all necessary regulatory filings if discontinuation is approved by the IHFSRB.

I, A. Richard Kriegsman, Chairman of Progressive Health Systems, and Pekin Hospital do hereby certify the above is a true and correct copy of a resolution adopted at a meeting of the Board of Trustees of Progressive Health Systems and Pekin Hospital respectively at which a quorum was present and voted.


Signature

A. Richard Kriegsman, Chairman
Progressive Health Systems and Pekin Hospital

SEAL



December 20, 2011

Dear Pekin Hospital Medical Staff Member:

This letter is to inform you of organizational changes that are taking place. As the healthcare environment changes, our organization must also be able to change to maintain a strong financial position. Since we cannot predict the full effect of healthcare reform, we must reduce expenses and ensure cash flow for the future. The plans we will be implementing over the next few months, along with other cost-saving initiatives will result in over **\$1.5 million annual savings**, which is necessary for the current and future financial health of our organization.

Skilled Nursing Unit

Over the past years, Medicare has continued to reduce reimbursement for hospital-based skilled nursing services and recently reduced payments again by 11.1% effective October 1, 2011. After years of a declining census and operating at a loss, we have started the process with the State of Illinois Certificate of Need program to close the unit. This requires approval by the Certificate of Need program and the timeframe for the closure will be determined by that process. We anticipate converting 6 North to a medical/surgical unit, which will increase the number of private rooms throughout the organization. This will allow us to remain attractive to potential patients and remain competitive with other local healthcare facilities.

Additional changes that will be implemented over the next few months include:

- We have given IPMR our contract termination notice. Effective March 1, 2012, Professional Therapy Services, Inc. (PTS) will begin providing rehab therapy services at Pekin Hospital. We are committed to retaining as many staff members as possible and have asked PTS and IPMR to include this in the transition plan.
- We will consolidate the Senior Management staff and not fill the vacant position for the Vice President of Physician Services. Responsibilities of the position have been reassigned effective today to current members of the Senior Management Team, with changes in a variety of reporting relationships throughout the organization. A revised organizational chart is available on the Intranet.

These are significant changes and we realize they will affect a number of staff members. Our goal is to preserve jobs as much as possible and ensure the financial health of our organization. We will continue to invest in core services in preparation for changes from healthcare reform.

Please know that I am committed to ensuring the best possible future for Pekin Hospital and ProHealth. At this point, there are no additional significant organizational changes planned. I appreciate your continued support during these turbulent times. If you have questions about the changes, please contact a member of Senior Management.

Sincerely,

A handwritten signature in cursive script that reads "Kevin R. Andrews".

Kevin Andrews
Chief Executive Officer



December 20, 2011

Dear Pekin Hospital/ProHealth Employee:

This letter is to inform you of organizational changes that are taking place. As the healthcare environment changes, our organization must also be able to change to maintain a strong financial position. Since we cannot predict the full effect of healthcare reform, we must reduce expenses and ensure cash flow for the future. The plans we will be implementing over the next few months, along with other cost-saving initiatives will result in over **\$1.6 million annual savings**, which is necessary for the current and future financial health of our organization.

Skilled Nursing Unit

Over the past years, Medicare has continued to reduce reimbursement for hospital-based skilled nursing services and recently reduced payments again by 11.1% effective October 1, 2011. After years of a declining census and operating at a loss, we have started the process with the State of Illinois Certificate of Need program to close the unit. This requires approval by the Certificate of Need program and the timeframe for the closure will be determined by that process. We anticipate converting 6 North to a medical/surgical unit, which will increase the number of private rooms throughout the organization. This will allow us to remain attractive to potential patients and remain competitive with other local healthcare facilities.

Additional changes that will be implemented over the next few months include:

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- We will consolidate the Senior Management staff and not fill the vacant position for the Vice President of Physician Services. Responsibilities of the position have been reassigned effective today to current members of the Senior Management Team, with changes in a variety of reporting relationships throughout the organization. A revised organizational chart is available on the Intranet.

These are significant changes and we realize they will affect a number of staff members. Our goal is to preserve jobs as much as possible and ensure the financial health of our organization. We will continue to invest in core services in preparation for changes from healthcare reform.

Please know that I am committed to ensuring the best possible future for Pekin Hospital and ProHealth. At this point, there are no additional significant organizational changes planned. I appreciate your continued support during these turbulent times. If you have questions about the changes, please contact your director or a member of Senior Management.

Sincerely,

A handwritten signature in cursive script that reads "Kevin R. Andrews".

Kevin Andrews
Chief Executive Officer



December 21, 2011

Dear Pekin Hospital Volunteers and Escorts:

This letter is to inform you of organizational changes taking place at Pekin Hospital that enable us to maintain a strong financial position. The cost-saving initiatives we will implement over the next few months will result in over **\$1.5 million annual savings**, which is necessary for the current and future financial health of our organization.

Skilled Nursing Unit

After years of declining volumes and operating at a loss, we have started the process with the State of Illinois Certificate of Need program to close our Skilled Nursing Unit. We anticipate converting the Skilled Nursing Unit to a medical/surgical unit, which will increase our number of private rooms. This will allow us to remain attractive to potential patients and remain competitive with other local healthcare facilities. Depending upon the Certificate of Need process, we will at some point stop taking admissions to the floor. We will continue to provide future patients a variety of local options for skilled nursing services as part of discharge planning process.

Additional changes that will be implemented over the next few months include:

- We have given IPMR our contract termination notice. Effective March 1, 2012, Professional Therapy Services, Inc. (PTS) will begin providing rehab therapy services at Pekin Hospital. We are committed to retaining as many staff members as possible and have asked PTS and IPMR to include this in the transition plan.
- We will consolidate the Senior Management staff and not fill the vacant position for the Vice President of Physician Services. Responsibilities of the position have been reassigned to current members of the Senior Management Team, with changes in a variety of reporting relationships throughout the organization.

Please know that I am committed to ensuring the best possible future for Pekin Hospital and ProHealth. At this point, there are no additional significant organizational changes planned. I appreciate your continued support. If you have questions about the changes, please contact a member of Administration.

Sincerely,

A handwritten signature in cursive script that reads "Kevin R. Andrews".

Kevin Andrews
Chief Executive Officer



December 21, 2011

Dear Pekin Hospital League Members:

This letter is to inform you of organizational changes taking place at Pekin Hospital that enable us to maintain a strong financial position. The cost-saving initiatives we will implement over the next few months will result in over **\$1.5 million annual savings**, which is necessary for the current and future financial health of our organization.

Skilled Nursing Unit

After years of declining volumes and operating at a loss, we have started the process with the State of Illinois Certificate of Need program to close our Skilled Nursing Unit. We anticipate converting the Skilled Nursing Unit to a medical/surgical unit, which will increase our number of private rooms. This will allow us to remain attractive to potential patients and remain competitive with other local healthcare facilities. Depending upon the Certificate of Need process, we will at some point stop taking admissions to the floor. We will continue to provide future patients a variety of local options for skilled nursing services as part of discharge planning process.

Additional changes that will be implemented over the next few months include:

- We have given IPMR our contract termination notice. Effective March 1, 2012, Professional Therapy Services, Inc. (PTS) will begin providing rehab therapy services at Pekin Hospital. We are committed to retaining as many staff members as possible and have asked PTS and IPMR to include this in the transition plan.
- We will consolidate the Senior Management staff and not fill the vacant position for the Vice President of Physician Services. Responsibilities of the position have been reassigned to current members of the Senior Management Team, with changes in a variety of reporting relationships throughout the organization.

Please know that I am committed to ensuring the best possible future for Pekin Hospital and ProHealth. At this point, there are no additional significant organizational changes planned. I appreciate your continued support. If you have questions about the changes, please contact a member of Administration.

Sincerely,

A handwritten signature in cursive script that reads "Kevin R. Andrews".

Kevin Andrews
Chief Executive Officer

Exhibit K

Current Room / Bed Distribution
 Select Patient Care Units (M/S & LTC)
 Pekin Hospital

<u>Unit</u>	<u>Current Service</u>	<u>Patient Rooms</u>	<u>Accommodations</u>		<u>Beds</u>
			<u>Private</u>	<u>Semi-Private</u>	
4N	Surgical	12	6	6	18
5N	Medical	17	3	14	31
7N	Telemetry / Step down	<u>13</u>	<u>7</u>	<u>6</u>	<u>19</u>
Subtotal Medical Surgical		<u>42</u>	<u>16</u>	<u>26</u>	<u>68</u>
6N	LTC/SNF	<u>15</u>	<u>3</u>	<u>12</u>	<u>27</u>
Total		<u>57</u>	<u>19</u>	<u>38</u>	<u>95</u>
Patient Room % Distribution		100%	33%	66.4%	--
Beds		--	19	76	95
Bed % Distribution		--	20%	80%	100%

Source: Hospital Records

Compiled by: PRISM Healthcare Consulting; January 26, 2012

Exhibit L

Proposed Room / Bed Distribution
 Post LTC Discontinuation
 Select Patient Care Units (M/S Only)
 Pekin Hospital

<u>Unit</u>	<u>Proposed Service</u>	<u>Current Patient Rooms</u>	<u>Proposed Patient Rooms</u>	<u>Accommodations</u>		
				<u>Private</u>	<u>Semi-Private</u>	<u>Beds</u>
4N	Surgical	12	12	7	5	17
5N	Medical	17	17	17	0	17
6N	Medical / Surgical	15	15	14	1	16
7N	Telemetry / Step down	<u>13</u>	<u>13</u>	<u>8</u>	<u>5</u>	<u>18</u>
Total M/S		<u>57</u>	<u>57</u>	<u>46</u>	<u>11</u>	<u>68</u>
Patient Room % Distribution			100%	80.7%	19.3%	--
Beds			--	46	22	68
Bed % Distribution			--	67.9%	32.4%	100%

Source: Hospital Records

Compiled by: PRISM Healthcare Consulting; January 26, 2012



NEWS RELEASE

FOR IMMEDIATE RELEASE

Contact: Carrie L. Warner
(309) 353-0559

Pekin Hospital Proposes to Discontinue Its Long Term Care Category of Service

(February 7, 2012) - Pekin Hospital is in the process of developing and submitting a permit application to the IHFSRB (Illinois Health Facilities State Review Board) to discontinue its Skilled Nursing Facility. The Skilled Nursing Facility has been in operation since 1993, but in the past few years has seen a significant decline in utilization and reimbursement. Additional cuts in Medicare reimbursement of 11% as of October 2011, further compromises the financial viability of the Unit.

As part of the application process, impact letters have been sent to 55 Long-Term Care (LTC) Facilities in the region to determine their ability to care for these types of patients and their capacity to do so. Our initial analysis indicates there are sufficient LTC beds in the area so access will not be compromised.

The closing of the Skilled Nursing Facility will allow Pekin Hospital to utilize the space for acute care patients and provide the Hospital the ability to increase the number of private patient rooms. The discontinuation is seen as a necessary move for improving infection control processes, quality of care, safety, privacy, and patient satisfaction.

Pekin Hospital will be working with the current staff of the Skilled Nursing Facility over the next several months to find other positions within the system as appropriate. The Skilled Nursing Facility is not expected to close until midsummer or until all regulatory requirements are met.

###

Carrie L. Warner
Director of Marketing
600 South 13th Street
Pekin, IL 61554
Phone: (309) 353-0559
Fax: (309) 347-1593
Email: cwarner@pekinhospital.com

Exhibit N

TRANSFER AGREEMENT BETWEEN

Pekin Manor and Pekin Memorial Hospital

This Transfer Agreement shall be effective as of this 1st day of May, 2002 and between Pekin Manor (FACILITY) located at 1520 El Camino Drive, Pekin, IL 61554 and Pekin Memorial Hospital (HOSPITAL), located at 600 South 13th Street, Pekin, IL 61554, an Illinois not-for-profit corporation.

WHEREAS, each party desires to assure continuity of care and treatment appropriate to the needs of its respective patients, and to use the skills, resources, and physician plant to both parties in a coordinated and cooperative fashion to improve patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, IN CONSIDERATION of the mutual advantages occurring to the parties, the parties hereby covenant and agree with each other as follows:

ARTICLE I

The parties shall be independent contractors and neither party shall have the right to act as the agent or representative of the other or to take any action which purports to bind the other. The governing body of each party shall continue to have exclusive control of its management, assets, and affairs, and neither party by virtue of this Agreement shall assume any liability for any debts or obligations which have been or which may be incurred by the other.

ARTICLE II

Whenever the attending physician of any patient of either party shall determine that a transfer of such patient from one party to the other is medically appropriate, the parties shall take whatever steps may be necessary to effect the transfer as promptly as possible. The transfer of patients shall be in accordance with those procedures established by and agreed upon by the parties. The parties shall give preference in their admission policies to patients requiring transfer, subject to availability of bed space and provided that all of the usual conditions for admission are met. Each party shall give notice to the other, as far in advance as possible, of an impending transfer. Prior to initiating a transfer, the transferring party shall obtain confirmation from a representative of the receiving party (to be designated by the receiving party and identified in the transfer procedures referred to above) that the patient has been accepted for admission to such party.

It shall be the responsibility of the transferring party, with input from the attending physician initiating transfer as necessary, to make arrangements for transfer in accordance with the transfer procedures referred to above, to determine the form of transportation that is medically appropriate, and to assure that the patient receives the appropriate level of care during transfer. The responsibilities of the transferring party will cease when the patient has been transferred to the custody of the person at the receiving party (to be designated by the receiving party) who will accept patients on behalf of said party.

ARTICLE III

In establishing its admission policies for patients transferred from the FACILITY pursuant to Article II, the HOSPITAL shall be guided by the following plan:

- (A) Patients designated as emergencies by their attending physicians shall be admitted to the HOSPITAL without delay;
- (B) Patients no designated strictly emergency, but who require early admission to the HOSPITAL, shall be placed on the HOSPITAL's urgent list; and

Exhibit N

- (C) Patients designated as elective admissions shall be booked for future admissions according to the established routine of the HOSPITAL.

ARTICLE IV

In establishing its admission policies for patients transferring to the HOSPITAL pursuant to Article II, the FACILITY shall be guided by the following plan:

- (A) Patients from the HOSPITAL shall be admitted as promptly as possible, provided general admission requirements established by the FACILITY are met; and
- (B) Patients previously transferred from the FACILITY to the HOSPITAL shall be given priority.

Except in the following cases, the FACILITY shall not refuse to readmit any patient who has been transferred from the FACILITY to the HOSPITAL:

- (A) The medical condition of the patient makes readmission to the FACILITY inappropriate or inadvisable; or
- (B) The FACILITY is operating at full capacity and has no bed available for the patient.

ARTICLE V

The parties shall exchange all medical and other information which may be necessary or useful in the care and treatment of patients transferred between them or which may be relevant in determining whether such patients can be adequately cared for otherwise by either party. All such information shall be provided by the transferring party in advance, where possible, and in any event, at the time of the transfer and shall be recorded on a transferal and referral form which shall be mutually agreed upon by the parties. This information shall include, but shall not be limited to, current medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment followed, nursing and dietary information useful in the care of the patient, ambulation status, and pertinent administrative and social information. The name of the physician treating the patient at the transferring party shall also be included.

ARTICLE VI

The transfer of patients' personal effect and valuables shall be in accordance with those procedures established by and agreed upon by the parties. A standard inventory form shall be adopted and used by both parties for identifying patients' personal effects and valuables. The personal effects and valuables of a patient transferred to the HOSPITAL shall be the responsibility of the FACILITY until delivered to and accepted by the appropriate personnel of the HOSPITAL (to be designated by the HOSPITAL and identified in the transfer of valuables procedures referred to above) at which time such personal effects and valuables shall become the sole responsibility of the HOSPITAL. The personal effects and valuables of a patient transferred to the FACILITY shall be the responsibility of the HOSPITAL until delivered to and accepted by a representative of the FACILITY (to be designated by the FACILITY and identified in the transfer procedures describe above) at which time such personal effects and valuables shall become the sole responsibility of the FACILITY. The designated representatives of the FACILITY may be the attendants/driver of the ambulance (or other form of transportation) transporting the patient, or a relative, or a relative or friend of the patient.

ARTICLE VII

Charges for services performed by one party for the patients transferred from the other party pursuant to this Agreement shall be collected by the party rendering such services directly from the patient or from other sources normally billed. Neither party shall have any liability to the other for such charges, except to the extent that such liability would exist separate and apart from this Agreement. Nor

Exhibit N

shall either party receiving a transferred patient be responsible for collecting any account receivable of the other party from such patient which may still be outstanding after such transfer takes place. The cost of transporting a patient from one party to the other shall be the responsibility of the patient, his family or a third party payor.

ARTICLE VIII

This Agreement shall commence upon the Effective Date hereof and shall continue until terminated by either party at any time upon the giving of at least thirty (30) days' prior written notice. Notwithstanding any notice which may have been given, however, the Agreement shall be automatically terminated:

- (A) Whenever either party shall have its license to operate revoked, suspended, or not renewed;
or
- (B) Whenever either party's agreement with the Secretary of Health and Human Services under Section 1866 of the Social Security Act (or under any amendment thereof) is terminated.

ARTICLE IX

The FACILITY shall be maintained and operated in accordance with all applicable state, local and federal laws or regulations, shall make available to the HOSPITAL upon request, the reports of its most recent inspection by a state licensing agency or such other regulatory or accrediting body, as may be applicable, and shall immediately inform the HOSPITAL of its receipt of any notice of deficiency or threatened suspension, revocation or non-renewal of its operating license, or of the termination of the agreement referred to in Section B of Article VIII.

ARTICLE X

Facility hereby agrees to perform service in accordance with the policies and procedures of HOSPITAL and in conformance to the standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other accrediting organizations duly recognized by JCAHO as meeting such acceptable standards. FACILITY will also provide service in accordance with the applicable Medicare Conditions of Participation and agrees to provide information related to ensuring and improving quality of patient care upon the request of HOSPITAL. FACILITY agrees to submit individual credentials and relevant competency validation to HOSPITAL upon request for any staff involved in patient services that are not subject to the Allied health staff credentialing process of HOSPITAL.

ARTICLE XI

Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other. FACILITY shall save, indemnify and hold HOSPITAL harmless of and from any and all liability, loss, costs and expenses incurred directly or indirectly from any act or omission of FACILITY, its agents, employees or invitees from any cause arising from or relating to FACILITY's performance under this Agreement. HOSPITAL shall save, indemnify and hold FACILITY harmless of and from any and all liability, loss, costs and expenses incurred directly or indirectly from any act or omission of HOSPITAL, its agents, employees or invitees from any cause arising from or relating to HOSPITAL's performance under this Agreement. If either party becomes involved as a party to litigation in connection with services provided under this Agreement, that party shall give the other party written notice immediately. The party so notified, at its sole election, may enter into such litigation to protect its interests as they may appear.

Exhibit N

ARTICLE XII

Both parties shall maintain insurance in such amounts are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the ownership and operation of facilities of comparable type and size, shall furnish to the HOSPITAL a certificate of insurance as evidence of its insurance coverage, and shall notify the HOSPITAL immediately of any notice from an insurance carrier of an intent to modify or terminate the FACILITY's insurance coverage.

ARTICLE XIII

Neither party shall use the name of the other party or any recognized trademarks of the other party, in any promotional or advertising material unless prior review and consent in writing has been obtained from the other party.

ARTICLE XIV

Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis, while this Agreement is in effect.

ARTICLE XV

This Agreement may be modified, amended or supplemented by agreement of both parties, but no such modification, amendment, or supplement shall be binding on either party unless and until the same is attached hereto in writing and signed by authorized officials of both parties.

ARTICLE XVI

This Agreement shall be governed by and interpreted according to the laws of the State of Illinois.

ARTICLE XVII

This Agreement may not be assigned, either in whole or in part, by either party without the express written consent of the other

ARTICLE XVIII

Any notice pertaining to this Agreement shall be in writing, postage prepaid, and shall be sent by personal delivery, reputable overnight carrier, certified or registered mail, return receipt requested to FACILITY or HOSPITAL at the addresses indicated below.

To the HOSPITAL:

Pekin Memorial Hospital
600 South 13th Street
Pekin, IL 61554
Attention: Vice President of Nursing Services

To the FACILITY:

Pekin Manor
1520 El Camino Drive
Pekin, IL 61554
Attention: Administrator

**PATIENT TRANSFER AGREEMENT
BETWEEN
ROSEWOOD CARE CENTER, INC. OF EAST PEORIA
AND
PEKIN MEMORIAL HOSPITAL**

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made and entered into on the last date written below, by and between ROSEWOOD CARE CENTER, INC. OF EAST PEORIA ("Rosewood.") and PEKIN MEMORIAL HOSPITAL ("Hospital"),

WITNESSETH

WHEREAS, Rosewood is a skilled nursing facility that provides comprehensive rehabilitation and long term care services to persons needing such services;

WHEREAS, Hospital is licensed by the State of Illinois to provide general emergency and acute care inpatient and outpatient hospital services;

WHEREAS, the parties desire to arrange for the transfers of persons between the parties as deemed medically appropriate by the attending physician of the person being transferred, and to provide for an interchange of medical and other information necessary or useful in the care and treatment of persons so transferred;

WHEREAS, the parties desire to assure continuity of care and treatment appropriate to the needs of each Hospital patient and Rosewood resident, and to use the skills, resources and physical plant of both parties in a coordinated and cooperative fashion to improve patient care;

NOW, THEREFORE, in consideration of the mutual covenants and conditions, herein set forth, and other good and valuable consideration, the receipt and sufficiency of which is hereby expressly acknowledged, the parties covenant and agree as follows:

1.0 TRANSFER

1.1 To Hospital. Subject to bed availability, Hospital shall provide all necessary inpatient hospital services for those residents of Rosewood for whom hospitalization is deemed necessary by such residents' attending physician.

1.2 To Rosewood. Subject to bed availability, Rosewood shall provide necessary extended care services for those patients of the Hospital who meet Rosewood's established admission criteria and for whom such services are deemed necessary by such residents' attending physician.

1.3 Transportation. The transferring institution shall be responsible for arranging for transportation of the person being transferred in accordance with applicable federal and state laws and regulations.

1.4 Bed Holds. Rosewood shall hold a bed for any person transferred from Rosewood to Hospital in accordance with the terms of the Resident Contract between such person and Rosewood. Rosewood shall readmit a person transferred to Hospital upon such person's discharge from Hospital, provided that such person continues to meet Rosewood's admissions criteria and that a bed is available for such person.

1.5 Transfer Information. The transferring institution shall provide, either in advance of a transfer or along with the person being transferred, all medical and administrative information needed to provide continuing care to the transferee. Such information shall be provided on a transfer and referral form mutually agreed upon between the parties. Other than in an emergency, the transferring institution shall also provide, prior to the transfer, sufficient information to permit the other institution to determine whether it can provide the care needed.

1.6 Patient Valuables. The parties shall develop mutually acceptable procedures for effecting the transfer of a transferee's personal effects and valuables and shall adopt a standard for recording such transfer.

1.7 Non-Exclusivity. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other hospital or extended care facility, on either a limited or general basis, while this Agreement is in effect.

2.0 COMPENSATION

2.1 Generally. Rosewood shall compensate Hospital for all Medicare Part B services that Hospital provides to Rosewood residents who are eligible for and enrolled in Medicare Part B other than those services for which the Balanced Budget Act of 1997 does not impose liability on Rosewood for payment (collectively "the Medicare Services"). Rosewood shall compensate Hospital for all Medicare Services at the Medicare fee schedule rates in effect for the geographic area in which the Rosewood facility is located.

2.2 Non-Reimbursable Services. Rosewood shall have no obligation to compensate Hospital for services provided by Hospital that are not Medicare Services. Further, if the Medicare Program subsequently denies or disallows reimbursement to Rosewood for any Medicare Service for which Rosewood has compensated Hospital, then Hospital will promptly reimburse Rosewood the entire amount of such compensation and shall bill the affected resident directly for such service within three (3) days of receiving notice from Rosewood of such denial or disallowance.

2.3 Limitation on Charges. Hospital shall not charge Rosewood for any services provided to a Rosewood resident that is not part of such resident's plan of care.

3.0 TERM AND TERMINATION

3.1 Term of Agreement. This Agreement shall become effective on January 1, 1999, and shall continue in effect for one (1) year thereafter (the "Initial Term") unless terminated as set forth below. Thereafter, this Agreement shall be automatically renewed from year to year unless either party gives written notice of its intent not to so renew the Agreement at least ninety (90) days prior to the annual renewal date.

3.2 Termination. Either party may terminate this Agreement with or without cause by giving the other party at least thirty (30) days advance written notice of such termination.

4.0 RELATIONSHIP OF PARTIES

The relationship between Rosewood and Hospital is solely that of two independent parties contracting with each other at arm's length for the purpose of effectuating the provisions of this Agreement. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any other relationship; neither party, nor their respective agents, employees or representative shall be deemed the agent, employee or representative of the other (except as expressly provided herein), and no joint venture or partnership shall result from this Agreement. Each party shall be solely responsible for and shall comply with all state and federal laws pertaining to employment taxes, income withholding, unemployment compensation contributions and other employment-related statutes applicable to that party.

5.0 MISCELLANEOUS

5.1 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois.

5.2 Entire Agreement. This Agreement contains the entire understanding of Rosewood and the Hospital with respect to the subject matter hereof, and supersedes all negotiations, prior or contemporaneous discussions, agreements or understandings, whether written or oral.

5.3 Captions. The captions to this Agreement are for convenience of reference only and in no way define, limit or describe the scope or intent of this Agreement or any part hereof, nor in anyway affect this Agreement or any part hereof.

5.4 Amendments. This Agreement may be amended or modified only by a writing signed by both parties. Notwithstanding the foregoing, either party may amend this Agreement upon written notice to the other party as required to comply with applicable statutes, laws and regulations.

5.5 Strict Compliance. No failure by the parties herein to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, or to exercise any right or remedy consequent upon a breach thereof, shall constitute a waiver of any such breach or any subsequent breach of such covenant, agreement, term or condition. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, agreement, term and condition of this Agreement shall continue in full force and effect with respect to any other then existing or subsequent breach thereof.

5.6 Severability. This Agreement shall be construed to be in accordance with federal and state statutes and Medicare, Medicaid and intermediary carrier rules, regulations, principles and interpretations regarding reimbursement and rates charged to patients. If any provision of this Agreement, or any portion thereof, is found to be invalid, illegal or unenforceable, under any applicable statute or rule of law, then such provision or portion thereof shall be deemed omitted, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

5.7 Advertising. Neither party shall use the name of the other party in any promotional or advertising material unless review and approval of the intended use shall first be obtained from the party whose name is to be used.

5.8 Assignment. This Agreement may not be assigned, delegated or transferred by either party hereto without the advance written consent of the other party; provided, however, that either party may assign, delegate or transfer this Agreement or any rights or obligations hereunder to another corporation or entity, now or hereafter existing, which is an affiliate or successor of such party.

5.9 Notices. Any notice required or permitted to be given under this Agreement shall be sufficient if in writing and delivered in person or sent Registered or Certified United States mail, return receipt requested, postage prepaid, or by recognized courier, addressed as follows:

Exhibit O

If to Rosewood:

Rosewood Care Center, Inc. of East Peoria
11701 Borman Drive
Suite 315
St. Louis, MO 63146
Attn: Larry Vander Maten

If to Hospital:

Pekin Memorial Hospital
600 S. 13th Street
Pekin, IL 61554
Attention: Robert Moore

or such other address as either party may designate in writing.

5.10 No Obligations to Third Parties. None of the obligations and duties of Rosewood or Hospital under this Agreement shall in any way or in any manner be deemed to create any obligation of Rosewood or Hospital to, or any rights in, any person or entity not a party to this Agreement.

5.11. Force Majeure. Neither party shall be liable for or deemed to be in default for any delay or failure to perform any act under this Agreement (other than the payment of money) resulting, directly or indirectly, from Acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work stoppages by either party's employees, or any other cause beyond the reasonable control of such party.

5.12 Authority. Signators below represent and warrant that they are duly empowered to execute this Agreement.

IN WITNESS WHEREOF, the undersigned have executed or caused this Agreement to be executed on the day and year first written above.

ROSEWOOD CARE CENTER, INC.
OF EAST PEORIA

By: _____

Larry Vander Maten
President

PEKIN MEMORIAL HOSPITAL

By: _____

Robert Moore
CEO

**Impact Letters Sent
(See Exhibit B)**

PEKIN HOSPITAL

January 6, 2012

Christina Durbin
Briarbrook Place
228 Briarbrook Drive
East Peoria, IL 61611

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Christina Durbin,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

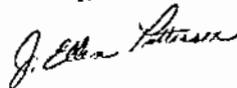
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
2011	371	3,220	8.8

We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Candy Moore
Heartland of Riverview
500 Centennial Dr.
East Peoria, IL 61611

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Candy Moore,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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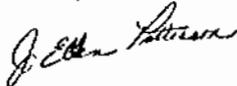
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
2011	371	3,220	8.8

We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Becky Woiwode
Rosewood Care Center
900 Centennial Dr.
East Peoria, IL 61611

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Becky Woiwode,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

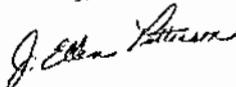
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
2011	371	3,220	8.8

We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Renee Gass
Fondulac Rehab & Healthcare Center
901 Illini Dr.
East Peoria, IL 61611

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Renee Gass,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

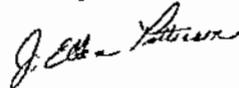
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We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Don Dadds
OSF Saint Clare Home
5533 N. Galena Rd.
Peoria Heights, IL 61616

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Don Dadds,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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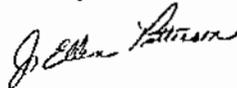
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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

John Kelley
Apostolic Christian Restmor
1500 Parkside Ave
Morton, IL 61550

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear John Kelley,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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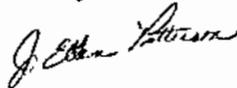
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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Ron Messner
Apostolic Christian – Tiberridge
2125 Veteran's Road
Morton, IL 61550

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Ron Messner,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

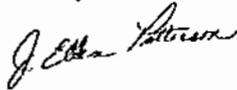
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
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We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Matt Feucht
Apostolic Christian Skylines
7023 NE Skyline Dr.
Peoria, IL 61614

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Matt Feucht,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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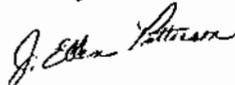
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Tom Hoffman
Apostolic Christian—Eureka
610 W. Cruger Ave.
Eureka, IL 61530

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Tom Hoffman,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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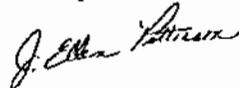
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Matt Nieukirk
Belwood Nursing Home
6701 Plank Rd.
Peoria, IL 61604

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Matt Nieukirk,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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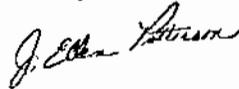
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Stacy Neubert
Christian Buehler Memorial Home
3415 N. Sheridan Rd.
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Stacy Neubert,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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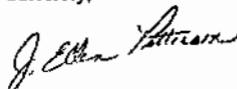
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Wade Cies
Heritage Manor—Chillicothe
1028 W. Hillcrest Dr.
Chillicothe, IL 61523

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Wade Cies,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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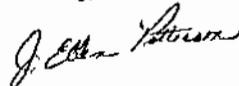
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Donna Malone
John C. Proctor Endowment Home
272 W. Reservoir Blvd.
Peoria, IL 61614

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Donna Malone,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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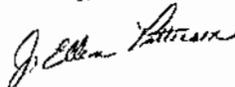
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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Janelle Clark
Lutheran Home
7019 N. Galena Rd.
Peoria, IL 61615

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Janelle Clark,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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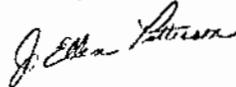
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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Carol Williams
Heartland Healthcare
5600 Glen Elm Dr.
Peoria, IL 61614

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Carol Williams,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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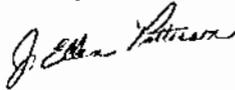
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Nyla Krabbenhofp
Maple Lawn Health Center
700 N. Main St.
Eureka, IL 61530

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Nyla Krabbenhofp,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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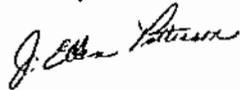
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

David McDaniels
Morton Terrace
191 E. Queenwood
Morton, IL 61550

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear David McDaniels,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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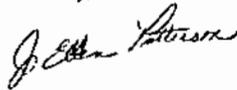
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Ben Perkins
Pekin Manor
1520 El Camino Dr.
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Ben Perkins,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Kevin Andrews
Pekin Memorial Hospital
600 S. 13th
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Kevin Andrews,

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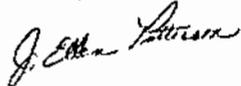
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Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Christina Durbin
Harris Place
209 Harris Rd.
East Peoria, IL 61611

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Christina Durbin,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

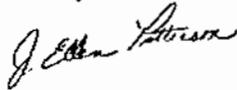
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
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We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Mark Rossi
Hopedale Hospital
107 W. Tremont
Hopedale, IL 61747

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Mark Rossi,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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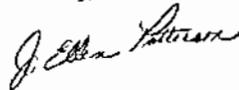
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Lorraine Foust
Bella Vista Care Center
1629 E. Gardner Ln.
Peoria Heights, IL 61616

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Lorraine Foust,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Timothy Wiley
Rosewood Care Center—Peoria
1500 W. Northmoor Rd.
Peoria, IL 61614

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Timothy Wiley,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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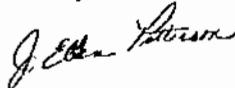
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Sharyl Ford
Sharon Health Care Elms
3611 N. Rochelle Ln.
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Sharyl Ford,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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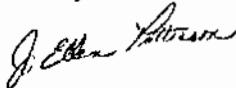
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Randall Bauer
Sharon Health Care Pines
3614 N. Rochelle Ln.
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Randall Bauer,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Cindy Jones
Sharon Health Care Willows
3520 N. Rochelle Ln.
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Cindy Jones,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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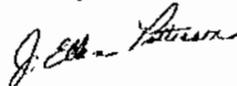
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Thomas Becker
Snyder Village
1200 E. Partridge
Metamora, IL 61548

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Thomas Becker,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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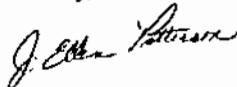
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Brent Morgan
Timbercreek Rehab & Healthcare
2220 State St
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Brent Morgan,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Stacy Brenton
Washington Christian Village
1201 Newcastle Rd
Washington, IL 61571

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Stacy Brenton,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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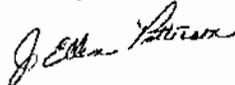
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Matthew Steffen
Linden Estate
1000 Linden
Morton, IL 61550

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Matthew Steffen,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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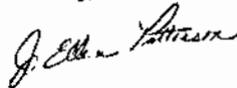
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Clinton McDaniel
Morton Villa Care Center
190 E. Queenwood Road
Morton, IL 61550

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Clinton McDaniel,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Matthew Steffen
Oakwood Estate
2213 Veterans Road
Morton, IL 61550

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Matthew Steffen,

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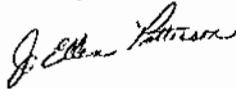
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Please send your response to Mrs. Jo Ellen Patterson, RN, MS, Pekin Memorial Hospital, 600 South 13th Street, Pekin, IL 61554. You may also want to send a copy directly to Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois Department of Public Health, 525 West Jefferson, 2nd Floor, Springfield, IL 62761.

If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Adam Tabor
Davies Square
1817 Crescent Drive
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Adam Tabor,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

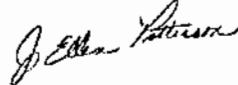
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
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We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Cora Dillman
Marigold Estates
3240 Barney Avenue
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Cora Dillman,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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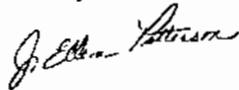
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Theresa Appleyard
Twin Oaks
2011 14th Street
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Theresa Appleyard,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Sue Wujek
Crabel Court
1105 Crabel Court
Chillicothe, IL 61523

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Sue Wujek,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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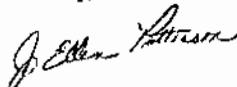
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Edith Morris
Andover
4636 W. Andover Dr.
Peoria, IL 61615

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Edith Morris,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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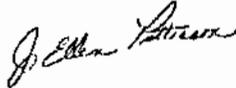
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Marie Dixon
Hart House
905 NE Perry St.
Peoria, IL 61610

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Marie Dixon,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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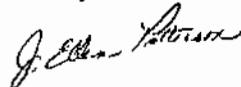
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Marie Dixon
Hartwick House
702 NE Madison
Peoria, IL 61607

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Marie Dixon,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Marie Dixon
Hunter House
605 NE Perry St
Peoria, IL 61610

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Marie Dixon,

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Edith Morris
Lyons Court
4505 W. Lyons
Peoria, IL 61615

Re: Proposed Discontinuation, Long Term Care Category of Service

Dear Edith Morris,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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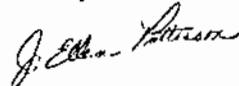
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Linda Patton
Manor Court of Peoria
6900 N. Stalworth Drive
Peoria, IL 61615

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Linda Patton,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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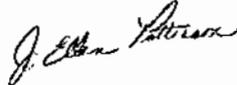
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Edith Morris
North Frostwood
61116 N. Frostwood Parkway
Peoria, IL 61615

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Edith Morris,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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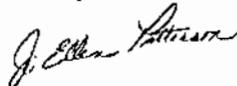
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Paul Macek
Proctor Community Hospital
5409 N. Knoxville Ave.
Peoria, IL 61614

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Paul Macek,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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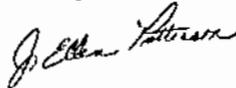
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Mona Robinson
Rochelle
3505A N. Rochelle
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Mona Robinson,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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If you have any questions about our plans or how we can work together to relocate patients, please do not hesitate to contact me at 309-353-0728 or via email at jpatterson@pekinhospital.com

Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Bobby Ford
Sharon Healthcare Woods
3223 W. Richwoods Blvd.
Peoria, IL 61604

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Bobby Ford,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

We invite you to share with us any impact this action may have on your facility. Our long term care utilization for the latest 36 month period is as follows:

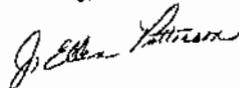
Year	Admissions	Patient Days	Average Daily Census
2009	463	4,261	11.7
2010	426	3,770	10.3
2011	371	3,220	8.8

We greatly appreciate your written response notifying us within 15 days of receiving this letter, whether your facility has available capacity to assume additional long-term care patients "without restrictions, conditions, limitations, or discrimination." If you are able to assume additional patients under these requirements, please provide your total bed capacity, number of available beds, average daily census, and the estimated number of the additional patients your facility could accept.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Edith Morris
South Frostwood
6101 N. Frostwood
Peoria, IL 61605

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Edith Morris,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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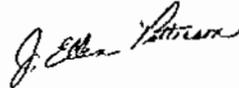
Year	Admissions	Patient Days	Average Daily Census
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Anna Laible
Eureka Hospital
101 S. Major
Eureka, IL 61530

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Anna Laible,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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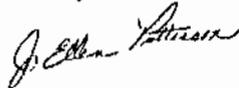
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Lora Dillman
Emerald Estates
1577 E. Myrtle
Canton, IL 61520

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Lora Dillman,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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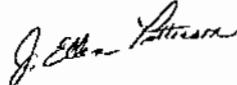
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Robert Senneff
Graham Hospital
210 W. Walnut St.
Canton, IL 61520

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Robert Senneff,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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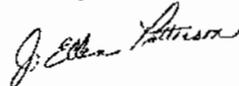
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Martha Jones
Heartland of Canton
2081 N. Main
Canton, IL 61520

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Martha Jones,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

In accordance with Section 1110.130 amended rules effective February 6, 2009, any certificate of need permit application submitted for discontinuation requires the applicants contact all "existing or approved" providers with similar services located within a 45-minute normal travel time of the applicant facility at least 30 days prior to filing an application. We have determined your facility is located within this area and are providing this notice of our intent to discontinue the 27-bed general long-term care category of service at the Hospital. Our anticipated date of discontinuation, pending approval, is July 1, 2012, assuming IHFSRB action at their June 5, 2012 meeting.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Leann Thomas
Renaissance Care Center
1675 E. Ash St.
Canton, IL 61520

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Leann Thomas,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Aaron Anderson
Sunset Rehab & Health Center
129 S. 1st Ave
Canton, IL 61520

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Aaron Anderson,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

PEKIN HOSPITAL

January 6, 2012

Jenifer Baker
Farrington Country Manor
701 S. Main St.
Farrington, IL 61531

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Jenifer Baker,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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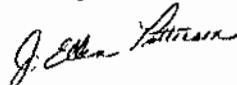
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital


PEKIN HOSPITAL

January 6, 2012

Joyce Conrady
Mason City Area Nursing Home
520 N. Price Ave
Mason City, IL 62664

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Joyce Conrady,

Pekin Memorial Hospital intends to file a Certificate of Need Permit Application to discontinue the general long-term care category of services at the Hospital.

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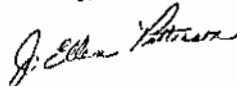
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Sincerely,



Jo Ellen Patterson
VP of Nursing
Pekin Hospital

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Sent To: **Lora Dillman**
 Street, Apt. No., or PO Box No.: **Emerald Estates**
1577 E. Myrtle
 City, State, ZIP+4: **Canton, IL 61520**

PS Form 3800, Aug 08

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

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Sent To: **Leann Thomas**
 Street, Apt. No., or PO Box No.: **Renaissance Care Center**
1675 E. Ash St.
 City, State, ZIP+4: **Canton, IL 61520**

PS Form 3800, Aug 08

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

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Sent To: **Robert Senneff**
 Street, Apt. No., or PO Box No.: **Graham Hospital**
210 W. Walnut St.
 City, State, ZIP+4: **Canton, IL 61520**

PS Form 3800, Aug 08

7011 1570 0001 6445 0538

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

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Sent To: **Jenifer Baker**
 Street, Apt. No., or PO Box No.: **Farrington Country Manor**
701 S. Main St.
 City, State, ZIP+4: **Farmington, IL 61531**

PS Form 3800, Aug 08

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

Sent To: **Martha Jones**
 Street, Apt. No., or PO Box No.: **Heartland of Canton**
2081 N. Main
 City, State, ZIP+4: **Canton, IL 61520**

PS Form 3800, August 08

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U.S. Postal Service...
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Return Receipt Fee (Endorsement Required)	\$
Restricted Delivery Fee (Endorsement Required)	\$
Total Postage & Fees	\$

Postmark Here

Sent To: **Becky Woiwode**
 Street, Apt. No., or PO Box No.: **Rosewood Care Center**
900 Centennial Dr.
 City, State, ZIP+4: **East Peoria, IL 61611**

PS Form 3800, August 08

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 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Paul Macek
 Street, Apt. No., or PO Box No.: Proctor Community Hospital
 5409 N. Knoxville Ave.
 City, State, ZIP+4: Peoria, IL 61614

PS Form 3800, Au

7011 1570 0001 6445 0421

U.S. Postal Service
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OFFICIAL USE

PEKIN, ILL 61654
 Certified Fee
 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Anna Laible
 Street, Apt. No., or PO Box No.: Eureka Hospital
 101 S. Major
 City, State, ZIP+4: Eureka, IL 61530

PS Form 3800, Au

7011 1570 0001 6445 0525

U.S. Postal Service
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OFFICIAL USE

PEKIN, ILL 61654
 Certified Fee
 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Aaron Anderson
 Street, Apt. No., or PO Box No.: Sunset Rehab & Health Center
 129 S. 1st Ave
 City, State, ZIP+4: Canton, IL 61520

PS Form 3800, Au

7011 1570 0001 6445 0457

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
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PEKIN, ILL 61654
 Certified Fee
 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Bobby Ford
 Street, Apt. No., or PO Box No.: Sharon Healthcare Woods
 3223 W. Richwoods Blvd.
 City, State, ZIP+4: Peoria, IL 61604

PS Form 3800, Au

7011 1570 0001 6445 0440

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PEKIN, ILL 61654
 Certified Fee
 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Mona Robinson
 Street, Apt. No., or PO Box No.: Rochelle
 3505A N. Rochelle
 City, State, ZIP+4: Peoria, IL 61604

PS Form 3800, Au

7011 1570 0001 6445 0464

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PEKIN, ILL 61654
 Certified Fee
 Return Receipt Fee (Endorsement Required)
 Restricted Delivery Fee (Endorsement Required)
 Total Postage & Fees \$

Sent To: Edith Morris
 Street, Apt. No., or PO Box No.: South Frostwood
 5101 N. Frostwood
 City, State, ZIP+4: Peoria, IL 61605

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7011 1570 0001 6445 0372

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

Postmark Here

Sent To: Marie Dixon
 Street, Apt. No., or PO Box No.: Hart House
 905 NE Perry St.
 City, State, ZIP+4: Peoria, IL 61610

PS Form 3800, Au

7011 1570 0001 6445 0402

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

Postmark Here

Sent To: Edith Morris
 Street, Apt. No., or PO Box No.: Lyons Court
 4505 W. Lyons
 City, State, ZIP+4: Peoria, IL 61615

PS Form 3800, Au

7011 1570 0001 6445 0389

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

Postmark Here

Sent To: Marie Dixon
 Street, Apt. No., or PO Box No.: Hartwick House
 702 NE Madison
 City, State, ZIP+4: Peoria, IL 61607

PS Form 3800, Au

7011 1570 0001 6445 0419

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

Postmark Here

Sent To: Linda Patton
 Street, Apt. No., or PO Box No.: Manor Court of Peoria
 6900 N. Stalworth Drive
 City, State, ZIP+4: Peoria, IL 61615

PS Form 3800, Au

7011 1570 0001 6445 0396

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

Postmark Here

Sent To: Marie Dixon
 Street, Apt. No., or PO Box No.: Hunter House
 605 NE Perry St
 City, State, ZIP+4: Peoria, IL 61610

PS Form 3800, Au

7011 1570 0001 6445 0426

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

Postmark Here

Sent To: Edith Morris
 Street, Apt. No., or PO Box No.: North Frostwood
 61116 N. Frostwood Parkway
 City, State, ZIP+4: Peoria, IL 61615

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7011 1570 0001 6445 0310

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

Sent To: **Matthew Steffen**
 Street, Apt. No.,
 or PO Box No.: **Oakwood Estate**
2213 Veterans Road
 City, State, ZIP+4: **Morton, IL 61550**

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

Sent To: **Theresa Appleyard**
 Street, Apt. No.,
 or PO Box No.: **Twin Oaks**
2011 14th Street
 City, State, ZIP+4: **Pekin, IL 61554**

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7011 1570 0001 6445 0327

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

Sent To: **Adam Tabor**
 Street, Apt. No.,
 or PO Box No.: **Davies Square**
1817 Crescent Drive
 City, State, ZIP+4: **Pekin, IL 61554**

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7011 1570 0001 6445 0352

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

Sent To: **Sue Wujek**
 Street, Apt. No.,
 or PO Box No.: **Crabel Court**
1105 Crabel Court
 City, State, ZIP+4: **Chillicothe, IL 61523**

PS Form 3800, Au

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7011 1570 0001 6445 0334

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

Sent To: **Cora Dillman**
 Street, Apt. No.,
 or PO Box No.: **Marigold Estates**
3240 Barney Avenue
 City, State, ZIP+4: **Pekin, IL 61554**

PS Form 3800, Au

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7011 1570 0001 6445 0365

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

Sent To: **Edith Morris**
 Street, Apt. No.,
 or PO Box No.: **Andover**
4636 W. Andover Dr.
 City, State, ZIP+4: **Peoria, IL 61615**

PS Form 3800, Au

7011 1570 0001 6445 0259

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

Sent To: **Cindy Jones**
 Street, Apt. No., or PO Box No.: **Sharon Health Care Willows**
 City, State, ZIP+4: **3520 N. Rochelle Ln. Peoria, IL 61604**

PS Form 3800, Aug 07

7011 1570 0001 6445 0260

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OFFICIAL USE

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

Sent To: **Stacy Brenton**
 Street, Apt. No., or PO Box No.: **Washington Christian Village**
 City, State, ZIP+4: **1201 Newcastle Rd Washington, IL 61571**

PS Form 3800, Aug 07

7011 1570 0001 6445 0266

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OFFICIAL USE

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

Sent To: **Thomas Becker**
 Street, Apt. No., or PO Box No.: **Snyder Village**
 City, State, ZIP+4: **1200 E. Partridge Metamora, IL 61548**

PS Form 3800, Aug 07

7011 1570 0001 6445 0267

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OFFICIAL USE

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

Sent To: **Matthew Steffen**
 Street, Apt. No., or PO Box No.: **Linden Estate**
 City, State, ZIP+4: **1000 Linden Morton, IL 61550**

PS Form 3800, Aug 07

7011 1570 0001 6445 0273

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OFFICIAL USE

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

Sent To: **Brent Morgan**
 Street, Apt. No., or PO Box No.: **Timbercreek Rehab & Healthcare**
 City, State, ZIP+4: **2220 State St Pekin, IL 61554**

PS Form 3800, Aug 07

7011 1570 0001 6445 0303

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OFFICIAL USE

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

Sent To: **Clinton McDaniel**
 Street, Apt. No., or PO Box No.: **Morton Villa Care Center**
 City, State, ZIP+4: **190 E. Queenwood Road Morton, IL 61550**

PS Form 3800, Aug 07

7011 1570 0001 6445 0198

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OFFICIAL USE

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

Postmark Here

Sent To
Christina Durbin
 Street, Apt. No.,
 or PO Box No. **Harris Place**
 City, State, ZIP+4® **209 Harris Rd.**
East Peoria, IL 61611

PS Form 3800, A

7011 1570 0001 6445 0235

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OFFICIAL USE

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

Postmark Here

Sent To
Sharyl Ford
 Street, Apt. No.,
 or PO Box No. **Sharon Health Care Elms**
 City, State, ZIP+4® **3611 N. Rochelle Ln.**
Peoria, IL 61604

PS Form 3800, A

7011 1570 0001 6445 0264

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OFFICIAL USE

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

Postmark Here

Sent To
Mark Rossi
 Street, Apt. No.,
 or PO Box No. **Hopedale Hospital**
 City, State, ZIP+4® **107 W. Tremont**
Hopedale, IL 61747

PS Form 3800, A

7011 1570 0001 6445 0226

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OFFICIAL USE

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

Postmark Here

Sent To
Timothy Wiley
 Street, Apt. No.,
 or PO Box No. **Rosewood Care Center—Peoria**
 City, State, ZIP+4® **1500 W. Northmoor Rd.**
Peoria, IL 61614

PS Form 3800, A

7011 1570 0001 6445 0211

U.S. Postal Service...
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OFFICIAL USE

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

Postmark Here

Sent To
Lorraine Foust
 Street, Apt. No.,
 or PO Box No. **Bella Vista Care Center**
 City, State, ZIP+4® **1629 E. Gardner Ln.**
Peoria Heights, IL 61616

PS Form 3800, A

7011 1570 0001 6445 0242

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OFFICIAL USE

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

Postmark Here

Sent To
Randall Bauer
 Street, Apt. No.,
 or PO Box No. **Sharon Health Care Pines**
 City, State, ZIP+4® **3614 N. Rochelle Ln.**
Peoria, IL 61604

PS Form 3800, A

7011 1570 0001 6445 0161

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

Sent to: Ben Perkins
 Street, Apt. No., or PO Box No.: Pekin Manor
 City, State, ZIP+4: 1520 El Camino Dr.
 Pekin, IL 61554
 PS Form 3800, A

7011 1570 0001 6445 0167

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

Sent to: Nyla Krabbenhof
 Street, Apt. No., or PO Box No.: Maple Lawn Health Center
 City, State, ZIP+4: 700 N. Main St.
 Bureka, IL 61530
 PS Form 3800, A

7011 1570 0001 6445 0136

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

Sent to: Donna Malone
 Street, Apt. No., or PO Box No.: John C. Proctor Endowment Home
 City, State, ZIP+4: 272 W. Reservoir Blvd.
 Peoria, IL 61614
 PS Form 3800, A

7011 1570 0001 6445 0150

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

Sent to: Carol Williams
 Street, Apt. No., or PO Box No.: Heartland Healthcare
 City, State, ZIP+4: 5600 Glen Elm Dr.
 Peoria, IL 61614
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7011 1570 0001 6445 0146

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

Sent to: Janelle Clark
 Street, Apt. No., or PO Box No.: Lutheran Home
 City, State, ZIP+4: 7019 N. Galena Rd.
 Peoria, IL 61615
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7011 1570 0001 6445 0174

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OFFICIAL USE

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

Sent to: David McDaniels
 Street, Apt. No., or PO Box No.: Morton Terrace
 City, State, ZIP+4: 191 E. Queenwood
 Morton, IL 61550
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Postage	\$	Postmark Here
Certified Fee	\$	
Return Receipt Fee (Endorsement Required)	\$	
Restricted Delivery Fee (Endorsement Required)	\$	
Total Postage & Fees	\$	

Sent To: **Tom Hoffman**
 Apostolic Christian—Eureka
 Street, Apt. No.,
 or PO Box No. **610 W. Cruger Ave.**
 City, State, ZIP+4® **Eureka, IL 61530**

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

Sent To: **Lynn Brady**
 Hallmark House Nursing Center
 Street, Apt. No.,
 or PO Box No. **2501 Allentown Rd.**
 City, State, ZIP+4® **Pekin, IL 61554**

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

Sent To: **Matt Nieukirk**
 Belwood Nursing Home
 Street, Apt. No.,
 or PO Box No. **6701 Plank Rd.**
 City, State, ZIP+4® **Peoria, IL 61604**

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

Sent To: **Candy Moore**
 Heartland of Riverview
 Street, Apt. No.,
 or PO Box No. **500 Centennial Dr.**
 City, State, ZIP+4® **East Peoria, IL 61611**

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

Sent To: **Stacy Neubert**
 Christian Buchler Memorial Home
 Street, Apt. No.,
 or PO Box No. **3415 N. Sheridan Rd.**
 City, State, ZIP+4® **Peoria, IL 61604**

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

Sent To: **Wade Cies**
 Heritage Manor—Chillicothe
 Street, Apt. No.,
 or PO Box No. **1028 W. Hillcrest Dr.**
 City, State, ZIP+4® **Chillicothe, IL 61523**

PS Form 3800, 2011

7011 1570 0001 6445 0549

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OFFICIAL USE

Postage	\$ 2.00
Certified Fee	\$ 0.00
Return Receipt Fee (Endorsement Required)	\$ 0.00
Restricted Delivery Fee (Endorsement Required)	\$ 0.00
Total Postage & Fees	\$ 2.00

Sent To: **Joyce Conrady**
 Street, Apt. No., or PO Box No.: **Mason City Area Nursing Home**
520 N. Price Ave
 City, State, ZIP+4: **Mason City, IL 62664**

PS Form 3800, Apr 08

7011 1570 0001 6445 0053

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
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For delivery information visit our website at www.usps.com

OFFICIAL USE

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

Sent To: **John Kelley**
 Street, Apt. No., or PO Box No.: **Apostolic Christian Restmor**
1500 Parkside Ave
 City, State, ZIP+4: **Morton, IL 61550**

PS Form 3800, Apr 08

7011 1570 0001 6445 0066

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
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For delivery information visit our website at www.usps.com

OFFICIAL USE

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

Sent To: **Ron Messner**
 Street, Apt. No., or PO Box No.: **Apostolic Christian - Tiberridge**
2125 Veteran's Road
 City, State, ZIP+4: **Morton, IL 61550**

PS Form 3800, Apr 08

7011 1570 0001 6445 0044

U.S. Postal Service
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For delivery information visit our website at www.usps.com

OFFICIAL USE

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

Sent To: **Don Dadds**
 Street, Apt. No., or PO Box No.: **OSF Saint Clare Home**
5533 N. Galena Rd.
 City, State, ZIP+4: **Peoria Heights, IL 61616**

PS Form 3800, Apr 08

7011 1570 0001 6445 0075

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

Sent To: **Matt Feucht**
 Street, Apt. No., or PO Box No.: **Apostolic Christian Skylines**
7023 NE Skyline Dr.
 City, State, ZIP+4: **Peoria, IL 61614**

PS Form 3800, Apr 08

7011 1570 0001 6445 0037

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

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

Sent To: **Rence Gass**
 Street, Apt. No., or PO Box No.: **Fondulac Rehab & Healthcare Center**
901 Illini Dr.
 City, State, ZIP+4: **East Peoria, IL 61611**

PS Form 3800, Apr 08

Impact Letter Return Receipts

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Theresa Appleyard Twin Oaks 2011 14th Street Pekin, IL 61554</p> <p>2. Article Number (Transfer from service label) <u>7011 1570 0001 6445 0341</u></p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Theresa Appleyard</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Theresa Appleyard</i></p> <p>C. Date of Delivery <i>1-10-12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102565-02-M-1540

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Leann Thomas Renaissance Care Center 1675 E. Ash St. Canton, IL 61520</p> <p>2. Article Number (Transfer from service label) <u>7011 1570 0001 6445 0518</u></p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Leann Thomas</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Leann Thomas</i></p> <p>C. Date of Delivery <i>1-10-12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102565-02-M-1540

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Mark Rossi Hopedale Hospital 107 W. Tremont Hopedale, IL 61747</p> <p>2. Article Number (Transfer from service label) <u>7011 1570 0001 6445 0204</u></p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Mark Rossi</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>Don Miller</i></p> <p>C. Date of Delivery <i>1-10-12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No <i>Box 267</i></p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102565-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> Signature <input type="checkbox"/> Agent <input type="checkbox"/> Address</p> <p>B. Received by (Printed Name) MARIE DIXON</p> <p>C. Date of Delivery 7/12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
1. Article Addressed to: Marie Dixon Hart House 905 NE Perry St. Peoria, IL 61610	3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.
2. Article Number (Transfer from service label)	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes
7011 1570 0001 6445 0372	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> Signature <input type="checkbox"/> Agent <input type="checkbox"/> Address</p> <p>B. Received by (Printed Name) Candy Moore</p> <p>C. Date of Delivery 7-10</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
1. Article Addressed to: Candy Moore Heartland of Riverview 500 Centennial Dr. East Peoria, IL 61611	3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.
2. Article Number (Transfer from service label)	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes
7011 1570 0001 6445 0013	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> Signature <input type="checkbox"/> Agent <input type="checkbox"/> Address</p> <p>B. Received by (Printed Name) TOM WEERS</p> <p>C. Date of Delivery 7/11/12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
1. Article Addressed to: Robert Senneff Graham Hospital 210 W. Walnut St. Canton, IL 61520	3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.
2. Article Number (Transfer from service label)	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes
7011 1570 0001 6445 0495	
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>Sharon Elms</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> C. Date of Delivery <i>Sharon Elms</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Sharyl Ford Sharon Health Care Elms 3611 N. Rochelle Ln. Peoria, IL 61604</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0235</p>	<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>Cindy Jones</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> C. Date of Delivery <i>Cindy Jones</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Cindy Jones Sharon Health Care Willows 3520 N. Rochelle Ln. Peoria, IL 61604</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0259</p>	<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>Rachel Byrd</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> C. Date of Delivery <i>Rachel Byrd 1-10-10</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Marie Dixon Hunter House 605 NE Perry St Peoria, IL 61604</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0396</p>	<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addresssee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Marie Dixon Hartwick House 702 NE Madison Peoria, IL 61607			1/10
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 10255-02-44-1540	
		7011 1570 0001 6445 0389	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addresssee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Matthew Steffen Linden Estate 1000 Linden Morton, IL 61550		KATHY TANNER	1/11/12
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input checked="" type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 10255-02-44-1540	
		7011 1570 0001 6445 0297	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addresssee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Stacy Neubert Christian Buehler Memorial Home 3415 N. Sheridan Rd. Peoria, IL 61604		STACY NEUBERT	1-10-12
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 10255-02-44-1540	
		7011 1570 0001 6445 0105	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Linda Patton
Manor Court of Peoria
6900 N. Stalworth Drive
Peoria, IL 61615

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0419

PS Form 3811, February 2004

Domestic Return Receipt

102395-02-M-1540

COMPLETE THIS SECTION ON DELIVERYA. Signature
X *Linda Patton* 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: No3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.4. Restricted Delivery? (Extra Fee) Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Edith Morris
Lyons Court
4505 W. Lyons
Peoria, IL 61615

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0402

PS Form 3811, February 2004

Domestic Return Receipt

102395-02-M-1540

COMPLETE THIS SECTION ON DELIVERYA. Signature
X *Joyce Cooper* Agent
 AddresseeB. Received by (Printed Name) C. Date of Delivery
JOYCE COOPER 1-10-12D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.4. Restricted Delivery? (Extra Fee) Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Edith Morris
Andover
4636 W. Andover Dr.
Peoria, IL 61615

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0365

PS Form 3811, February 2004

Domestic Return Receipt

102395-02-M-1540

COMPLETE THIS SECTION ON DELIVERYA. Signature
X *Jill Smith* Agent
 AddresseeB. Received by (Printed Name) C. Date of Delivery
1-10-12D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.4. Restricted Delivery? (Extra Fee) Yes

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Randall Bauer Sharon Health Care Pines 3614 N. Rochelle Ln. Peoria, IL 61604</p> <p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0242</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> Agent <i>[Signature]</i> <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102505-02-16-1540

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Bobby Ford Sharon Healthcare Woods 3223 W. Richwoods Blvd. Peoria, IL 61604</p> <p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0457</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input type="checkbox"/> Agent <i>[Signature]</i> <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102505-02-16-1540

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Mona Robinson Rochelle 3505A N. Rochelle Peoria, IL 61604</p> <p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0440</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> Agent <i>[Signature]</i> <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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PS Form 3811, February 2004 Domestic Return Receipt 102505-02-16-1540

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>X <i>Joyce Cooper</i></p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>JOYCE COOPER 1-10-12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>6116</p>	
<p>1. Article Addressed to:</p> <p>Edith Morris North Frostwood 6116 N. Frostwood Parkway Peoria, IL 61615</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0426</p>		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 10295-02-04-1540</p>			

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>X <i>Stacy Brenton</i></p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>Stacy Brenton 1-10-12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Stacy Brenton Washington Christian Village 1201 Newcastle Rd Washington, IL 61571</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0280</p>		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 10295-02-04-1540</p>			

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>X <i>Brent Morgan</i></p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>Brent Morgan 1-11-12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Brent Morgan Timbercreek Rehab & Healthcare 2220 State St Pekin, IL 61554</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0273</p>		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 10295-02-04-1540</p>			

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> <i>Aaron Anderson</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
1. Article Addressed to:	B. Received by (Printed Name)	C. Date of Delivery 1/10
Aaron Anderson Sunset Rehab & Health Center 129 S. 1st Ave Canton, IL 61520	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0525	
PS Form 3811, February 2004 Domestic Return Receipt 102585-02-44-1540		

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> <i>Martha Jones</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
1. Article Addressed to:	B. Received by (Printed Name)	C. Date of Delivery 1-10-12
Martha Jones Heartland of Canton 2081 N. Main Canton, IL 61520	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0501	
PS Form 3811, February 2004 Domestic Return Receipt 102585-02-44-1540		

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	<p>A. Signature <input checked="" type="checkbox"/> <i>Carol Williams</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
1. Article Addressed to:	B. Received by (Printed Name)	C. Date of Delivery 1-9-12
Carol Williams Heartland Healthcare 5600 Glen Elm Dr. Peoria, IL 61614	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0150	
PS Form 3811, February 2004 Domestic Return Receipt 102585-02-44-1540		

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressed</p> <p>X: <i>Judy Miller</i></p>	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Joyce Conrady Mason City Area Nursing Home 520 N. Price Ave Mason City, IL 62664			1/10/12
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
7011 1570 0001 6445 0549			
PS Form 3811, February 2004		Domestic Return Receipt 10295-02-M-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.			

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressed</p> <p><i>Wade Cies</i></p>	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Wade Cies Heritage Manor—Chillicothe 1028 W. Hillcrest Dr. Chillicothe, IL 61523		Dane Dencker	1/10/12
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
7011 1570 0001 6445 0129			
PS Form 3811, February 2004		Domestic Return Receipt 10295-02-M-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.			

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressed</p> <p><i>Lora Dillman</i></p>	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Lora Dillman Emerald Estates 1577 E. Myrtle Canton, IL 61520		Marcia Rose	1/10/12
2. Article Number (Transfer from service label)		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
7011 1570 0001 6445 0488			
PS Form 3811, February 2004		Domestic Return Receipt 10295-02-M-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.			

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> <i>R. Brady</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Lynn Brady Hallmark House Nursing Center 2501 Allentown Rd. Pekin, IL 61554		<i>R. Brady</i>	<i>1/16</i>
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
7011 1570 0001 6445 0312			
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-44-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> <i>Kathy Tanner</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Ron Messner Apostolic Christian - Tiberridge 2125 Veteran's Road Morton, IL 61550		<i>KATHY TANNER</i>	<i>1/10/12</i>
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No	
7011 1570 0001 6445 0068			
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-44-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature <input checked="" type="checkbox"/> <i>Eric Mogler</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Matthew Steffen Oakwood Estate 2213 Veterans Road Morton, IL 61550		<i>Eric Mogler</i>	<i>1-10-12</i>
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No	
7011 1570 0001 6445 0310			
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-44-1540	
3. Service Type		4. Restricted Delivery? (Extra Fee)	
<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		<input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	A. Signature <input checked="" type="checkbox"/> <i>Karen Wilcox</i>	<input type="checkbox"/> Agent <input type="checkbox"/> Addressee
1. Article Addressed to:	B. Received by (Printed Name) <i>MARLEA WILCOX</i>	C. Date of Delivery <i>1/10/12</i>
Jenifer Baker Farrington Country Manor 701 S. Main St. Farmington, IL 61531	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0532	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	A. Signature <input checked="" type="checkbox"/> <i>Susan Sullivan</i>	<input type="checkbox"/> Agent <input type="checkbox"/> Addressee
1. Article Addressed to:	B. Received by (Printed Name) <i>Susan Sullivan</i>	C. Date of Delivery <i>1-10-12</i>
Ben Perkins Pekin Manor 1520 El Camino Dr. Pekin, IL 61554	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0181	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 	A. Signature <input checked="" type="checkbox"/> <i>Matt Niekirk</i>	<input type="checkbox"/> Agent <input type="checkbox"/> Addressee
1. Article Addressed to:	B. Received by (Printed Name) <i>Matt Niekirk</i>	C. Date of Delivery <i>1-10-12</i>
Matt Niekirk Belwood Nursing Home 6701 Plank Rd. Peoria, IL 61604	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 1570 0001 6445 0099	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Sue Wujek
Crabel Court
1105 Crabel Court
Chillicothe, IL 61523

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X *Sue Wujek* Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
Sue Wujek *1/10/12*

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

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) **7011 1570 0001 6445 0358**

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Clinton McDaniel
Morton Villa Care Center
190 E. Queenwood Road
Morton, IL 61550

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X *Patty Hefflin* Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
PATTY HEFFLIN *1/10/12*

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

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) **7011 1570 0001 6445 0303**

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

David McDaniels
Morton Terrace
191 E. Queenwood
Morton, IL 61550

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X *Jul Briner* Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
JUL BRINER *1/10/12*

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

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) **7011 1570 0001 6445 0174**

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature X <i>Renee Gass</i> <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Renee Gass Fondulac Rehab & Healthcare Center 901 Illini Dr. East Peoria, IL 61611		Renee Gass	1/16/12
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-M-1540	
		7011 1570 0001 6445 0037	
		3. Service Type	
		<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature X <i>Christina Durbin</i> <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Christina Durbin Harris Place 209 Harris Rd. East Peoria, IL 61611		Christina Durbin	1-10-12
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-M-1540	
		7011 1570 0001 6445 0198	
		3. Service Type	
		<input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		A. Signature X <i>Becky Woiwode</i> <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee	
1. Article Addressed to:		B. Received by (Printed Name)	C. Date of Delivery
Becky Woiwode Rosewood Care Center 900 Centennial Dr. East Peoria, IL 61611		Becky Woiwode	1/10/12
2. Article Number <i>(Transfer from service label)</i>		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
PS Form 3811, February 2004		Domestic Return Receipt 102595-02-M-1540	
		7011 1570 0001 6445 0020	
		3. Service Type	
		<input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input checked="" type="checkbox"/> <i>C. Macek</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>C. Macek</i></p> <p>C. Date of Delivery <i>1-10-12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Paul Macek Proctor Community Hospital 5409 N. Knoxville Ave. Peoria, IL 61614</p>		<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p>		<p>7011 1570 0001 6445 0433</p>	
<p>PS Form 3811, February 2004</p>		<p>Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input checked="" type="checkbox"/> <i>Annette L. Jackson</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>Annette L. Jackson</i></p> <p>C. Date of Delivery <i>1-10-12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>John Kelley Apostolic Christian Restmor 1500 Parkside Ave Morton, IL 61550</p>		<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p>		<p>7011 1570 0001 6445 0051</p>	
<p>PS Form 3811, February 2004</p>		<p>Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input checked="" type="checkbox"/> <i>C. Becker</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>C. Becker</i></p> <p>C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Thomas Becker Snyder Village 1200 E. Partridge Metamora, IL 61548</p>		<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p>		<p>7011 1570 0001 6445 0266</p>	
<p>PS Form 3811, February 2004</p>		<p>Domestic Return Receipt 102595-02-M-1540</p>	

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Linda Patton Manor Court of Peoria 6900 N. Stalworth Drive Peoria, IL 61615</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> <i>Linda Patton</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <hr/> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0419</p> <p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Edith Morris Lyons Court 4505 W. Lyons Peoria, IL 61615</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> <i>Joyce Cooper</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery JOYCE COOPER 1-10-12</p> <p>D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 4405</p> <hr/> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0402</p> <p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

<p>SENDER: COMPLETE THIS SECTION</p> <ul style="list-style-type: none"> Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. 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. <p>1. Article Addressed to:</p> <p>Edith Morris Andover 4636 W. Andover Dr. Peoria, IL 61615</p>	<p>COMPLETE THIS SECTION ON DELIVERY</p> <p>A. Signature <input checked="" type="checkbox"/> <i>Edith Morris</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery 1-10-12</p> <p>D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <hr/> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0365</p> <p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Lorraine Foust
Bella Vista Care Center
1629 E. Gardner Ln.
Peoria Heights, IL 61616

2. Article Number

(Transfer from service label)

7011 1570 0001 6445 0211

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-14-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
Sonya R. Wilson Addressee
B. Received by (Printed Name) Addressee
Sonya R. Wilson C. Date of Delivery
1-10-12
D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Timothy Wiley
Rosewood Care Center—Peoria
1500 W. Northmoor Rd.
Peoria, IL 61614

2. Article Number

(Transfer from service label)

7011 1570 0001 6445 0228

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-14-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
Allen DeBrie Addressee
B. Received by (Printed Name) Addressee
Allen DeBrie C. Date of Delivery
1-10-12
D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Don Dadds
OSF Saint Clare Home
5533 N. Galena Rd.
Peoria Heights, IL 61616

2. Article Number

(Transfer from service label)

7011 1570 0001 6445 0044

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-14-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
Myrae Burns Addressee
B. Received by (Printed Name) Addressee
Myrae Burns C. Date of Delivery
1-10-12
D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ 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. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery <i>John C. Proctor</i> <i>1/10/12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p>Janelle Clark Lutheran Home 7019 N. Galena Rd. Peoria, IL 61615</p>	<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0143</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-44-1540</p>	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ 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. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery <i>Leah Ramsey</i> <i>1/10/12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p>Matt Feucht Apostolic Christian Skylines 7023 NE Skyline Dr. Peoria, IL 61614</p>	<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0075</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-44-1540</p>	

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ 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. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery <i>Donna Malone</i> <i>1/10/12</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p>Donna Malone John C. Proctor Endowment Home 272 W. Reservoir Blvd. Peoria, IL 61614</p>	<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 1570 0001 6445 0136</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-44-1540</p>	

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Adam Tabor
 Davies Square
 1817 Crescent Drive
 Pekin, IL 61554

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0327

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-00-1540

COMPLETE THIS SECTION ON DELIVERY

- A. Signature
 X *Jerry Garcia* Agent Addressee
- B. Received by (Printed Name)
Jerry Garcia
- C. Date of Delivery
1-10-12
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Anna Laible
 Eureka Hospital
 101 S. Major
 Eureka, IL 61530

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0471

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-00-1540

COMPLETE THIS SECTION ON DELIVERY

- A. Signature
 X *Anna Laible* Agent Addressee
- B. Received by (Printed Name)
ANNA LAIBLE
- C. Date of Delivery
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- 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:

Nyla Krabbenhoff
 Maple Lawn Health Center
 700 N. Main St.
 Eureka, IL 61530

2. Article Number
(Transfer from service label)

7011 1570 0001 6445 0367

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-00-1540

COMPLETE THIS SECTION ON DELIVERY

- A. Signature
 X *Nyla Krabbenhoff* Agent Addressee
- B. Received by (Printed Name)
Nyla Krabbenhoff
- C. Date of Delivery
1/10/12
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressed</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>SLUG NORTH 1/10/12</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Tom Hoffinan Apostolic Christian—Eureka 610 W. Cruger Ave. Eureka, IL 61530</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0082</p>		<p>PS Form 3811, February 2004 Domestic Return Receipt 102596-02-M-1540</p>	

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. 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. 		<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressed</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>Jul 5/02 1-12-12</p> <p>D. Is delivery address different from item 1? <input checked="" type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>PO Box 992 Pekin IL 61555</p>	
<p>1. Article Addressed to:</p> <p>Cora Dillman Marigold Estates 3240 Barney Avenue Pekin, IL 61554</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7011 1570 0001 6445 0334</p>		<p>PS Form 3811, February 2004 Domestic Return Receipt 102596-02-M-1540</p>	

Impact Letter Responses

Hallmark House Nursing Home	Pekin
Heartland of Riverview	East Peoria
Hopedale Hospital	Hopedale
Morton Villa Care Center	Morton
Pekin Manor	Pekin
Timbercreek Rehab & Health Center	Pekin
Washington Christian Village	Washington
Bella Vista Care Center	Peoria Heights
Heritage Health - Chillicothe	Chillicothe
Snyder Village	Metamora
Farmington Country Manor	Farmington
Graham Health System	Canton
Renaissance Care Center	Canton
Sunset Rehab & Health Center	Canton

Rec'd
1/17/12

HALLMARK HOUSE NURSING CENTER
2501 Allentown Road
Pekin, IL 61554
(309) 347-3121
(309) 347-3607 Fax
lbrady@hallmarknursingcenter.com

January 12, 2012

Jo Ellen Patterson
Pekin Memorial Hospital
600 South 13th Street
Pekin, IL 61554

RE: Proposed Discontinuation; Long Term Care Category of Service

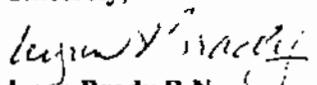
Dear Jo Ellen,

This letter is in response to your letter dated January 6, 2012. Hallmark House will have available capacity to assume additional long-term care patients. Hallmark has the capacity of 25,200 patient days per year and averages 23,932 patient days per year. Average daily census is 67 with a capacity of 70. We are capable of admitting 63 more residents per year if the average stay is 20 days.

Good luck and I hope this information is helpful.

Thank you.

Sincerely,


Lynn Brady R.N.
Administrator

cc: Ms. Courtney R. Avery, Administrator
Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson, 2nd Floor
Springfield, IL 62761

1

Riverview Healthcare
500 Centennial Dr.
East Peoria, IL 61611
309-694-9865
309-699-2192 Fax

Received 1-17-12



January 17, 2012

Pekin Hospital
Attn: Jo Ellen Patterson RN, MS
600 South 13th Street
Pekin, IL 61554-4969

Dear Mrs. Patterson:

Thank you for contacting us regarding your intent to discontinue the long-term general care category at your facility! While we understand the business need surrounding your intent, we are certain the decision to do so did not come lightly.

In response to your request for additional information, Heartland at Riverview has the available capacity to assume additional long-term care patients "without restrictions", "conditions", "limitations" or "discrimination". Our total bed capacity is seventy (70), with sixty-six (66) available beds. There is also a possibility of accepting an additional Eight to ten (8-10) patients. Heartland at Riverview's current average daily census is 57.

Please be assured that Heartland at Riverview is very capable of providing Pekin and the surrounding communities with the levels of therapy and skilled nursing care necessary to return area residents to their home sooner. In fact, we pride ourselves on our 89% return to home rate!

If you should have any questions, please feel free to contact me at 309-694-9865.

Sincerely,

A handwritten signature in cursive script that reads "Candy Moore".

Candy Moore
Property Administrator

cc: IL Dept. of Public Health
file copy

An HCR Manor Care Company

Received 1-12-12



Hopedale Medical Complex
Over fifty years of healthcare excellence

January 10, 2012

Writer's Dial Direct
(309) 449-4394

Jo Ellen Patterson
VP of Nursing
Pekin Hospital
600 S. 13th Street
Pekin, IL 61554-4969

Re: Proposed Discontinuation; Long Term Care Category of Service

Dear Ms. Patterson:

Hopedale Medical Complex (Hopedale Hospital) is in receipt of your January 6 correspondence wherein you notified us of Pekin Hospital's intent to file a Certificate of Need permit application to discontinue the general long-term care category of service at your hospital. This is to advise that Hopedale Hospital has no objection to this application and understands your reasoning.

As you may be aware, our hospital has Medicare certified "swingbeds", so if we can assist any of your patients who may live in this area, we would be happy to do so.

Thank you very much for sharing this information with us, and please do not hesitate to contact me if you are in need of any further assistance.

Sincerely,


Mark F. Rossi
Chief Operating Officer

Cc: Courtney R. Avery
Administrator, Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson, 2nd Floor
Springfield, IL 62761

MFR/jef

107 Tremont
P.O. Box 267
Hopedale, IL 61747

ph: 309.449.3321
fax 309.449.5441
www.hopedalemc.com



Hopedale
Hospital

Hopedale
Wellness
Center

Hopedale
Nursing
Home

 Midwest
Vascular
Institute

Hopedale
Commons
Independent
& Assisted
Living

Medical
Arts
Physicians'
Offices

Hopedale
Pharmacy

Satellite
Doctors'
Offices
Atlanta
Delavan
Markinaw
Manito

Sleep
Disorders
Center

Rehabilitation
& Sports
Medicine
Services

Miss Mona's
Child Care



Received 1/9/12

January 13, 2012

Pekin Memorial Hospital

600 South 13th Street

Pekin, Illinois 61554

Attn: Mrs. Jo Ellen Patterson RN,MS

Dear Mrs. Patterson

Thank you for sending your information regarding available beds, Morton Villa Care Center has beds available for long-term care patients, we are a 106 bed facility and census is running in the 70's at this time.

We would be happy to help you with the relocation of patients.

Any questions or help needed, please call me at 309-266-9741 or 309-232-3600

Sincerely,

A handwritten signature in black ink that reads "David McDaniel LNHA".

David McDaniel LNHA

190 E. Queenwood Rd. • Morton, IL 61550 • Phone: 309.266.9741 • Fax: 309.263.0706



Pekin Manor

January 20, 2012

Jo Ellen Patterson

V.P. Nursing

Pekin Hospital

600 S. 13th Street

Pekin, IL 61554

Dear Ms. Patterson,

I am in receipt of your letter dated January 6, 2012 regarding your proposed discontinuance of LTC Category of services. Please be advised that Pekin Manor currently represents a Skilled License for 120 Long Term Care Beds and is certified to provide services for Medicare and Medicaid recipients "without restrictions, conditions, limitations, or discrimination". This facility is within 1 1/4 miles driving distance from Pekin Hospital, allowing us to serve most all residents your services formerly provided for within your Hospital Facility. Pekin Manor presently operates at an average of 80-85% daily capacity and could easily accommodate an additional 15-20 residents on a daily basis to reach maximum capacity.

Thank you for notifying us of your projected plans, if I may be of any additional service or you have further questions please feel free to contact me at (309) 353-1099.

Respectfully,

Ben Perkins

Administrator

1520 El Camino Drive • Pekin, Illinois 61554
Phone 809/353-1099 • Fax 809/353-1868

Received 1-13-12



Timbercreek
REHAB &
HEALTH CARE

"Caring for Everyone Begins with Us"

2220 State Street
Pekin, IL 61554
Phone: 309-347-1110
Fax: 309-347-2135

1-11-12

Pekin Hospital
Attn: Mrs. Jo Ellen Patterson, RN, MS
600 South 13th Street
Pekin, IL 61554

Dear Mrs. Patterson,

First of all, I'm sorry to hear that Pekin Hospital is closing its SNF Floor. The SNF Floor has provided valuable service to the Pekin community for years. Hopefully, this area will continue to be utilized in the future for the communities benefit as the Hospital sees fit.

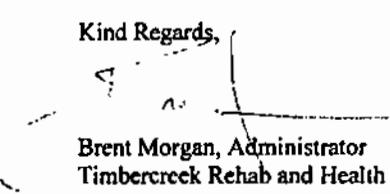
In response to the certified letter dated 1-6-12, it was asked that a response be sent regarding Timbercreek Rehab and Health Care's capacity, available beds, average daily census and estimated number of additional patients that could be accepted into the facility. Below are the responses to those questions:

Timbercreek is 202 bed dually certified Medicare/Medicaid facility. Currently, the facility is setup for 160 beds and has an average daily census of 120 residents. Therefore, Timbercreek would be willing and able to assist with any necessary placement for up to 40 residents. Timbercreek boast an excellent Pathway's Unit assisting residents in need of short term rehab to assist them in obtaining their ultimate goal of returning home. Furthermore, Timbercreek's Long Term Care is second to none for those needing longer placement.

Should it be necessary, Timbercreek would be glad to come up and meet with some or all of the current residents and explain our services to them and answer any questions they might have.

We look forward to working with you on this transition.

Kind Regards,


Brent Morgan, Administrator
Timbercreek Rehab and Health Care

cc: Ms. Courtney R. Avery – Health Facilities and Services Review Board

 *Timbercreek Rehab & Health Care is a proud member of the Petersen Health Care family.*

Received 1/17/12

January 16, 2012

Mrs. Jo Ellen Patterson, RN, MS
Pekin Memorial Hospital
600 S. 13th St.
Pekin, IL 61554

Re: Proposed Discontinuation; Long Term Care Category of Service

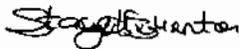
Dear Mrs. Patterson:

I am responding to the letter recently sent indicating Pekin Memorial Hospital's intention to discontinue the general long-term category of services at the hospital. We currently have the capacity to assume some additional long-term care patients. Here is the requested information for Washington Christian Village:

- Total bed capacity: 114
- Number of beds available: 20 (effective 1/16/12)
- Average daily census: 96
- Estimated number of additional patients to accept: 10

If you have any questions or need any additional information, please contact me at 309-886-2500 or sbrenton.wcv@christianhomes.org.

Sincerely,



Stacy Brenton, LNHA



christian homes, inc.
ESTABLISHED 1962

www.washingtonchristianvillage.org

Jo Ellen Patterson

From: Becki Rohrs [brohrs@platinumhc.net]
Sent: Monday, January 16, 2012 4:31 PM
To: Jo Ellen Patterson

Bella Vista Care Center, located in Peoria Heights, is able to assume admission of additional patients. Our bed capacity is 110, current census is in the mid 90's and has stayed at that number for the past few months. We could easily admit new residents for you following admission assessment procedures. Please add our facility to the list for referrals.
Thank you.

*Becki Rohrs
Assistant Administrator*



*1629 East Gardner Lane
Peoria Heights, IL 61616
Phone: (309) 685-1545
Fax: (309) 685-1571*

01/17/2012

Received 1/13/12



HeritageOfCare.com/chillicothe

January 12, 2012

Mrs. Jo Ellen Patterson, RN, MS
Pekin Memorial Hospital
600 S. 13th Street, Pekin, IL 61554

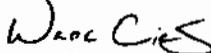
Re: Proposed Discontinuation; Long Term Care Category of Service

Mrs. Patterson,

In response to correspondence sent January 6, 2012, Heritage Health Chillicothe does have available capacity to assume additional long term care patients. We are licensed for 110 residents, and maintain an average census of 100 residents. We estimate that we could take a potential of 5 residents if needed.

We appreciate your consideration in this matter, and if you have any questions about our ability to assume additional patients you can reach me with the contact information provided.

Sincerely,


Wade Cies
Administrator
Heritage Health, Chillicothe

p: 309.274.2194 f: 309.274.2198
1028 Hillcrest Drive Chillicothe, IL 61523

Jo Ellen Patterson

From: Judy Jesse [jjesse@snydervillage.com]
Sent: Thursday, January 19, 2012 8:08 AM
To: Jo Ellen Patterson
Subject: LTC needs

JoEllen,

In response to your letter r/t long term care needs of clients we would be able to help & would do the same screening processes that we do for all of your admissions.

Financial application completed & then medical screening on site.

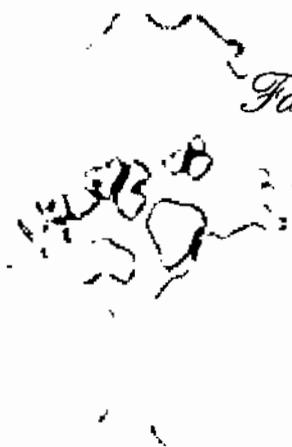
I can direct u to the SV web site for applications & added info about our campus for prospective clients.

Just let me know what your needs are & I would be glad to assist you.

Judy Jesse, RNC
Snyder Village
Nurse Liaison

01/19/2012

Received 1-17-12



Farmington Country Manor

701 South Main Street • Farmington, Illinois 61531
Ph. (309) 245-2407 • Fax (309) 245-2420

January 10, 2012

Re: Assume additional long term care patients pending discontinuation of long term care services at Pekin Hospital

Dear Jo Ellen Patterson, VP of Nursing Pekin Hospital

Farmington Country Manor (FCM) located at 701 S Main, Farmington IL. 61531 have available capacity to assume additional long term care patients without restrictions, conditions, limitations or discrimination.

FCM has a capacity of 92 long term beds. We averaged about 12 available beds in 2011 with an average daily census of 80.

We would be able to accommodate 10 patients for admission placement.

If I can be of any further assistance, please contact me directly at 309-245-2407 extension 415 or at my at my email address: j.baker@fcmnr.com

Respectfully submitted,

JL Baker, LNHA

Jennifer L. Baker
Administrator



Phone (309) 647-5240
210 W. Walnut Street
Canton, IL 61520
www.grahamhealthsystem.org

January 19, 2012

Ms. Jo Ellen Patterson
VP of Nursing
Pekin Hospital
600 South 13th St.
Pekin, IL 61554-4969

Re: Proposed Discontinuation; Longer Term Care Category of Service

Dear Ms. Patterson:

Our Long Term Care (Skilled) utilization over the prior 36 months is as follows

<u>Year</u>	<u>Admissions</u>	<u>Pt. Days</u>	<u>ADC</u>	<u>Beds</u>	<u>Occupancy</u>
2009	477	7225	21.5	32	67.2%
2010	423	7354	20.1	32	62.8%
2011	378	7594	20.8	32	65%

We do have available capacity to assume additional long term care patients "without restrictions, conditions, limitations or discrimination".

Sincerely,

A handwritten signature in black ink, appearing to read "R. Senneff", with a horizontal line extending to the right.

Robert G. Senneff, FACHE
President/CEO

cc: Ms. Courtney R. Avery, Administrator, Health Facilities and Services Review Board, Illinois
Department of Public Health

Graham Hospital • Graham Medical Group • Graham Wellness Center • Graham Home Health and Hospice
Graham Home Medical Equipment • Graham School of Nursing • Graham Foundation

Received 1-23-12

Renaissance Care Center, Inc.

1675 East Ash Street
Canton, Illinois 61520



Pekin Hospital

600 South 134th Street

Pekin, IL 61554-4969

Re: Proposed discontinuation of Long-Term Care Category of Services

Dear Jo Ellen Paterson,

Renaissance Care Center is licensed for 120 geriatric residents with 25 beds available, an average census of 55 and could accept an additional 20 residents. RCC can accommodate these additional residents without restrictions, conditions, limitations, discrimination as per its license.

Sincerely,



Roger D Herman

Administrator

Phone: 309-647-5631 • Fax: 309-647-8957



129 South 1st Avenue
Canton, Illinois 61520
Phone: 309-647-4327
Fax: 309-647-4358

Sunset
REHABILITATION
& HEALTH CARE

January 30, 2012

"Touching the Hearts of Those You Love"

Mrs. Jo Ellen Patterson RN, MS
Pekin Memorial Hospital
600 S. 13th St.
Pekin, IL 61554

Dear Mrs. Patterson,

Please accept this letter as a response to your request for information about our facility dated January 6, 2012.

Sunset Rehabilitation & Healthcare is a 115 bed skilled nursing facility located just southeast of downtown Canton. As of today, our census stands at 97 residents. Therefore, our total number of available beds as of today is 18. We have seen a very sharp increase in our census over the last six weeks as our average daily census was 86 for the last three months of last year. However, due to a very positive reputation within our community, I project our census to steadily increase over the coming months. For estimating purposes, it would be reasonable to assume that we could easily accept 15-18 new residents should you need us to do so.

Please let us know if we can help in any way to make your transition away from long-term care as smooth as possible. If you have any questions or need assistance, please call me at 309-647-4327. Thanks so much.

Sincerely,

Aaron M. Anderson
Administrator
Sunset Rehabilitation & Healthcare

cc: Ms. Courtney R. Avery

S Sunset Rehabilitation & Health Care is a proud member of the Petersen Health Care family.

XI. Safety Net Impact Statement (See narrative and table which follow)

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

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

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

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

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

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

Safety Net Impact Statement

1. To the best of our knowledge, there will be no impact on community-based essential safety-net services. There will be no change in Pekin Hospital's acute care services nor admission policies. The impact letter responses indicate the availability to accept 53 to 60 LTC patients "without conditions" per State Agency rules. The current LTC unit ADC approximated 8.8 patients in 2011. Hence, there is no impact on access due to bed availability or financial restrictions.
2. The applicants have no knowledge as to other provider's ability to cross-subsidize safety net services.
3. The applicants do not believe there will be any impact on safety net providers in the community or region; see also statements 1 and 2 above.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
May 1 – April 30	2008	2009	2010
Inpatient	13	55	91
Outpatient	123	611	1,171
Total	136	666	1,262
Charity (cost In dollars)	\$ 315,496	\$ 431,015	\$ 423,267
Inpatient	612,433	512,589	594,237
Outpatient	\$ 927,929	\$ 943,604	\$ 1,107,504
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
May 1 – April 30	2008	2009	2010
Inpatient	644	621	671
Outpatient	19,633	21,268	23,078
Total	20,272	21,889	23,749
Medicaid (revenue)			
Inpatient	\$ 121,432	\$ 281,916	\$ 2,751,173
Outpatient	2,623,472	4,106,572	2,424,562
Total	\$ 2,744,904	\$ 4,388,488	\$ 5,175,735

XII. Charity Care Information

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

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

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

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

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

CHARITY CARE			
	Year	Year	Year
May 1 – April 30	2008	2009	2010
Net Patient Revenue	\$ 74,765,642	\$ 76,095,011	\$ 77,117,098
Amount of Charity Care (charges)	3,320,000	5,060,000	4,295,000
Cost of Charity Care	927,929	943,604	1,017,504