ORIGINAL 10-029

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
APR 29 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. Francis Hospital			
Street Address: 1215 Franciscan Drive			
City and Zip Code: Litchfield, IL 62056			
County: Montgomery	Health Service Area	3	Health Planning Area:E-02

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

Exact Legal Name:St. Francis Hospital of the Hospital Sisters of the Third Order of St. Francis
Address:1215 Franciscan Drive
Name of Registered Agent: Daniel Perryman
Name of Chief Executive Officer: Daniel Perryman
CEO Address: 1215 Franciscan Drive, Litchfield, IL 62056
Telephone Number: 217-324-8500

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

Type of Ownership

X	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.

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

Name: Diane Lindsay
Title: Chief Financial Officer
Company Name: St. Francis Hospital
Address: 1215 Franciscan Drive, Litchfield, IL 62056
Telephone Number: 217-324-8510
E-mail Address: dlindsay@sfl.hshs.org
Fax Number: 217-324-8724

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

Name: Carol Jaco
Title: Chief Nursing Officer/Chief Operating Officer
Company Name: St. Francis Hospital
Address: 1215 Francis Drive, Litchfield, IL 62056
Telephone Number: 217-324-8596
E-mail Address: cjaco@sfl.hshs.org
Fax Number: 217-324-3081

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name: Diane Lindsay
Title: Chief Financial Officer
Company Name: St. Francis Hospital
Address: 1215 Franciscan Drive, Litchfield, IL 62056
Telephone Number: 217-324-8510
E-mail Address: dlindsay@sfl.hshs.org
Fax Number: 217-324-8724

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: St. Francis Hospital of the Hospital Sisters of the Third Order of St. Francis
Address of Site Owner: 1215 Franciscan Drive, Litchfield, IL 62056
Street Address or Legal Description of Site: 1215 Franciscan Drive

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:
Address:

X	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.

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	X Part 1120 Not Applicable
X 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				11	11
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					

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

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☐ No ☒ N/A
Purchase Price: $ 0
Fair Market Value: $ 0

The project involves the establishment of a new facility or a new category of service
☐ Yes X 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 $ 0.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): June 1, 2010

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

☐ 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:

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

Cost Space Requirements N/A

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	0						
Medical Surgical	0						
Intensive Care	0						
Diagnostic Radiology	0						
MRI	0						
Total Clinical	0						
	0						
NON CLINICAL	**0**						
Administrative	0						
Parking	0						
Gift Shop	0						
Total Non-clinical	0						
TOTAL	**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. Francis Hospital	**CITY: Litchfield, IL 62056**				
REPORTING PERIOD DATES:	**From: January 1, 2009**		**to: December 31, 2009**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	18	1136	4434	0	18
Obstetrics	3	329	569	0	3
Pediatrics	0	0	0	0	0
Intensive Care	4	61	302	0	4
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	11	0	0	(11)	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	36	1526	5305	(11)	25

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. Francis Hospital requests discontinuation of eleven (11) general long term care beds located on the second floor of the Hospital at 1215 Franciscan Drive, Litchfield, IL 62056. The use of the beds will be discontinued the later of June 1, 2010 or upon receipt of approval from the Health Facilities and Services Review Board (HFSRB). The rooms formerly occupied by the beds will be used for general and administrative offices. Medical records for the patients who had occupied the long-term beds will be stored in the hospital's electronic and paper records and will be retained for a minimum of ten (10) years after the date of the patient's most recent care at the hospital, or for longer periods of time when requested by the patient's physician, the patient or person acting legally in the patient's behalf, or appropriate legal counsel.

Skilled nursing services will continue to be provided at St. Francis Hospital. Skilled nursing patients will be treated in the swing beds in the medical/surgical unit.

The project is classified as non-substantive because it is solely and entirely limited to the discontinuation of the use of the identified long-term care beds as described in Section 1110.130 of the Administrative Code.

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. Francis Hospital 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

Daniel Perryman
PRINTED NAME

President/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of April 2010

Signature of Notary

Seal

OFFICIAL SEAL
DAWN D. STOECKER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 2-13-2011

SIGNATURE

Stephanie McCutcheon
PRINTED NAME

President and CEO HSHS
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26 day of April, 2010

Signature of Notary

Seal

Official Seal
Sylvia Rebecca Gansz
Notary Public State of Illinois
My Commission Expires 04/17/2012

*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 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.

SAFETY NET IMPACT STATEMENT that describes all of the following:

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

APPEND DOCUMENTATION AS ATTACHMENT-77, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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39	Components	
40	Documentation	
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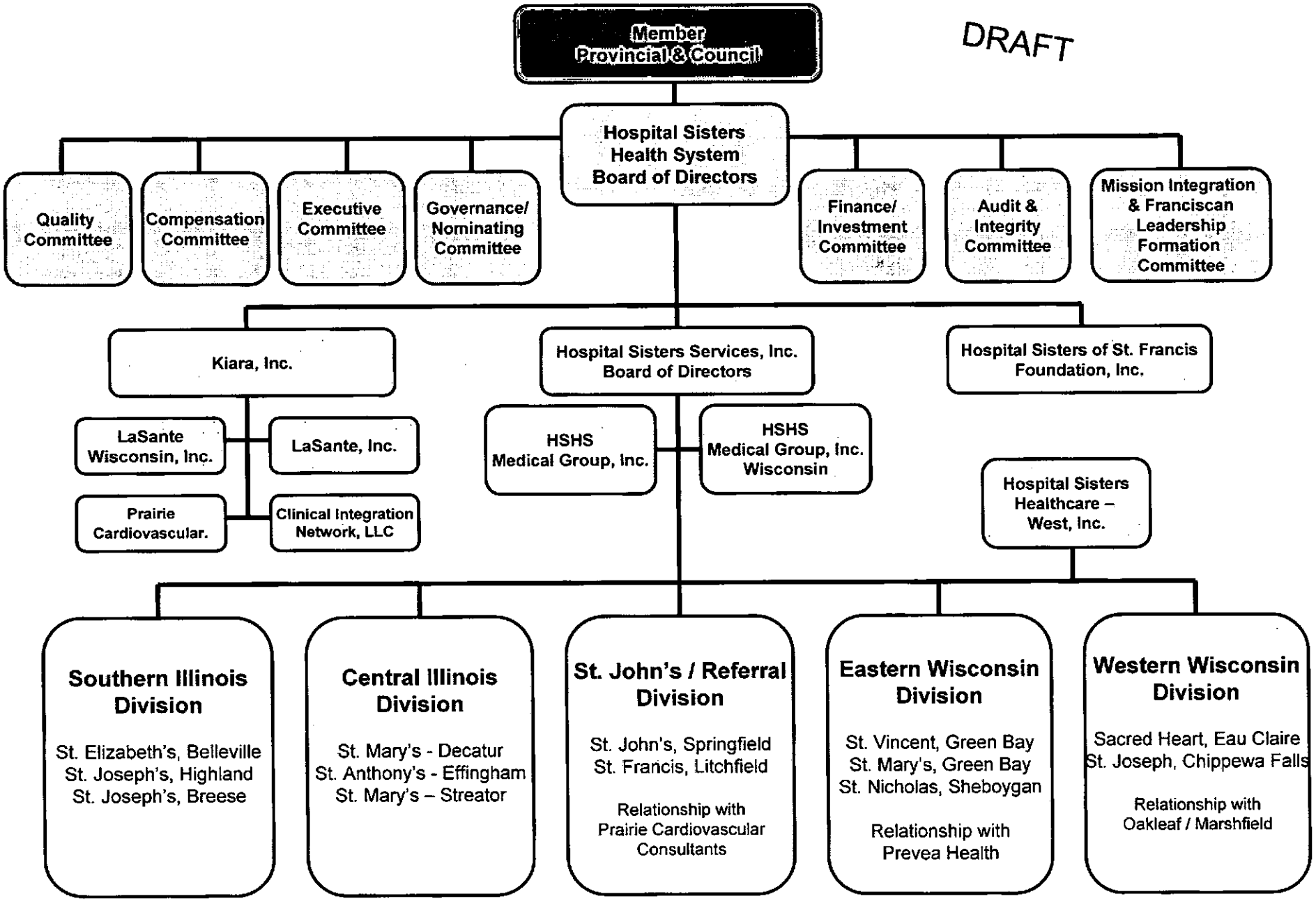
Corporate Organization Chart

DRAFT



ATTACHMENT - 3

14

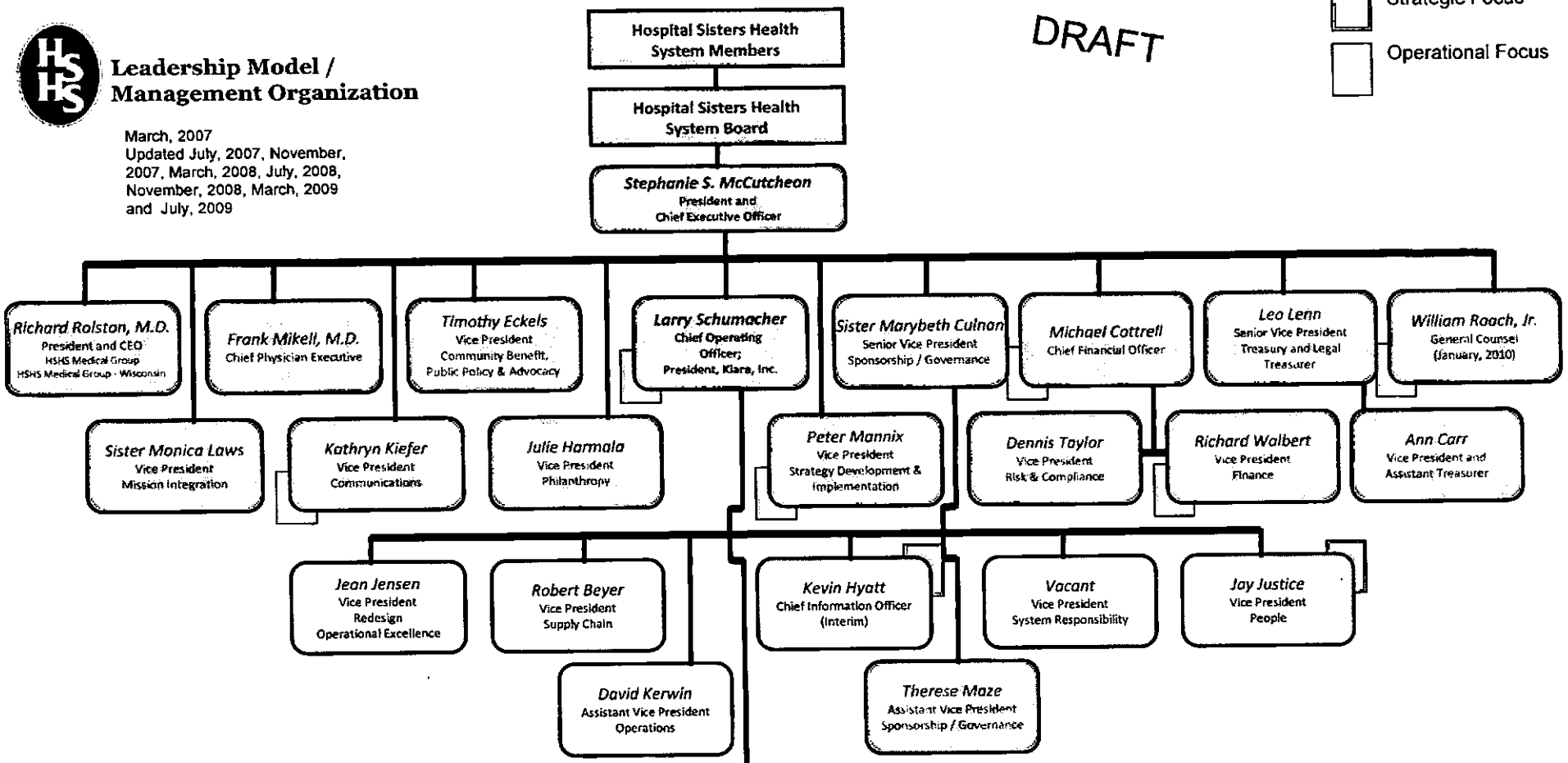
Leadership Model / Management Organization

March, 2007
Updated July, 2007, November, 2007, March, 2008, July, 2008, November, 2008, March, 2009 and July, 2009

DRAFT

Strategic Focus

Operational Focus



* Relationship Management

Attachment - 3

15

File Number 3528-155-0

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. FRANCIS HOSPITAL, 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* 15TH *day of* FEBRUARY *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1004600764

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

ATTACHMENT - 3

ST. FRANCIS HOSPITAL

APPLICATION FOR PERMIT
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

DISCONTINUATION

General Information:

Category of service and number of beds to be discontinued

Eleven (11) general long-term care beds are to be discontinued.

Other clinical services to be discontinued

No other clinical services are to be discontinued.

Anticipated date of discontinuation

The use of the long-term care beds will be discontinued the later of June 1, 2010 or upon receipt of approval from the Health Facilities and Services Review Board (HFSRB).

Anticipated use of the rooms and beds after discontinuation

The rooms formerly occupied by the beds will be used for general and administrative offices. The beds will be removed from the rooms and will be placed into storage. The stored beds will only be used if needed to replace broken or obsolete beds in other areas of the hospital.

Anticipated disposition and location of medical records

Medical records for the patients who had occupied the long-term beds will be stored in the hospital's electronic and paper records and will be retained for a minimum of ten (10) years after the date of the patient's most recent care at the hospital, or for longer periods of time when requested by the patient's physician, the patient or person acting legally in the patient's behalf, or appropriate legal counsel.

Reasons for Discontinuation:

The request for discontinuation is due to insufficient volume and lack of demand for the service. In December of 2006 St. Francis Hospital applied for a permit to establish swing beds for extended care service. Permission was granted to use the hospital's acute care beds as swing beds, and the skilled nursing patients were treated in those beds beginning in March, 2007.

Long-term care beds admissions and days:

Calendar year 2007	88 admissions	965 days
Calendar year 2008	0 admissions	0 days
Calendar year 2009	0 admissions	0 days

ST. FRANCIS HOSPITAL

APPLICATION FOR PERMIT
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

DISCONTINUATION

Skilled nursing patients admitted to swing beds:

Calendar year 2007	40 admissions	375 days
Calendar year 2008	37 admissions	240 days
Calendar year 2009	18 admissions	107 days

Impact on Access:

See Safety Net Impact Statement Attachment - 77

ST. FRANCIS HOSPITAL

APPLICATION FOR PERMIT
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

SAFETY NET IMPACT STATEMENT

Project's material impact on essential safety net services in the community

The project will have no material impact on essential safety net services in the community. St. Francis Hospital will continue to provide subacute services in the hospital's swing beds. During the last fiscal year from July 1, 2008 through June 30, 2009, St. Francis admitted fourteen skilled nursing patients to the swing beds for a total of seventy-nine patient days. During the current fiscal year through November 30, thirteen skilled nursing patients were admitted into the swing beds for a total of eighty patient days. During the current and prior fiscal year no patients were admitted into the eleven general long-term care beds that are requested to be discontinued.

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

The discontinuance of the beds will not impact the ability of other providers or health care systems to cross-subsidize safety net services.

How the discontinuation of the long-term care beds might impact the remaining safety net providers in a given community

Area providers were informed of St. Francis' intent to discontinue the use of the long-term care beds. The following responses were received:

Heritage Manor, Litchfield, IL	No response
Heritage Manor, Gillespie, IL	No impact
Heritage Manor, Staunton, IL	No response
Heritage Manor, Carlinville, IL	No response
Friendship Home, Carlinville, IL	No response
Carlinville Rehab, Carlinville, IL	No response
Hillsboro Rehab and Healthcare, Hillsboro, IL	No impact
Litchfield HealthCare Center, Litchfield, IL	No response
Litchfield Terrace, Litchfield, IL	No response
Montgomery County Nursing and Rehab, Hillsboro, IL	No response
Nokomis Rehabilitation and Health Care Center, Nokomis, IL	No response
Carlinville Area Hospital, Carlinville, IL	No response
Community Memorial Hospital, Staunton, IL	No impact

The amount of charity care provided by St. Francis Hospital

Charity care is defined as care for which the provider does not expect to receive payment from the patient or a third-party payor. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other Federal, State, or local indigent health care programs, eligibility for which is based on financial need. Charity care is reported as the actual cost of services provided, based on the cost to charge ratio of the hospital, and not the actual charges for the services.

Attachment - 77

ST. FRANCIS HOSPITAL

APPLICATION FOR PERMIT
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

SAFETY NET IMPACT STATEMENT

Cost of charity care provided:

FY 2007	$262,419
FY 2008	$208,826
FY 2009	$461,329

The amount of care provided to Medicaid patients by St. Francis Hospital

Amount of care provided to Medicaid patients based on net revenue received:

FY 2007	$7,280,000
FY 2008	$4,810,507
FY 2009	$4,779,544

Note: Fiscal Year 2007 Medicaid reimbursement includes two years of the Medicaid Provider Assessment payments. The payments for Fiscal Year 2006 were not received until Fiscal Year 2007 and were recorded in the financial statements as increased payments for Medicaid services during that year. Excluding the payments related to Fiscal Year 2006, the Fiscal Year 2007 Medicaid payments would have been $4,514,441.

PHONE (618) 635-2200

COMMUNITY MEMORIAL HOSPITAL

400 CALDWELL ST.

STAUNTON, ILLINOIS 62088-1499

December 28, 2009

Diane Lindsay
Chief Financial Officer
St. Francis Hospital
1215 Franciscan Drive
Litchfield, IL 62056

Dear Ms. Lindsay,

Thank you for your notification of the intent to discontinue use of the eleven (11) general long term care beds that St. Francis has maintained. You requested an impact statement from the area healthcare facilities, and I want to provide that to you.

The proposed closing of the eleven (11) long term care beds will not have any impact upon Community Memorial Hospital. Access to long term beds is available within Staunton, Gillespie, and Alhambra, and we have not found it necessary to go outside that geographical area unless the family requested placement at another facility.

I trust this statement will suffice for your needs, and I wish you success with this new endeavor.

Sincerely,

Sue Campbell

Sue Campbell, CEO
Community Memorial Hospital

C: File

HERITAGE MANOR

Sharing a Heritage of Care

1/4/10

Diane Lindsey SFO
St. Francis Hospital
1215 Franciscan Drive
Litchfield, IL 62056

Dear Ms Lindsey,

I have received your letter regarding discontinuing the use of eleven general long term care beds. I am writing to let you know this will have no impact on us at Heritage Manor Gillespie LLC. We are happy to accept additional long term care patients. We do not foresee any limitations or restrictions. We have a history of accepting challenging individuals and situations. We enjoy our relationship with St. Francis Hospital.

Best Regards,

Jean Strausbaugh

Jean Strausbaugh
Administrator

Hillsboro
REHAB & HEALTH CARE

January 7, 2010

Diane Lindsay
Chief Financial Officer
St. Francis Hospital
1215 Franciscan Drive
Litchfield, IL 62056

Dear Ms. Diane Lindsay

We anticipate that the discontinuation of St. Francis Hospital use of the long-term bed will have no impact on the Hillsboro Rehab facility located within the hospitals market area. Hillsboro Rehab will have capacity to accept additional long-term care patients, as we are a Licensed Skilled facility.

Sincerely

Joann Newell
Administrator