ORIGINAL

12-035

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

APR 1 1 2012

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	St. Mary's Hospital
Street Address:	111 Spring Street
City and Zip Code:	Streator, Illinois 61364
County: LaSalle	Health Service Area: 2 Health Planning Area: C-02, 2-LaSalle

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

Exact Legal Name:	St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis
Address:	111 Spring Street Streator, Illinois 61364
Name of Registered Agent:	Ms. Amy K. Bulpitt
Name of Chief ~~Executive~~ Operating Officer:	Mr. Mark Dabbs
~~CEO~~ COO/CNO Address:	111 Spring Street Streator, Illinois 61364
Telephone Number:	815-673-4624

Type of Ownership of Applicant/Co-Applicant

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which 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:	Ms. Karen S. Clark
Title:	Chief Financial Officer
Company Name:	St. Mary's Hospital
Address:	111 Spring Street Streator, Illinois 61364
Telephone Number:	815-673-4514
E-mail Address:	kclark@sms.hshs.org
Fax Number:	815-673-4590

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

Name:	Ms. Andrea R. Rozran
Title:	Principal
Company Name:	Diversified Health Resources, Inc.
Address:	65 E. Scott Street Suite 9A Chicago, Illinois 60610-5274
Telephone Number:	312-266-0466
E-mail Address:	arozran@diversifiedhealth.net
Fax Number:	312-266-0715

001

Additional Applicant Identification

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

Exact Legal Name:	Hospital Sisters Services, Inc.
Address:	4936 LaVerna Road Springfield, Illinois 62794
Name of Registered Agent:	Mr. William H. Roach, Jr.
Name of Chief Executive Officer:	Ms. Mary Starmann-Harrison, President and CEO
CEO Address:	4936 LaVerna Road Springfield, Illinois 62794
Telephone Number:	217-523-4747

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

Type of Ownership

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

Additional Applicant Identification

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

Exact Legal Name:	Hospital Sisters Health System
Address:	4936 Leverna Road Springfield, Illinois 62794
Name of Registered Agent:	Mr. William H. Roach, Jr.
Name of Chief Executive Officer:	Ms. Mary Starmann-Harrison, President and CEO
CEO Address:	4936 LaVerna Road Springfield, Illinois 62794
Telephone Number:	217-523-4747

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

Type of Ownership

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ 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
- o each partner specifying whether each is a general or limited partner.

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:	Ms. Karen S. Clark
Title:	Chief Financial Officer
Company Name:	St. Mary's Hospital
Address:	111 Spring Street Streator, Illinois 61364
Telephone Number:	815-673-4514
E-mail Address:	kclark@sms.hshs.org
Fax Number:	815-673-4590

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis

Address of Site Owner: 111 Spring Street Streator, Illinois 61364

Street Address or Legal Description of Site: 111 Spring Street Streator, Illinois 61364

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis

Address: 111 Spring Street Streator, Illinois 61364

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

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

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

Organizational Relationships

Provide (for each 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.

003

Flood Plain Requirements

[Refer to application instructions.] NOT APPLICABLE TO THIS PROJECT

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

[Refer to application instructions.] NOT APPLICABLE TO THIS PROJECT

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☒ Part 1120 Not Applicable
☒ Non-substantive	☐ Category A Project
	☐ Category B Project
	☐ DHS or DVA Project

004

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.

This project proposes the discontinuation of the 30-bed General Long-Term Care Category of Service at St. Mary's Hospital.

This category of service was temporarily suspended on August 12, 2011, and, in accordance with 77 Ill. Adm. Code 1130.240(d), monthly Notices of Temporary Suspension have been submitted to the Illinois Health Facilities and Services Review Board since that time.

This project is "Non-Substantive" in accordance with 77 Ill. Adm. Code 1110.40.b) because it is solely for the discontinuation of a category of service.

There are no capital costs associated with this project.

St. Mary's Hospital is located in Planning Area 2-LaSalle, which has an excess of 55 General Long-Term Care beds as of February 15, 2012.

005

Project Costs and Sources of Funds

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

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

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

006

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): Upon receipt of CON Permit

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

NOT APPLICABLE BECAUSE THIS PROJECT HAS NO COSTS

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☐ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

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

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

007

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.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

008

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: St. Mary's Hospital		**CITY: Streator**			
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	79	1,614*	8,271*	0	79
Obstetrics	7	340	1,038**	0	7
Pediatrics	3	35	66	0	3
Intensive Care	8	286	1,240***	0	8
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	30	226	2,641	-30	0
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	127	2,501****	13,256	-30	97

*Medical/Surgical patient days include Observation Days on the nursing units
**Obstetric patient days include Observation Days on the nursing unit
***Intensive Care patient days include Observation Days in the Intensive Care Unit
****Admissions exclude transfers into the Intensive Care Unit

CERTIFICATION

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

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

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

SIGNATURE

STEVEN P. BROADUS

PRINTED NAME

BOARD CHAIR

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20TH day of MARCH

Signature of Notary

Seal

Official Seal
Nancy K Hayes
Notary Public State of Illinois
My Commission Expires 06/28/2012

SIGNATURE

JIMMIE D. CRAWFORD

PRINTED NAME

SECRETARY

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20TH day of MARCH

Signature of Notary

Seal

Official Seal
Nancy K Hayes
Notary Public State of Illinois
My Commission Expires 06/28/2012

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Larry P. Schumacher
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of March, 2012

Sylvia Rebecca Gansz
Signature of Notary

Seal

OFFICIAL SEAL
SYLVIA REBECCA GANSZ
Notary Public - State of Illinois
My Commission Expires Apr 17, 2016

SIGNATURE

Ann M. Carr
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of March, 2012

Donna J. Chase
Signature of Notary

Seal

OFFICIAL SEAL
DONNA J. CHASE
Notary Public - State of Illinois
My Commission Expires Jun 21, 2014

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE	SIGNATURE
Larry P. Schumacher	Ann M. Carr
PRINTED NAME	PRINTED NAME
Chief Operating Officer	Treasurer
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 19th day of March, 2012	Notarization: Subscribed and sworn to before me this 19th day of March, 2012
Signature of Notary	Signature of Notary
Seal: OFFICIAL SEAL SYLVIA REBECCA GANSZ Notary Public - State of Illinois My Commission Expires Apr 17, 2016	Seal: OFFICIAL SEAL DONNA J. CHASE Notary Public - State of Illinois My Commission Expires Jun 21, 2014

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

D. Projected Operating Costs

NOT APPLICABLE BECAUSE THIS PROJECT HAS NO COSTS

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

E. Total Effect of the Project on Capital Costs

NOT APPLICABLE BECAUSE THIS PROJECT HAS NO COSTS

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

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

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

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

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

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

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

Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-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.

015

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	17
2	Site Ownership	20
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	21
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	22
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	24
8	Obligation Document if required	25
9	Cost Space Requirements	26
10	Discontinuation	28
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	
40	Financial Waiver	
41	Financial Viability	
42	Economic Feasibility	
43	Safety Net Impact Statement	118
44	Charity Care Information	123

016

File Number 3528-160-6

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

ST. MARY'S HOSPITAL, STREATOR, OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 7TH *day of* MARCH *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1206702712

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

017

File Number 5325-639-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOSPITAL SISTERS SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 04, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* MARCH *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1206902568

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

File Number 5163-355-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOSPITAL SISTERS HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 26, 1978, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* MARCH *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1206902576

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

Hospital Sisters
HEALTH SYSTEM

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

March 8, 2012

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

Dear Ms. Avery:

Hospital Sisters of the Third Order of St. Francis hereby certifies that St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis is the owner of the site on which the hospital is located.

Sincerely,

Larry P. Schumacher

Larry P. Schumacher, RN, MSN, FAAN
Chief Operating Officer

Notary: Sylvia Rebecca Gansz

OFFICIAL SEAL
SYLVIA REBECCA GANSZ
Notary Public - State of Illinois
My Commission Expires Apr 17, 2016

P.O. Box 19456
Springfield, Illinois
62794-9456
P: 217-523-4747
F: 217-523-0542
www.hshs.org

Sponsored by the Hospital Sisters of St. Francis

File Number 3528-160-6

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

ST. MARY'S HOSPITAL, STREATOR, OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 7TH *day of* MARCH *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1206702712

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

021

ATTACHMENT 3

I.
Organizational Relationships

This project has 3 co-applicants: St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis; Hospital Sisters Services, Inc. (HSSI); and Hospital Sisters Health System.

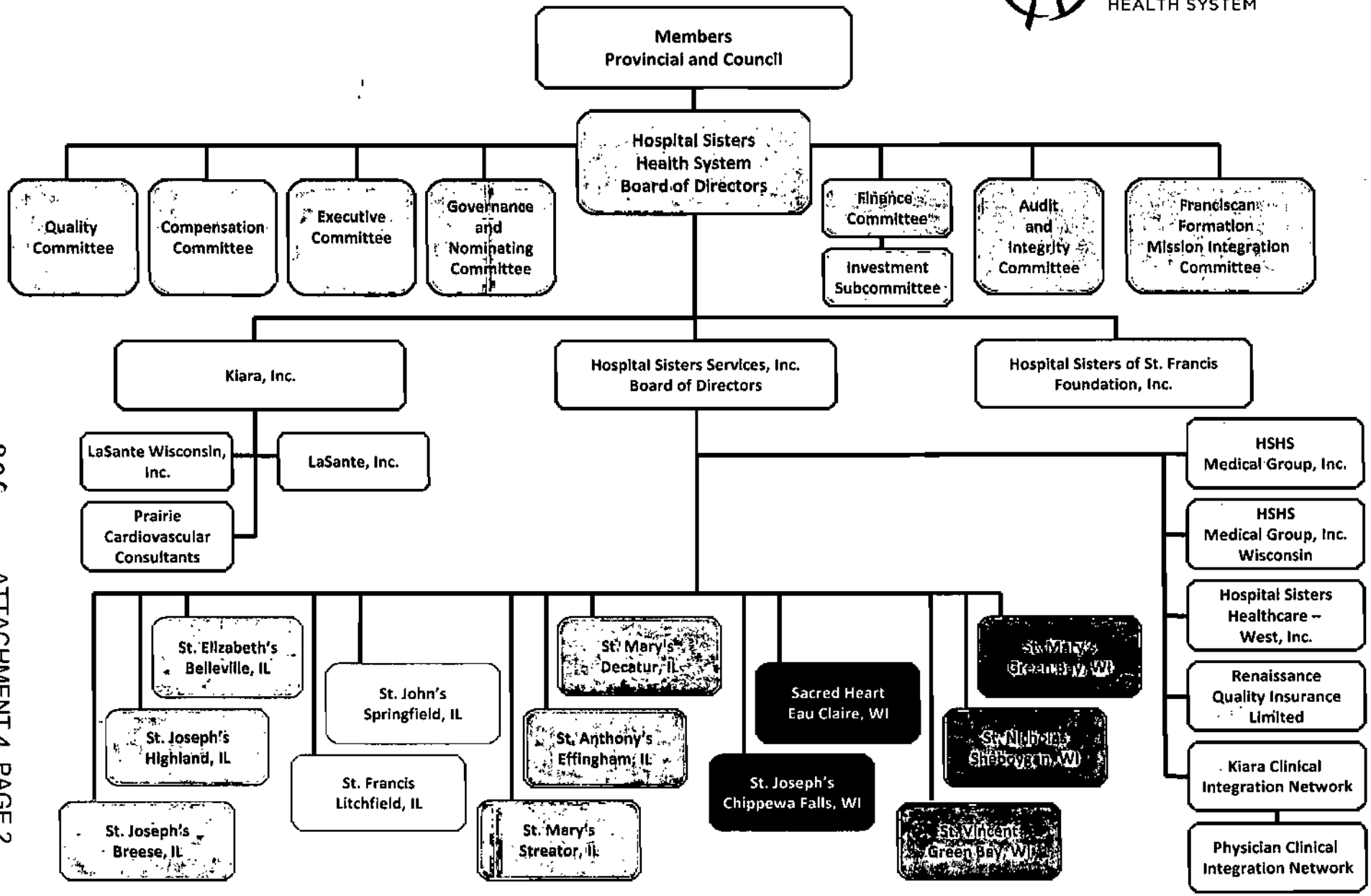
As will be seen on the Organizational Chart that appears on the following page, HSSI is the sole corporate member of St. Mary's Hospital, and Hospital Sisters Health System is the sole corporate member of HSSI.

There are no capital costs for this project.

Governance Organization Chart

August 2011

Hospital Sisters HEALTH SYSTEM



I.
Project Costs

This Attachment is not applicable because the discontinuation of St. Mary's Hospital's General Long Term Care Category of Service does not have any project costs.

ATTACHMENT 7

I.
Project Status

This Attachment is not applicable because the discontinuation of St. Mary's Hospital's General Long Term Care Category of Service does not have any project costs.

As a result, there will not be any project expenditures associated with this project, and the CON permit is not subject to "obligation," as defined in 77 Ill. Adm. Code 1130.140.

ATTACHMENT 8

I.
Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
General Long Term Care (Skilled Nursing Unit)	$0	11,411	0	0	0	0	11,411
Total Clinical	$0	11,411	0	0	0	0	11,411
NON CLINICAL							
Total Non-Clinical	$0	0	0	0	0	0	0
TOTAL	$0	11,411	0	0	0	0	11,411

I.
Cost Space Requirements

The discontinuation of the General Long Term Care Category of Service (Skilled Nursing Service) at St. Mary's Hospital will result in 11,411 gross square feet of space being vacated.

St. Mary's Hospital has not yet determined the use of this vacated space after the General Long Term Care Category of Service is discontinued. The hospital currently has an Interim Chief Executive Officer, who is not authorized to implement permanent facility changes. At the present time, while St. Mary's Hospital's General Long Term Care Category of Service is temporarily suspended, part of this space is being used on a temporary basis as classrooms for student nursing education.

It should be noted that mechanical space and equipment occupies the balance of the space on the sixth floor of St. Mary's Hospital, the floor on which the Skilled Nursing Unit (General Long Term Care Unit) is currently located.

This project does not include any changes in bed capacity other than the discontinuation of the General Long Term Care beds.

II.
Discontinuation

A. General Information Requirements

1. This project proposes to discontinue St. Mary's Hospital's General Long Term Care Category of Service (Skilled Nursing Service), which has an authorized capacity of 30 beds.

2. The General Long Term Care Category of Service is the only clinical or non-clinical service that will be discontinued.

3. The General Long Term Care Category of Service will be discontinued upon receipt of a Certificate of Need permit.

   However, as stated in the Notices of Temporary Suspension that St. Francis Hospital has been submitting monthly since August, 2011, the hospital temporarily suspended its General Long Term Care Category of Service and ceased providing this category of service on August 12, 2011, pending receipt of the CON permit.

4. The use of the rooms on the Skilled Nursing Unit has not been determined. As noted in Attachment 9, St. Mary's Hospital currently has an Interim Chief Executive Officer, who is not authorized to implement permanent facility changes. At the present time, while St. Mary's Hospital's General Long Term Care Category of Service is temporarily suspended, part of this space is being used on a temporary basis as classrooms for student nurses.

   All beds and other furnishings and equipment on the Skilled Nursing Unit have been or will be removed from the rooms. The equipment and furnishings have been inventoried, and the disposition of these items will be as follows.

   Some equipment has been transferred to other nursing units in the hospital:

   1 Circular Tub
   1 Vera Lift II
   2 Patient Bed Scales
   2 Air Flow Mattresses
   1 Barton Chair
   1 Bariatric Barton Chair

A warming cabinet has been transferred to Angiography

A bladder scanner has been transferred to Women's Health

An ice machine has been transferred to Same Day Surgery

A Safe T Rail Scale has been transferred to the Sleep Lab

Some equipment will be sold, transferred, or junked:

4 Recliners
1 Dresser
1 Piano
1 Square Table
6 Bed Exit Alarms
1 File Cabinet
1 Crash Cart
2 Refrigerators
5 Wheelchairs
3 Med Carts
1 Sling Lift

The equipment and furniture listed below will be donated to health facilities in other countries through Mission Outreach, which is sponsored by the Hospital Sisters Health System. These donations will be accomplished by sending the equipment and furniture to Hospital Sisters Health System's corporate headquarters, where a warehouse is maintained to collect these items prior to shipment.

30 beds
64 chairs
30 overbed tables
30 bedside tables
14 flower tables
6 Geri Chairs
3 Shower Chairs
12 Commodes
1 Chart Holder and Charts
1 Traction System
1 Lifepak Defib 9P

Some equipment will be recycled:

15 Television Sets
1 Fax Machine

5. All medical records pertaining to the General Long Term Care Category of Service (Skilled Nursing Service) will continue to be stored with the hospital's electronic legal records (SoftMed/Meditech).

   In accordance with the Hospital Sisters Health System's policies, all patient records will be retained for 30 years after the date of discharge.

6. This Item is not applicable because this application does not propose to discontinue an entire facility.

B. Reasons for Discontinuation

This application seeks approval for the discontinuation of St. Mary's Hospital's General Long Term Care Category of Service (Skilled Nursing Service) for the reason identified in 77 Ill. Adm. Code 1110.130.b)1): "Insufficient volume or demand for the service."

St. Mary's Hospital is seeking a CON permit to discontinue this Service because it has been impossible to maintain occupancy of at least 60% during any of the past 3 fiscal years.

Fiscal Year	Average Daily Census	% Occupancy
FY09	16.3	54%
FY10	15.4	51%
FY11	13.6	45%

Average Daily Census reported on the Annual Hospital Questionnaire and Annual Long-Term Care Facility Report is by calendar year. Calendar Year utilization has reported similar decreases in Average Daily Census.

Calendar Year	Average Daily Census	% Occupancy
CY09	16.0	53%
CY10	14.9	50%
CY11	11.8*	39%

*St. Mary's Hospital temporarily suspended its General Long Term Care Category of Service on August 12, 2011

Average daily census varied widely on a monthly basis, ranging from 17.8 in July, 2010, to 9.8 in May, 2011, 11.3 in October, 2010, and 11.8 in December, 2010, and March, 2011.

As a result of the low occupancy, the financial losses experienced by this service have exceeded $1,000,000 during each of the past 4 fiscal years.

The low occupancy experienced in St. Mary's Hospital's Skilled Nursing Unit appears to be directly related to the fact that beds are available in area nursing homes.

St. Mary's Hospital's data show that more than 24% of the hospital's acute care patients are discharged to a General Long Term Care facility that offers Skilled Nursing Care. Despite the hospital's medical staff's support of the Skilled Nursing Unit, the physicians were unable to refer a sufficient number of patients to St. Mary's Hospital's Skilled Nursing Unit during Calendar Years 2010 and 2011 to maintain a higher census.

Having engaged In discussions with local nursing homes, St. Mary's Hospital is confident that these facilities have the ability to accept and care for patients formerly admitted to St. Mary's Skilled Nursing Unit. The responses received to the "impact letter" that St. Mary's Hospital sent to these facilities reveals that there is adequate capacity to accommodate St. Mary's Hospital's caseload.

C. Impact on Access

1. The discontinuation of St. Mary's Hospital's General Long Term Care Category of Service (Skilled Nursing Service) will not have an adverse effect upon access to care for residents of the hospital's market area for the following reasons.

   a. St. Mary's Hospital is located in Planning Area 2-LaSalle for General Long Term Care, which has an excess of 55 General Long Term Care (Skilled Nursing) beds as of February 15, 2012.

      There are 2 freestanding nursing homes in Streator that provide this category of service, both of which have responded that they are able to care for patients requiring skilled nursing services.

      There are a total of 23 facilities providing the General Long Term Care Category of Service that are located within 45 minutes travel time of St. Mary's Hospital, some of which are located in other planning areas.

   b. St. Mary's Hospital surveyed all facilities providing the General Long Term Care Category of Service that are located within 45 minutes travel time and received 9 responses representing 11 facilities, of which 10 were from facilities that agreed to accept any of St. Francis Hospital's patients that require this category of care

without conditions, limitations, or discrimination. The eleventh facility does not accept patients with ventilator dependency or a Sub Part S primary diagnosis.

Copies of the written requests for impact statements that were sent to each of these facilities are appended to this Attachment, followed by documentation that the requests were received at each facility.

Facility and Town Planning Area	Travel Time*
Asta Care Center of Pontiac Pontiac 4-Livingston	39 minutes
Asta Care Center of Toluca Toluca 2-Marshall/Stark	31 minutes
Evenglow Lodge Pontiac 4-Livingston	39 minutes
Flanagan Rehabilitation & Health Care Flanagan 4-Livingston	27 minutes
The Good Samaritan Home - Flanagan Flanagan 4-Livingston	28 minutes
Good Samaritan - Pontiac Pontiac 4-Livingston	42 minutes
Heartland Health Care Center of Henry Henry 2-Marshall/Stark	41 minutes
Heritage Health Therapy & Senior Care - Dwight (formerly Heritage Manor - Dwight) Dwight 4-Livingston	34 minutes

Facility and Town Planning Area	Travel Time*
Heritage Home Therapy & Senior Care - Minonk (formerly Heritage Manor - Minonk) Minonk 2-Woodford	34 minutes
Heritage Health Therapy & Senior Care - Peru (formerly Heritage Manor - Peru) Peru 2-LaSalle	35 minutes
Heritage Health Therapy & Senior Care - Streator (formerly Heritage Manor Nursing Home) Streator 2-LaSalle	6 minutes
Illinois Valley Community Hospital (swing beds) Peru 2-LaSalle	35 minutes
Illinois Veterans Home at LaSalle (LaSalle Veterans Home) LaSalle 2-LaSalle	39 minutes
LaSalle County Nursing Home Ottawa 2-LaSalle	35 minutes
LaSalle Health Care Center (Heritage Health Therapy and Senior Care - LaSalle) LaSalle 2-LaSalle	37 minutes
Manor Court of Peru Peru 2-LaSalle	38 minutes
Meadows Mennonite Home Chenoa 4-McLean	43 minutes

Facility and Town Planning Area	Travel Time*
Ottawa Pavilion, Skilled Nursing & Rehabilitation Center Ottawa 2-LaSalle	25 minutes
Parker Nursing & Rehab Center (formerly Camelot Terrace) Streator 2-LaSalle	1 minute
Pleasant View Luther Home Ottawa 2-LaSalle	25 minutes
Rivershores Rehab & Nursing Care Center Marseilles 2-LaSalle	32 minutes
Spring Valley Nursing Center Spring Valley 2-Bureau/Putnam	45 minutes
St. Joseph's Nursing Home Lacon 2-Marshall/Stark	44 minutes
St. Margaret's Hospital (swing beds) Spring Valley 2-Bureau/Putnam	44 minutes

*Travel Time was calculated using www.mapquest.com

2.. As noted above, there are 23 facilities in addition to St. Mary's Hospital that are located within 45 minutes travel time of St. Mary's Hospital and provide the General Long Term Care Category of Service.

Each of these facilities was sent a written request to provide an impact statement, indicating the extent to which it will absorb St. Mary's Hospital's General Long Term Care workload without conditions, limitations, or discrimination.

A copy of each letter is found in this Attachment, along with proof that these letters were sent by certified mail and received.

3. Impact statements were received from the following facilities, stating that they are willing and able to accommodate a portion or all of St. Mary's Hospital's General Long Term Care caseload.

Asta Care Center of Pontiac, Pontiac
Evenglow Lodge, Pontiac
Flanagan Rehabilitation and Health Care Center, Flanagan
Good Samaritan - Pontiac, Pontiac
Heritage Health - Dwight
Heritage Health - Minonk
Heritage Health - Streator
Manor Court of Peru, Peru
Meadows Mennonite Retirement Community, Chenoa
Ottawa Pavilion, Ottawa
Parker Nursing and Rehabilitation Center, Streator

In addition, a letter was received from Illinois Valley Community Hospital (Peru), stating that the hospital does not have a Skilled Nursing Unit.

The impact statements received from these facilities are found in this Attachment.

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Lorrie Stogsdill
Administrator
Asta Care Center of Pontiac
300 W. Lowell Avenue
Pontiac, Illinois 61764

Dear Ms. Stogsdill:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

036

7008 1830 0003 1010 1184

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

CERTIFIED MAIL™

7008 1830 0003 1010 1184

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To	Ms. Lorrie Stogsdill
	Administrator
Street, Apt. No.; or PO Box No.	Asta Care Center of Pontiac
City, State, ZIP+4	300 W. Lowell Avenue
	Pontiac, Illinois 61764

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Lorrie Stogsdill
Administrator
Asta Care Center of Pontiac
300 W. Lowell Avenue
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Lorrie Stogsdill
Administrator
Asta Care Center of Pontiac
300 W. Lowell Avenue
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Dot Henry ☐ Agent ☐ Addressee

B. Received by (Printed Name) Dot Henry
C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1184

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Jennifer Diaz
Administrator
Asta Care Center of Toluca
101 E. Via Ghiglieri
Toluca, Illinois 61369

Dear Ms. Diaz:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

039

7008 1830 0003 1010 1177

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

CERTIFIED MAIL™

7008 1830 0003 1010 1177

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Ms. Jennifer Diaz
Administrator

Street, Apt. No.; or PO Box No.: Asta Care Center of Toluca

City, State, ZIP+4: 101 E. Via Ghiglieri
Toluca, Illinois 61369

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Jennifer Diaz
Administrator
Asta Care Center of Toluca
101 E. Via Ghiglieri
Toluca, Illinois 61369

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Jennifer Diaz
Administrator
Asst. Care Center of Toluca
101 E. Via Ghiglieri
Toluca, Illinois 61369

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Gail Shane ☐ Agent ☐ Addressee

B. Received by (Printed Name) Gail Shane C. Date of Delivery 2/2/12

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)* 7008 1830 0003 1010 1177

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Mark Hovren
President/CEO
Evenglow Lodge
215 E. Washington Street
Pontiac, Illinois 61764

Dear Mr. Hovren:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

042

7008 1830 0003 1010 1153

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

CERTIFIED MAIL™

7008 1830 0003 1010 1153

7008 1830 0003 1010 1153

CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To	Mr. Mark Hovren President/CEO
Street, Apt. No.; or PO Box No.	Evenglow Lodge ~~215 E. Washington Street~~
City, State, ZIP+4	Pontiac, Illinois 61764

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Mark Hovren
President/CEO
Evenglow Lodge
215 E. Washington Street
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Mr. Mark Hovren
President/CEO
Evenglow Lodge
215 E. Washington Street
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Joann Stanton ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Joann S Stanton C. Date of Delivery 8-2-2012

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) 7008 1830 0003 1010 1153

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Flanagan Rehabilitation and Health Care
210 E. Falcon Highway
Flanagan, Illinois 61740

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

045

7008 1830 0003 1010 1146

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

CERTIFIED MAIL™

7008 1830 0003 1010 1146

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 7.95

Postmark Here

2-1-12

Sent To Administrator
Flanagan Rehabilitation and health Care

Street, Apt. No.; or PO Box No. 210 E. Falcon Highway

City, State, ZIP+4 Flanagan, Illinois 61740

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Flanagan Rehabilitation and Health Care
210 E. Falcon Highway
Flanagan, Illinois 61740

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Flanagan Rehabilitation and Health Care
210 E. Falcon Highway
Flanagan, Illinois 61740

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) Greg Green
C. Date of Delivery 2-2-12

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) 7010 1830 0003 1010 1146

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
The Good Samaritan Home-Flanagan
205 N. Adams Street
Flanagan, Illinois 61740

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D. Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

7008 1830 0003 1010 1139

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

CERTIFIED MAIL™

7008 1830 0003 1010 1139

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Administrator

Street, Apt. No.; or PO Box No.: The Good Samaritan Home-Flanagan 205 N. Adams Street

City, State, ZIP+4: Flanagan, Illinois 61740

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
The Good Samaritan Home-Flanagan
205 N. Adams Street
Flanagan, Illinois 61740

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
The Good Samaritan Home-Flanagan
205 N. Adams Street
Flanagan, Illinois 61740

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Pam McCollum ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Pam McCollum

C. Date of Delivery 8-2-12

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) 7008 1830 0003 1010 1139

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

050

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Stephen Johnson
Administrator
The Good Samaritan Home-Pontiac
14335 Old Route 66
Pontiac, Illinois 61764

Dear Mr. Johnson:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D. Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

051

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

CERTIFIED MAIL™

7008 1830 0003 1010 1122

7008 1830 0003 1010 1122

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To Mr. Stephen Johnson

Street, Apt. No.; or PO Box No. Administrator
The Good Samaritan Home

City, State, ZIP+4 14335 Old Route 66
Pontiac, Illinois 61764

PS Form 3800, August 2006 See Reverse for Instructions

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:

Mr. Stephen Johnson
Administrator
The Good Samaritan Home-Pontiac
14335 Old Route 66
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Mr. Stephen Johnson
Administrator
The Good Samaritan Home-Pontiac
14335 Old Route 66
Pontiac, Illinois 61764

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x Martha Beck ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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) 7008 1830 0003 1010 1122

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Susan Legner
Administrator
Heartland Health Care Center of Henry
1650 Indiantown Road
Henry, Illinois 61537

Dear Ms. Legner:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

054

7008 1830 0003 1010 1115

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

CERTIFIED MAIL™

7008 1830 0003 1010 1115

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To	Ms. Susan Legner Administrator
Street, Apt. No.; or PO Box No.	Heartland Health Care Center of Henry 1650 Indiantown Road
City, State, ZIP+4	Henry, Illinois 61537

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Susan Legner
Administrator
Heartland Health Care Center of Henry
1650 Indiantown Road
Henry, Illinois 61537

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Susan Legner
Administrator
Heartland Health Care Center of Henry
1650 Indiantown Road
Henry, Illinois 61537

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Chris Beschler ☒ Agent ☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery 2-8-12

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

PO BX 215
Henry IL 61537

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) 7008 1830 0003 1010 1115

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

05E

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Randy Provence
Administrator
Heritage Health Therapy & Senior Care-Dwight
300 E. Mazon Avenue
Dwight, Illinois 60420

Dear Mr. Provence:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

057

7008 1830 0003 1010 1108

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

CERTIFIED MAIL™

7008 1830 0003 1010 1108

7008 1830 0003 1010 1108

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Mr. Randy Provence
Street, Apt. No.; or PO Box No.: Administrator Heritage Health Therapy ~~& Senior Care~~ 300 E. Mazon Avenue
City, State, ZIP+4: Dwight, Illinois 60420

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Randy Provence
Administrator
Heritage Health Therapy & Senior Care
300 E. Mazon Avenue
Dwight, Illinois 60420

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

[redacted]

Mr. Randy Provence
Administrator
Heritage Health Therapy & Senior Care
300 E. Mazon Avenue
Dwight, Illinois 60420

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 8-3-12

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) 7008 1830 0003 1010 1108

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

059

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Kim Seaman
Administrator
Heritage Health Therapy & Senior Care-Minonk
201 Locust
Minonk, Illinois 61760

Dear Ms. Seaman:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

060

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

CERTIFIED MAIL™

7008 1830 0003 1010 1061

7008 1830 0003 1010 1061

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 7.95

Postmark Here

2-1-12

Sent To: Ms. Kim Seaman

Street, Apt. No.; or PO Box No.: ~~Administrator~~ Heritage Health Therapy & Senior Care

City, State, ZIP+4: 201 Locust Minonk, Illinois 61760

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Kim Seaman
Administrator
Heritage Health Therapy & Senior Care
201 Locust
Minonk, Illinois 61760

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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

061

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:

Ms. Kim Seaman
Administrator
Heritage Health Therapy & Senior Care
201 Locust
Minonk, Illinois 61760

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Alison Duncan ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* | C. Date of Delivery
CS-2-22-12

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) 7008 1830 0003 1010 1061

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

062

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Caroline Daugherity
Administrator
Heritage Health Therapy & Senior Care-Peru
1301 21st Street
Peru, Illinois 61354

Dear Ms. Daugherity:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

06

7008 1830 0003 1010 1054

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

CERTIFIED MAIL™

7008 1830 0003 1010 1054

7008 1830 0003 1010 1054

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To: Ms. Caroline Daugherity
Administrator

Street, Apt. No.; or PO Box No.: Heritage Health Therapy & Senior Care
1301 21st Street

City, State, ZIP+4: Peru, Illinois 61354

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Caroline Daugherity
Administrator
Heritage Health Therapy & Senior Care
1301 21st Street
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Caroline Daugherity
Administrator
Heritage Health Therapy & Senior Care
1301 21st Street
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1054

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

065

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Janette Strabala
Administrator
Heritage Health Therapy & Senior Care-Streator
1525 E. Main Street
Streator, Illinois 61364

Dear Ms. Strabala:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

066

7008 1830 0003 1010 1047

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

CERTIFIED MAIL™

7008 1830 0003 1010 1047

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	1.55
Total Postage & Fees	$ 5.95

Postmark Here: 2-1-12

Sent To	Ms. Janette Strabala Administrator
Street, Apt. No.; or PO Box No.	Heritage Health Therapy & Senior Care
City, State, ZIP+4	1525 E. Main Street Streator, Illinois 61364

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Janette Strabala
Administrator
Heritage Health Therapy & Senior Care
1525 E. Main Street
Streator, Illinois 61364

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Janette Strabala
Administrator
Heritage Health Therapy & Senior Care
1525 E. Main Street
Streator, Illinois 61364

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Pat Clayton ☐ Agent ☒ Addressee

B. Received by (Printed Name) Pat Clayton
C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1047

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Tommy Hobbs
Chief Executive Officer
Illinois Valley Community Hospital
925 West Street
Peru, Illinois 61354

Dear Mr. Hobbs:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

069

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

CERTIFIED MAIL™

7008 1830 0003 1010 1030

7008 1830 0003 1010 1030

7008 1830 0003 1010 1030

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To: Mr. Tommy Hobbs

Street, Apt. No.; or PO Box No.: ~~Chief Executive Officer~~ Illinois Valley Community Hospital

City, State, ZIP+4: 925 West Street Peru, Illinois 61354

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Tommy Hobbs
Chief Executive Officer
Illinois Valley Community Hospital
925 West Street
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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

070

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:

Mr. Tommy Hobbs
Chief Executive Officer
Illinois Valley Community Hospital
925 West Street
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

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

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

3. Service Type
☒ 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) 7008 1830 0003 1010 1030

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Illinois Veterans Home of LaSalle
1015 O'Conor Avenue
LaSalle, Illinois 61301

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

07

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

CERTIFIED MAIL™

7008 1830 0003 1010 1023

7008 1830 0003 1010 1023

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.65
Total Postage & Fees	$ 5.75

Postmark Here: 2-1-12

Sent To: Administrator

Street, Apt. No.; or PO Box No.: Illinois Veterans Home of LaSalle 1015 O'Conor Avenue

City, State, ZIP+4: LaSalle, Illinois 61301

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Illinois Veterans Home of LaSalle
1015 O'Conor Avenue
LaSalle, Illinois 61301

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Illinois Veterans Home of LaSalle
101 O'Conor Avenue
LaSalle, Illinois 61301

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Kelli Casey ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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) 7008 1830 0003 1010 1023

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Lori Walsh
Administrator
LaSalle Health Care Center
1445 Chartres Street
LaSalle, Illinois 61301

Dear Ms. Walsh:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

075

7008 1830 0003 1010 1009

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

CERTIFIED MAIL™

7008 1830 0003 1010 1009

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To	Ms. Lori Walsh
Street, Apt. No.; or PO Box No.	~~Administrator~~ LaSalle Health Care Center
City, State, ZIP+4	1445 Chartres Street LaSalle, Illinois 61301

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Lori Walsh
Administrator
LaSalle Health Care Center
1445 Chartres Street
LaSalle, Illinois 61301

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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

07E

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:

Ms. Lori Walsh
Administrator
LaSalle Health Care Center
1445 Chartres Street
LaSalle, Illinois 61301

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Barb Moreland ☐ Agent ☐ Addressee

B. Received by (Printed Name) B Moreland
C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1009

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Chris Csernus
Administrator
LaSalle County Nursing Home
1380 N. 27th Road
Ottawa, Illinois 61350

Dear Mr. Csernus:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D. Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

078

7008 1830 0003 1010 1016

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

CERTIFIED MAIL™

7008 1830 0003 1010 1016

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To	Mr. Chris Csernus
	Administrator
Street, Apt. No.; or PO Box No.	LaSalle County Nursing Home
City, State, ZIP+4	~~1380 N. 27th Road~~
	Ottawa, Illinois 61350

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Chris Csernus
Administrator
LaSalle County Nursing Home
1380 N. 27th Road
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Mr. Chris Csernus
Administrator
[redacted]Salle County Nursing Home
[redacted]80 N. 27th Road
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Ed Flanigan ☐ Agent ☐ Addressee

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

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

OTTAWA IL
FEB 02 2012
61350

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) 7008 1830 0003 1010 1016

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

[illegible] 080

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Lisa Funfsinn
Administrator
Manor Court of Peru
3230 Becker Drive
Peru, Illinois 61354

Dear Ms. Funfsinn:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

P.U. 081

7008 1830 0003 1010 0996

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

CERTIFIED MAIL™

7008 1830 0003 1010 0996

7008 1830 0003 1010 0996

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Ms. Lisa Funfsinn
Administrator
Street, Apt. No.; or PO Box No.: Manor Court of Peru
City, State, ZIP+4: 3230 Becker Drive
Peru, Illinois 61354

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Lisa Funfsinn
Administrator
Manor Court of Peru
3230 Becker Drive
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Lisa Funfsinn
Administrator
Manor Court of Peru
3230 Becker Drive
Peru, Illinois 61354

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Lisa Funfsinn ☐ Agent ☒ Addressee

B. Received by (Printed Name) C. Date of Delivery 2-2-12

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 lat 7008 1830 0003 1010 0996

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

082

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Bob Bertsche
CEO & Administrator
Meadows Mennonite Home
24218 Gundy Drive
Chenoa, Illinois 61726

Dear Mr. Bertsche:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

084

7008 1830 0003 1010 0989

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

CERTIFIED MAIL™

7008 1830 0003 1010 0989

7008 1830 0003 1010 0989

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.95

Postmark Here

2-1-12

Sent To	Mr. Bob Bertsche
	CEO & Administrator
Street, Apt. No.; or PO Box No.	Meadows Mennonite Home
	~~24218 Gundy Drive~~
City, State, ZIP+4	Chenoa, Illinois 61726

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Bob Bertsche
CEO & Administrator
Meadows Mennonite Home
24218 Gundy Drive
Chenoa, Illinois 61726

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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

085

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:

Mr. Bob Bertsche
CEO & Administrator
Meadows Mennonite Home
24218 Gundy Drive
Chenoa, Illinois 61726

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Margi Steffen ☐ Agent ☐ Addressee

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

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

24588 Church St.

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) 7008 1830 0003 1010 0989

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Ottawa Pavilion, Skilled Nursing & Rehabilitation Center
704 E. Glover Street
Ottawa, Illinois 61350

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

087

7008 1830 0003 1010 0958

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

CERTIFIED MAIL™

7008 1830 0003 1010 0958

CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To	Administrator
Street, Apt. No.; or PO Box No.	Ottawa Pavilion, Skilled Nursing & Rehabilitation Center
City, State, ZIP+4	704 E. Glover Street Ottawa, Illinois 61350

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Ottawa Pavilion, Skilled Nursing &
Rehabilitation Center
704 E. Glover Street
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Ottawa Pavilion, Skilled Nursing &
Rehabilitation Center
704 E. Glover Street
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Margie Lyle ☐ Agent ☐ Addressee

B. Received by (Printed Name) Margie Lyle C. Date of Delivery 2/2/12

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

FEB 02 2012

USPS-61350

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) 7008 1830 0003 1010 0958

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Parker Nursing and Rehabilitation Center
516 W. Frech Street
Streator, Illinois 61364

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

090

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

CERTIFIED MAIL™

7008 1830 0003 1010 1140

7008 1830 0003 1010 1140

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Administrator
Street, Apt. No.; or PO Box No.: Parker Nursing and Rehabilitation Center
City, State, ZIP+4: ~~516 W. Frech Street~~ Streator, Illinois 61364

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Parker Nursing and Rehabilitation Center
516 W. Frech Street
Streator, Illinois 61364

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Parker Nursing and Rehabilitation Center
516 W. Frech Street
Streator, Illinois 61364

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Dolly Barrett ☐ Agent ☒ Addressee

B. Received by *(Printed Name)* Dolly Barrett
C. Date of Delivery 2/2/12

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) 7008 1830 0003 1010 1160

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Pleasant View Luther Home
505 College Avenue
Ottawa, Illinois 61350

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

093

7008 1830 0003 1010 1207

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

CERTIFIED MAIL™

7008 1830 0003 1010 1207

7008 1830 0003 1010 1207

CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ 1.45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 8.95

Postmark Here

2-1-12

Sent To: Administrator
Street, Apt. No.; or PO Box No.: Pleasant View Luther Home
City, State, ZIP+4: ~~505 College Avenue~~ Ottawa, Illinois 61350

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Pleasant View Luther Home
505 College Avenue
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☑ 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)

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:

Administrator
Pleasant View Luther Home
505 College Avenue
Ottawa, Illinois 61350

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery
2/2/2012

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

OTTAWA IL
FEB 02 2012
USPS - 6135

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) 7008 1830 0003 1010 1207

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

095

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Rivershores Rehab & Nursing Care Center
578 Commercial Street
Marseilles, Illinois 61341

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

096

7008 1830 0003 1010 0972

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

CERTIFIED MAIL™

7008 1830 0003 1010 0972

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Administrator

Street, Apt. No.; or PO Box No.: Rivershores Rehab & Nursing Care Center, 578 Commercial Street

City, State, ZIP+4: Marseilles, Illinois 61341

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Rivershores Rehab & Nursing Care Center
578 Commercial Street
Marseilles, Illinois 61341

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Rivershores Rehab & Nursing Care Center
578 Commercial Street
Marseilles, Illinois 61341

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X B. Wright ☒ Agent ☐ Addressee

B. Received by (Printed Name) Betty Wright
C. Date of Delivery 2-2-12

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)* 7008 1830 0003 1010 0972

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Administrator
Spring Valley Nursing Center
1300 N. Greenwood Street
Spring Valley, Illinois 61362

Dear Administrator:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

099

7008 1830 0003 1010 1092

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

CERTIFIED MAIL™

7008 1830 0003 1010 1092

7008 1830 0003 1010 1092

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	1.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Administrator

Street, Apt. No.; or PO Box No.: Spring Velley Nursing Center
~~1300 N. Greenwood Street~~

City, State, ZIP+4: Spring Valley, Illinois 61362

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Administrator
Spring Velley Nursing Center
1300 N. Greenwood Street
Spring Valley, Illinois 61362

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Administrator
Spring Velley Nursing Center
1300 N. Greenwood Street
Spring Valley, Illinois 61362

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* | C. Date of Delivery 2-2-12

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)* 7008 1830 0003 1010 1092

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Ms. Lisa Helms
Administrator
St. Joseph's Nursing Home
401 9th Street
Lacon, Illinois 61540

Dear Ms. Helms:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

7008 1830 0003 1010 1085

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

CERTIFIED MAIL™

7008 1830 0003 1010 1085

7008 1830 0003 1010 1085

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	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.75

Postmark Here

2-1-12

Sent To: Ms. Lisa Helms

Street, Apt. No.; or PO Box No.: Administrator St. Joseph's Nursing Home

City, State, ZIP+4: 401 9th Street Lacon, Illinois 61540

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Ms. Lisa Helms
Administrator
St. Joseph's Nursing Home
401 9th Street
Lacon, Illinois 61540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Ms. Lisa Helms
Administrator
St. Joseph's Nursing Home
401 9th Street
Lacon, Illinois 61540

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Judy Watkins | C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1085

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

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

111 Spring Street
Streator, Illinois 61364
P: 815-673-2311
F: 815-672-5163
www.stmaryshospital.org

An Affiliate of Hospital Sisters Health System

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

February 1, 2012

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. 1st Street
Spring Valley, Illinois 61362

Dear Mr. Muntz:

St. Mary's Hospital is submitting a Certificate of Need (CON) application to discontinue our General Long Term Care (Skilled Nursing) Service upon receipt of approval from the Health Facilities and Services Review Board, which we expect to occur no later than June 30, 2012. This discontinuation follows our temporary suspension of the operations of our Skilled Nursing Unit in August, 2011.

During the past two years, we provided Skilled Nursing Care to the following number of patients.

Year	Skilled Nursing Admissions	Skilled Nursing Patient Days
CY2010	464	5,433
CY2011	226	2,641

The purpose of this letter is to ascertain whether your facility has capacity available to accommodate a portion or all of our hospital's Skilled Nursing caseload and whether your facility has any restrictions or limitations that preclude you from providing service to residents of our hospital's market area.

I would appreciate it if you would send us a letter indicating the impact of the discontinuation of our General Long Term Care Service upon your facility and whether your facility is willing and able to absorb part or all of our hospital's Skilled Nursing caseload without conditions, limitations, or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Services Review Board that your failure to respond to this request for an impact statement within fifteen (15) days following your receipt of this letter shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact upon your facility.

If you have any questions, please feel free to contact me at 815-673-4500.

Thank you in advance for your support.

Sincerely,

Sharon D. Timmons

Sharon D. Timmons
Interim President/Chief Executive Officer

7008 1830 0003 1010 1078

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

CERTIFIED MAIL™

7008 1830 0003 1010 1078

7008 1830 0003 1010 1078

CERTIFIED MAIL™ RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

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

OFFICIAL USE

Postage	$ .45
Certified Fee	2.95
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	4.55
Total Postage & Fees	$ 5.78

Postmark Here

2-1-12

Sent To: Mr. Tim Muntz
President & CEO

Street, Apt. No., or PO Box No.: St. Margaret's Hospital
600 E. 1st Street

City, State, ZIP+4: Spring Valley, Illinois 61362

PS Form 3800, August 2006 — See Reverse for Instructions

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:

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. 1st Street
Spring Valley, Illinois 61362

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

3. Service Type
☒ 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)

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:

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. 1st Street
Spring Valley, Illinois 61362

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Clark ☐ Agent ☐ Addressee

B. Received by (Printed Name) CLARK

C. Date of Delivery 2-2-12

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) 7008 1830 0003 1010 1078

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

ASTA
Care Center of Pontiac

FEB 08 2012

February 6, 2012

Ms. Sharon D. Timmons
Interim President/Chief Executive Officer
St. Mary's Hospital
111 Spring St.
Streator, Il. 61364

Dear Ms. Timmons:

Asta Care Center of Pontiac has received your letter regarding your plan to discontinue your General Long Term Care, Skilled Nursing, Service.

We are willing and able to accommodate that portion of your caseload and have no restrictions that would prevent us from serving those patients needing skilled care in your hospital's marketing area.

We also have skilled nursing facilities in Toluca, Bloomington, Colfax, Paxton, Rockford and Elgin. All of our facilities are able to accommodate any of your patients.

We look forward to working with you in meeting your patients' needs for skilled nursing care.

Respectfully,

Tisha Harty
Admissions Coordinator

Lorrie Stogsdill
Administrator

300 W. Lowell Avenue Pontiac, Illinois 61764 Tel: 815-842-1181 Fax: 815-842-3406

Joint Commission
on Accreditation of Healthcare Organizations

FEB 0 6 2012

Evenglow
A United Methodist
Continuing Life Community

February 3, 2012

Ms. Sharon Timmons
Interim President/Chief Executive Officer
St. Mary's Hospital
111 Spring Street
Streator, Illinois 61364

Dear Ms. Timmons,

Evenglow supports St. Mary's application to discontinue General Long Term Care Services and is willing and able to assist in absorbing part of the Skilled Nursing caseload without conditions, limitations, or discrimination. Naturally Evenglow is limited by its bed capacity, licensing and certification. Evenglow is licensed for 73 skilled nursing beds, of which 37 are certified for Medicare and 26 are certified for Medicaid. Eighteen of these beds are dually certified for both Medicare and Medicaid.

Please contact me if we can assist in any way.

Sincerely,

Mark Hovren
President & CEO
Evenglow

Evenglow Lodge 815.844.6131 • Tjardes Health Center 815.844.6131 • Evenglow Inn 815.842.9040
215 East Washington Street • Pontiac, IL 61764
www.evenglowlodge.org

Flanagan
REHABILITATION &
HEALTH CARE CENTER
"Caring With a Hometown Touch"

201 E. Falcon Highway
Flanagan, IL 61740
Phone: 815-796-2267
Fax: 815-796-4434

FEB 13 2012

February 8th, 2012

Sharon D Timmons
St. Mary's Hospital
111 Spring Street
Streator, Illinois 61364

Mrs. Timmons,

Flanagan Rehabilitation and Health Care Center received your letter requesting information regarding our ability to accommodate patients with a skilled need.

We are willing and able to accommodate a portion of St Mary's Skilled Nursing caseload. Two doctors affiliated with St Mary's Hospital, Dr. Pal and Dr. Zafar, visit their patients at our facility monthly. Our skilled nursing facility is the area expert in wound care, one of the only nursing homes, in the area, that has the skilled staff to care of a new tracheostomy and provide IV therapy.

When contacted by the hospital our admissions team reviews the paperwork, the Community Relations Coordinator (CRC) will come up to meet the patient and give a response within an hour if we can accept. The CRC will determine if we can meet the patients' needs or if one of our sister facilities may be able to meet their needs.

There are three categories we are unable to accept: Developmentally disabled, ventilator dependant and sex offenders.

Flanagan Rehabilitation and Health Care Center will help meet the skilled needs of Streator and surrounding area. We also believe the closing of the St Mary's General Long Term Care Service will not cause a hardship to our nursing home.

If you have any further questions, please contact me at 815-796-2267.

Thank you,

Greg Green
Administrator

Flanagan Rehabilitation & Health Care Center is a proud member of the Petersen Health Care family.

Good Samaritan
Pontiac

FEB 0 6 2012

February 2, 2012

Ms. Sharon D. Timmons
Interim President/ Chief Executive Officer
St. Mary's Hospital
111 Spring Street
Streator, IL 61364

Dear Ms. Timmons:

This letter is in response to your letter dated February 1, 2012 regarding the discontinuation of your General Long Term Care Service. We would be willing and able to absorb your entire case load, thus the impact your discontinuation would prove a positive impact to us.

If you need any further information, please feel free to contact me at 815-844-5121.

Sincerely,

Glenda Tannahill

Glenda Tannahill, MBA, Ph.D.
CEO/CFO/Temp Administrator

14335 US Highway 66, Pontiac, IL 61764 Phone: (815) 844-5121 Fax: (815) 844-5690 www.yourgoodsamaritanpontiac.com

HERITAGE ENTERPRISES

FEB 13 2012

HERITAGEOFCARE.COM

February 10, 2012

Ms. Sharon Timmons
Interim President/Chief Executive Officer
St. Mary's Hospital
111 Spring Street
Streator, IL 61364

Dear Ms. Timmons:

This letter is in response to your communication regarding the discontinuation of your General Long Term Care (Skilled Nursing) Service at St. Mary's Hospital in Streator. Please consider this our impact statement in compliance with the policy of the Illinois Health Facilities and Services Review Board.

Heritage Health locations in Streator, Minonk and Dwight have availability to accommodate a portion of St. Mary's skilled nursing caseload. All admissions will be based on availability at the time of need in addition to the level of care needed.

Sincerely,

Cheri Lowney
Chief Operations Offer
Heritage Operations Group

Janette Strabala Administrator Heritage Health (Streator)	Kim Seaman Administrator Heritage Health (Minonk)	Randy Provence Administrator Heritage Health (Dwight)

p: 309.828.4361 f: 309.829.5477
115 W. Jefferson Street, Suite 401 P.O. Box 3188 Bloomington, IL 61702-3188

FEB 13 2012

Manor Court of Peru

February 9, 2012

Ms. Sharon D. Timmons
Interim President/CEO
St. Mary's Hospital
111 Spring Street
Streator, Il 61364

Dear Ms. Timmons:

Liberty Village of Peru was saddened that St. Mary's Hospital had suspended operations of the SNF Services back in August, 2011 and to, most recently the plan for discontinuation of the skilled Nursing Services.

St. Mary's SNF Unit has provided Streator and the surrounding communities with many years of excellent services. Your SNF has been and will be missed. On a personal note, my family has had the opportunity to experience the nursing care and therapy services provided on the SNF at St. Mary's over the years, the care they received was felt to be exceptional.

Liberty Village of Peru since August of 2011 has been receiving referrals and accepting admission from the Streator and surrounding communities. It is our goal to continue to assist in providing services to persons admitted into our care. Manor Court with our current census and bed availability would be able to accommodate the 200(+) admissions per year.

We currently offer Physical, Occupational, and Speech Therapies, and are able to accommodate patients with wound vacs, and tracheostomies, Tubal Feedings, Chest tubes and IV therapies of a wide variety with Central Line Care. We are unable to accommodate patients on ventilators, have disqualifying offenses, and persons in need of rehabilitation from Drugs or alcohol.

If you have any questions, please fee free to contact me at 815-220-1400.

Thank you for your support and the services you provide

Sincerely,

Lisa Funfsinn RN

Lisa Funfsinn RN/Administrator
Liberty Village of Peru
Manor Court of Peru

113

3230 Becker Drive • Peru, Illinois 61354
Phone 815/220-1400 opt. #1 • Fax 815/220-1581

Meadows
Mennonite Retirement Community

24588 Church Street Chenoa, IL 61726-9705 • Phone: Gridley (309) 747-2702 • Fax: (309) 747-2944

FEB 06 2012

February 2, 2012

Board of Directors

John McDonald
Chairperson
Morton, IL

Paul Watkins
Vice-Chairperson
Bloomington, IL

Kathy Trachsel
Secretary
Pontiac, IL

V. Curtis Oyer, CPA
Treasurer
Bloomington, IL

Mary Dyck
Normal, IL

Warren Johnson
Bloomington, IL

Tom Kahle
Chenoa, IL

Lowell Litwiller
[illegible]ey, IL

[illegible]Moran
Fairbury, IL

Alice Raber
Flanagan, IL

Helen Roth
Gridley, IL

Administrative Staff

Robert O. Bertsche
President/CEO

Roger W. Hasler
Chief Financial Officer

Mary Ann Watkins
Director of Development

Sharon Timmons
Interim President/Chief Executive Officer
St. Mary's Hospital
111 Spring Street
Streator, IL. 61364

Dear Ms. Timmons,

Meadows Mennonite Home of 24588 Church Street, Chenoa, IL. 61726 currently has 93 residents and a capacity of 114.

Our nursing home would welcome the opportunity to work with St. Mary's hospital in determining placement of residents from the St. Mary's Skilled Nursing Service at Meadows Mennonite Home.

Sincerely,

Robert O. Bertsche

Robert O. Bertsche, President/CEO

114

Meadows Mennonite Retirement Community is an equal opportunity provider, and employer.

Ottawa Pavilion, Ltd.

FEB 15 2012

February 13, 2012

St. Mary's Hospital
111 Spring Street
Streator, IL 61364

ATT: Sharon Timmons

RE: Discontinuation of Long Term Care Service

Dear Ms. Timmons:

Ottawa Pavilion, a skilled nursing facility, is willing and able to absorb part all of you're your hospital's Skilled Nursing caseload.

Thank you.

Cordially,

Margie Lyle
Administrator

800 East Center Street
Ottawa, Illinois 61350
Tel 815.434.7014
Fax 815.434.2376
www.dynamichc.com

115

Parker
NURSING AND REHABILITATION CENTER

FEB 0 7 2012

February 6, 2012

Dear Sharon Timmons,

I am in receipt of your letter re: the impact of closure and discontinuation of your general long term care service.

Parker Nursing and Rehabilitation Center is happy to consider and evaluation without discrimination any and all those appropriate for skilled services impacted by such closure. We are not able to serve those with ventilator dependency or a Sub Part S primary diagnosis.

As your partner in health care we are hear to assist in providing necessary and appropriate health care services over the continuum.

Should you have any further need please call me at 815-672-2600.

Sincerely,

Cindy Duncan RN LNHA
Administrator

11E

516 FRECH ST. | STREATOR, IL 61364 | TEL (815) 672-2600
FAX (815) 672-2282 | INFO@PARKERNRC.COM

Illinois Valley Community Hospital
925 West Street, Peru, Illinois 61354
Phone 815-223-3300 • Fax 815-223-3394
www.ivch.org

FEB 15 2012

February 14, 2012

Ms. Sharon D. Timmons
Interim President/Chief Executive Officer
St. Mary's Hospital
111 Spring Street
Streator, Illinois 61364

Dear Ms. Timmons:

Illinois Valley Community Hospital (IVCH) does not have a Skilled Nursing Unit. Therefore, IVCH is not in a position to absorb part or all of St. Mary's Hospital Skilled Nursing caseload.

If you have any questions, please feel free to contact me at 815-780-3508.

Sincerely,

Tommy Hobbs
Chief Executive Officer

XI. Safety Net Impact Statement

1. The project's material impact, if any, on essential safety net services in the community

Health Safety Net Services have been defined as services provided to patients who are low-income and otherwise vulnerable, including those uninsured and covered by Medicaid. (Agency for Healthcare Research and Quality, Public Health Service, U.S. Department of Health and Human Services, "The Safety Net Monitoring Initiative," AHRQ Pub. No. 03-P011, August, 2003)

This modernization project will discontinue the General Long Term Care Category of Service (Skilled Nursing Service) at St. Mary's Hospital.

As discussed in Attachment 10, the following issues are relevant to this issue.

- St. Mary's Hospital is located in Planning Area 2-LaSalle, which has an excess of 55 General Long Term Care (Skilled Nursing and Intermediate Care) beds as of February 15, 2012.

- There are 2 freestanding nursing homes in Streator and 8 additional freestanding nursing homes in the planning area (2-LaSalle) that provide this category of service, as well as 13 other facilities (including 1 Swing Bed Unit) located within 45 minutes travel time that also provide the General Long Term Care Category of Service. Some of these 13 facilities are located in other planning areas.

- St. Mary's Hospital surveyed all 23 other facilities providing the General Long Term Care Category of Service that are located within 45 minutes travel time. The hospital received responses from 10 facilities that agreed to accept any of St. Mary's Hospital's patients that require this category of care without conditions, limitations, or discrimination and 1 additional facility that agreed to accept any of St. Mary's Hospital's patients that require this category of care except for those with ventilator dependency or a Sub Part S primary diagnosis.

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

This project will not have any impact on other providers or health care systems and, as such, it will not have any impact on other providers' or health care systems' abilities to cross-subsidize safety net services.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community

There are no other hospitals in Streator.

There are 2 nursing homes in Streator that provide the General Long Term Care Category of Service. Both of these facilities received a letter from St. Mary's Hospital asking them to assess the impact of the proposed discontinuation upon their facility, and each responded to this request. The response letters are found in Attachment 10.

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.

   A notarized certification describing the amount of charity care provided by St. Mary's Hospital for 2009 through 2011 is found on Page 3 of this Attachment.

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 Illinois Health Facilities and Services Review Board under Section 13 of the Illinois Health Facilities Act and published in the Annual Hospital Profile.

   A notarized certification describing the amount of care provided to Medicaid patients by St. Mary's Hospital for 2009 through 2011 is found on Page 4 of this Attachment.

3. Any other information the applicant believes is directly relevant to safety net services

   This document includes all information that St. Mary's Hospital believes is directly relevant to safety net services.

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

   This table will be found on Page 5 of this Attachment.

Hospital Sisters
HEALTH SYSTEM

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

March 8, 2012

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

Dear Ms. Avery:

St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis, an affiliate of Hospital Sisters Health System hereby certifies that it provided the amount of charity care at cost that is shown below for the three audited fiscal years prior to submission of this certificate of need application.

Charity Care	2009	2010	2011
Inpatient	$ 258,229	$ 346,849	$ 699,226
Outpatient	$ 619,547	$ 1,008,048	$ 1,776,123
Total	$ 877,776	$ 1,354,897	$ 2,475,349

This amount was calculated in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act.

Sincerely,

Larry P. Schumacher, RN, MSN, FAAN
Chief Operating Officer

Notary: Sylvia Rebecca Gansz

OFFICIAL SEAL
SYLVIA REBECCA GANSZ
Notary Public - State of Illinois
My Commission Expires Apr 17, 2016

P.O. Box 19456
Springfield, Illinois
62794-9456
P: 217-523-4747
F: 217-523-0542
www.hshs.org

Sponsored by the Hospital Sisters of St. Francis

120

Hospital Sisters
HEALTH SYSTEM

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

March 8, 2012

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

Dear Ms. Avery:

St. Mary's Hospital, Streator, of the Hospital Sisters of the Third Order of St. Francis, an affiliate of Hospital Sisters Health System hereby certifies that it provided the amount of Medicaid that is shown below for the three audited fiscal years prior to submission of this certificate of need application.

Medicaid Net Revenue	2009	2010	2011
Inpatient	$ 945,812	$ 537,741	$ 777,436
Outpatient	$ 3,149,826	$ 3,458,603	$ 3,545,910
Total	$ 4,095,638	$ 3,996,344	$ 4,323,346

This information is provided in a manner consistent with 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 Illinois Health Facilities and Services Review Board under Section 13 of the Illinois Health Facilities Planning Act and published in the Annual Hospital Profile.

Sincerely,

Larry P. Schumacher

Larry P. Schumacher, RN, MSN, FAAN
Chief Operating Officer

Notary: Sylvia Rebecca Gansz

OFFICIAL SEAL
SYLVIA REBECCA GANSZ
Notary Public - State of Illinois
My Commission Expires Apr 17, 2016

P.O. Box 19456
Springfield, Illinois
62794-9456
P: 217-523-4747
F: 217-523-0542
www.hshs.org

Sponsored by the Hospital Sisters of St. Francis

ST. MARY'S HOSPITAL
SAFETY NET INFORMATION PER P.A. 96-0031

CHARITY CARE			
	FY2009	FY2010	FY2011
Charity (# of Patients)			
Inpatients	142	199	263
Outpatients	631	1,911	2.336
Total Patients	773	2,110	2,599
Charity (Cost in dollars)			
Inpatients	$258,229	$346,849	$699,226
Outpatients	$619,547	$1,008,048	$1,776,123
Total	$877,776	$1,354,897	$2,475,349

MEDICAID			
	FY2009	FY2010	FY2011
Medicaid (# of Patients)			
Inpatients	244	212	262
Outpatients	8,997	9,186	9,261
Total Patients	9,241	9,398	9,523
Medicaid (Revenue)			
Inpatients	$945,812	$537,741	$777,436
Outpatients	$3,149,826	$3,458,603	$3,545,910
Total	$4,095,638	$3,996,344	$4,323,346

XII. Charity Care Information

1. The amount of charity care for the last 3 audited fiscal years for St. Mary's Hospital, the cost of charity care, and the ratio of that charity care cost to net patient revenue are presented below.

ST. MARY'S HOSPITAL

	FY2009	FY2010	FY2011
Net Patient Revenue	$52,339,449	$59,660,748	$56,252,478
Amount of Charity Care (charges)	$2.255.575	$4,181,781	$8,036,849
Cost of Charity Care	$877,776	$1,354,897	$2,475,349

2. This chart is provided for St. Mary's Hospital only.

3. This item is not applicable because St. Mary's Hospital is an existing facility.