

13-066

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

NOV 25 2013

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD**Facility/Project Identification**

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

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name: Ruthie Baum
Title: Director, Compliance and Contracting
Company Name: St. Mary's Hospital Decatur
Address: 1800 E. Lakeshore Drive, Decatur, Illinois 62521
Telephone Number: (217) 464-1305
E-mail Address: ruthie.baum@hshs.org
Fax Number: (217) 464-1615

Additional Contact

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

Name: Mark Swearingen
Title: Legal Counsel
Company Name: Hall Render Killian Heath & Lyman, P.C.
Address: One American Square, Suite 2000, Indianapolis, Indiana 46282
Telephone Number: (317) 977-1458
E-mail Address: mswearingen@hallrender.com
Fax Number: (317) 633-4878

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact**[Person to receive ALL correspondence or inquiries)**

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

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

Name: Mark Swearingen
Title: Legal Counsel
Company Name: Hall Render Killian Heath & Lyman, P.C.
Address: One American Square, Suite 2000, Indianapolis, Indiana 46282
Telephone Number: (317) 977-1458
E-mail Address: mswearingen@hallrender.com
Fax Number: (317) 633-4878

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

Exact Legal Name: Hospital Sisters Services, Inc.
Address: P.O. Box 19456, Springfield, Illinois 62794
Name of Registered Agent: Amy L. Marquardt
Name of Chief Executive Officer: Mary Starman-Harrison, RN, FACHE
CEO Address: 4936 LaVerna Road, Springfield, Illinois 62707
Telephone Number: (217) 523-4747

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact**[Person to receive ALL correspondence or inquiries)**

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

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

Name: Mark Swearingen
Title: Legal Counsel
Company Name: Hall Render Killian Heath & Lyman, P.C.
Address: One American Square, Suite 2000, Indianapolis, Indiana 46282
Telephone Number: (317) 977-1458
E-mail Address: mswearingen@hallrender.com
Fax Number: (317) 633-4878

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 applicants propose to discontinue the 14-bed Long Term Care/Skilled Unit located on the 7th floor east corridor of St. Mary's Hospital Decatur. St. Mary's has not yet determined the use of the space that will be vacated as a result of the discontinuation. The discontinuation will occur on January 28, 2014, upon approval by the Illinois Health Facilities and Services Review Board.

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

This is a substantive project because it proposes the discontinuation of an IDPH designated category of service.

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:

<p>Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Purchase Price: \$ _____</p> <p>Fair Market Value: \$ _____</p>
<p>The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>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.</p> <p>Estimated start-up costs and operating deficit cost is \$ _____.</p>

Project Status and Completion Schedules

<p>For facilities in which prior permits have been issued please provide the permit numbers.</p> <p>Indicate the stage of the project's architectural drawings:</p> <p><input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary</p> <p><input type="checkbox"/> Schematics <input type="checkbox"/> Final Working</p> <p>Anticipated project completion date (refer to Part 1130.140): <u>January 28, 2014</u></p> <p>Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):</p> <p><input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.</p> <p><input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies</p> <p><input checked="" type="checkbox"/> Project obligation will occur after permit issuance.</p>
<p>APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</p>

State Agency Submittals

<p>Are the following submittals up to date as applicable:</p> <p><input checked="" type="checkbox"/> Cancer Registry</p> <p><input checked="" type="checkbox"/> APORS</p> <p><input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted</p> <p><input checked="" type="checkbox"/> All reports regarding outstanding permits</p> <p>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</p>
--

ATTACHMENT-10

Discontinuation

General Information Requirements

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

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

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

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

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

The discontinuation will occur on January 28, 2014, upon approval of the Illinois Health Facilities and Services Review Board.

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

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

5. *Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.*

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

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.*

Not applicable.

Reasons for Discontinuation

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

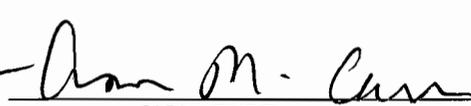
St. Mary's Hospital Decatur has provided quality long term care services to its patients for many years. However, utilization of those services has declined over the past several years to the point that it is no longer economically prudent to continue operating the unit. With the discontinuation of its long term care unit, St. Mary's will be better able to focus its resources on its core services of acute care hospital services.

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

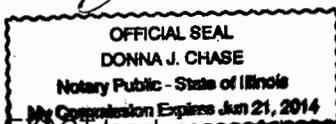
This Application for Permit is filed on the behalf of Hospital Sisters Services, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf 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	SIGNATURE
Mary Starmann-Harrison, RN, FACHE	Ann Carr
PRINTED NAME	PRINTED NAME
President	Treasurer
PRINTED TITLE	PRINTED TITLE

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


Signature of Notary

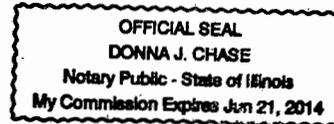
Seal



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


Signature of Notary

Seal



*Insert EXACT legal name of the applicant