10-002

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
JAN 26 2010
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. Margaret's Skilled Nursing Unit
Street Address:	600 E. First St.
City and Zip Code:	Spring Valley, IL 61362
County: Bureau	Health Service Area HSA2 Health Planning Area: C-02

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

Exact Legal Name:	St. Margaret's Hospital (Skilled Nursing Unit)
Address:	600 E. First St.
Name of Registered Agent:	Timothy A. Muntz
Name of Chief Executive Officer:	Timothy A. Muntz
CEO Address:	600 E. First St., Spring Valley, IL 61362
Telephone Number:	815-664-1372

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

Type of Ownership

- [x] 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.

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

Name:	Timothy A. Muntz
Title:	President & CEO
Company Name:	St. Margaret's Hospital
Address:	600 E. First St., Spring Valley, IL 61362
Telephone Number:	815-664-1372
E-mail Address:	tmuntz@aboutsmh.org
Fax Number:	815-664-1335

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

Name:	Mary L. Mattes
Title:	Vice President of Nursing
Company Name:	St. Margaret's Hospital
Address:	600 E. First St., Spring Valley, IL 61362
Telephone Number:	815-664-1561
E-mail Address:	mmattes@aboutsmh.org
Fax Number:	815-664-1195

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	St. Margaret's Skilled Nursing Unit
Street Address:	600 E. First St.
City and Zip Code:	Spring Valley, IL 61362
County: Bureau	Health Service Area HSA 2 Health Planning Area: C-02

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

Exact Legal Name:	Sisters of Mary of the Presentation Health System
Address:	1202 Page Drive SW, Fargo, ND 58103
Name of Registered Agent:	Timothy A. Muntz
Name of Chief Executive Officer:	Aaron Alton
CEO Address:	1202 Page Drive SW, Fargo ND 58103
Telephone Number:	701-237-9290

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

Type of Ownership

- [x] Non-profit Corporation
- [ ] For-profit Corporation
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- [ ] Partnership
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- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Name:	Timothy A. Muntz
Title:	President & CEO
Company Name:	St. Margaret's Hospital
Address:	600 E. First St., Spring Valley, IL 61362
Telephone Number:	815-664-1372
E-mail Address:	tmuntz@aboutsmh.org
Fax Number:	815-664-1335

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

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name:	Timothy A. Muntz
Title:	President & CEO
Company Name:	St. Margaret's Hospital
Address:	600 E. First St., Spring Valley, IL 61362
Telephone Number:	815-664-1372
E-mail Address:	tmuntz@aboutsmh.org
Fax Number:	815-664-1335

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	St. Margaret's Hospital
Address of Site Owner:	600 E. First St., Spring Valley, IL 61362
Street Address or Legal Description of Site:	600 E. First Street, Spring Valley, IL 61362

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. Margaret's Hospital (Skilled Nursing Unit)

Address: 600 E. First St., Spring Valley, IL 61362

- [x] 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.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person 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-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.idph.state.il.us/about/hfpb.htm)**.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

APPEND DOCUMENTATION AS ATTACHMENT-5, 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

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care				X	29 beds
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

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

3. 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.

St. Margaret's Hospital proposes to close its Skilled Nursing Unit due to financial losses from its operations and the availability of the Swing Bed Program:

1) There have been no residents on the Skilled Nursing Unit since September 25, 2009.

2) St. Margaret's Hospital will provide nursing care through its established Swing Bed Program.

As described above, this project is non-substantive due to being a discontinuation.

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-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

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

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _____

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

☐ 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.

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

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. 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
CLINICAL							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	0	0	0	0	0	0	0

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: St. Margaret's Hospital (Skilled Nursing Unit)	**CITY:** Spring Valley
REPORTING PERIOD DATES:	**From:** 01/01/08 **to:** 12/31/08

Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	29	404	3483	(29)	0
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

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. Margaret's Hospital (Skilled Nursing Unit) * **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.**

Timothy A. Muntz
SIGNATURE

Timothy A. Muntz
PRINTED NAME

President & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of January, 2010

Erika S. McNally
Signature of Notary

Seal

OFFICIAL SEAL
ERIKA S. McNALLY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 3-16-10

Kim Santman
SIGNATURE

Kim Santman
PRINTED NAME

Vice President of Finance
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of January, 2010

Erika S. McNally
Signature of Notary

Seal

OFFICIAL SEAL
ERIKA S. McNALLY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 3-16-10

*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: Attachment 9

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, 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-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0961-499-1

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. MARGARET'S HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 19, 1905, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 0935102822

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 17TH *day of* DECEMBER *A.D.* 2009 .

Jesse White

SECRETARY OF STATE

File Number 6601-983-7

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

SISTERS OF MARY OF THE PRESENTATION HEALTH SYSTEM, INCORPORATED IN NORTH DAKOTA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON FEBRUARY 27, 2008, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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* 22ND *day of* JANUARY *A.D.* 2010 .

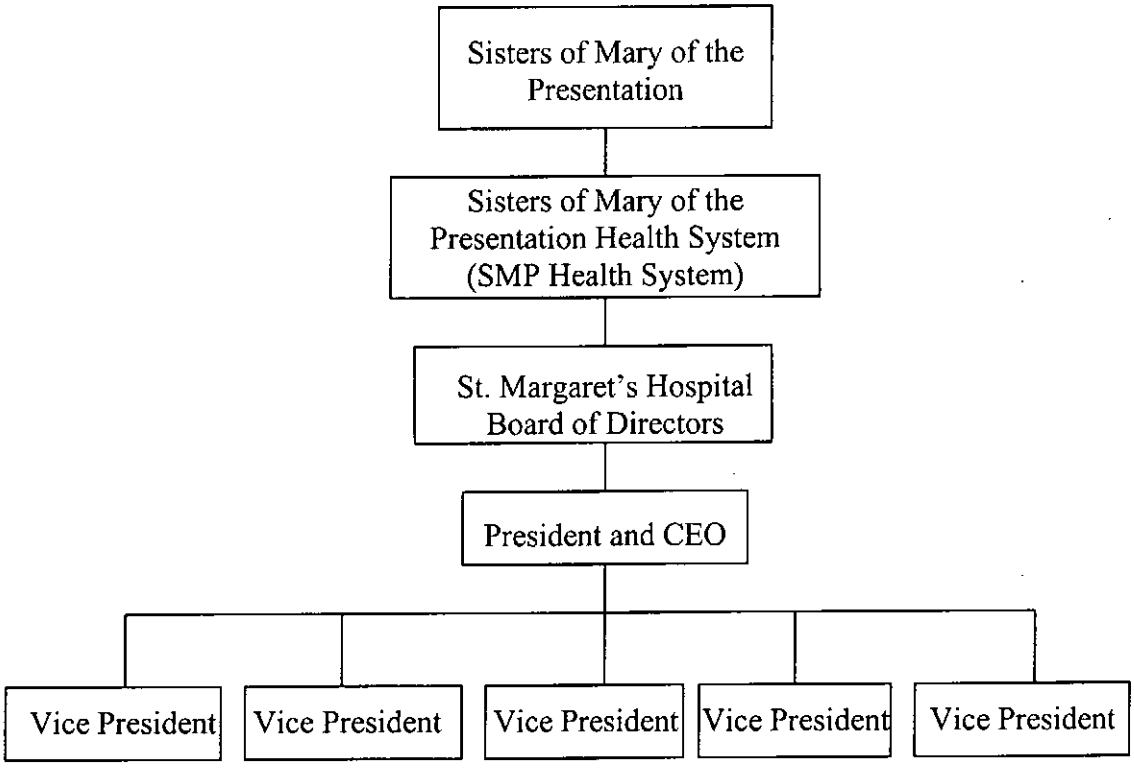
Jesse White

SECRETARY OF STATE

Authentication #: 1002202152

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

ORGANIZATIONAL CHART



General Information Requirements:

1. St. Margaret's Hospital will discontinue its Skilled Nursing Unit, which consists of 29 CON-authorized beds.

2. No other services will be discontinued.

3. The St. Margaret's Skilled Nursing Unit will be closed as April 30, 2010.

4. The physical department will be closed and there are no immediate plans for usage of the space.

5. St. Margaret's Hospital will retain the medical records under appropriate record retention policy.

Reason for Discontinuation:

The Skilled Nursing Unit needs to be discontinued because it is not economically feasible. Continued operation of this service threatens the financial viability of St. Margaret's Hospital.

The operating losses for the Skilled Nursing Unit for the two most recent fiscal years were $1.5 million (FYE 09/30/08) and $1.4 million (FYE 09/30/07) respectively. Continuation of this service would impair the future financial viability of St. Margaret's Hospital. The Skilled Nursing Unit at St. Margaret's Hospital loses in excess of $1.5 million per year.

Impact on Access:

1. The discontinuation of St. Margaret's Hospital Skilled Nursing Unit will not have an adverse effect upon access to care for residents of Bureau and LaSalle County. St. Margaret's Hospital has a designated Swing Bed Program, and there are multiple nursing homes in both counties that can easily absorb any patient requiring long-term care.

2. Sample impact letter attached. Twenty-eight (28) letters were sent to area long-term care nursing homes via certified US mail.

3. Five (5) copies of impact statements received from other resources or health care facilities located with 45 minutes travel time attached.

IMPACT LETTER

January 13, 2010

SENT VIA CERTIFIED MAIL

Dear _____:

For the past several months, St. Margaret's Hospital Board of Directors and its leadership team has been laboring over a difficult decision with regard to our Skilled Nursing Unit services. After careful thought and in-depth analysis, we have made the decision to close our Skilled Nursing Unit. However, we are committed to providing patients requiring longer lengths of stay the use of our Swing Bed Program.

We have begun the process of formal discontinuation by filing, with the Illinois Health Facilities and Services Review Board, a letter of intent stating our plans to discontinue our 29-bed Skilled Nursing Unit as of April 30, 2010.

We are working closely with area physicians and case managers to ensure continuity of care is provided to patients requiring long-term care following discharge from St. Margaret's.

The intent of this letter is to ask that _____work with us during our transition. **We ask that you indicate to us in writing that you have the capacity and desire to accommodate those patients/residents who may need long-term, skilled care in your facility.** We would like to include information about your facility and services as a viable option to families during our notification process.

Our leadership team, nursing and case management staff, and our Board of Directors thank you in advance for your assistance in assuring that our patients are well cared for. We are committed to supporting _____ in any way possible. Please contact me at (815) 664-1372 should you have any questions or concerns.

Sincerely,

Tim Muntz
President & CEO

TM: clp

St. Margaret's Hospital
Analysis of the Skilled Nursing Facility Operations
For the Years ended September 30, 2008 and 2007

	FYE 09/30/08	FYE 09/30/07
Medicare Revenue	$ 1,008,853	$ 885,487
Other Revenue	359,022	494,842
Net Revenue	1,367,875	1,380,329
Salary Expense	887,250	841,899
Other Expense	35,392	29,926
Medicare Ancillary	628,277	649,773
Total Direct Expense	1,550,919	1,521,598
Net Loss Before Allocated Overhead	(183,044)	(141,269)
Allocated Overhead		
Capital Related Costs	63,252	62,245
Employee Benefits	207,049	190,839
Administration	213,452	191,679
Operation of Plant	233,384	215,364
Laundry and Linen	77,855	74,875
Housekeeping	73,350	67,718
Dietary	212,953	206,898
Cafeteria	56,951	49,672
Nursing Administration	167,681	153,177
Medical Record	21,732	20,690
Social Service	12,040	11,291
Total Allocated Overhead	1,339,699	1,244,448
Net Loss After Overhead Allocation	(1,522,743)	(1,385,717)
Medicare Revenue Per Patient Day	$ 335.28	$ 317.26
Other Revenue PPD	$ 599.37	$ 1366.97
Direct Expense PPD	$ 429.86	$ 482.59
Overhead Allocation PPD	$ 371.31	$ 394.69
Medicare Days	3,009	2,791
Other Days	599	362
Total Days	3,608	3,153
Total Hours	40,279	39,730
Hours Per Patient Day	11.2	12.6

LASALLE
HealthCare Center

January 15, 2010

Mr. Tim Muntz
President & CEO
St. Margaret's Health
600 E. First Street
Spring Valley, IL 61362

Dear Mr. Muntz:

Thank you for contacting LaSalle Healthcare Center concerning the closure of your skilled nursing unit, effective April 30, 2010. We have the capacity and the desire to accommodate residents who need to discuss living arrangements with us.

We are pleased to continue our cooperation with St. Margaret's Hospital in providing quality care for all residents.

If you have any questions, please fee free to contact me at 815-223-4700.

Sincerely,

Lori Walsh

Lori Walsh, Administrator
LaSalle Healthcare Center

1445 Chartres Street • LaSalle, IL 61301 • Tel: 815-223-4700 • Fax: 815-223-4708 • email: admin.la.il@familysc.com

Liberty Village of Peru

January 15, 2010

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. First Street
Spring Valley, IL 61362

Dear Mr. Muntz:

We have been made aware that St. Margaret's Hospital intends to discontinue their skilled nursing unit by April 30, 2010.

Please accept this letter as notice that Manor Court of Peru, located at 3230 Becker Drive, Peru Il 61354, has the capability to accommodate those residents who wish to discuss new care and living arrangements with us.

We would be pleased to work with you to ensure that all residents are well cared for.

If you have any questions, please contact me at 815-224-1400, ext. 1.

Thank you for your attention to this matter.

Sincerely,

Darcee D Fanning

Darcee Fanning, Administrator
Manor Court of Peru
Liberty Village of Peru

1107 - 31st. Street • Peru, Illinois 61354
Phone 815/223-2286 • Fax 815/223-2001

Manor Court of Peru

January 15, 2010

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. First Street
Spring Valley, IL 61362

Dear Mr. Muntz:

We have been made aware that St. Margaret's Hospital intends to discontinue their skilled nursing unit by April 30, 2010.

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We would be pleased to work with you to ensure that all residents are well cared for.

If you have any questions, please contact me at 815-224-1400, ext. 1.

Thank you for your attention to this matter.

Sincerely,

Darcee Fanning

Darcee Fanning, Administrator
Manor Court of Peru

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

Hawthorne Inn

Assisted Living

January 15, 2010

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. First Street
Spring Valley, IL 61362

Dear Mr. Muntz:

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We would be pleased to work with you to ensure that all residents are well cared for.

If you have any questions, please contact me at 815-224-1400, ext. 1.

Thank you for your attention to this matter.

Sincerely,

Darcee D Fanning

Darcee Fanning, Administrator
Manor Court of Peru
Hawthorne Inn of Peru

1101 - 31st. Street • Peru, Illinois 61354 • Phone 815/224-2200 • Fax 815/224-3358

Liberty Village of Princeton

January 15, 2010

Mr. Tim Muntz
President & CEO
St. Margaret's Hospital
600 E. First Street
Spring Valley, IL 61362

Dear Mr. Muntz:

We are aware that St. Margaret's Hospital intends to discontinue their skilled nursing unit by April 30, 2010.

Please accept this letter as notice that Manor Court of Princeton, located at 140 N. Sixth Street, Princeton, IL 61356, has the capacity and willingness to accommodate those residents who wish to discuss new care and living arrangements with us.

We would be pleased to work with you to ensure that all residents are well cared for.

If you have any questions, please contact me at 815-875-6600.

Thank you for your attention to this matter.

Sincerely,

Kathleen Dilbeck

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St. Margaret's Health
Summary of Quantifiable Community Benefits

Use the categories and data elements shown in this form to report quantifiable community benefits.

Reporting period September 30, 2007

	Community Benefit Category *	See Worksheet	Number of activities or programs	Persons served	Total community benefit expense	Direct offsetting revenue	Net community benefit expense	Percent of total expense
Benefits for persons living in poverty								
Charity care at cost	I	3		715	558,385	0	558,385	0.9%
Unreimbursed costs of public programs	II							
Medicaid		4		6,190	6,625,722	4,838,690	1,787,032	2.9%
Other indigent programs		4		0	0	0	0	0.0%
Community health improvement services	III.A	6	-	-	0	0	0	0.0%
Health professions education	III.B	7	0	0	0	0	0	0.0%
Subsidized health services	III.C	8	1	2,235	138,095	48,535	89,560	0.1%
Cash and in-kind contributions to other community groups	III.E	10	5	811	14,600	0	14,600	0.0%
Community building activities	III.F	6,11		0	171	0	171	0.0%
Total quantifiable benefits for persons living in poverty			6	9,951	7,336,973	4,887,225	2,449,748	4.0%
Benefits for the broader community								
Community health improvement services	III.A	6	133	5,796	30,453	3,235	27,218	0.0%
Health professions education	III.B	7	-	-	0	0	0	0.0%
Subsidized health services	III.C	8	1	2,235	1,520,890	1,228,607	292,283	0.5%
Research	III.D	9					0	0.0%
Cash and in-kind contributions to other community groups	III.E	10	9	654	28,154	0	28,154	0.0%
Community building activities	III.F	6,11	10	370	10,231	0	10,231	0.0%
Community benefit operations	III.G	--	0	0	0	0	0	0.0%
Total quantifiable benefits for the broader community			153	9,055	1,589,728	1,231,842	357,886	0.6%
Total quantifiable community benefits			159	19,006	8,926,701	6,119,067	2,807,634	4.6%
See Reference I for description of community benefit categories*								

St. Margaret's Health
Summary of Quantifiable Community Benefits

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Reporting period September 30, 2008

	Community Benefit Category *	See Worksheet	Number of activities or programs	Persons served	Total community benefit expense	Direct offsetting revenue	Net community benefit expense	Percent of total expense
Benefits for persons living in poverty								
Charity care at cost	I	3		860	816,743	0	816,743	1.2%
Unreimbursed costs of public programs	II							
Medicaid		4		6,120	6,712,288	4,826,661	1,885,627	2.9%
Other indigent programs		4		0	0	0	0	0.0%
Community health improvement services	III.A	6	-	-	0	0	0	0.0%
Health professions education	III.B	7	0	0	0	0	0	0.0%
Subsidized health services	III.C	8	1	2,290	143,555	115,096	28,459	0.0%
Cash and in-kind contributions to other community groups	III.E	10	5	419	23,891	0	23,891	0.0%
Community building activities	III.F	6,11		0	0	0	0	0.0%
Total quantifiable benefits for persons living in poverty			6	9,689	7,696,477	4,941,757	2,754,720	4.2%
Benefits for the broader community								
Community health improvement services	III.A	6	147	7,359	31,067	5,800	25,267	0.0%
Health professions education	III.B	7	1	-	4,000	0	4,000	0.0%
Subsidized health services	III.C	8	2	498	2,404,308	1,801,911	602,397	0.9%
Research	III.D	9					0	0.0%
Cash and in-kind contributions to other community groups	III.E	10	19	606	37,415	0	37,415	0.1%
Community building activities	III.F	6,11	7	70	31,742	0	31,742	0.0%
Community benefit operations	III.G	--	0	0	0	0	0	0.0%
Total quantifiable benefits for the broader community			176	8,533	2,508,532	1,807,711	700,821	1.1%
Total quantifiable community benefits			182	18,222	10,205,009	6,749,468	3,455,541	5.3%
See Reference I for description of community benefit categories*								

St. Margaret's Health
Summary of Quantifiable Community Benefits

Use the categories and data elements shown in this form to report quantifiable community benefits.

Reporting period September 30, 2009

	Community Benefit Category *	See Worksheet	Number of activities or programs	Persons served	Total community benefit expense	Direct offsetting revenue	Net community benefit expense	Percent of total expense
Benefits for persons living in poverty								
Charity care at cost	I	3		708	414,184	0	414,184	0.6%
Unreimbursed costs of public programs	II							
Medicaid		4		6,411	8,835,398	5,378,412	3,456,986	5.2%
Other indigent programs		4		0	0	0	0	0.0%
Community health improvement services	III.A	6	-	-	0	0	0	0.0%
Health professions education	III.B	7	0	0	0	0	0	0.0%
Subsidized health services	III.C	8	1	2,290	173,080	147,556	25,524	0.0%
Cash and in-kind contributions to other community groups	III.E	10	5	708	18,331	0	18,331	0.0%
Community building activities	III.F	6,11		0	0	0	0	0.0%
Total quantifiable benefits for persons living in poverty			6	10,117	9,440,993	5,525,968	3,915,025	5.9%
Benefits for the broader community								
Community health improvement services	III.A	6	150	8,734	37,621	4,240	33,381	0.1%
Health professions education	III.B	7	1	-	4,000	0	4,000	0.0%
Subsidized health services	III.C	8	2	427	2,587,062	1,859,675	727,387	1.1%
Research	III.D	9					0	0.0%
Cash and in-kind contributions to other community groups	III.E	10	16	661	32,637	0	32,637	0.0%
Community building activities	III.F	6,11	9	73	8,887	0	8,887	0.0%
Community benefit operations	III.G	--	0	0	0	0	0	0.0%
Total quantifiable benefits for the broader community			178	9,895	2,670,207	1,863,915	806,292	1.2%
Total quantifiable community benefits			184	20,012	12,111,200	7,389,883	4,721,317	7.2%

See Reference I for description of community benefit categories*