

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION MAY 19 2011

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Decatur Memorial Hospital		
Street Address: 2300 N. Edward St		
City and Zip Code: Decatur, IL 62526		
County: Macon	Health Service Area HSA 4	Health Planning Area: D-04

Applicant /Co-Applicant Identification

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

Exact Legal Name: Decatur Memorial Hospital	
Address: 2300 N. Edward St, Decatur, Illinois, 62526	
Name of Registered Agent: Kenneth L. Smithmier	
Name of Chief Executive Officer: Kenneth L. Smithmier	
CEO Address: 2300 N. Edward St. Decatur, IL 62526	
Telephone Number: 217-876-2109	

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

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

Name: Linda Fahey
Title: Vice President and Chief Nursing Officer
Company Name: Decatur Memorial Hospital
Address: 2300 N. Edward St. Decatur, IL 62526
Telephone Number: 217-876-2113
E-mail Address: lindaf@dmhhs.org
Fax Number: 217-876-2125

Additional Contact

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

Name: Timothy D. Stone, Jr
Title: Senior Vice President and COO
Company Name: Decatur Memorial Hospital
Address: 2300 N. Edward St. Decatur, IL 62526
Telephone Number: 217-876-2114
E-mail Address: tstone@dmhhs.org
Fax Number: 217-876-2125

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: Linda Fahey
Title: Vice President and Chief Nursing Officer
Company Name: Decatur Memorial Hospital
Address: 2300 North Edward Street, Decatur, IL 62526
Telephone Number: 217-876-2113
E-mail Address: lindaf@dmhhs.org
Fax Number: 217-876-2125

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Decatur Memorial Hospital
Address of Site Owner: 2300 North Edward Street, Decatur, Illinois 62526
Street Address or Legal Description of Site: 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 <u>ATTACHMENT-2</u> , 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: Decatur Memorial Hospital
Address: 2300 North Edward Street, Decatur, Illinois 62526
<input checked="" type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS <u>ATTACHMENT-3</u> , 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.

Flood Plain Requirements Not applicable – No construction

[Refer to application instructions.]

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

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements Not applicable – No construction

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Decatur Memorial Hospital is requesting approval to discontinue the skilled nursing service and eliminate 61 licensed skilled nursing beds. After the elimination of those skilled nursing beds, 31 currently licensed medical-surgical beds will be moved to that area. There is no cost for this project and it is therefore, classified as non-substantive.

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary
 Schematics Final Working

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

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.

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.

Cost Space Requirements Not applicable – No Construction

Provide in the following format, the department/area DGSF or the building/area BGSF and cost. The type of gross square footage either DGSF or BGSF must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Decatur Memorial Hospital			CITY: Decatur, Illinois		
REPORTING PERIOD DATES: From: Apr 1, 2010 to: Apr 1, 2011					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	204	4960	27,843		204
Obstetrics	26	1068	2756		26
Pediatrics	18	503	1295		18
Intensive Care	32	2558	7546		32
Comprehensive Physical Rehabilitation	0	0	0		0
Acute/Chronic Mental Illness	0	0	0		0
Neonatal Intensive Care	0	0	0		0
General Long Term Care	61	512	8022	-61	0
Specialized Long Term Care	0	0	0		0
Long Term Acute Care	0	0	0		0
Other ((identify))	0	0	0		0
TOTALS:	341	9601	47,462	-61	280

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Decatur Memorial Hospital * 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.

Kenneth L. Smithmier
SIGNATURE

Kenneth L. Smithmier

PRINTED NAME

President & CEO

PRINTED TITLE

Timothy D. Stone, Jr.
SIGNATURE

Timothy D. Stone, Jr.

PRINTED NAME

Executive VP & COO

PRINTED TITLE

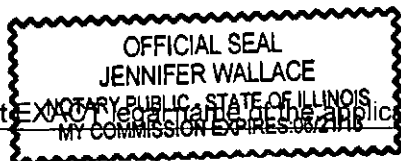
Notarization:
Subscribed and sworn to before me
this 16 day of May, 2011

Notarization:
Subscribed and sworn to before me
this 16 day of May, 2011

Jennifer Wallace
Signature of Notary

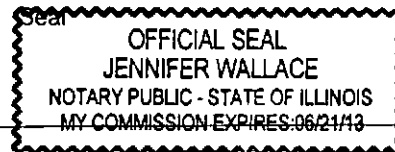
Jennifer Wallace
Signature of Notary

Seal



*Insert EXACT legal name of the applicant

Seal



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

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

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)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	14
2	Site Ownership	15
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	14
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	17
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	18
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:	
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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	
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37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	
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41	Financial Viability	
42	Economic Feasibility	
43	Safety Net Impact Statement	19-51
44	Charity Care Information	52



To all to whom these Presents Shall Come, Greeting:

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

DECATUR MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 09, 1902, 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 10TH day of MAY A.D. 2011

Jesse White

SECRETARY OF STATE

Authentication #: 1113000560

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

MACON COUNTY

2010

2010 REAL ESTATE TAX BILL
 EDWARD D. YODER, TAX COLLECTOR
 MACON COUNTY OFFICE BUILDING
 141 S MAIN ST ROOM 302
 DECATUR, IL 62523
 PHONE (217) 424-1426

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS BILL REGARDING YOUR TAXES.

The County Collector only collects your taxes and is not responsible for the amount of your assessment or the amount of your tax bill. We will be happy to assist you or direct you to the proper authority regarding questions about your tax bill.

DECATUR MEMORIAL HOSPITAL

ASSESSED TO: 36345
 BILL NUMBER:

DECATUR MEMORIAL HOSPITAL
 2300 N EDWARD
 DECATUR, IL 62526

PROPERTY ADDRESS DMH 2ND ADDITION LOT 1 ST DOC# 91-58-125 IRREG 03BK3315/458 Main hospital bldg			PERMANENT INDEX NUMBER 04-12-03-401-015																																																																																																																									
LOCATION OF PROPERTY Section 03 Township 16 Range 2E Acres 24.370			ACRES 24.370	TAXABLE VALUE 4,604,517																																																																																																																								
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RECEIPT PORTION - KEEP FOR YOUR RECORDS

PAY TO: MACON COUNTY COLLECTOR

FORMULA TAX CALCULATION - 2010	74,900
Farm Land +	0
Buildings +	4,529,617
Farm Bldg +	0
B. Of R. Equalized =	4,604,517
State Eq. Factors * x	1,00000
State Eq. Value =	4,604,517
IMPROVEMENT -	0
OWNER OCC EX -	0
SENIOR EX -	0
VETERAN EX -	0
SEN FREEZE -	0
Taxable Value =	4,604,517
Tax Rate x	8.92454
Real Estate Tax =	\$410,931.96
Drainage Tax =	\$0.00
* Not to be used for farm land and farm buildings	
Township Multiplier: 1.00000	
INTEREST 1 1/2% PER MONTH	TOTAL TAX DUE \$410,931.96
1977 EQUALIZED VALUE 100	FAIR MARKET VALUE \$410,931.96

FIRST INSTALLMENT 06/06/2011 AMOUNT \$205,465.98

SECOND INSTALLMENT 09/01/2011 AMOUNT \$205,465.98



1

BILL NUMBER	36345	FORFEITED TAXES OR YEARS	\$0.00
PERMANENT INDEX NUMBER	04-12-03-401-015	CURRENT TAX DUE	\$205,465.98
DUE DATE	06/06/2011	TAX PAYMENT - 1 ST INST.	\$0.00
PAID BY OTHER		INTEREST	
		COSTS	
TOTAL TAX	\$410,931.96	TOTAL PAID	

04-12-03-401-015
 DECATUR MEMORIAL HOSPITAL
 2300 N EDWARD
 DECATUR, IL 62526



2

DETACH HERE

BILL NUMBER	36345	FORFEITED TAXES OR YEARS	\$0.00
PERMANENT INDEX NUMBER	04-12-03-401-015	CURRENT TAX DUE	\$205,465.98
DUE DATE	09/01/2011	TAX PAYMENT - 2 ND INST.	\$0.00
PAID BY OTHER		INTEREST	
		COSTS	
TOTAL TAX	\$410,931.96	TOTAL PAID	

04-12-03-401-015
 DECATUR MEMORIAL HOSPITAL
 2300 N EDWARD
 DECATUR, IL 62526

Attachment 2

RETURN THIS STUB WITH YOUR 1ST INSTALLMENT
 FIRST INSTALLMENT - 2010. CHECK CASH BANK OTHER 15

RETURN THIS STUB WITH YOUR 2ND INSTALLMENT
 SECOND INSTALLMENT - 2010. CHECK CASH BANK OTHER



To all to whom these Presents Shall Come, Greeting:

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

DECATUR MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 09, 1902, 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 #: 1113000560

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 10TH day of MAY A.D. 2011 .

Jesse White

SECRETARY OF STATE

Decatur Memorial Hospital Board of Directors

Kenneth L. Smithmier
President & Chief Executive Officer

Community and Government Relations
Customer Service

Physician Services

Human Resources

DMH Medical Group

Timothy D. Stone Jr.
Executive Vice President & Chief Operating Officer

Anesthesia/Pain Mgmt. Svcs.
Cancer Care Institute
Central Illinois Surgery Center, LLC
Clinical Research
Digestive Disease Center, LLC
Food Services
Fortsyth Imaging Center
Heart & Lung Services
Laboratory
Marketing
Materials Management
Neurodiagnostics
Occupational Health Services
Publications
Radiation Oncology
Radiology
Real Estate
Rehabilitation Services
Six Sigma Black Belt
S.S. Diagnostic Center
Support Services
Surgical Services
Wellness Center
Women's Health Center

David Oppenlander
Senior Vice President & Chief Financial Officer

Accounting
Business Office
Case Management
Patient Registration
Decision Support
Information Systems
Managed Care
Medical Records
Utilization and Review

Linda L. Fahey, R.N.
Vice President & Chief Nurse Executive

Cardiac CVU/5400
Critical Care Nursing
Education
Emergency Care Center
Family Birth Center/2400
Home Health/Hospice
Durable Medical Equipment
Medical Nursing/4100
Observation Unit
Outpatient Care Center/OCC
Pediatrics/3100
Pharmacy Services
Senior Services
Six Sigma Black Belt
Surgical Nursing/5100
Transitional Care/6400
Long Term Care/6400
Patient Transportation
Wellness Center

Michael J. Zia, M.D.
Vice President Quality Systems & Medical Affairs

Cancer Care Institute
Clinical Research
Customer Service
Infection Control
Medical Staff Affairs
Pastoral Services
Quality Systems
Regulatory Affairs
Six Sigma Black Belt

General information for Discontinuation

1. Categories of service and licensed beds to be discontinued
The skilled nursing service will be discontinued along with a decrease in 61 licensed skilled nursing beds, of which 40 are Medicare certified.
2. Other clinical services to be discontinued
No other services will be discontinued
3. Anticipated date of discontinuation
The service will be discontinued approximately two weeks after approval of this application. The service will be discontinued approximately 2 weeks after approval of this request. This is the normal length of stay for most residents allowing for appropriate continuing care.
4. Anticipated use of plant and equipment after discontinuation
After discontinuation of skilled nursing services, 31 medical surgical licensed beds will be re-located to this space from semi-private rooms on other units. The proposed updated bed inventory file is included with this packet in excel format.
5. Anticipated disposition and location of medical records
All medical records for this unit will be maintained at least 10 years in electronic format. The records are stored at the hospital
6. 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.
All questionnaires and data required by HFSRB or DPH will be provided through the date of discontinuation and will be provided no later than 60 days after discontinuation. Certified by the Chief Executive Officer per submission of this application

REASONS FOR DISCONTINUATION

The skilled nursing service is being discontinued due to low census for that area and the need to more effectively use that space for other inpatients. Changes in Medicare reimbursement have impacted both the census and the financial viability of the unit. The average daily census is 20 residents. Due to the high fixed costs required for Medicare certified skilled nursing care, the service will experience a loss of over \$140,000 this fiscal year. Additionally, the need to provide privacy for patients and protect patients from infections has increased our needs for private medical-surgical rooms rather than the large number of semi-private rooms reflected in our current inventory. This change will allow Decatur Memorial Hospital to use this under-utilized space more appropriately to meet the needs of our community.

IMPACT ON ACCESS

1. No negative impact on access for the community
A survey of area skilled nursing facilities revealed 80 vacant skilled beds in Decatur alone indicating that the community needs were being adequately addressed by those facilities. Another 49 beds are currently under construction locally.
2. Copy of letter sent to surrounding facilities along with mapquest information and evidence of receipt follows.
3. Copies of all response letters follow

Safety Net Impact Statement (section XI)

1. No impact on essential safety net services. The service addressed in this application only serves Medicare patients.
2. No impact on cross-subsidy of safety services.
3. No impact on the remaining safety net providers.

Community Impact Report for FY 2010 follows with additional pertinent information on Decatur Memorial Hospital safety net functions.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2010	2009	2008
Inpatient	843	1683	2129
Outpatient	10825	10048	8575
Total	11668	11731	10704
Charity (cost in dollars)			
Inpatient	2,207,775	2,243,199	2,024,026
Outpatient	3,429,472	2,970,009	2,447,625
Total	5,637,247	5,213,208	4,471,651
MEDICAID			
Medicaid (# of patients)	2010	2009	2008
Inpatient	2156	2202	2203
Outpatient	41,685	39,438	38,848
Total	43,841	41,640	41,051
Medicaid (revenue)			
Inpatient	33,061,695	30,721,006	30,736,193
Outpatient	73,487,143	63,737,537	55,208,025
Total	106,548,838	94,458,543	85,944,218

DECATUR MEMORIAL HOSPITAL

COPY

Annual Non-Profit Hospital Community Benefits Plan Report

Fiscal Year Ended
September 30, 2010



2300 North Edward Street . Decatur, Illinois 62526 . 217-876-8121

www.dmhcares.com

Annual Non-Profit Hospital Community Benefits Plan Report

Hospital or Hospital System: Decatur Memorial Hospital

Mailing Address: 2300 N. Edward St. Decatur, IL 62526
(Street Address/P.O. Box) (City, State, Zip)

Physical Address (If different than mailing address):

(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: 10/01/2009 through 09/30/2010 Taxpayer Number: 37-0661199

If filing a consolidated financial report for a health system, list below the Illinois hospitals included in the consolidated report.

<u>Hospital Name</u>	<u>Address</u>	<u>FEIN #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. **ATTACH Mission Statement:**
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and specify the date it was adopted.

2. **ATTACH Community Benefits Plan:**
The reporting entity must provide its most recent Community Benefits plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
 1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
 2. Identify the populations and communities served by the hospital.
 3. Disclose health care needs that were considered in developing the plan

3. **REPORT Charity Care:**
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. 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. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services.

Charity Care\$ 5,435,662

ATTACH Charity Care Policy:
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

4. **REPORT Community Benefits actually provided other than charity care:**
 See instructions for completing Section 4 of the Annual Non Profit Hospital Community Benefits Plan Report.

Community Benefit Type

Language Assistant Services.....	\$	11,453
Government Sponsored Indigent Health Care.....	\$	9,842,895
Donations.....	\$	51,950
Volunteer Services		
a) Employee Volunteer Services.....	\$	160,800
b) Non-Employee Volunteer Services.....	\$	332,160
c) Total (add lines a and b).....	\$	492,960
Education.....	\$	225,479
Government-sponsored program services.....	\$	5,016,919
Research.....	\$	0
Subsidized health services.....	\$	1,234,300
Bad debts.....	\$	28,084,856
Other Community Benefits.....	\$	177,063

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

David M. Oppenlander, Senior Vice President and
Chief Financial Officer
 Name/Title (Please Print)

Signature

David M. Oppenlander
 Name of Person Completing Form

doppenlander@dmhhs.org
 Electronic / Internet Mail Address

(217) 876-2107
 Phone: Area Code / Telephone No.

3/24/11
 Date

(217) 876-2107
 Phone: Area Code / Telephone No.

(217) 876-2125
 FAX: Area Code / FAX No.

Our Mission

Improve the health of the people of Central Illinois.

Our Vision

The greatest care delivered by the best people.

Our Values

- **Compassion**
 - Takes time to listen to the needs of others
 - Keeps customers informed and includes them in decisions where appropriate
 - Anticipates and looks for ways to provide assistance to others
 - Demonstrates empathy and provides reassurance to all

- **Agility**
 - Encourages and participates in the development and implementation of new ideas
 - Quickly accepts and willingly adapts to change
 - Communicates positively about change and provides constructive feedback
 - Actively looks for ways to remove obstacles and move toward our Vision and Goals
 - Is flexible with accepting various job duties

- **Respect**
 - Maintains confidentiality and privacy
 - Listens without interrupting or prejudging
 - Keeps promises and tells the truth
 - Values the contribution each individual makes without regard to their position
 - Interacts with others in a non-judgmental manner
 - Demonstrates the ability to get along well with others

- **Excellence**
 - Knows, practices and exceeds the standards in their field
 - Contributes to departmental and / or organizational goals
 - Maintains a neat, clean professional appearance
 - Focuses on a clean, safe and comfortable work environment
 - Effectively uses knowledge to teach or mentor others

- **Service**
 - Demonstrates a positive attitude
 - Provides service in a timely manner
 - Communicates effectively with customers and coworkers
 - Follows through on promises and commitments to others
 - Is passionate about exceeding customer expectations

Our Pillars of Excellence

- Service – Consistently provide exceptional customer service
- Quality – Relentless pursuit of best outcomes
- Finance – Create the resources needed for our future
- People – Recruit and retain the best

Our Foundation

- Committed physicians
- Constructive culture
- Responsible governance
- Process innovation
- Managerial competence
- Engaged employees

Background

Decatur Memorial Hospital, since its inception in 1916, has continuously responded to the health care needs of communities it serves. As an independent community hospital with a local Board of Directors, the Hospital has always had as its primary focus the health care needs of Decatur, Macon County and surrounding counties. As part of its overall mission, Decatur Memorial Hospital has continuously provided both intellectual and financial resources to our communities for expertise and assistance in assessment of health care needs, support of various community services and agencies in addressing the identified needs, and the continual health education of patients, the community, and other relevant publics. Decatur Memorial Hospital has participated directly in charity and indigent care for a significant segment of our community.

Community Benefits Plan

◦ **Populations and Communities Served**

Decatur Memorial Hospital is located in Decatur, Illinois. The city has a population of 76,000, which represents a population decline of 5.8% since 2000. Macon County, within which it resides, has a population of approximately 108,000. The overall market area for Decatur Memorial Hospital includes approximately 250,000 residents. The demographics of Macon County indicate an aging population. Projections for the next ten years suggest relatively flat population growth with a continued gradual increase in the aged population. There are approximately 20,000 Medicaid recipients located in Macon County. Medicare is the largest inpatient care payor category. The unemployment rate in the Decatur Metro Area decreased from 12.4% in September 2009 to 10.9% in September 2010.¹

¹ US Bureau of Labor Statistics.

- **Goals and Objectives for Providing Community Benefits**

Decatur Memorial Hospital has embraced the philosophy that to improve the health of people, an organization must become involved in the education, awareness, and prevention of disease and illness that negatively impact a person's health status. We strive to give community residents tools to empower them to make lifestyle decisions that will maintain and enhance a desirable quality of life. To help people reach this goal, Decatur Memorial Hospital seeks out opportunities and actively involves itself in the community.

Decatur Memorial Hospital is, and always has been, very mindful of its mission regarding charity care. By Hospital policy, the threshold for the provision of charity care is very liberal, and was further expanded in fiscal 2009 to **six times the federal poverty guidelines**. For patients whose income is above these thresholds, we review the pertinent factors including the magnitude of the bill and the individual's financial situation, and offer a sliding scale discount and extended payment terms to those individuals. Approval or denial of these guidelines is made without regard to race, creed, national origin, sex or age. The Hospital does not place limits on the aggregate amounts of charity care provided in any year.

- **Charity Care (Financial Assistance)**

Please note that Decatur Memorial Hospital uses both the terms **Charity Care** and **Financial Assistance** to describe charity care policy and financial assistance programs. Hospital staff has found that many patients are offended by the term "charity" and feel a negative stigma is attached to a person who needs "charity." Therefore, the Hospital often advertises and promotes charity care policy and programs as "Financial Assistance" rather than "Charity Care."

- *Charity Care / Financial Assistance program options available to those who qualify*
 - The Hospital provides Financial Assistance through foregone Hospital charges pursuant to the Hospital's Financial Assistance Policy which is updated annually and based on Federal Poverty Guidelines.
 - The Hospital also provides Financial Assistance through foregone Hospital charges pursuant to the Hospital's Underinsured Assistance Policy which is based on Federal Poverty Guidelines.
 - All patients without any form of insurance, public or private support, receive free or discounted services in the emergency care center. The fees vary from free, or zero pay, for those with incomes up to 200% of the federal poverty guidelines up to 135% of cost for those between 201%-600% of the federal poverty guidelines. Those patients who are above 601% or fail to complete the necessary financial aid application to qualify for a deeper discount, will still receive a discount of 40%

- off of gross charges, which is comparable to most private insurance reimbursement.
 - The Hospital provides a third party resource for application services for the Medicaid Assistance Program.
 - The Hospital provides interest-free payment plans.
 - An additional ten percent discount is given if the account balance is paid in full.
 - The Hospital provides taxi and Decatur ambulance service for the indigent and/or those that qualify. In addition, the Hospital provides pharmacy for the indigent and/or those that qualify.
 - The Hospital provides free prime time van transportation for individuals that need a ride home at discharge from 11:00 a.m. to 2:00 p.m.
- *How the general public is made aware of the Hospital's Charity Care / Financial Assistance Program*
- Decatur Memorial Hospital's Business Office has five Financial Counselors who review patient accounts for possible charity / financial assistance consideration.
 - The home page of the Hospital's website, www.dmhcares.com, contains links to all information concerning the Charity Care / Financial Assistance Program, including the policies, patient financial worksheet forms and payment agreement forms (See Attachment 3).
 - Posters are placed in our Patient Registration area in visible locations where patients and their families can see them. These posters are 24" by 31". In addition to our Patient Registration area in Kirkland Lobby we also placed posters in our Emergency Care Center and in our Imaging Centers in South Shores and Forsyth (See Attachment 4).
 - Tent cards and patient brochures are placed in the patient registration booths, accessible to all patients and their families (See Attachment 5).
- Patient account statements include the phone number for "Financial Assistance."
- *Charity Care / Financial Assistance Process*
- Decatur Memorial Hospital's Business Office has five Financial Counselors (one of whom is located in Patient Registration) that review patient accounts for possible charity / financial assistance consideration.

Financial Counselors interview and contact our patients to discuss the financial application process and follow-through with the application process via phone calls and correspondence. Often, the Financial Counselors work with families in personal interviews and continue the application process until all documentation is received and completed to proceed with finalizing the charity adjustment. When the documentation is completed, the Financial Counselors proceed with formalizing a letter that is signed by our CFO to inform our patients that they have received financial assistance in accordance with Federally Published Poverty Guidelines

Lastly there are those instances where patients have incurred a financial hardship, but do not qualify for financial assistance under the guidelines. Such cases are reviewed individually and, where deemed appropriate, earnings on restricted funds, set aside for such purposes, are used to pay the patients bills.

As stated above, it is important to note that Decatur Memorial Hospital does not have a limit on the aggregate amounts of charity care provided in any year.

For a detailed look at Decatur Memorial Hospital's Financial Assistance policy see Attachment 1; see Attachment 2 for the Underinsured Assistance policy.

• **Community Health Needs Assessment**

Decatur Memorial Hospital has provided personnel time and resources to assist in the Macon County Health Department planning processes. Information defining our specific health issues has been obtained through various community meetings and assessments as well as input from our public and community board of directors. Further information is collected from census surveys, national and local health surveys, and various reports published throughout the year. Employees of the hospital volunteer time to serve on many local health committees, and volunteer to participate in health fairs, community health events, and other community organizations, including leadership positions on the United Way, Komen Foundation Race for the Cure, and American Cancer Society Relay for Life. For the past four years DMH has sponsored a Day for Hearts, with screenings, education, and tours of the cardiac diagnostic areas of the hospital. All these interactions contribute to our understanding of the various health care needs of our community. Colon, prostate, and breast cancer awareness programs attempt to improve cancer screening, early diagnosis, and improved outcomes.

The health assessments we have performed over the past several years have all indicated the following significant health care access and provision needs within the community.

• *Access to primary care physicians and specialists.*

Evaluation of the physician population ratios in Macon County indicated that Decatur was underserved both in terms of primary care physicians and specialists. The

waiting time for a new patient to see a primary care physician in the community was as long as two to three months. Based on this information, Decatur Memorial Hospital has recruited, and continues to recruit, primary and specialist physicians to the community. Costs of recruitment were generally born by the hospital and amounted to over \$1 million during the last fiscal year.

Decatur Memorial Hospital also significantly supports the Southern Illinois University Family Practice Residency program, which graduates up to six family practitioners per year. The retention rate of the graduates within central Illinois area has been very high. Support for the residency program costs \$162,000 a year. Our employed physicians contribute volunteer teaching hours towards resident training.

In addition to physicians, it has become apparent other health care professionals are also in very short supply. Provision of adequate community health depends on an adequate supply of such professionals. As such, Decatur Memorial Hospital has volunteered hours on planning and curriculum design at our two nursing schools and contributes over 2,500 hours of uncompensated teaching and clinical experience to nursing students in the Decatur nursing programs. Additional training programs for other allied health professionals have also been undertaken and supported by Decatur Memorial Hospital.

The hospital also supports the Parish Nurse Program. This program has substantially improved the ability of community members to obtain basic health information and screening from trained Parish nurses.

- *Health Care Screening*

Decatur Memorial Hospital participates in the Komen Foundation Race for the Cure. This event allows us continued support for breast cancer programs in the community. Many hours of volunteer effort are contributed to this campaign. The hospital provides ongoing education regarding breast cancer and has a breast cancer program utilizing Decatur Memorial Hospital nurses as case managers to help support newly diagnosed breast cancer patients throughout the course of their illness. Multiple support groups for breast cancer patients and other diseases are also maintained by the hospital at no cost to patients.

Additional cancer screening lectures are provided to the community utilizing DMH facilities and staff. Decatur Memorial Hospital also supports educational speakers for the medical staff, clinical staff, and community. The recent focus has been on prostate and colon cancer screenings.

- *Cardiac screenings*

Recognizing that coronary heart disease is the number one cause of death in Macon County, Decatur Memorial Hospital offers free blood pressure and cholesterol screenings to the community.

- *Obesity*

Obesity in Macon County as well as throughout the country is an increasingly severe problem. Decatur Memorial Hospital provides educational programs related to weight and weight control, and has instituted a comprehensive bariatric program to assist the members of the community in appropriate weight loss methods.

- *Diabetes*

Lifetime risk for developing diabetics in this country is now approaching 40%. Lower social economic groups have additional challenges in terms of appropriate diet control and education. Decatur Memorial Hospital provides diabetic education and community programs.

- *Indigent outpatient longitudinal care*

Decatur Memorial Hospital has supported the Community Health Improvement Center (C.H.I.C.). Their primary patient base is the lower social economic group of patients. Our Hospitalist service cares for all C.H.I.C. pediatric inpatients as well as newborns without a physician.

The cost of ambulance and taxi fares are paid by DMH when such transportation is required for the care of patients without the means to pay for such services. Also, for a nominal \$10 per year, members of our community may access all the services of our Prime Time program, including van transportation.

Due to the high percentage of indigent patients seen in our Emergency Room, Decatur Memorial Hospital provides a substantial subsidy to the Emergency Room Physicians in order to allow them to provide competitive salaries to the providers

- *Cancer Diagnosis and Care*

Decatur Memorial Hospital created a Cancer Care Institute. The primary goal of this institute is the dissemination of knowledge regarding education in the prevention and care of cancer. In addition, it supports activities such as "Survivor's Day" which is a community event honoring all cancer survivors, and financed in a large part by Decatur Memorial Hospital in conjunction with local oncologists. The Institute also supports grant writing activities in efforts to obtain additional resources to further cancer care within the community. The Cancer Care Institute provides resources for a

cancer survivors support group, which meets on a monthly basis. Staff also participates in numerous free health fairs throughout the year.

In addition to the programs listed and outlined above, DMH has been designated as a Central Illinois recipient of a Community Oncology Program multi-year grant. This grant includes many "in-kind" hours, and allows leading cancer research protocols to be delivered in Decatur, providing access to these treatments that otherwise might be impossible for some patients to access.

Decatur Memorial Hospital has developed a program called the Mammography Initiative. This program provides free mammograms to local low-income women. This important program is funded through the Komen Decatur Race for the Cure of which DMH has been a major sponsor for 20 years. In 2010, 3,840 people participated in the Race. A portion of the race proceeds paid for screening and diagnostic mammograms for 393 women.

• *Other*

Influenza Vaccine (H1N1) – Decatur Memorial Hospital established free H1N1 vaccinations for the community during the flu outbreak of 2009-2010, providing a location at DMH, staffing by volunteer nurses, physicians, and other DMH employees, and utilizing the excess stock of vaccine ordered for employees and patients in Macon County.

The hospital will also provide home medications for those patients unable to fill prescriptions necessary for their continued treatment after hospitalization.

DMH has also provided support for the Pre-Natal care clinic that serves indigent mothers who then deliver at Decatur Memorial Hospital. We have also supported Baby Talk as a program designed to improve infant outcomes.

The demographics of Macon County indicate an increasing average age of population. A specific Senior Life Enrichment Program was inaugurated to help patients and families cope with the challenges of geriatrics. The program offers a variety of assessments, education, and interventions for this segment of our community.

• **Community Benefits Committee**

The Community Benefits Committee is a multidisciplinary, diverse group representing the community. Our health care providers are involved including:

- Senior DMH Administration
- President, DMH Foundation
- President, DMH Medical Staff

Other invited participants include:

- Local health department representative
- Decatur city and county governmental representative
- Community Health Improvement Clinic representative
- Senior Center representative
- Dove and other community health related services representatives
- Parish nurse representative
- Decatur school system representative
- President, Macon County Medical Society
- Nursing Home administrative representative
- Home Health Care representative
- Other stakeholders as identified and appropriate

Current identified issues include:

- Diabetes
- Obesity
- Infant mortality

**DECATUR MEMORIAL HOSPITAL
OPERATING POLICY**

SUBJECT: FINANCIAL ASSISTANCE - HOSPITAL

EFFECTIVE: 6/76

I. POLICY

A. Decatur Memorial Hospital (“**DMH**” or “**Hospital**”) is a not-for-profit, tax-exempt entity with a charitable mission to promote the health of its community and thus is committed to providing medically necessary inpatient and outpatient hospital services (collectively, the “**Hospital Services**”) to residents of Decatur, Illinois and Hospital’s defined service areas, regardless of such patients’ financial status and ability to pay.

B. It is the policy of DMH to comply with the Illinois Hospital Uninsured Patient Discount Act by providing “**Financial Assistance**” (either free care or reduced patient financial obligations) for Hospital Services to patients who: (i) are not covered under a policy of health insurance and are not beneficiaries under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers’ compensation, accident liability insurance, or other third party liability; (ii) fail to qualify for governmental assistance (for example, Medicare or Medicaid); and (iii) cooperate with the Hospital in providing the requested information regarding income, assets and residency.

C. It is also the policy of DMH to require it’s employed and contracted physicians and other non-physician providers who provide separately billable patient care services in connection with the Hospital Services to provide Financial Assistance for such related professional services (the “**Related Professional Services**”) in accordance with this Financial Assistance Policy. Please note, Financial Assistance is available with respect to Hospital Services and Related Professional Services only; Financial Assistance generally shall not be available for other services, including but not limited to cosmetic or elective procedures or professional (office) services unrelated to Hospital Services.

D. After the Hospital determines that a patient is eligible for Financial Assistance, the Hospital will determine the amount of Financial Assistance available to the patient by utilizing the Charitable Assistance Guidelines (**Exhibit 1**), which shall be based at all times upon the most recent federal poverty guidelines.

E. DMH shall annually review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Hospital; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable State and federal laws, rules, and regulations concerning the provision of financial assistance to indigent patients.

II. PURPOSE

A. DMH is committed to providing outstanding patient care and shaping tomorrow's Hospital through clinical innovation, biomedical and health services research, and education. Consistent with this mission, DMH recognizes its obligation to be a responsible corporate citizen in the communities it serves by providing Financial Assistance for Hospital Services and Related Professional Services to indigent persons within those communities.

B. In furtherance of its charitable mission, DMH will provide Financial Assistance for Hospital Services and Related Professional Services to persons who are permanent residents of Illinois who meet the conditions and criteria set forth in this Policy for (i) emergency treatment rendered at the Hospital; *and* (ii) medically necessary *non-emergent* care rendered at the Hospital that would be covered under Title XVIII of the federal Social Security Act if the person were eligible for coverage thereunder. A determination by DMH to provide Financial Assistance with respect to one inpatient Hospital admission or outpatient Hospital service will be specific to that admission or service and the Financial Assistance will be made available only for those inpatient or outpatient hospital procedures/services that would be covered under Title XVIII of the federal Social Security Act in the course of care relating to the admission or procedure. Cosmetic procedures, elective procedures and physician office visits (other than those for Related Professional Services) generally will not be considered essential, non-emergent care and generally will not be eligible for Financial Assistance.

III. ELIGIBILITY AND DETERMINATION OF AMOUNT

A. Eligibility: A patient will be eligible for Financial Assistance for Hospital Services and Related Professional Services if the patient: (i) is not covered under a policy of health insurance and are not beneficiaries under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability; (ii) fails to qualify for governmental assistance (for example, Medicare or Medicaid); and (iii) cooperates with the Hospital in providing the requested information regarding income, assets and residency.

B. Financial need: There are two ways a patient who is eligible for Financial Assistance may be deemed to have financial need: (i) by a determination that the patient's income is below certain federal poverty guidelines¹ ("**income**" means annual earnings and cash benefits from all sources before taxes, including but not limited to salaries, legal judgments, unemployment compensation, Social Security Income, pension or retirement plan payments, alimony, dividends, and interest checks, less payments made for child support) – such a patient will be designated to have a financial hardship; and (ii) medical hardship.

¹ Federal poverty guidelines for the current year are available at <http://aspe.hhs.gov/poverty/index.shtml>. The Hospital's use of federal poverty guidelines will be updated annually in conjunction with the federal poverty guideline updates published by the United States Department of Health and Human Services.

1. Financial Hardship: If a patient's income and assets ("assets" include checking, savings, certificates of deposit, investments and any other property of any kind, not counting the patient's primary residence, personal property exempt from judgment under Section 12-10001 of the Code of Civil Procedure, or amounts held in a pension or retirement plan) are below 600% of the federal poverty guidelines, the patient will receive some form of Financial Assistance for Hospital Services and Related Professional Services. The Financial Assistance for Hospital Services and Related Professional Services may be either a complete waiver of all patient responsibility or a discount or reduced patient obligation relating to such Hospital Services and Related Professional Services, depending on the exact level of the patient's income.

(a) If a patient's income falls below 200% of the federal poverty guidelines and the patient does not have assets that, if liquid, would lift the patient above 200% of the federal poverty guidelines, the patient will have no financial responsibility for the Hospital Services and Related Professional Services. This means that both the fees for Hospital Services and Related Professional Services and the copayment and deductible amounts for the Hospital Services and Related Professional Services are completely waived.

(b) If a patient's income falls between 201% and less than 600% of the federal poverty guidelines and the patient does not have assets that, if liquid, would lift the patient to at least 600% of the federal poverty guidelines:

(i) the patient is eligible for Financial Assistance for Hospital Services in the form of a discount, which is to be applied, at the time of billing, to charges exceeding \$300 in any one inpatient admission or outpatient encounter, and which results in the patient being charged no more than 135% of the Hospital's cost of providing the Hospital Services, as determined by the Hospital based on the Hospital's then-most recently filed Medicare cost report, in accordance with applicable law, as set forth on **Exhibit 1**; and

(ii) the patient is eligible for Financial Assistance for Related Professional Services on a sliding scale basis in the amount determined by the physician from time to time, as set forth on **Exhibit 1**.

2. Medical Hardship: In addition to income and assets, the Hospital also will consider Financial Assistance for Hospital Services and Related Professional Services where a patient's medical bills for services rendered at the Hospital are of such an amount that payment threatens the patient's financial survival. Such Financial Assistance may be in addition to Financial Assistance for Financial Hardship, and shall be determined based on an individual assessment of a patient's financial resources and the size of the patient's Hospital bill.

3. Documentation. To determine whether a patient is eligible for Financial Assistance for Hospital Services and Related Professional Services, the patient will be

required to complete the Patient Financial Worksheet (**Exhibit 2**). The Hospital will assist patients with this form as requested by the patient.

C. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and State governmental assistance programs, the Hospital's Business Office will assist patients in enrolling in federal and State governmental assistance programs. Trained financial counselors and other personnel may be contacted at (217) 876-4HLP ((217) 876-4437) for any assistance required in completing the Application for Financial Assistance or with any other materials required by the Hospital under this Policy. The Hospital also will make available translation services necessary to complete the Application for Financial Assistance. The information the patient provides when completing the Application for Financial Assistance, as well as any other information the patient provides pursuant to this Financial Assistance Policy will be maintained in accordance with the Hospital's policies governing confidentiality.

IV. PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE

A. Applications for Financial Assistance will be distributed to all persons identified in need.

B. Although ideally the Hospital will make a determination about Financial Assistance during pre-registration for the applicable Hospital Services and Related Professional Services or prior to discharge, this is not always possible – whether because the patient does not provide the necessary documentation, the patient's circumstances change after discharge, or in other circumstances where the information regarding a given patient's circumstances or need is identified. A patient may request consideration at any time, and the Hospital will evaluate a patient's eligibility for Financial Assistance for Hospital Services and Related Professional Services under this Policy, up to and including the collections and judgment phase. Patients are encouraged to contact the Hospital if their circumstances change or if they identify additional need. The Hospital will review all information provided and relevant circumstances bearing on the need for Financial Assistance for Hospital Services and Related Professional Services, will make a determination of eligibility, and will promptly notify the patient of his/her financial obligations, if any, as set forth below. The hospital will not refer the patients account to collection agency unless the patient has failed to provide all necessary information per the eligibility requirements and the hospital has made the patient aware of the financial assistance available. Further the hospital will not refer the patient to a collection agency until all efforts under the Financial Assistance Policy have been exhausted.

C. Eligibility Determination Procedure

1. The Hospital's Business Office staff will immediately forward a copy of the pre-admission record to the Hospital's financial counselors for any patient/guarantor who has no insurance. Financial counselors will contact the patient/guarantor to schedule a financial interview as soon as is practicable but ideally before admission for Hospital Services and Related Professional Services, and prior to discharge for an

emergency admission. For emergency services, the Hospital will not delay screening or treatment of an emergency medical condition pending this financial interview.

2. Patients are required to complete the Patient Financial Worksheet (**Exhibit 2**) and return it to the Patient Finance Coordinator in the self-addressed stamped envelope provided by the Hospital no later than sixty (60) days after the patient's date of discharge or date of service, or thirty (30) days following receipt of the Patient Financial Worksheet, whichever period is longer. Failure to timely supply required information will result in denial of a patient's request for provision of Financial Assistance; provided, however, patient may request reconsideration of eligibility for Financial Assistance at any time. Patients are obligated to cooperate and provide all information needed in a timely manner. Please note, if patients require assistance in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients should contact one of the Hospital's trained financial counselors at (217) 876-4HLP ((217) 876-4437). Financial counselors are also available to assist patients with assessing their financial situations, gathering information requested by the Hospital, and to otherwise assist patients in fulfilling their obligations under this policy.

3. As part of the financial interview process, financial counselors will request the following documentation in order to process and validate Financial Assistance applications:

- a. Confirmation of annual income and assets:
 - o Last two pay stubs and/or W2 form, 1099 form, social security award, and unemployment compensation letter.
 - o Most recent income tax return.
 - o Most recent checking and savings account statements for all accounts upon which patient is listed as an account-holder.
 - o Banking/investment account statements.
 - o Written income verification from Employer, if paid in cash.
- b. In an effort to obtain confirmation of patient's social security number and birth date, a copy of the Social Security card and/or driver's license may be used but it is not a requirement of the approval process.

D. Although the information above is required from patients seeking Financial Assistance, the Hospital may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation.

E. Financial Assistance determinations will be made for each inpatient admission or outpatient procedure for Hospital Services at DMH. If a patient has, within the twelve (12) months preceding the date on which he or she submits an application for Financial Assistance, submitted a complete application for Financial Assistance and Patient Financial Worksheet under this Policy, the patient need provide DMH only with updated and/or additional information relevant to the application for Financial Assistance or the Patient

Financial Worksheet not previously provided to DMH, provided, however, the patient must provide DMH with all additional information covered by this Policy as requested by DMH. Patients who have (i) previously submitted incomplete applications for Financial Assistance under this Policy, or (ii) submitted applications for Financial Assistance under this Policy related to an earlier Hospital admission or procedure more than three (3) months prior to the date on which they apply for Financial Assistance hereunder must re-submit a complete application for Financial Assistance and Patient Financial Worksheet.

F. Patients have an obligation to provide information reasonably requested by the Hospital so that the Hospital can make a determination of a patient's eligibility for Financial Assistance. If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Hospital within sixty (60) days after the patient's date of discharge or date of service, or thirty (30) days of a request by the Hospital, whichever period is longer, the Hospital will not extend Financial Assistance and standard Hospital collection efforts will be pursued in the Hospital's sole discretion.

G. Eligibility and Notification Process:

1. Upon receipt of a patient's Patient Financial Worksheet, the Hospital's Business Office will review the patient's application for completeness, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Hospital returns an application to a patient as incomplete, the Hospital will contact that patient by telephone. If the Hospital is able to reach the patient by telephone, the Hospital will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Hospital is unable to reach the patient by telephone or if the patient does not have an available telephone number, the Hospital will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Hospital within ten (10) days of receiving the letter. The Hospital's trained financial counselors will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination on the patient's eligibility for Financial Assistance.

2. The Business Office will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount of Financial Assistance to be made available to the patient, if any. The Business Office will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within five (5) business days of the determination.

3. The Business Office likewise will inform DMH's employed physicians, DMH's hospital-based physicians under contract with DMH (including, without limitation, contracted pathologists, radiologists, anesthesiologists and emergency department physicians), as well as other non-physician providers of DMH who provide separately billable services to patients at the Hospital, of the patient's eligibility for, and amount of, Financial Assistance. Such physicians or other service providers will provide Financial Assistance with respect to the Related Professional Services.

4. DMH will determine a patient's eligibility for Financial Assistance each time the patient requests such assistance.

V. COMMUNICATION

The Hospital will communicate the availability of Financial Assistance for Hospital Services and Related Professional Services to its patients by posting information on its website, placing signage in all patient registration areas and employed physicians' offices, and distributing brochures about the Financial Assistance program in strategic areas throughout the Hospital, including, but not limited to, the Emergency Department, the Business Office and the Admissions area. The signage and brochures will be in English, which is the language appropriate to the community that the Hospital serves. In addition, the Hospital will include with its bills and statements a prominent statement that patients meeting certain eligibility requirements may be eligible for Financial Assistance and information regarding how a patient can request Financial Assistance from the Hospital. The Hospital will assist patients in need with making applications to all other sources of assistance, including Medicare and Medicaid. Patients are encouraged to contact the Hospital's trained financial counselors at (217) 876-4HLP ((217) 876-4437) should they require assistance with making applications for other sources of financial assistance. This contact telephone number will be located strategically throughout the Hospital so that patients have a resource for obtaining support with any financial assistance questions they may have.

VI. DOCUMENTATION AND RECORDKEEPING

A. The Business Office will maintain all documentation of Financial Assistance within the Hospital's Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation shall include, at a minimum, the following: (1) the number of applicants for free and reduced cost services, (2) the number of approved applicants, (3) the total and average charges and costs of the amount of free and reduced cost care provided; and (4) the amount of free and discounted care provided by Hospital's contracted hospital-based physicians and other service providers. The foregoing list of required supporting documentation will be revised from time to time to comply with any requirements set forth by the State Attorney General, as well as any applicable State law or regulation.

B. The Director, Patient Financial Services will review the status of the Financial Assistance program with the President, or his/her designee, on a regular basis. The President or his/her designee will be responsible for presenting this Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on this Policy, the impact of this Policy on the Hospital's operations and the level of need and benefits being conferred to the community under the Hospital's Financial Assistance program.

C. Information about the amount of Financial Assistance provided will be described in a note to the Hospital's financial statements. The note will include this Policy and the dollar volume as it pertains to cost and/or percentage of total charges provided.

VII. PATIENT RIGHTS AND RESPONSIBILITIES

A. To be eligible for Financial Assistance, the patient must cooperate with the Hospital by providing the necessary information and documentation necessary to apply for appropriate federal and State governmental assistance and other financial resources that may be available to pay for his/her health care. Prior to being considered eligible for Financial Assistance from the Hospital, the patient must apply for all other appropriate sources of financial aid. The Hospital will assist patients with making such applications by helping patients to complete the relevant forms and by assisting the patient with understanding how his/her income and assets relate to the Hospital's Charitable Assistance Guidelines. Consistent with this Policy, where the Hospital is aware that a patient will not qualify for a particular type of federal or State governmental assistance, the Hospital may waive the requirement that the patient apply for such assistance prior to becoming eligible for Financial Assistance.

B. Any request for Financial Assistance shall be made by or on behalf of a patient. Patients may apply for, and will be encouraged to apply for, Financial Assistance before, during or within a reasonable time after Hospital Services are provided. In the event a patient does not initially qualify for any Financial Assistance, the patient may re-apply upon a showing of change in circumstances.

C. Each patient who is deemed eligible for Financial Assistance that does not cover his or her total liability to the Hospital must: (i) cooperate with the Hospital to establish a reasonable payment plan that takes into account all income and assets available to the patient, the amount of the patient's remaining liability to the Hospital, and any prior payments made by the patient; and (ii) enter into a payment agreement setting forth the patient's obligation to pay amounts owed by the patient to the Hospital pursuant to such payment plan in substantially the same form as that set forth at **Exhibit 4** (the "**Payment Agreement**"). Each patient is responsible for communicating to the Hospital any change in financial status that may impact his or her ability to honor the provisions of his or her Payment Agreement.

D. Notwithstanding anything in this Policy to the contrary, in the event a patient's financial circumstances become more favorable while receiving assistance under the Hospital's Financial Assistance program, the patient is required to notify the Hospital of such change in circumstances.

VIII. COLLECTION PRACTICES

A. Hospital will not send a patient's account to a third-party collections agency prior to making good faith efforts to determine a patient's eligibility for Financial Assistance. The Hospital will use good faith efforts to determine whether a patient is insured prior to initiating any collection action. The Hospital will not pursue legal action for nonpayment of bills for any patient receiving Financial Assistance so long as such patient is making payments in accordance with his/her established payment plan as set forth in a Payment Agreement. In the event the patient is unable to maintain such payments, the Hospital will contact the patient to determine whether an adjustment is appropriate. Notwithstanding the

foregoing, the Hospital may take legal action against patients receiving Financial Assistance to enforce the terms of an existing payment plan where there is evidence that the patient (or his/her family and/or guarantor, if applicable) has sufficient income and assets to meet his/her obligations under the existing payment plan; provided however, the Hospital will not pursue legal action for non-payment of bills against any patient receiving Financial Assistance who has clearly demonstrated that s/he does not have sufficient income and assets to meet his/her financial obligations to the Hospital.

B. It is the Hospital's policy to prohibit the use of certain types of legal action to obtain payment on Hospital bills. Specifically, the Hospital prohibits the use of body attachment and body attachment will not be used to require any patient receiving Financial Assistance to appear in court under any circumstances. In addition, the Hospital will not place a lien on the primary residence of a patient if this is the patient's sole real asset unless the value of the property clearly indicates an ability to assume significant financial obligations. The Hospital will not execute a lien by forcing the sale or foreclosure of the primary residence of a patient receiving Financial Assistance to pay for an outstanding medical bill.

C. The Hospital will use its best efforts to ensure that any third-party collection agency that it contracts with to obtain payment on existing financial accounts will comply with this Policy. The Hospital will enter into written agreements with such third-party collection agents that specifically incorporate the terms of this Section of this Policy as obligations each agency must satisfy.

D. Notwithstanding the foregoing, the maximum amount that the Hospital (or its designated third-party collection agency) may collect in any twelve (12) month period, for Hospital Services, from a patient who is eligible for Financial Assistance, is 25% of the annual pre-tax earnings and cash benefits from all sources of the patient and his or her household members combined, less payments made by such persons for child support. For purposes of this Section, the initial twelve (12) month period shall begin as of the first date upon which a patient receives Hospital Services and Related Professional Services at Hospital. For any subsequent services rendered to patient to be included in the aforementioned maximum, the patient must inform the Hospital that he or she received prior Hospital Services and Related Professional Services from Hospital that were determined to be eligible for Financial Assistance.

APPROVED BY:

Senior Vice President & CFO

Revised: 3/98, 11/98, 3/99, 3/03, 10/03, 3/05, 12/06, 3/09, 2/11

EXHIBIT 1

FINANCIAL ASSISTANCE GUIDELINES

Assistance for Hospital Services

<u>Percent of Federal Poverty Guidelines</u>	<u>Discount on Charges</u>
Less than and equal to 200%	100%
201 to less than 600%	*

* If a patient's income falls below 600% of the federal poverty guidelines, the patient's charges will be reduced, at a minimum, to an amount not to exceed 135% of the Hospital's costs for the Hospital Services component of Hospital Services and Related Professional Services exceeding \$300 in any one inpatient admission or outpatient service. See most recent cost report, Worksheet C, Part 1, for the Hospital's ratio of costs to charges (line 103). In addition, the maximum amount the Hospital shall collect in any 12-month period shall not exceed 25% of pre-tax earnings and cash benefits from all sources of the patient and his/her household members combined, less payments made for child support.

Assistance for Related Professional Services

<u>Percent of Federal Poverty Guidelines</u>	<u>Discount on Charges</u>
Less than and equal to 200%	100%
Over 201%	In accordance with the physician's financial assistance policy.

**DECATUR MEMORIAL HOSPITAL
OPERATING POLICY**

SUBJECT: UNDERINSURED ASSISTANCE - HOSPITAL

EFFECTIVE: 5/03

I. POLICY

A. Decatur Memorial Hospital (“DMH” or “Hospital”) is a not-for-profit, tax-exempt entity with a charitable mission to promote the health of its community and thus is committed to providing medically necessary inpatient and outpatient hospital services (collectively, the “Hospital Services”) to residents of Decatur, Illinois and Hospital’s defined service areas, regardless of such patients’ ability to pay.

B. It is the policy of DMH to provide a discount for such Hospital Services, in accordance with the sliding scale set forth on **Exhibit 1** (the “**Underinsured Discount**”), to patients who are (i) in the opinion of Hospital, underinsured by private health insurance or federal or state healthcare programs; (ii) not eligible for Financial Assistance pursuant to the Hospital’s Financial Assistance Policy; and (iii) cooperative in providing Hospital with requested information regarding income, assets and residency. The amount of the Underinsured Discount available to a patient will depend on the total amount billed and shall apply to all those individual patients with incomes up to 400% of the federal poverty guidelines. The Hospital has determined that patients with income up to 400% of the federal poverty guidelines may qualify for the Underinsured Discount on their co-payments, deductibles and other payment obligations for medically necessary care. This in no way commits the Hospital to provide insurance carriers or other third parties with further discounts in their obligation to pay for services rendered.

C. It is also the policy of DMH to require its employed and contracted physicians and other non-physician providers who provide separately billable patient care services in connection with the Hospital Services to provide the Underinsured Discount for such related professional services (the “**Related Professional Services**”).

D. The Underinsured Discount is available with respect to Hospital Services and Related Professional Services only, and generally shall not be available for other services, including but not limited to cosmetic or elective procedures or professional (office) services unrelated to Hospital Services.

II. PURPOSE

A. DMH is committed to providing outstanding patient care and shaping tomorrow’s Hospital through clinical innovation, biomedical and health services research, and education. Consistent with this mission, DMH recognizes its obligation to

be a responsible corporate citizen in the communities it serves by providing the Underinsured Discount for Hospital Services and Related Professional Services to indigent persons within those communities.

B. In furtherance of its charitable mission, DMH will provide the Underinsured Discount for Hospital Services and Related Professional Services to persons who are permanent residents of Illinois who meet the conditions and criteria set forth in this Policy for (i) emergency treatment rendered at the Hospital; and (ii) medically necessary non-emergent care rendered at the Hospital that would be covered under Title XVIII of the federal Social Security Act if the person were eligible for coverage thereunder.

C. A determination by DMH to provide the Underinsured Discount with respect to one inpatient Hospital admission or outpatient Hospital service will be specific to that admission or service and the Underinsured Discount will be made available only for those inpatient or outpatient hospital procedures/services that would be covered under Title XVIII of the federal Social Security Act in the course of care relating to the admission or procedure. Cosmetic procedures, elective procedures and physician office visits (other than those for Related Professional Services) generally will not be considered essential, non-emergent care and generally will not be eligible for the Underinsured Discount.

III. ELIGIBILITY AND DETERMINATION OF AMOUNT

A. A patient will be eligible for the Underinsured Discount for Hospital Services and Related Professional Services if the patient: (i) is, in the opinion of Hospital, underinsured by private health insurance or federal or state healthcare programs; (ii) is not eligible for Financial Assistance pursuant to the Hospital's Financial Assistance Policy; and (iii) cooperates in providing Hospital with requested information regarding income, assets and residency.

B. There are two ways a patient who is eligible for the Underinsured Discount may be deemed to have financial need: (i) by a determination that the patient's income is below certain federal poverty guidelines¹ ("income" means annual earnings and cash benefits from all sources before taxes, including but not limited to salaries, legal judgments, unemployment compensation, Social Security Income, pension or retirement plan payments, alimony, dividends, and interest checks, less payments made for child support) – such a patient will be designated to have a financial hardship; and (ii) medical hardship.

1. Financial Hardship: If a patient's income and assets ("assets" include checking, savings, certificates of deposit, investments and any other

¹ Federal poverty guidelines for the current year are available at <http://aspe.hhs.gov/poverty/index.shtml>. The Hospital's use of federal poverty guidelines will be updated annually in conjunction with the federal poverty guideline updates published by the United States Department of Health and Human Services.

property of any kind, not counting the patient's primary residence, personal property exempt from judgment under Section 12-10001 of the Code of Civil Procedure, or amounts held in a pension or retirement plan) are below 400% of the federal poverty guidelines, the patient will receive the Underinsured Discount in accordance with the sliding scale set forth in Exhibit 1.

2. **Medical Hardship:** In addition to income and assets, the Hospital also will consider the Underinsured Discount for Hospital Services and Related Professional Services where a patient's medical bills for services rendered at the Hospital are of such an amount that payment threatens the patient's financial survival.

C. To determine whether a patient is eligible for Financial Assistance for Hospital Services and Related Professional Services, the patient will be required to complete the Patient Financial Worksheet (**Exhibit 2**). The Hospital will assist patients with this form as requested by the patient.

D. Each patient who receives a Underinsured Discount that results in a balance due to the Hospital, which the patient is not able to pay in full within thirty (30) days of the application of the Underinsured Discount, must enter into a Self-Pay Agreement setting forth the patient's obligation to pay the patient's discounted Hospital bill pursuant to a payment plan in substantially the same form as that set forth at Exhibit 3 (the "**Self-Pay Agreement**"). Each Patient is responsible for communicating to the Hospital any change in financial status that may impact his or her ability to pay a discounted Hospital bill or to honor the provisions of his or her Self-Pay Agreement. The payment term under a patient's Self-Pay Agreement will not exceed three (3) years.

IV. PROCEDURE

A. Applications for the Underinsured Discount will be distributed to all persons identified in need.

B. Although ideally the Hospital will make a determination about eligibility for the Underinsured Discount during pre-registration for the applicable Hospital Services and Related Professional Services or prior to discharge, this is not always possible – whether because the patient does not provide the necessary documentation, the patient's circumstances change after discharge, or in other circumstances where the information regarding a given patient's circumstances or need is identified. A patient may request consideration at any time. Patients are encouraged to contact the Hospital if their circumstances change or if they identify additional need. The Hospital will review all information provided and relevant circumstances bearing on the need for the Underinsured Discount for Hospital Services and Related Professional Services, will make a determination of eligibility, and will promptly notify the patient of his/her financial obligations, if any. The Hospital will not refer the patients account to collection agency unless the patient has failed to provide all necessary information per

the eligibility requirements and the Hospital has made the patient aware of the discount available. Further the Hospital will not refer the patient to a collection agency until all efforts under the Policy have been exhausted.

C. Patients are required to complete the Patient Financial Worksheet (**Exhibit 2**) and return it to the Patient Finance Coordinator in the self-addressed stamped envelope provided by the Hospital no later than sixty (60) days after the patient's date of discharge or date of service, or thirty (30) days following receipt of the Patient Financial Worksheet, whichever period is longer. Failure to timely supply required information will result in denial of a patient's request for the Underinsured Discount; provided, however, patient may request reconsideration of eligibility for the Underinsured Discount at any time. Patients are obligated to cooperate and provide all information needed in a timely manner. Please note, if patients require assistance in gathering necessary information or materials requested as part of the Underinsured Discount qualifying process, patients should contact one of the Hospital's trained financial counselors at (217) 876-4HLP ((217) 876-4437). Financial counselors are also available to assist patients with assessing their financial situations, gathering information requested by the Hospital, and to otherwise assist patients in fulfilling their obligations under this Policy.

D. As part of the financial interview process, financial counselors will request the following documentation in order to process and validate Underinsured Discount applications:

1. Confirmation of annual income and assets:
2. Last two pay stubs and/or W2 form, 1099 form, social security award, unemployment compensation letter.
3. Most recent income tax return.
4. Most recent checking and savings account statements for all accounts upon which patient is listed as an account-holder.
5. Banking/investment account statements.
6. Written income verification from Employer, if paid in cash.

In an effort to obtain confirmation of patient's social security number and birth date, a copy of the Social Security card and/or driver's license may be used but it is not a requirement of the approval process.

Although the information above is required from patients seeking the Underinsured Discount, the Hospital may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation.

E. The Business Office will contact patients who are eligible for a Underinsured Discount by phone. Final arrangements for a patient's Underinsured Discount and Self-Pay Agreement will be made at a meeting between an appropriate Hospital representative and the patient or his or her representative (as applicable) in the Hospital's Business Office. During this meeting, the Hospital representative will explain

the Underinsured Discount and the Self-Pay Agreement to the patient (or his or her representative), and the patient (or his or her representative) and the Hospital's representative will execute the Self-Pay Agreement. The executed Self-Pay Agreement will then be forwarded to the Hospital's Senior Vice President and CFO for final approval.

F. The Business Office will monitor the patient's compliance with the terms of the Self-Pay Agreement on a monthly basis.

G. Underinsured Discount determinations will be made for each inpatient admission or outpatient procedure for Hospital Services at DMH. If a patient has, within the twelve (12) months preceding the date on which he or she submits an application for the Underinsured Discount, submitted a complete application for the Underinsured Discount and Patient Financial Worksheet under this Policy, the patient need provide DMH only with updated and/or additional information relevant to the application for the Underinsured Discount or the Patient Financial Worksheet not previously provided to DMH, provided, however, the patient must provide DMH with all additional information covered by this Policy as requested by DMH. Patients who have (i) previously submitted incomplete applications for the Underinsured Discount under this Policy, or (ii) submitted applications for the Underinsured Discount under this Policy related to an earlier Hospital admission or procedure more than three (3) months prior to the date on which they apply for the Underinsured Discount hereunder must re-submit a complete application for the Underinsured Discount and Patient Financial Worksheet.

H. Patients have an obligation to provide information reasonably requested by the Hospital so that the Hospital can make a determination of a patient's eligibility for the Underinsured Discount. If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Hospital within thirty (30) days of a request by the Hospital, the Hospital will not extend the Underinsured Discount and standard Hospital collection efforts will be pursued in the Hospital's sole discretion, in accordance with the collection practices set forth in the Hospitals' Financial Assistance Policy

I. The Hospital will communicate the availability of the Underinsured Discount for Hospital Services and Related Professional Services to its patients in accordance with the Hospital's Financial Assistance Policy.

J. The Hospital will maintain documentation regarding Underinsured Discounts in accordance with the Hospital's Financial Assistance Policy.

APPROVED BY:

Senior Vice President & CFO

Revised: 10/03, 6/06, 3/09, 5/09, 2/11

Exhibit 1

Underinsured Discount Sliding Scale

Total Amount Owed	Discount Percentage	Length of Contract
0-100% of FPG	100%	
101-133% of FPG	75%	
133- 200% of FPG	50%	
200-300% of FPG	25%	
301-400% of FPG	15%	



**Online
Account
Home**

My Account

Resources

**Billing
Policies**

**Frequently
Asked
Questions**

Contact Us

Log Out



Enroll for Online Account

Help

Home

Payment Option

Medicare Policies

Every account is eligible for a 10% discount if payment in full is made within 30 days.

**Blue Cross
Policies**

If accounts can not be paid in full then please contact our Financial Counselors at 217-876-3785 to set up a payment arrangement.

**Commercial
Insurance
Policies**

Decatur Memorial Hospital offers financial assistance programs that fulfill our mission "To improve the health of the people of Central Illinois". Listed below are the established federal poverty guidelines that support the criteria for the financial assistance program.

**Self Pay / Charity
Care Programs**

Below are several resources for our Assistance Programs which you can view and print as needed.

- [Financial Assistance Policy](#)
- [Patient Financial Worksheet](#)
- [Financial Assistance Payment Agreement](#)

Any patient that does not qualify for reimbursement through Medicare, Medicaid or Commercial Insurance and is not eligible for the above financial assistance programs, will be eligible for the Uninsured Program.

Patients are eligible for a discount that is based on the total amount billed. Patients are able to set up a 1-3 year payment plan for payment in full. A self pay contract will need to be completed with a DMH Financial Counselor. Below are resources for the Uninsured Program which you can view and print as needed.

- [Uninsured Program Policy](#)
- [Uninsured Assistance Payment Agreement](#)

DECATUR MEMORIAL HOSPITAL

DMH offers programs for UNINSURED



If you are uninsured and do not qualify for public programs such as Medicare and Medicaid, call the DMH Business Office at 876-4HLP for more information.

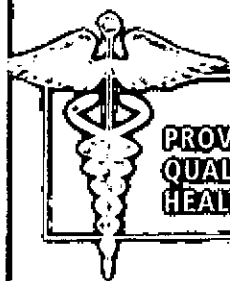


MASTERING MODERN MEDICINE



Programs for UNinsured, UNDERinsured

**If you are un-insured or under-insured
and do not qualify for public
programs such as Medicare and
Medicaid, call the DMH Business Office
at 876-4HLP for more information.**



**PROVEN
QUALITY
HEALTHCARE**

dmh

**Decatur
Memorial
Hospital**

DMH Financial Counselors

If you are un-insured or under-insured, DMH has professional financial counselors available to help you. For assistance or more information, please call one of these financial counselors:

Tonya 876-2072

Diane G. 876-2665

Heather. 876-2270

Stephanie 876-2287

Diane C. 876-2042

MASTERING MODERN MEDICINE



2300 North Edward Street Decatur, Illinois www.dmhcares.com

CHARITY CARE INFORMATION (section XII)

1. Ratio of Charity Care to Net Patient Revenue...2% each year
2. One facility ownership
3. Not applicable

CHARITY CARE			
	Year- 2010	Year - 2009	Year - 2008
Net Patient Revenue	279,160,753	273,222,461	262,001,994
Amount of Charity Care (charges)	18,068,100	16,709,000	15,181,100
Cost of Charity Care	5,637,247	5,213,208	4,471,651



May 12, 2011

Administrator
Fairhavens Christian Home
1790 S. Fairview Ave.
Decatur, IL 62521

Dear Administrator :

Decatur Memorial Hospital is submitting a CON application to discontinue our Skilled Nursing Service. We expect to discontinue this service on or about June 15, 2011. During the past 24 months, we have cared for 1,153 residents who received primarily rehabilitation services after hospitalization. Most were discharged to home after approximately 2 weeks.

The purpose of this letter is to ascertain whether your facility will have capacity available to accommodate a portion or our entire skilled nursing case load 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 if you would send me a letter indicating the impact of the discontinuation of our Skilled Nursing Service upon your facility and whether your facility is willing and able to absorb part or all of our caseload without conditions, limitations or discrimination.

Please note that it is the policy of the Illinois Health Facilities and Service Review Board that your failure to respond to this request for an impact statement within 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 217-876-2113.

Thank you in advance for your support.

Sincerely,

Linda Fahey, RN, MSN
Vice President of Nursing

Appendix 1



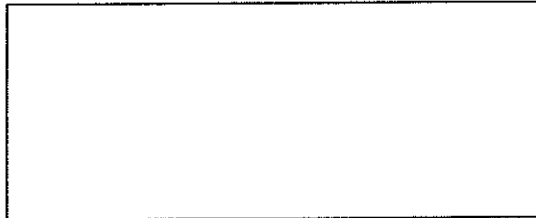
MAPQUEST.

Trip to Heritage Manor

700 E Walnut St, Bloomington, IL 61701 -
(309) 827-8004

45.07 miles - about 56 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.0 mi



3. Turn **RIGHT** onto **W KENWOOD AVE.**

go 0.2 mi



4. Turn **LEFT** onto **US-51-BR N / N WATER ST.** Continue to follow **US-51-BR N.**

go 2.8 mi



5. **US-51-BR N** becomes **US-51 N.**

go 38.1 mi



6. **US-51 N** becomes **US-51-BR N.**

go 2.9 mi



7. Turn **RIGHT** onto **E WASHINGTON ST.**

go 0.4 mi



8. Turn **LEFT** onto **N CLINTON ST / US-150.**

go 0.5 mi



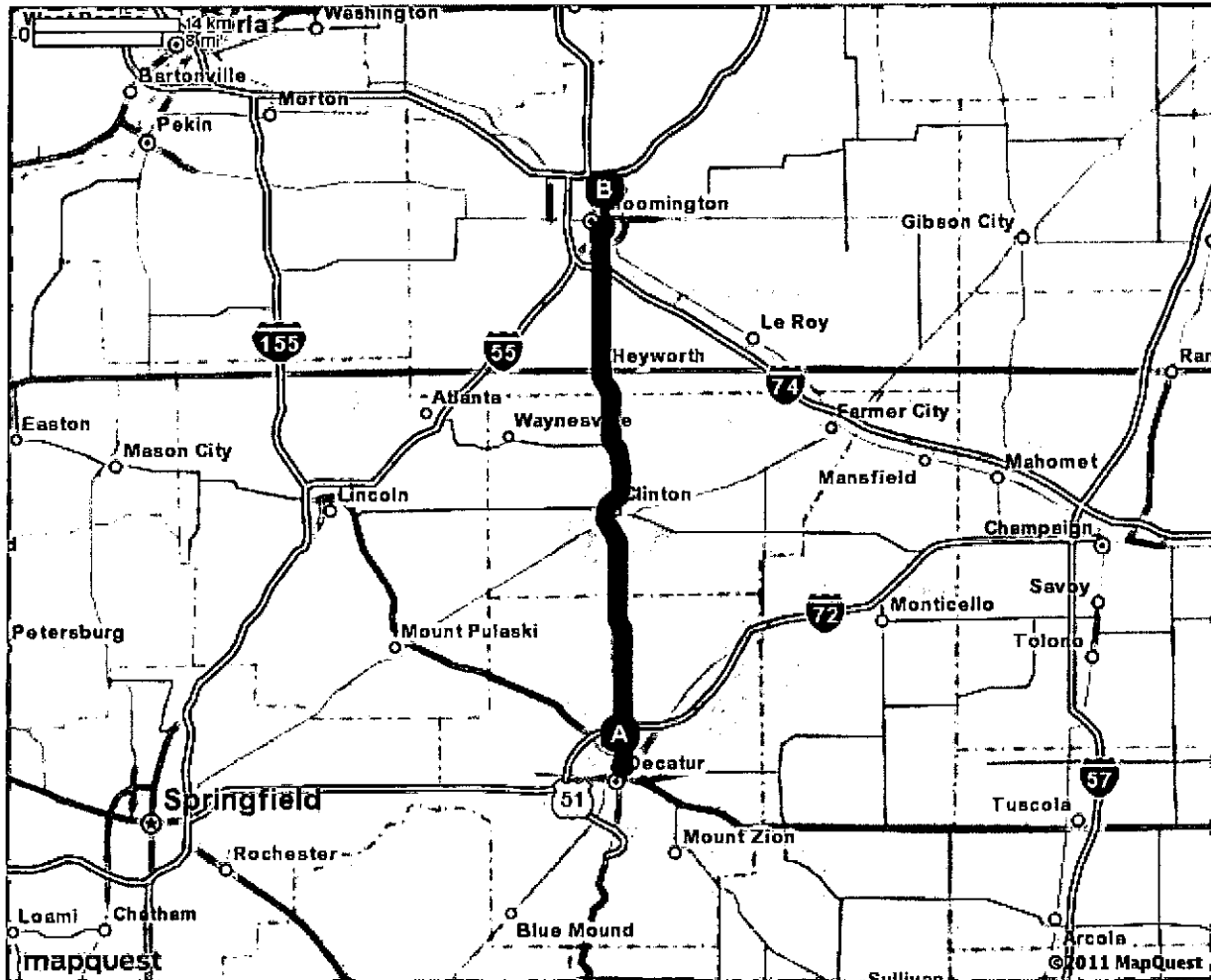
9. **700 E WALNUT ST.**

go 0.0 mi

Appendix 3

B Heritage Manor - (309) 827-8004
700 E Walnut St, Bloomington, IL 61701
Total Travel Estimate : 45.07 miles - about 56 minutes

Route Map Hide



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>x Diana S. Callahan</i>	
1. Article Addressed to: Administrator Fairhavens Christian Home 1790 S. Fairview Ave Decatur, IL 62521	B. Received by (Printed Name)	C. Date of Delivery 4-29-11
2. Article Number (Transfer from service label)	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D. 4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
7009 2250 0003 2946 3149		

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Fair Havens Christian Home

1790 S Fairview Ave, Decatur, IL 62521 -

(217) 429-2551

4.73 miles - about 11 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121
2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.0 mi



3. Turn RIGHT onto W KENWOOD AVE.

go 0.2 mi



4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S.

go 3.0 mi



5. Turn SLIGHT RIGHT.

go 0.3 mi



6. Turn SLIGHT RIGHT onto W SOUTHSIDE DR / IL-105 W.

go 0.8 mi



7. Turn LEFT onto IL-48.

go 0.4 mi



8. 1790 S FAIRVIEW AVE.

go 0.0 mi

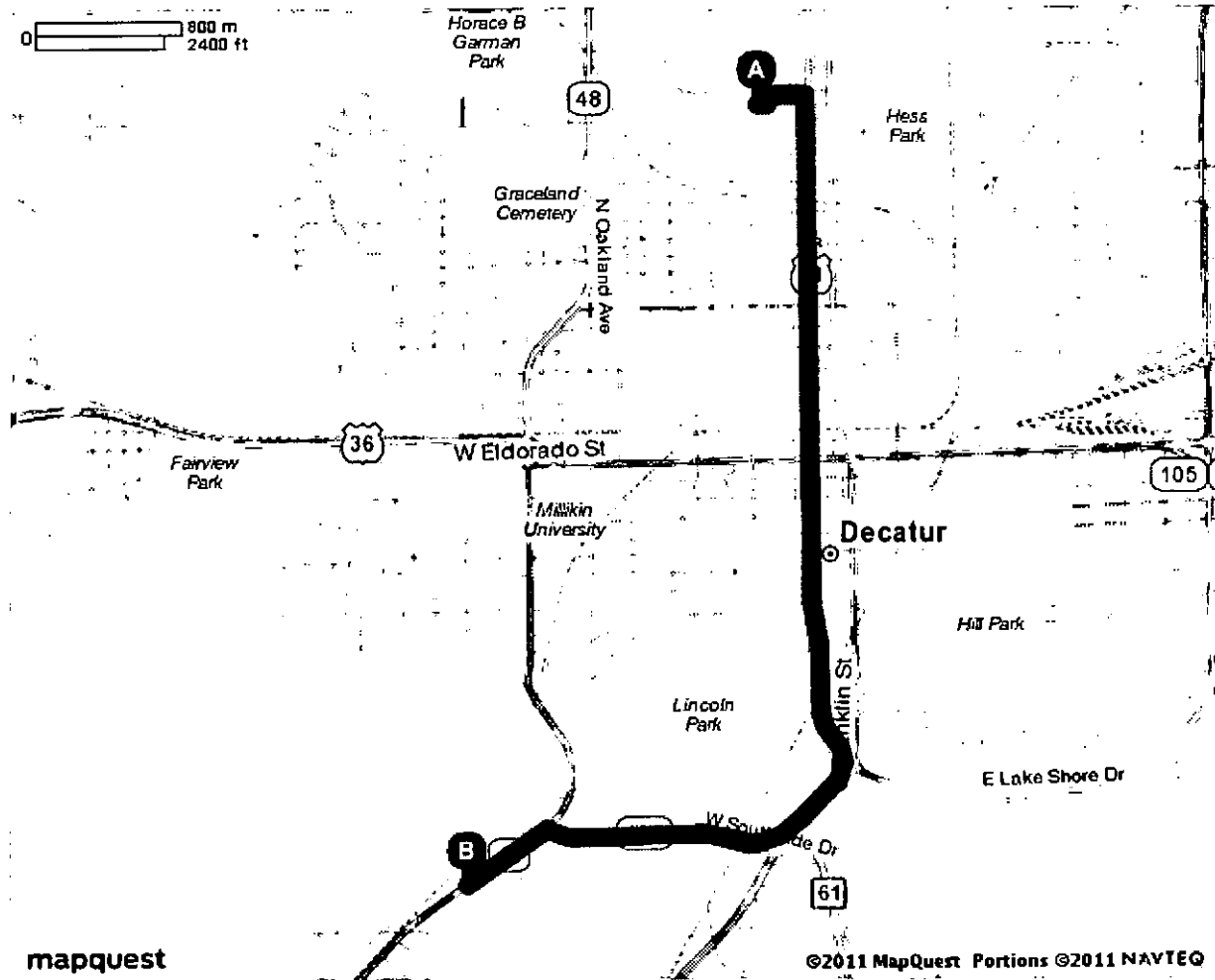


Fair Havens Christian Home - (217) 429-2551
1790 S Fairview Ave, Decatur, IL 62521

Appendix 6

Total Travel Estimate : 4.73 miles - about 11 minutes

Route Map [Hide](#)



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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:

Molly Carpenter, BA
 Imboden Creek Living Center
 180 W. Imboden
 Decatur, IL 62521

2. Article Number

(Transfer from service label)

7009 2250 0003 2946 3156

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Molly Carpenter* Agent Addressee

B. Received by (Printed Name)

Molly Carpenter

C. Date of Delivery

APR 29 2011

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



MAPQUEST.

Trip to Imboden Creek Living Center

180 W Imboden Dr, Decatur, IL 62521 -

(217) 422-6464

4.22 miles - about 11 minutes

Notes

★ Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.0 mi



3. Turn **RIGHT** onto **W KENWOOD AVE.**

go 0.2 mi



4. Turn **RIGHT** onto **US-51-BR S / N MAIN ST.** Continue to follow **US-51-BR S.**

go 3.1 mi



5. Turn **SLIGHT LEFT.**

go 0.0 mi



6. Turn **SLIGHT LEFT** onto **IL-105 E.**

go 0.0 mi



7. **IL-105 E** becomes **CR-61 S.**

go 0.6 mi



8. Turn **RIGHT** onto **W IMBODEN DR.**

go 0.1 mi

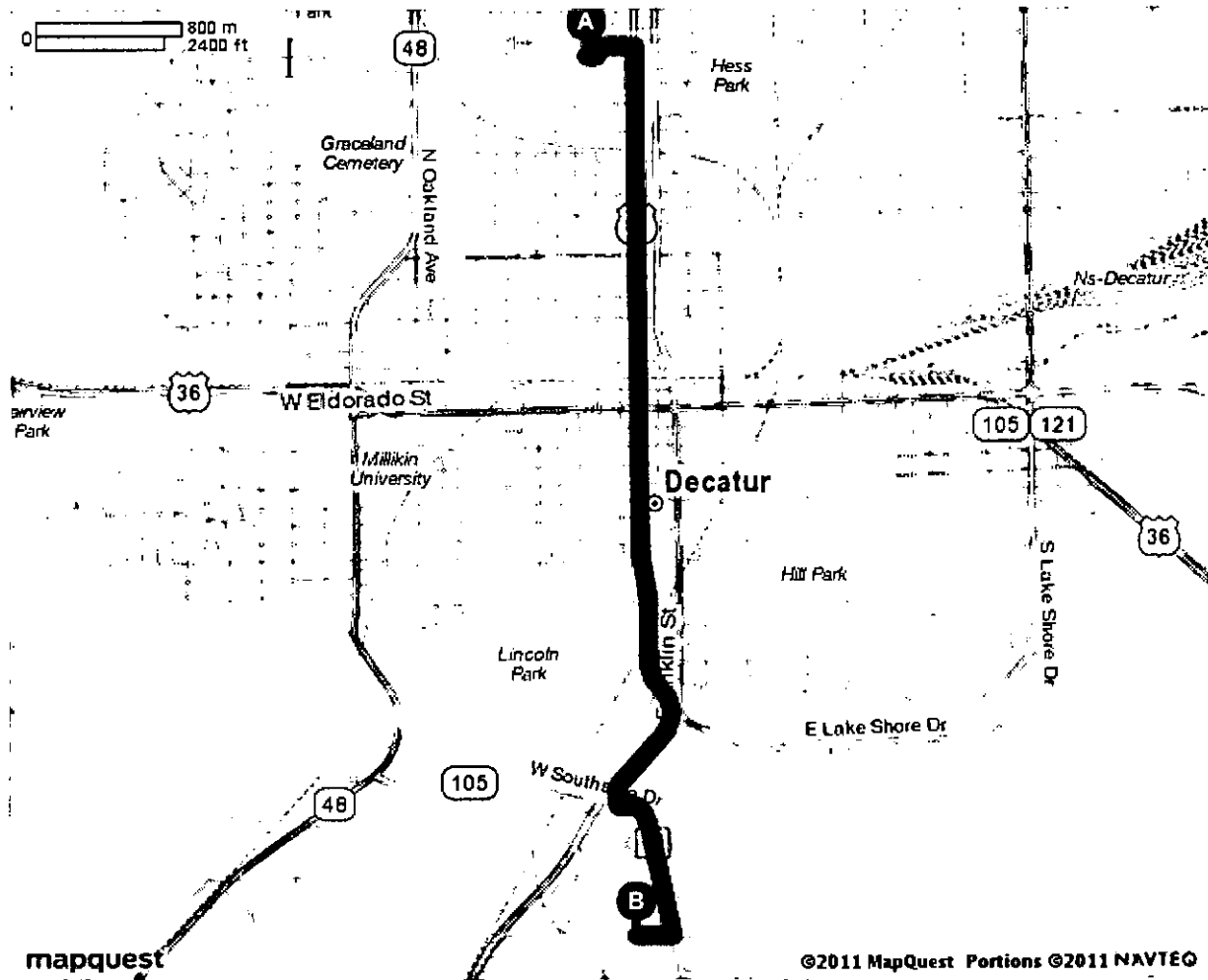


9. **180 W IMBODEN DR** is on the **RIGHT.**

go 0.0 mi

B Imboden Creek Living Center - (217) 422-6464
180 W Imboden Dr, Decatur, IL 62521
Total Travel Estimate : 4.22 miles - about 11 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION

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- 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
Heartland
444 W. Harrison
Decatur, IL 62526

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
x Brandy L. Senders

B. Received by (Printed Name) Agent
Brandy L. Senders

C. Date of Delivery
4-29

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) **7009 2250 0003 2946 3187**



MAPQUEST.

Trip to Heartland Health Care

444 W Harrison Ave, Decatur, IL 62526 -

(217) 877-7333

0.29 miles - about 1 minute

Notes

A Decatur Memorial Hospital - (217) 876-8121
2300 N Edward St, Decatur, IL 62526



1. Start out going **SOUTH** on **N EDWARD ST** toward **W HAY ST.**

go 0.3 mi



2. Turn **RIGHT** onto **W HARRISON AVE.**

go 0.0 mi

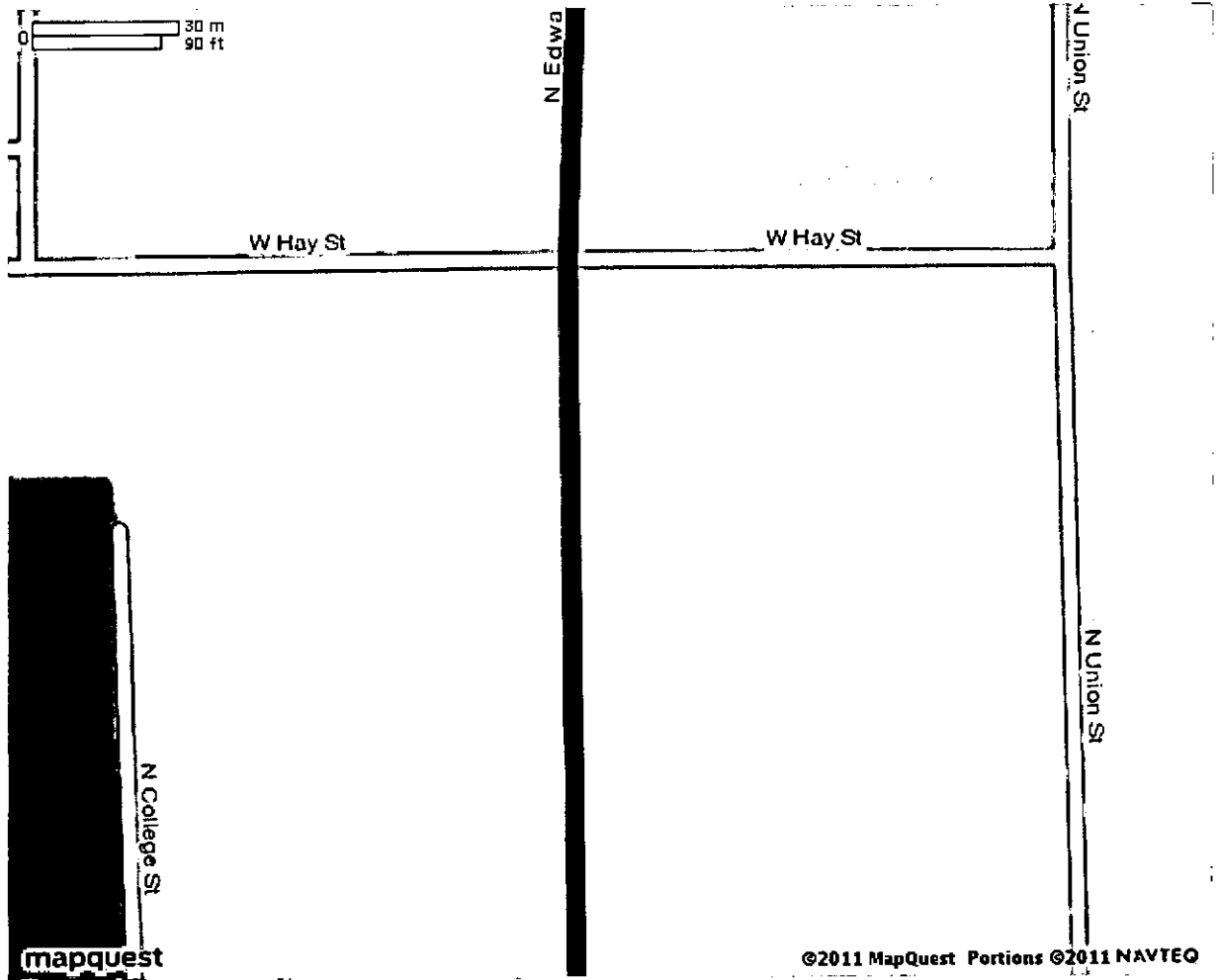


3. **444 W HARRISON AVE** is on the **RIGHT.**

go 0.0 mi

B Heartland Health Care - (217) 877-7333
444 W Harrison Ave, Decatur, IL 62526
Total Travel Estimate : 0.29 miles - about 1 minute

Route Map [Hide](#)



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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:

Kim Jordan
McKinley Court Care Center
500 W. McKinley Ave.
Decatur, IL 62526

2. Article Number
(Transfer from service label)

7009 2250 0003 2946 3200

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
Bethany Espar

B. Received by (Printed Name) C. Date of Delivery
Bethany Espar *4.29.11*

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



MAPQUEST.

Trip to Mc Kinley Court

500 W Mckinley Ave, Decatur, IL 62526 -

(217) 875-0020

0.39 miles - about 1 minute

Notes

A Decatur Memorial Hospital - (217) 876-8121
2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.2 mi



3. Turn LEFT onto W MCKINLEY AVE.

go 0.2 mi

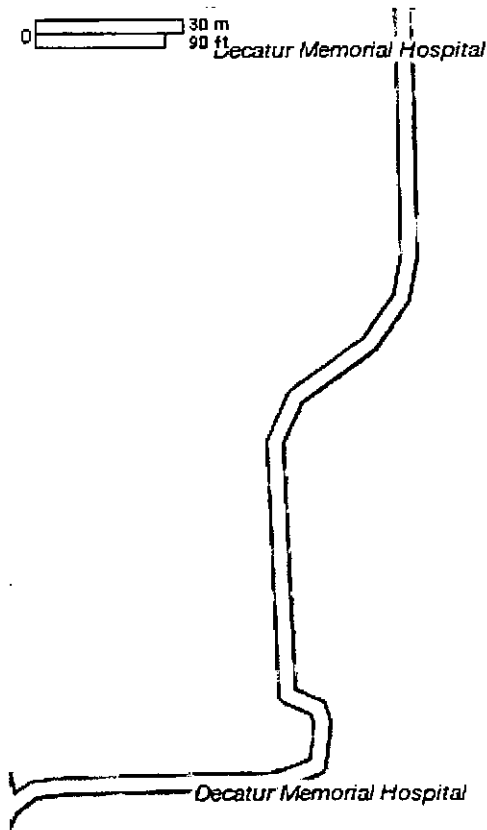


4. 500 W MCKINLEY AVE is on the RIGHT.

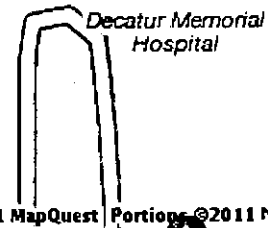
go 0.0 mi

B Mc Kinley Court - (217) 875-0020
500 W Mckinley Ave, Decatur, IL 62526
Total Travel Estimate : 0.39 miles - about 1 minute

Route Map [Hide](#)



Decatur Memorial Hospital



mapquest

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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
Decatur Rehab & Health Care
130 S. Dipper Lane
Decatur, IL 62522

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X  Agent
 Addressee

B. Received by (Printed Name)
CHRISTOPHER WARD

C. Date of Delivery
4-29-11

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)

7009 2250 0003 2946 3163

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Rehabcare Group Decatur Rehab

136 S Dipper Ln, Decatur, IL 62522 - (217)
422-3821

4.99 miles - about 10 minutes

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.0 mi



3. Turn RIGHT onto W KENWOOD AVE.

go 0.2 mi



4. Turn RIGHT onto US-51-BR S / N MAIN ST.

go 1.5 mi



5. Turn RIGHT onto US-36 W.

go 2.7 mi



6. Turn LEFT onto N MOFFET LN.

go 0.2 mi



7. Turn LEFT onto W MAIN ST.

go 0.3 mi



8. Turn RIGHT onto S DIPPER LN.

go 0.0 mi

9. 136 S DIPPER LN is on the LEFT.

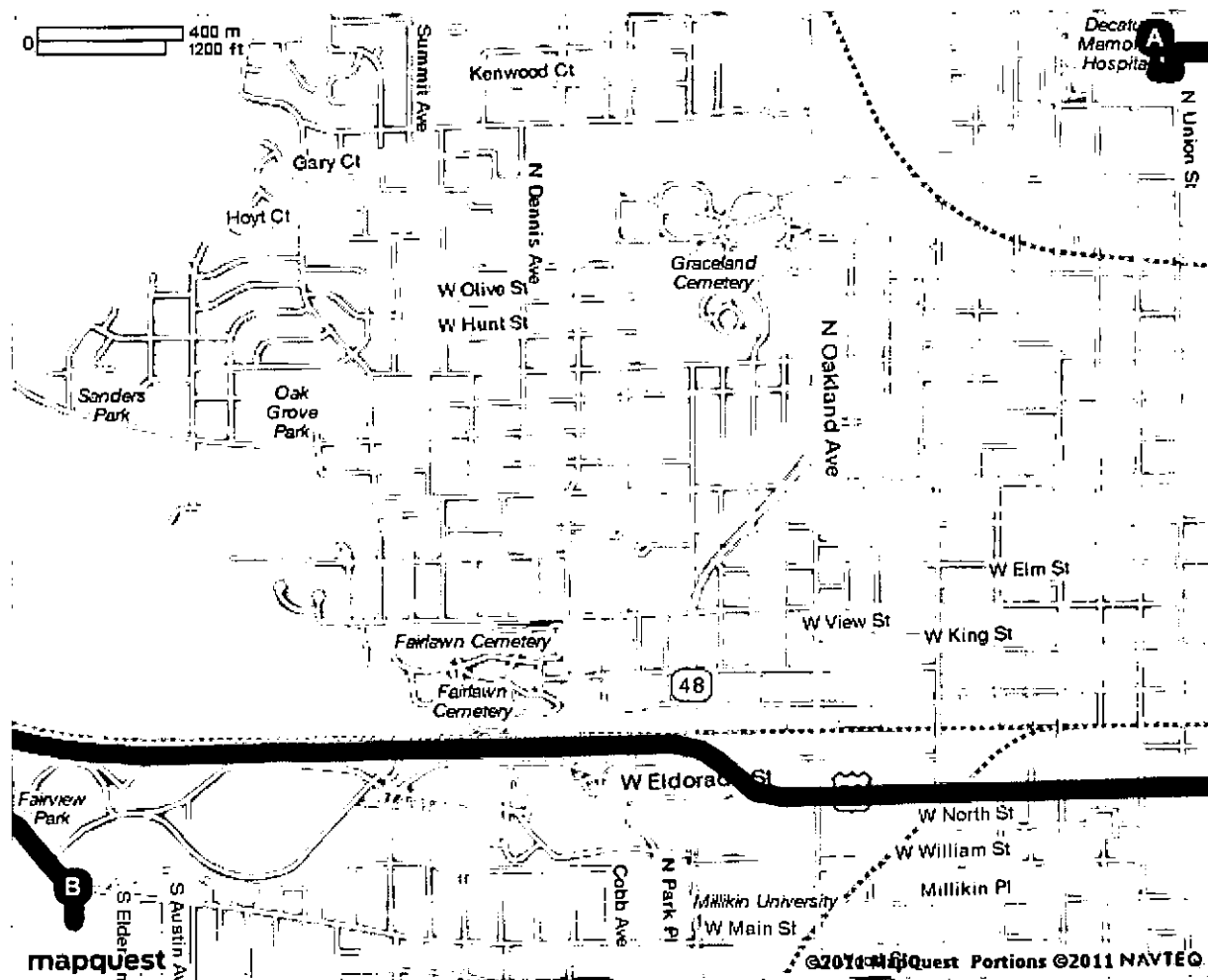
go 0.0 mi

Appendix 18

END

B Rehabcare Group Decatur Rehab - (217) 422-3821
136 S Dipper Ln, Decatur, IL 62522
Total Travel Estimate : 4.99 miles - about 10 minutes

Route Map Hide



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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:

Lisa Trudeau, Administrator
 Aspen Ridge Care Center
 2530 N. Monroe
 Decatur, IL 62526

COMPLETE THIS SECTION ON DELIVERY

A. 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)

7009 2250 0003 2946 3170

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Aspen Ridge

2530 N Monroe St, Decatur, IL 62526 -

(217) 875-0920

0.47 miles - about 1 minute

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.2 mi



3. Turn LEFT onto W MCKINLEY AVE.

go 0.2 mi



4. Turn RIGHT onto N MONROE ST.

go 0.0 mi



5. 2530 N MONROE ST is on the RIGHT.

go 0.0 mi

Aspen Ridge - (217) 875-0920 2530 N Monroe St, Decatur, IL 62526

Total Travel Estimate : 0.47 miles - about 1 minute

Route Map [Hide](#)

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:
Mary Buffington
Lincoln Manor
2650 N. Monroe
Decatur, IL 62526

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee
Candy Carroll

B. Received by (Printed Name)
Candy J. Carroll

C. Date of Delivery
4/29/11

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

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

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number
(Transfer from service label) 7009 2250 0003 2946 3194

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Lincoln Manor Inc

2650 N Monroe St, Decatur, IL 62526 -

(217) 875-1973

0.59 miles - about 1 minute

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.2 mi



3. Turn **LEFT** onto **W MCKINLEY AVE.**

go 0.2 mi



4. Turn **RIGHT** onto **N MONROE ST.**

go 0.1 mi



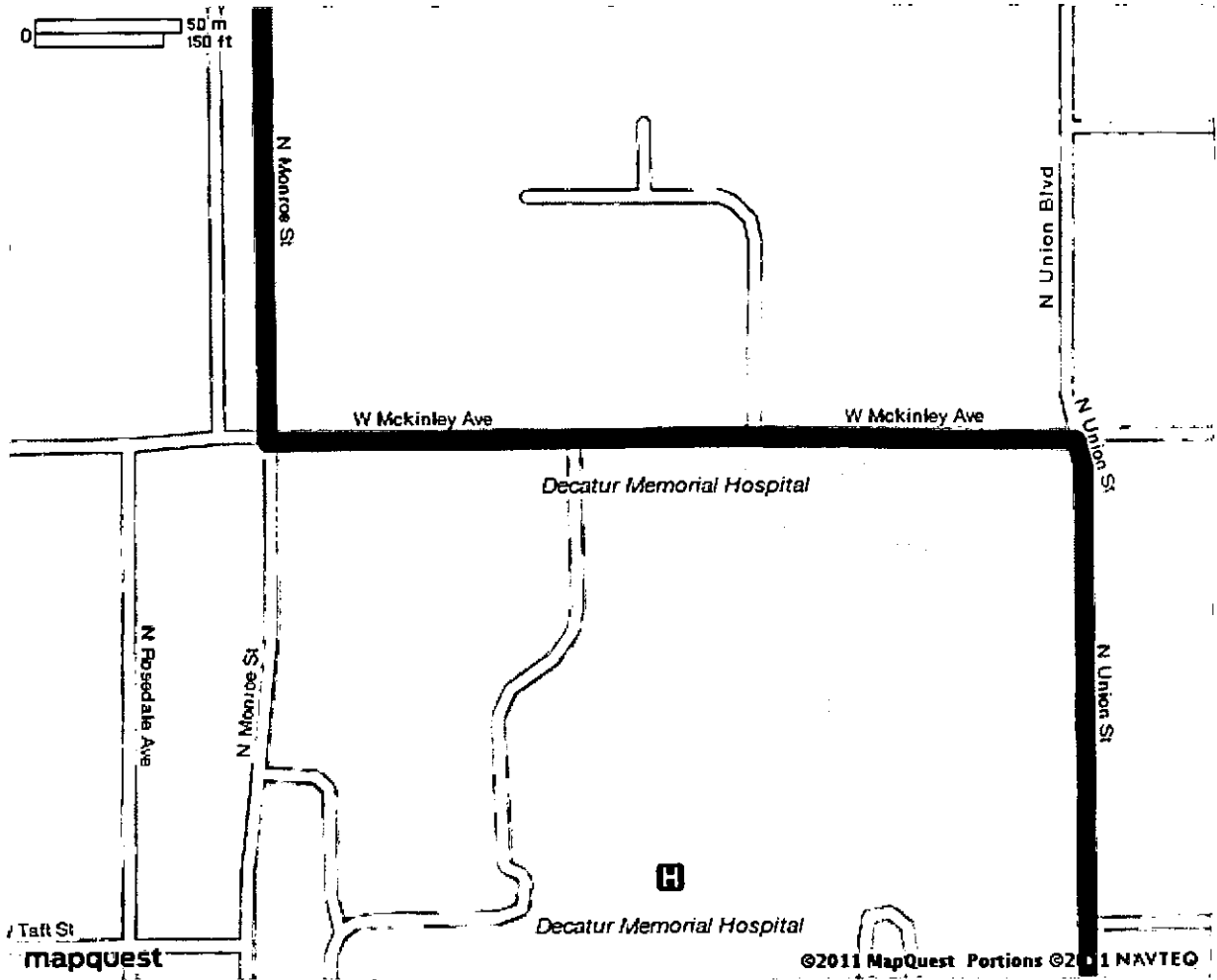
5. 2650 **N MONROE ST** is on the **RIGHT.**

go 0.0 mi

Lincoln Manor Inc - (217) 875-1973 2650 N Monroe St, Decatur, IL 62526

Total Travel Estimate : 0.59 miles - about 1 minute

Route Map [Hide](#)



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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
 Eastern Star
 9890 Star Lane
 Macon, IL 62544

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
Bobie Cunningham Addressee

B. Received by (Printed Name) C. Date of Delivery
BOBIE CUNNINGHAM 4.28.11

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 7009 2250 0003 2946 3217
 (Transfer from service label)

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



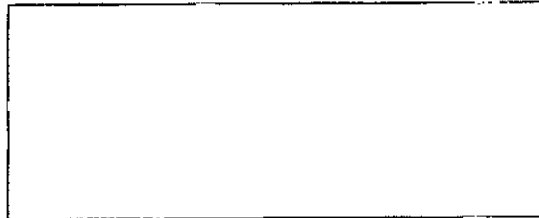
MAPQUEST.

Trip to Eastern Star Home of Macon











9890 Star Ln, Macon, IL 62544 - (217) 764-3348

11.88 miles - about 20 minutes

Notes



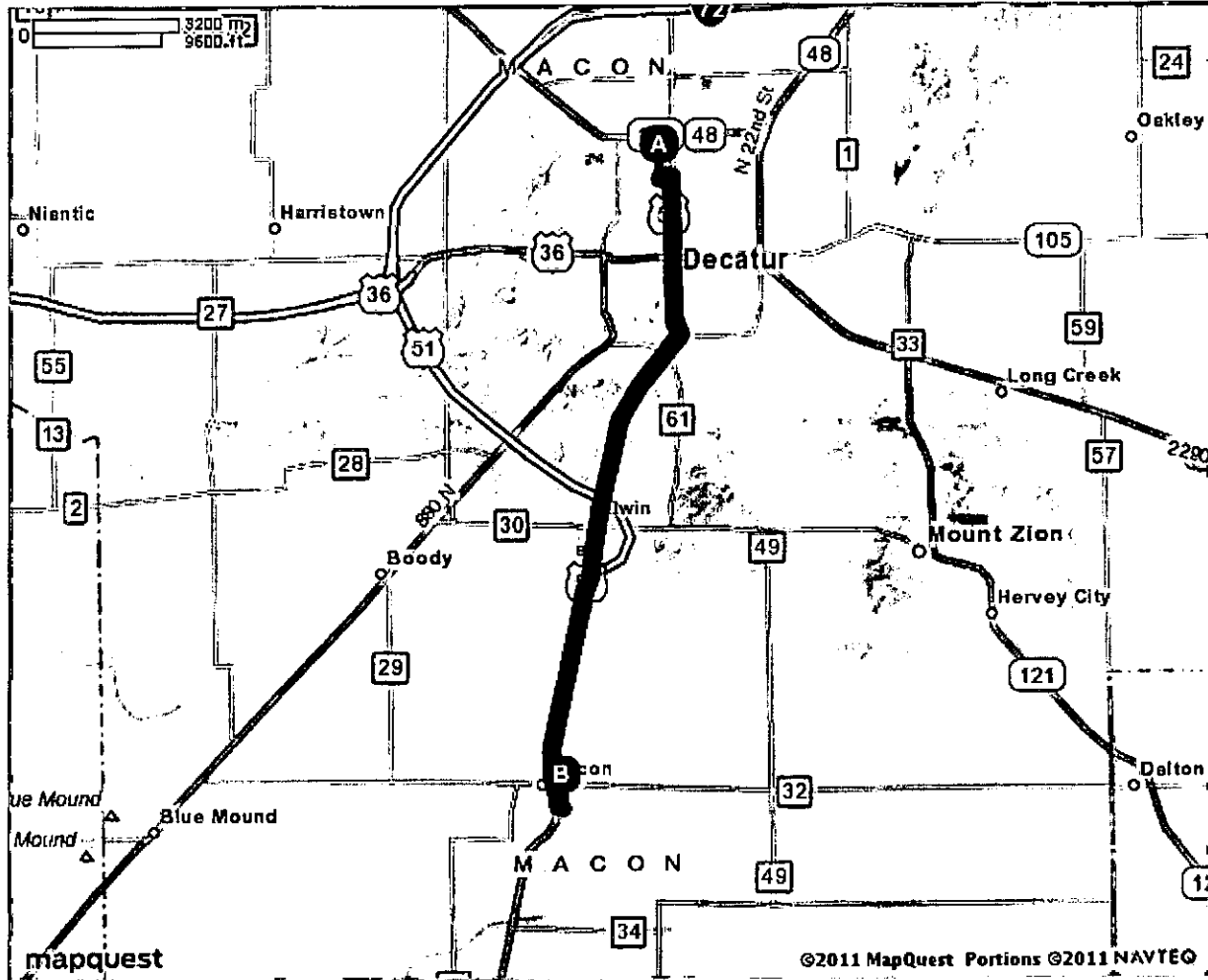
A Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|-----------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 8.0 mi |
|   | 5. US-51-BR S becomes US-51 S. | go 3.2 mi |
|  | 6. Turn LEFT onto CR-32 / E ANDREWS ST RD. Continue to follow CR-32. | go 0.0 mi |
|  | 7. Turn RIGHT onto STAR LN. | go 0.4 mi |
|  | 8. 9890 STAR LN. | go 0.0 mi |

B Eastern Star Home of Macon - (217) 764-3348 9890 Star Ln, Macon, IL 62544

Total Travel Estimate : 11.88 miles - about 20 minutes

Route Map [Hide](#)



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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:

Stephanie Taylor
Heritage Manor
1225 Woodland Dr.
Mt. Zion, IL 62549

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X Debbie D. Barker Agent Addressee

B. Received by (Printed Name)

Debbie D. Barker

C. Date of Delivery

4-28-11

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)

7009 2250 0003 2946 3224

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



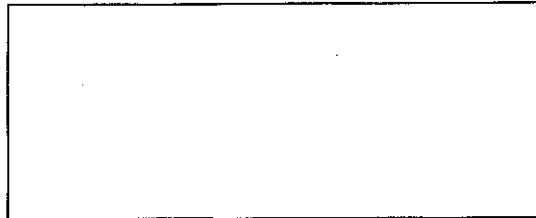
MAPQUEST.

Trip to Heritage Manor













1225 Woodland Dr, Mt Zion, IL 62549 -
(217) 864-2356

9.28 miles - about 17 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|-----------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
|   | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E. | go 4.7 mi |
|   | 6. Turn RIGHT onto IL-121. | go 2.6 mi |
|  | 7. Turn RIGHT onto W WOODLAND LN. | go 0.2 mi |
|  | 8. Turn LEFT onto WOODLAND DR. | go 0.0 mi |
|  | 9. 1225 WOODLAND DR is on the RIGHT. | go 0.0 mi |

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
Bloomington Rehab & HCC
1925 S. Main St.
Bloomington, IL 61704

COMPLETE THIS SECTION ON DELIVERY

A. Signature X <i>Randa L. Hair</i>		<input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee
B. Received by (Printed Name) <i>Randa L. Hair</i>	C. Date of Delivery <i>4/28/14</i>	
D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No		

3. Service Type

<input checked="" type="checkbox"/> Certified Mail	<input type="checkbox"/> Express Mail
<input type="checkbox"/> Registered	<input checked="" type="checkbox"/> Return Receipt for Merchandise
<input type="checkbox"/> Insured Mail	<input type="checkbox"/> C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number
(Transfer from service label)

7009 2250 0003 2946 3231

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

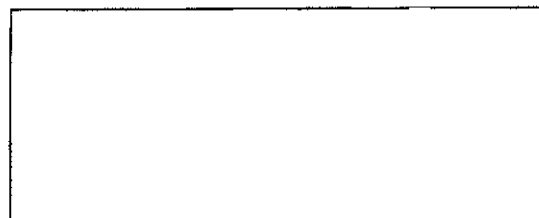
Trip to Bloomington Rehabilitation

1925 S Main St # A, Bloomington, IL 61704

- (309) 829-4348

42.58 miles - about 49 minutes

Notes



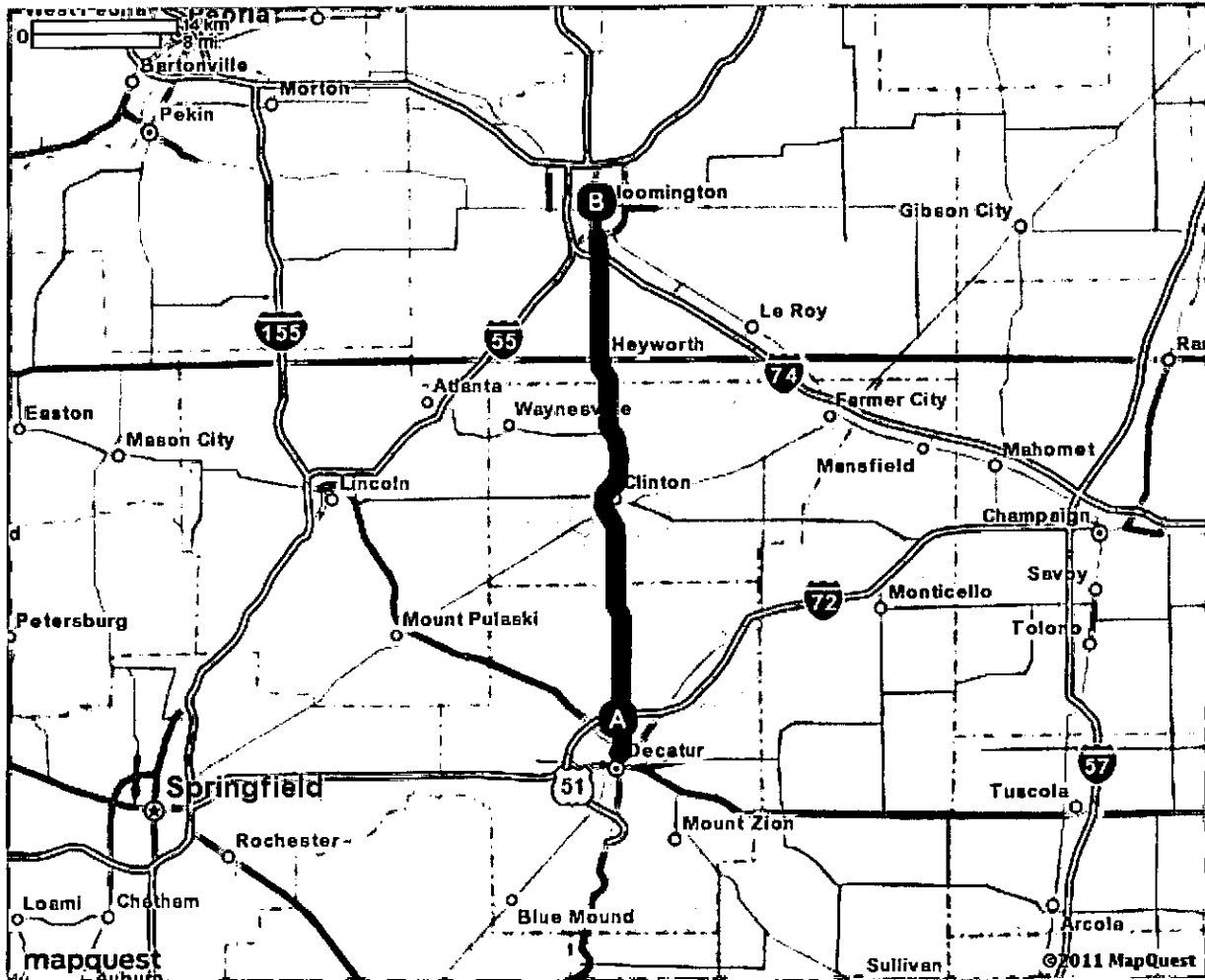
Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|--|---|------------|
| | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
| | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
| | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
| | 4. Turn LEFT onto US-51-BR N / N WATER ST. Continue to follow US-51-BR N. | go 2.8 mi |
| | 5. US-51-BR N becomes US-51 N. | go 38.1 mi |
| | 6. US-51 N becomes US-51-BR N / N 1450 EAST RD. | go 1.3 mi |
| | 7. Make a U-TURN at S MAIN ST onto S MAIN ST / US-51-BR S. | go 0.0 mi |
| | 8. 1925 S MAIN ST # A is on the RIGHT. | go 0.0 mi |

Bloomington Rehabilitation - (309) 829-4348 1925 S Main St # A, Bloomington, IL 61704

Total Travel Estimate : 42.58 miles - about 49 minutes

Route Map [Hide](#)



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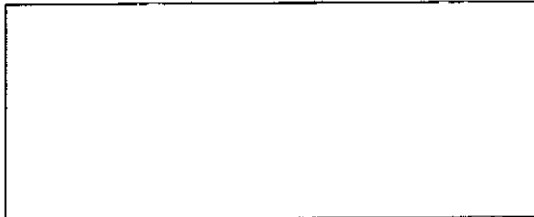
MAPQUEST.

Trip to Mason Point

1 Masonic Way, Sullivan, IL 61951 - (217) 728-4394

32.61 miles - about 46 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.0 mi



3. Turn RIGHT onto W KENWOOD AVE.

go 0.2 mi



4. Turn RIGHT onto US-51-BR S / N MAIN ST.

go 1.5 mi



5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E.

go 8.2 mi



6. Turn RIGHT onto CR-57 / 2130 E / 85TH ST / DALTON CITY RD. Continue to follow CR-57.

go 6.0 mi



7. Turn LEFT onto IL-121.

go 16.7 mi



8. 1 MASONIC WAY.

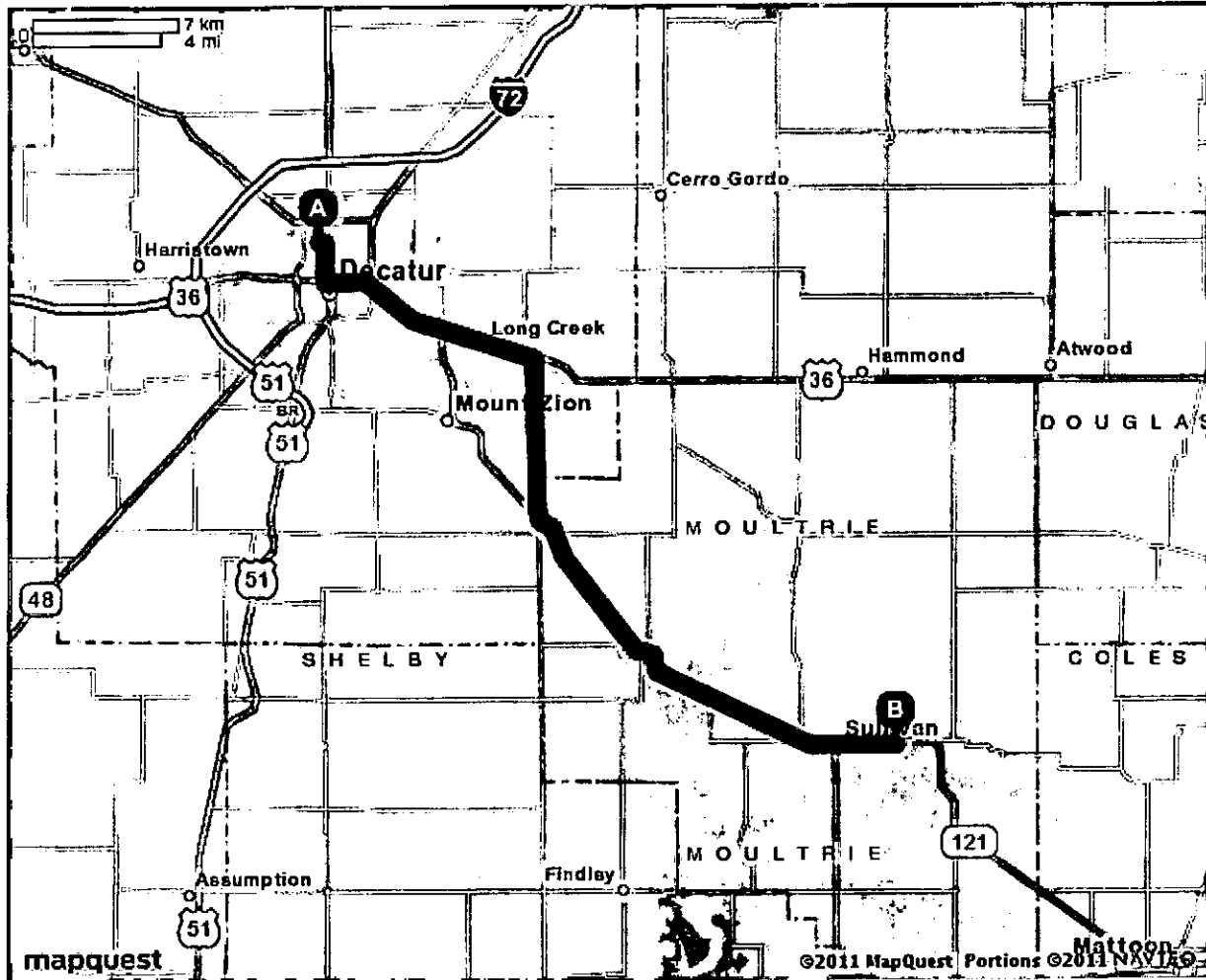
go 0.0 mi



Mason Point - (217) 728-4394 1 Masonic Way, Sullivan, IL 61951

Total Travel Estimate : 32.61 miles - about 46 minutes

Route Map [Hide](#)



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- 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
 Mason Point
 One Masonic Way
 Sullivan, IL 61951

2. Article Number
(Transfer from sender)

7009 2250 0003 2946 3255

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X



-
- Agent
-
-
- Addressee

B. Received by (Printed Name)

J. McDevitt

C. Date of Delivery

4-28-11

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



MAPQUEST.

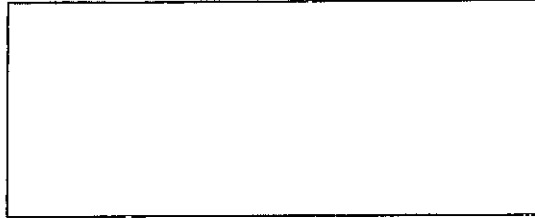
Trip to Eastview Terrace

100 Eastview Pl, Sullivan, IL 61951 - (217)













728-7367

31.32 miles - about 45 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
|   | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E. | go 8.2 mi |
|  | 6. Turn RIGHT onto CR-57 / 2130 E / 85TH ST / DALTON CITY RD. Continue to follow CR-57. | go 6.0 mi |
|   | 7. Turn LEFT onto IL-121. | go 15.2 mi |
|  | 8. Turn LEFT onto EASTVIEW DR. | go 0.2 mi |
|  | 9. Turn RIGHT onto EASTVIEW PL. | go 0.0 mi |

END

10. 100 EASTVIEW PL is on the LEFT.

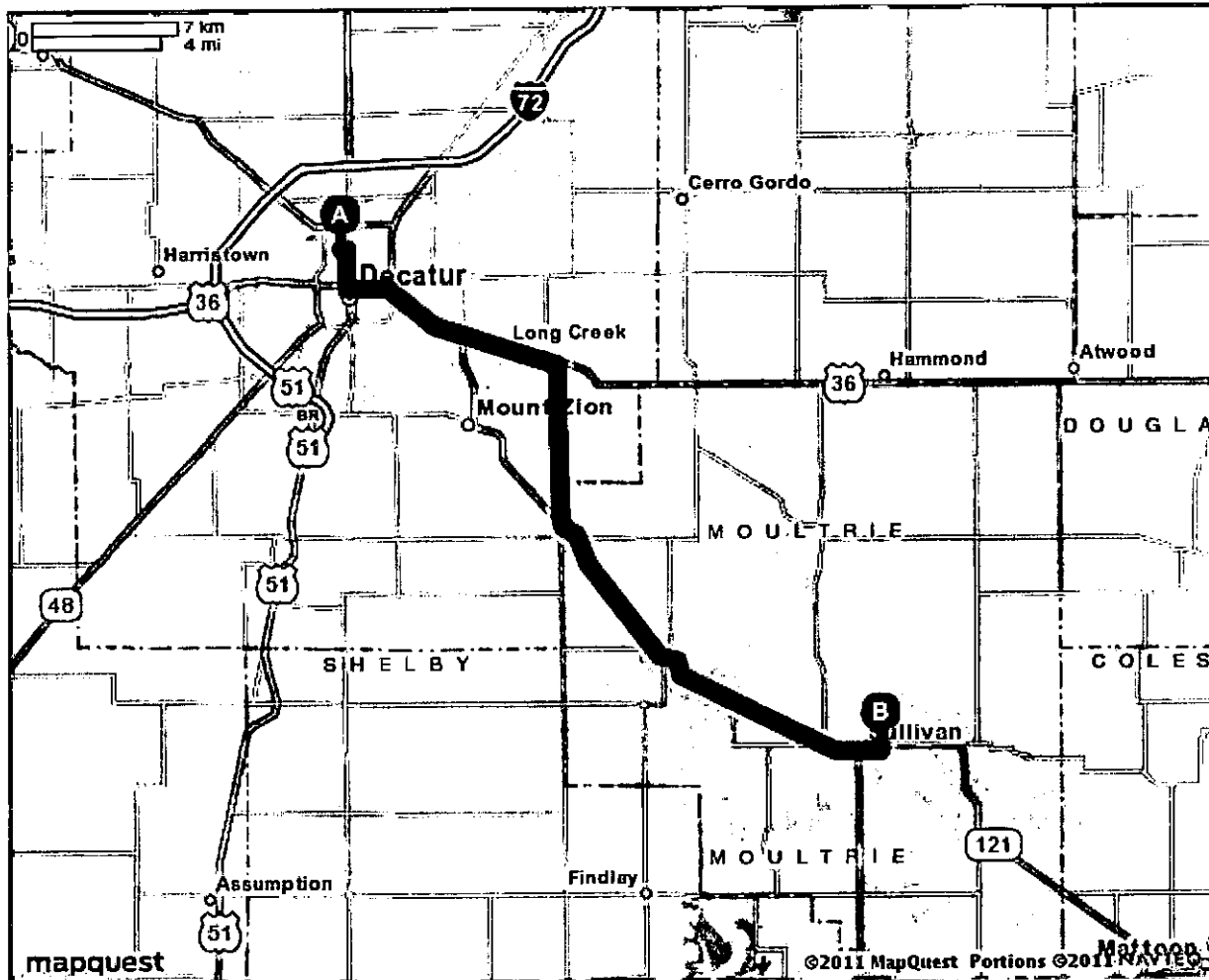
go 0.0 mi



Eastview Terrace - (217) 728-7367
100 Eastview Pl, Sullivan, IL 61951

Total Travel Estimate : 31.32 miles - about 45 minutes

Route Map [Hide](#)



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- 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
Eastview Terrace
100 Eastview Pl.
Sullivan, IL 61951

2. Article Number
(Transfer from service label)

7009 2250 0003 2946 3262

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee

B. Received by (Printed Name) C. Date of Delivery
Linda Doumel BOM 4-28-11

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

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

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Administrator
 Sullivan Rehan & Health Care Ctr
 11 Hawthorne Ln.
 Sullivan, IL 61951

2. Article Number

(Transfer from service)

7009 2250 0003 2946 3279

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

Linda Johnson

 Agent AddresseeB. Received by (*Printed Name*)

LINDA JOHNSON

C. Date of Delivery

4-28-11

D. Is delivery address different from item 1? YesIf 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



MAPQUEST.

Trip to Sullivan Health Care Center

11 Hawthorne Ln, Sullivan, IL 61951 - (217) 728-4327

728-4327

31.47 miles - about 45 minutes

Notes

★ Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.0 mi



3. Turn RIGHT onto W KENWOOD AVE.

go 0.2 mi



4. Turn RIGHT onto US-51-BR S / N MAIN ST.

go 1.5 mi



5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E.

go 8.2 mi



6. Turn RIGHT onto CR-57 / 2130 E / 85TH ST / DALTON CITY RD. Continue to follow CR-57.

go 6.0 mi



7. Turn LEFT onto IL-121.

go 14.4 mi



8. Turn RIGHT onto IL-32.

go 1.1 mi



9. Turn LEFT onto HAWTHORNE LN.

go 0.0 mi



10. 11 HAWTHORNE LN is on the RIGHT.

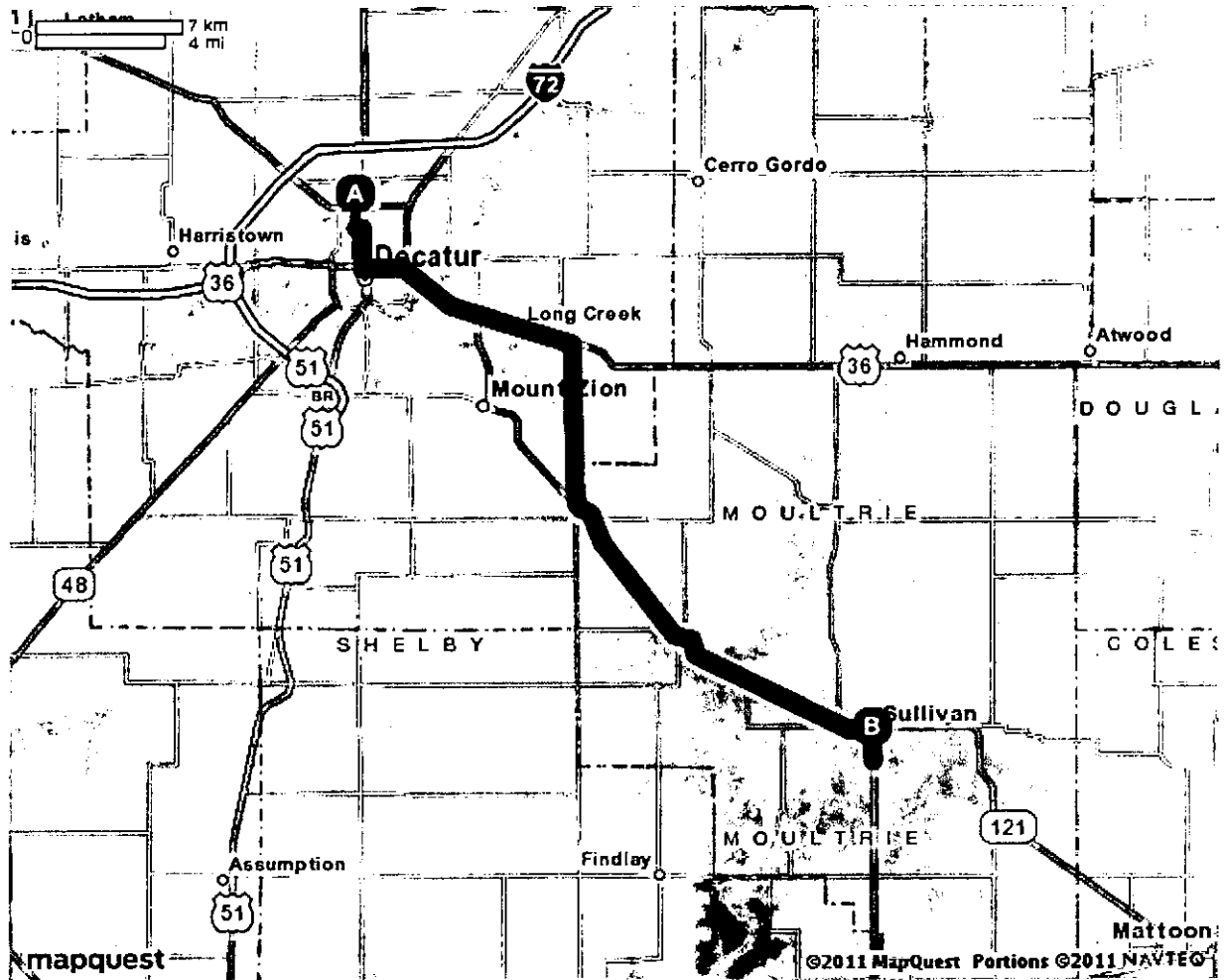
go 0.0 mi



Sullivan Health Care Center - (217) 728-4327
11 Hawthorne Ln, Sullivan, IL 61951

Total Travel Estimate : 31.47 miles - about 45 minutes

Route Map [Hide](#)



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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:
 Titus Memorial Presbyterian Home
 513 N. Worth St.
 Sullivan, IL 61951

ATTN: Administrator

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee

B. Received by (Printed Name): Agent
 Addressee

C. Date of Delivery
 4-28-11

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)

7009 2250 0003 2946 3286

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Titus Memorial Presbyterian

513 N Worth St, Sullivan, IL 61951 - (217)













728-4725

30.72 miles - about 44 minutes

Notes

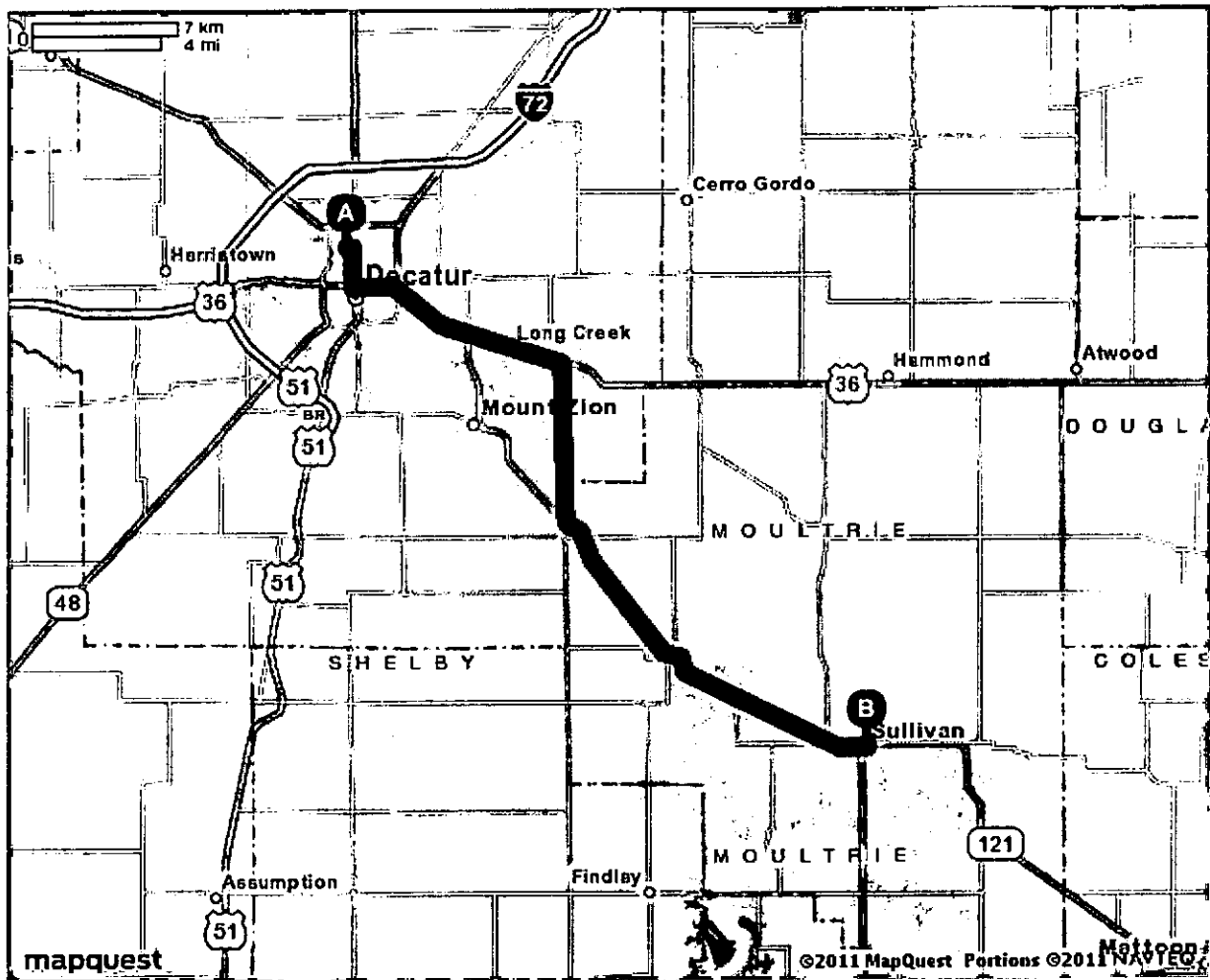


Decatur Memorial Hospital 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
|   | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E. | go 8.2 mi |
|  | 6. Turn RIGHT onto CR-57 / 2130 E / 85TH ST / DALTON CITY RD. Continue to follow CR-57. | go 6.0 mi |
|   | 7. Turn LEFT onto IL-121. | go 14.6 mi |
|  | 8. Turn LEFT onto N WORTH ST. | go 0.2 mi |
|  | 9. 513 N WORTH ST is on the LEFT. | go 0.0 mi |

B Titus Memorial Presbyterian - (217) 728-4725
513 N Worth St, Sullivan, IL 61951
Total Travel Estimate : 30.72 miles - about 44 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <input type="checkbox"/> C. Date of Delivery Adam Pulle.1 4/28/11</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Administrator Bement Health Care Ctr. 601 N. Morgan Bement, IL 61813</p>	<p>3. Service Type</p> <p><input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p>	<p>7009 2250 0003 2946 3293</p>	

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Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Bement Health Care Center

601 N Morgan St, Bement, IL 61813 - (217)

678-2191





27.42 miles - about 39 minutes

Notes



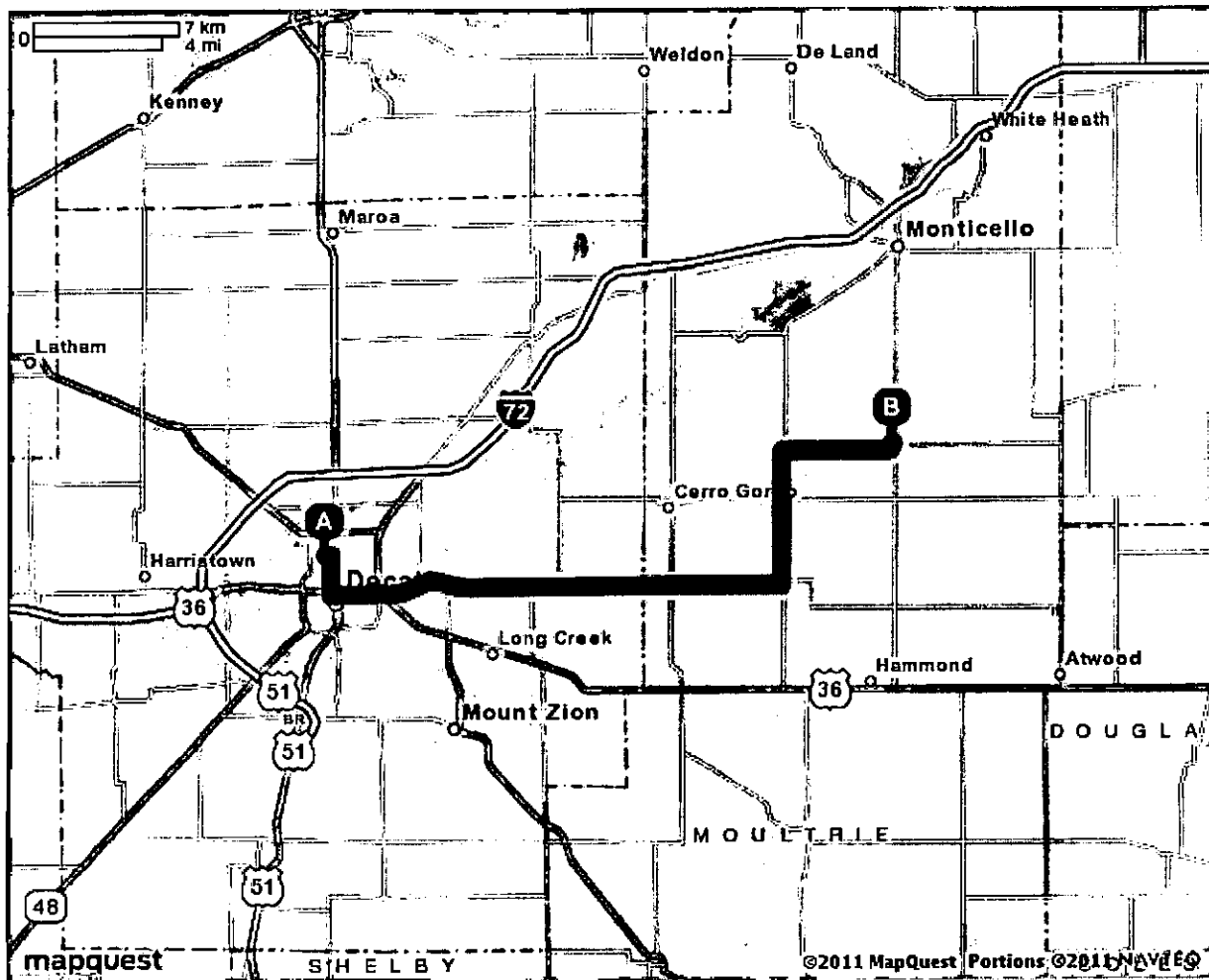
Decatur Memorial Hospital 2300 N Edward St, Decatur, IL 62526

- | | | |
|--|---|------------|
| | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
| | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
| | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
| | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
| | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow E ELDORADO ST. | go 1.6 mi |
| | 6. E ELDORADO ST becomes IL-105 E. | go 10.7 mi |
| | 7. Stay STRAIGHT to go onto CR-12. | go 4.0 mi |
| | 8. Turn LEFT onto CR-22. | go 5.0 mi |
| | 9. Turn RIGHT onto CR-7. | go 3.9 mi |

-  10. Turn LEFT onto N SANGAMON ST. go 0.2 mi
-  11. Turn SLIGHT RIGHT onto W FRANKLIN ST. go 0.0 mi
-  12. Turn LEFT onto N MORGAN ST. go 0.0 mi
-  13. 601 N MORGAN ST is on the LEFT. go 0.0 mi

B Bement Health Care Center - (217) 678-2191
601 N Morgan St, Bement, IL 61813
Total Travel Estimate : 27.42 miles - about 39 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature <input checked="" type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee	
1. Article Addressed to: Administrator Piatt Co. Nursing Home 1111 State St. Monticello, IL 61856	B. Received by (Printed Name) <i>Jodie Melton</i>	C. Date of Delivery <i>4/28/11</i>
2. Article Number (Transfer from service label)	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D. 4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
7009 2250 0003 2946 3309		

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Domestic Return Receipt

102595-02-M-1540



MAPQUEST.













Trip to Piatt County Nursing Home

1111 N State St # A, Monticello, IL 61856 -
(217) 762-2506

27.72 miles - about 33 minutes

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn LEFT onto US-51-BR N / N WATER ST. Continue to follow US-51-BR N. | go 2.5 mi |
|   | 5. Merge onto I-72 E toward CHAMPAIGN. | go 22.7 mi |
|  | 6. Merge onto CR-5 S via EXIT 164 toward BRIDGE ST. | go 1.6 mi |
|   | 7. Turn LEFT onto IL-105. | go 0.3 mi |
|  | 8. Turn RIGHT onto W OGLESBY ST. | go 0.0 mi |
|  | 9. Turn LEFT onto N STATE ST. | go 0.1 mi |



10. 1111 N STATE ST # A is on the RIGHT.

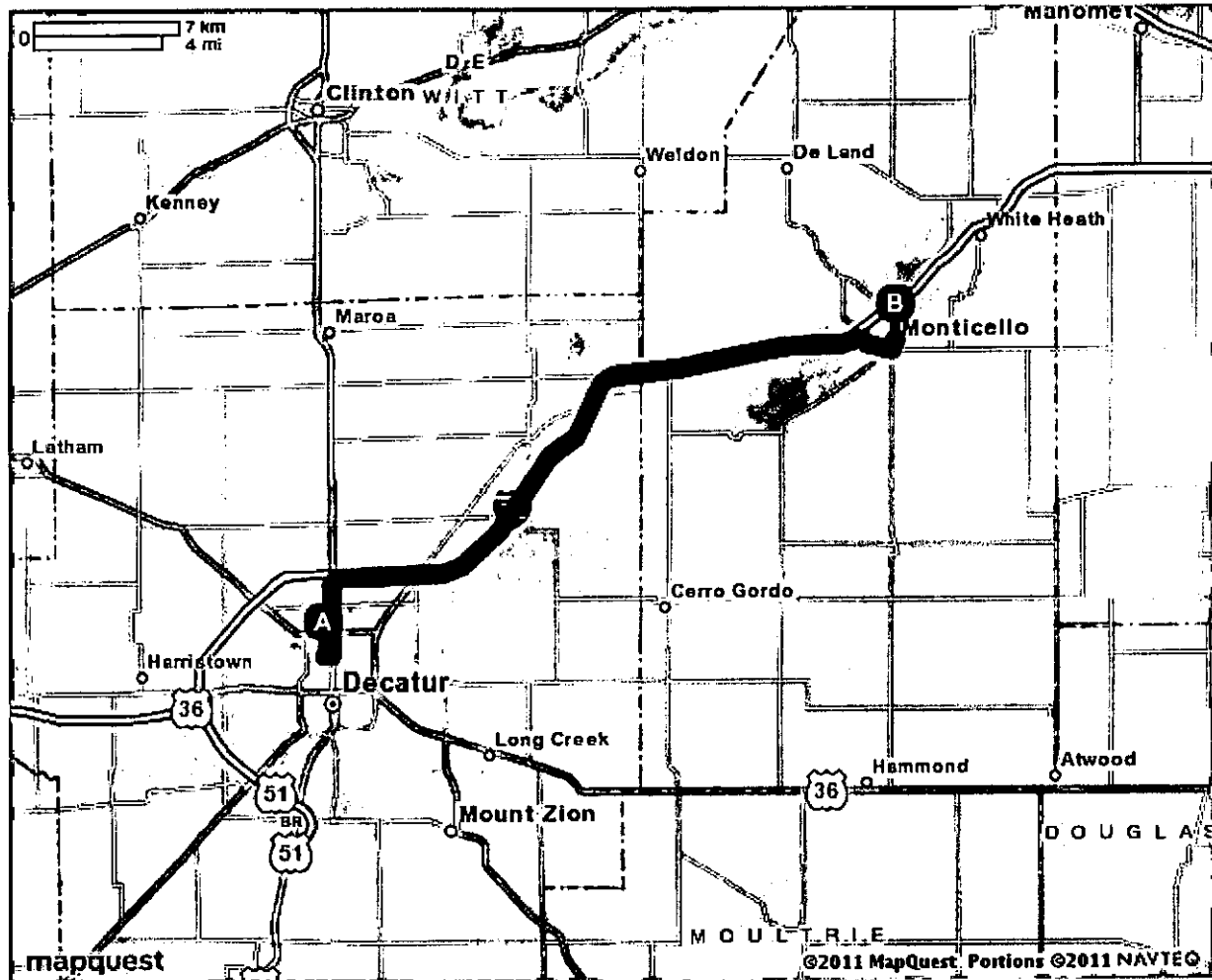
go 0.0 mi



Piatt County Nursing Home - (217) 762-2506
1111 N State St # A, Monticello, IL 61856

Total Travel Estimate : 27.72 miles - about 33 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>x [Signature]</i>	
1. Article Addressed to: Administrator Moweaqua Nursing & Retirement Ctr. 525 S. Macon St. Moweaqua, IL 62550	B. Received by (Printed Name)	C. Date of Delivery 4-28
2. Article Number (Transfer from service label)	D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D. 4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
7009 2250 0003 2946 3316		

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Moweaqua Nursing & Retirement

525 S Macon St, Moweaqua, IL 62550 -
(217) 768-3951

18.89 miles - about 28 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST. go 0.0 mi



2. Turn LEFT onto N UNION ST. go 0.0 mi



3. Turn RIGHT onto W KENWOOD AVE. go 0.2 mi



4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. go 8.0 mi



5. US-51-BR S becomes US-51 S. go 9.6 mi



6. Turn RIGHT onto 2800 N / CR-21. Continue to follow CR-21. go 0.8 mi



7. Turn LEFT onto S MACON ST. go 0.3 mi



8. 525 S MACON ST is on the RIGHT. go 0.0 mi

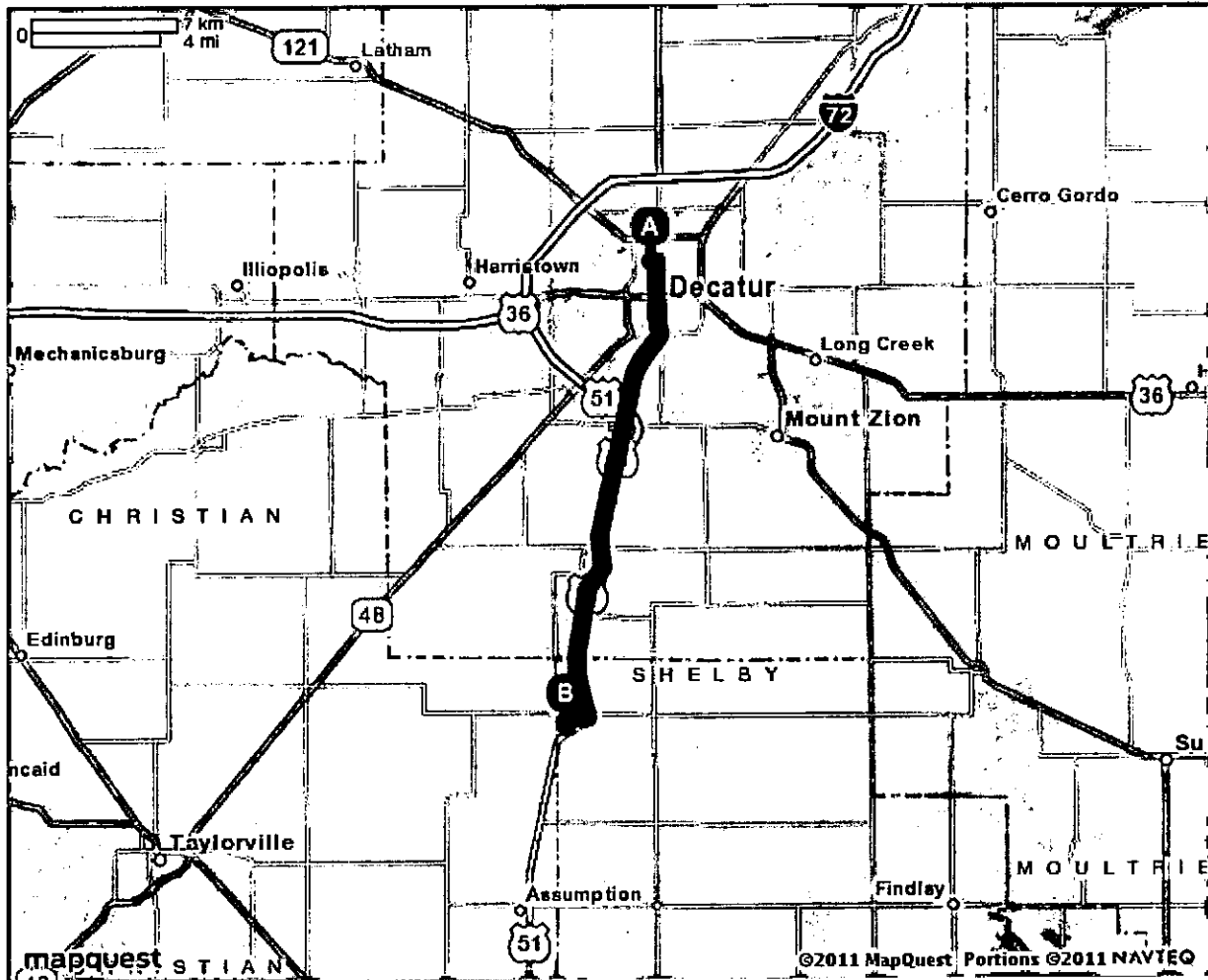


Moweaqua Nursing & Retirement - (217) 768-3951

525 S Macon St, Moweaqua, IL 62550

Total Travel Estimate : 18.89 miles - about 28 minutes

Route Map [Hide](#)



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- 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:

Nancy Pryor
Heritage Manor
1000 E. Sixth St.
Pana, IL 62557

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee

B. Received by (Printed Name) C. Date of Delivery
Missy Ade 4-28-11

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)

7009 2250 0003 2946 3446

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



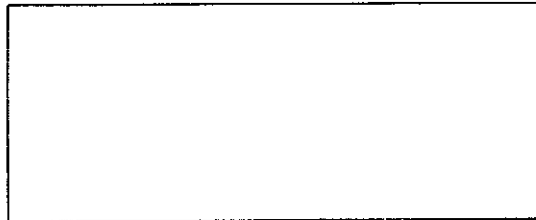
MAPQUEST.

Trip to Heritage Manor of Pana













1000 E 6th St, Pana, IL 62557 - (217) 562-2174

36.47 miles - about 48 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 8.0 mi |
|   | 5. US-51-BR S becomes US-51 S. | go 26.6 mi |
|   | 6. Turn RIGHT onto E 300N RD / US-51 / IL-16. | go 1.0 mi |
|  | 7. Turn LEFT onto N 2500E RD / FAIRGROUNDS RD.
Continue to follow N 2500E RD. | go 0.5 mi |
|  | 8. Turn RIGHT onto E 6TH ST / E 250N RD. | go 0.2 mi |
|  | 9. 1000 E 6TH ST. | go 0.0 mi |

B Heritage Manor of Pana - (217) 562-2174
1000 E 6th St, Pana, IL 62557
Total Travel Estimate : 36.47 miles - about 48 minutes

Route Map [Hide](#)



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- 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
Prarie Rose Health Care Ctr.
900 S. Chestnut
Pana, IL 62557

COMPLETE THIS SECTION ON DELIVERY

A. Signature

Laura Morrell

- Agent
- Addressee

B. Received by (Printed Name)

Laura Morrell

C. Date of Delivery

7/28/11

D. Is delivery address different from item 1? Yes

If YES, enter delivery address below: No

J. 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 lab)

7009 2250 0003 2946 3453



MAPQUEST.



Trip to Prairie Rose Health Care Center



900 S Chestnut St, Pana, IL 62557 - (217) 562-3996
37.88 miles - about 52 minutes


Notes


A **Decatur Memorial Hospital - (217) 876-8121**
2300 N Edward St, Decatur, IL 62526


- | | | |
|--|--|------------|
| | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
| | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
| | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
| | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 8.0 mi |
| | 5. US-51-BR S becomes US-51 S. | go 26.6 mi |
| | 6. Turn RIGHT onto E 300N RD / US-51 / IL-16. Continue to follow US-51 / IL-16. | go 1.5 mi |
| | 7. Turn LEFT onto US-51 / CEDAR ST / S CEDAR ST / IL-16. | go 0.0 mi |
| | 8. Turn RIGHT onto E 1ST ST / US-51 / IL-16. | go 0.4 mi |
| | 9. Turn LEFT onto US-51 / S POPLAR ST / IL-16. Continue | go 0.4 mi |


-   to follow US-51 / S POPLAR ST.

-   10. Turn SLIGHT LEFT onto FAIR AVE / US-51. go 0.3 mi

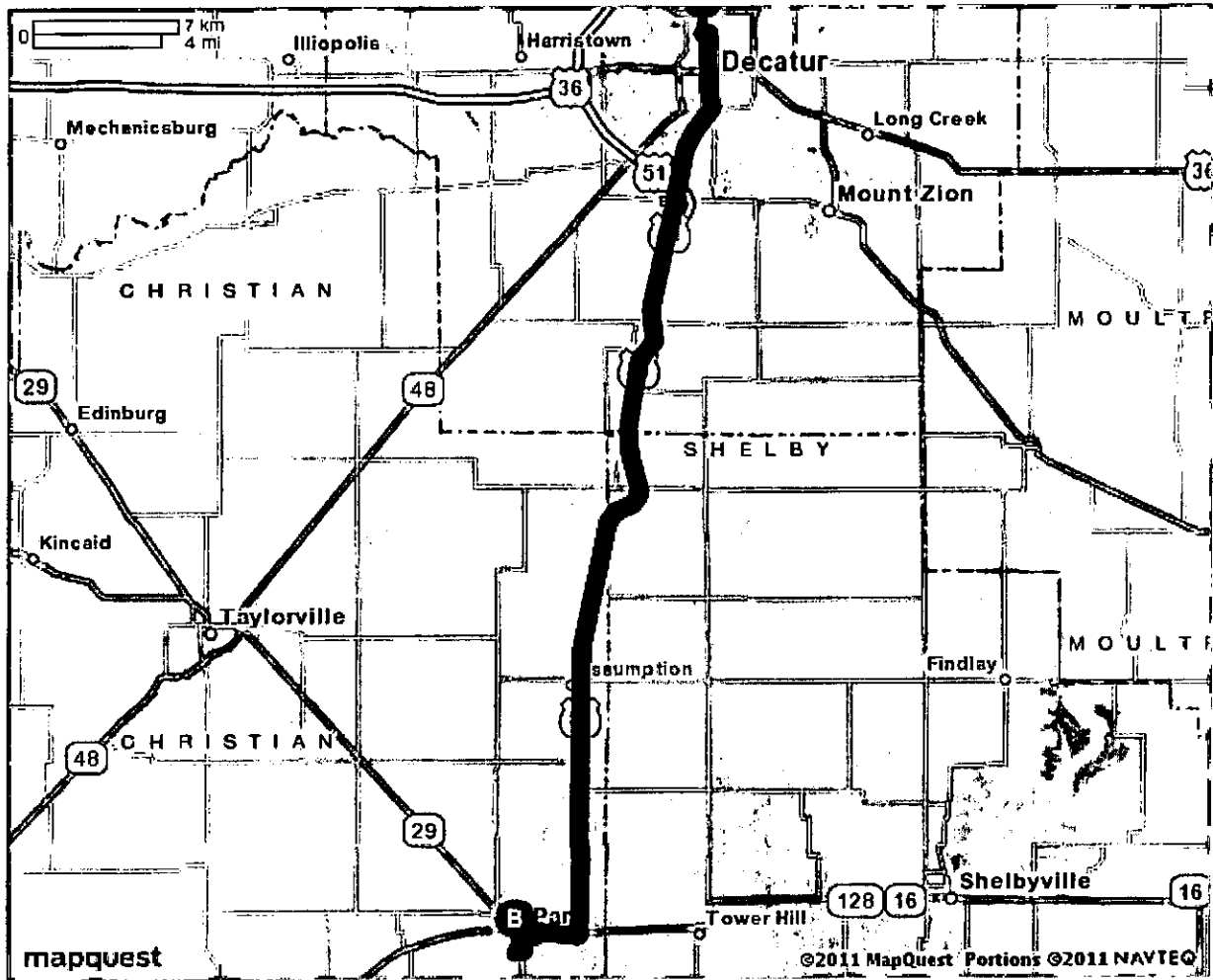
-  11. Turn RIGHT onto E 9TH ST. go 0.3 mi

-  12. Turn LEFT onto S CHESTNUT ST. go 0.0 mi

-  13. 900 S CHESTNUT ST is on the LEFT. go 0.0 mi

 **Prairie Rose Health Care Center - (217) 562-3996**
900 S Chestnut St, Pana, IL 62557
Total Travel Estimate : 37.88 miles - about 52 minutes

Route Map [Hide](#)



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- Print your name and address on the reverse so that we can return the card to you.
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1. Article Addressed to:

Susan Johnson
 Meadow Manor
 800 McAdam Dr.
 Taylorville, IL 62568

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Stephanie Duda* Agent
 Addressee

B. Received by (*Printed Name*)

Stephanie Duda

C. Date of Delivery

4/28/11

- 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

7009 2250 0003 2946 3460

(*Transfer from service label*)

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Meadow Manor Nursing Home












800 McAdam Dr, Taylorville, IL 62568 -
(217) 824-2277

28.97 miles - about 43 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

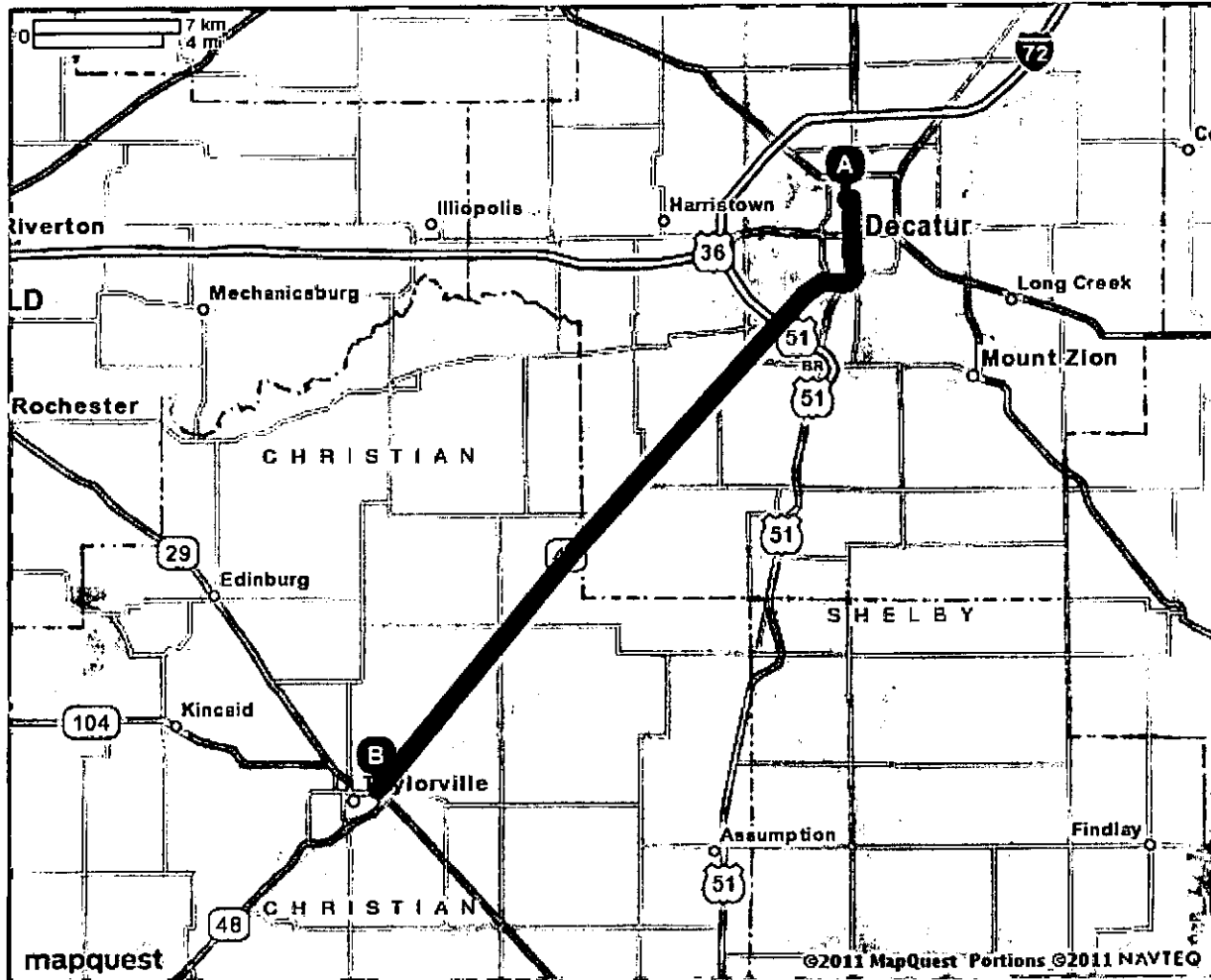
- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 3.0 mi |
|  | 5. Turn SLIGHT RIGHT. | go 0.3 mi |
|   | 6. Turn SLIGHT RIGHT onto W SOUTHSIDE DR / IL-105 W. | go 0.8 mi |
|   | 7. Turn LEFT onto IL-48 S. | go 24.3 mi |
|  | 8. Turn RIGHT onto MCADAM DR. | go 0.3 mi |
| | 9. 800 MCADAM DR is on the LEFT. | go 0.0 mi |

LND

B Meadow Manor Nursing Home - (217) 824-2277
800 McAdam Dr, Taylorville, IL 62568

Total Travel Estimate : 28.97 miles - about 43 minutes

Route Map [Hide](#)



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- 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
Arthur Home
423 Eberhardt Dr.
Arthur, IL 61911

2. Article Number
(Transfer from service label)

7009 2250 0003 2946 3514

PS Form 3811, February 2004

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Teresa Miller*

- Agent
 Addressee

B. Received by (Printed Name)

Teresa Miller

C. Date of Delivery

4-28-11

D. Is delivery address different from item 1?

Yes

If YES, enter delivery address below:

No *SM*

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

Domestic Return Receipt

102595-02-M-1540

MAPQUEST.

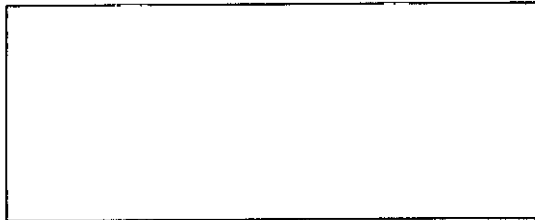
Trip to Arthur Home

423 S Eberhardt Dr, Arthur, IL 61911 - (217) 543-2103













543-2103

34.02 miles - about 44 minutes

Notes



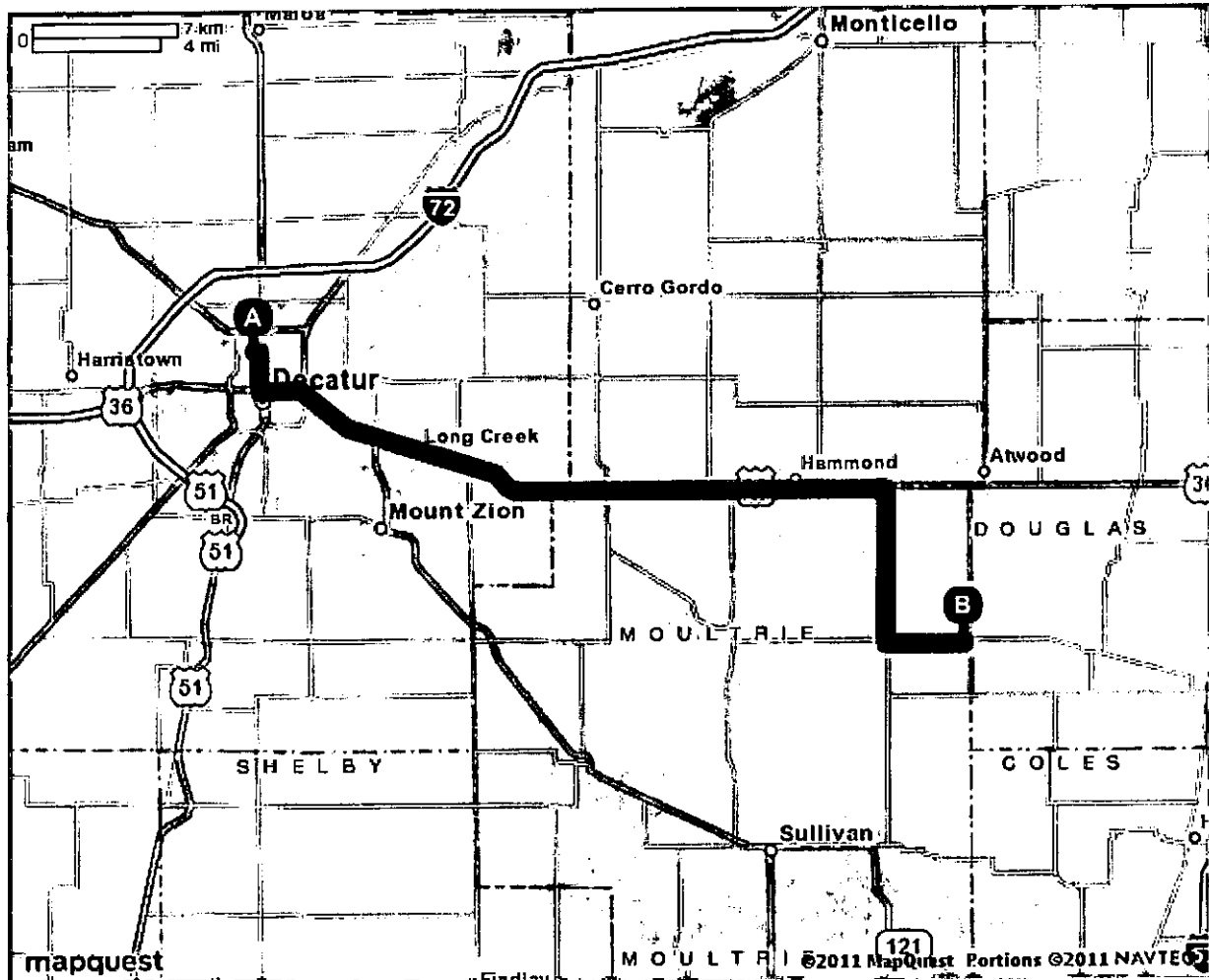
Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
|   | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E. | go 23.8 mi |
|  | 6. Turn RIGHT onto CR-8 / 1500 E / PIERSON RD. Continue to follow CR-8 / 1500 E. | go 5.7 mi |
|   | 7. Turn LEFT onto IL-133. | go 2.8 mi |
|  | 8. Turn LEFT onto S EBERHARDT ST. | go 0.0 mi |
|  | 9. 423 S EBERHARDT DR. | go 0.0 mi |

Arthur Home - (217) 543-2103

423 S Eberhardt Dr, Arthur, IL 61911
Total Travel Estimate : 34.02 miles - about 44 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> <i>Sheila McClure</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <input type="checkbox"/> C. Date of Delivery <i>Sheila McClure</i> <input type="checkbox"/> <i>4-28-11</i></p>
<p>1. Article Addressed to:</p> <p>Administrator Liberty Village 1 Park Lane West Clinton, IL 61727</p>	<p>D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p> <p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service)</p>	<p>7009 2250 0003 2946 3491</p>

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Clinton, IL













61727

20.80 miles - about 28 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn LEFT onto US-51-BR N / N WATER ST. Continue to follow US-51-BR N. | go 2.8 mi |
|   | 5. US-51-BR N becomes US-51 N. | go 15.4 mi |
|   | 6. Turn RIGHT onto 950 E / US-51-BR. Continue to follow US-51-BR. | go 1.4 mi |
|  | 7. Turn RIGHT onto W VAN BUREN ST / IL-54 W / IL-10 / IL-54. Continue to follow IL-54 W. | go 0.8 mi |
|  | 8. Turn RIGHT onto S ISABELLA ST. | go 0.0 mi |
|  | 9. Welcome to CLINTON, IL 61727. | go 0.0 mi |

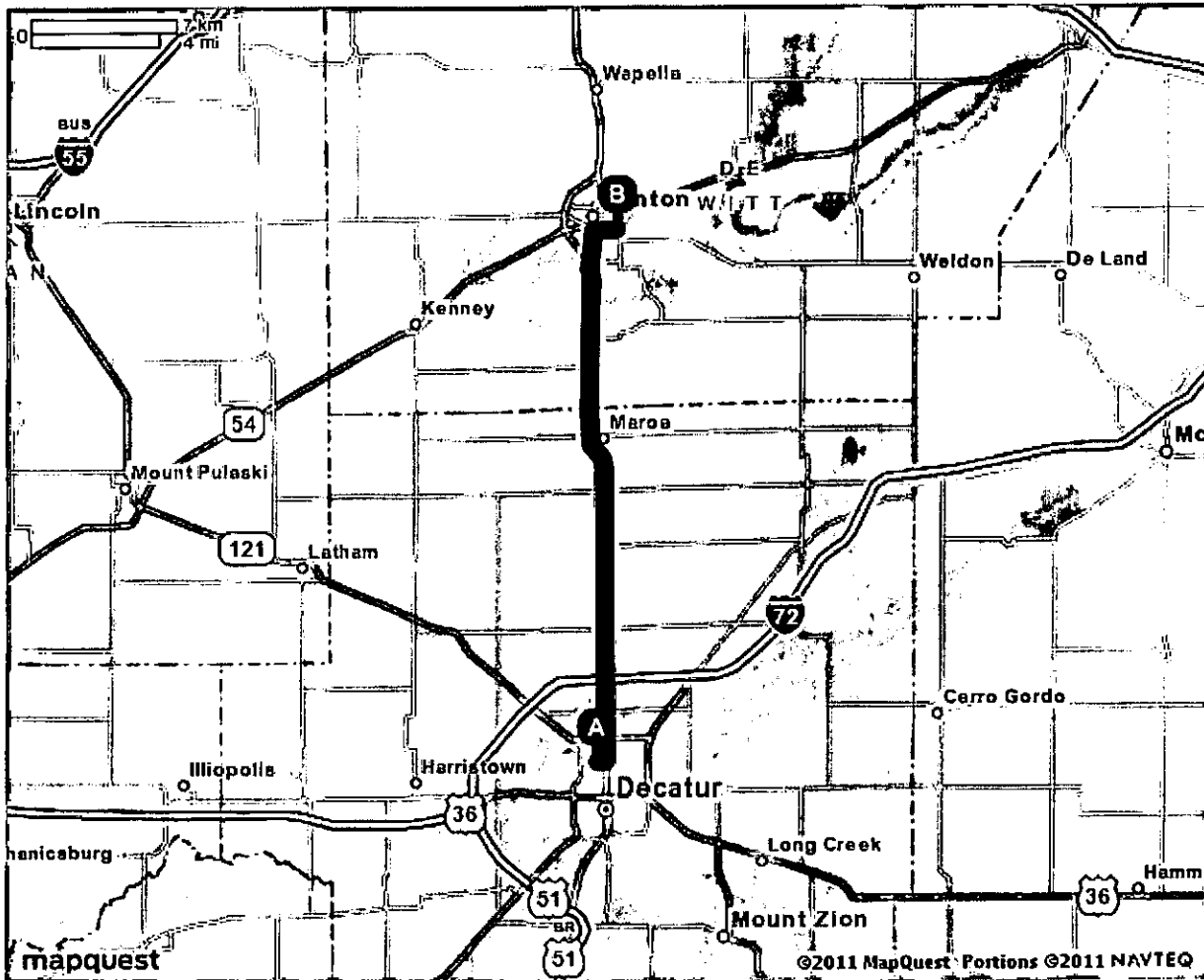
Appendix 70



Clinton, IL 61727

Total Travel Estimate : 20.80 miles - about 28 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p><i>* Marcella Tesh</i></p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p><i>MARCELLA TESH</i> <i>4-28-11</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>1. Article Addressed to:</p> <p>Administrator Christian Nursing Home 1507 7th St. Lincoln, IL 62656</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number 7009 2250 0003 2946 3521 <small>(Transfer from service label)</small></p>		

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Domestic Return Receipt

102595-02-M-1540

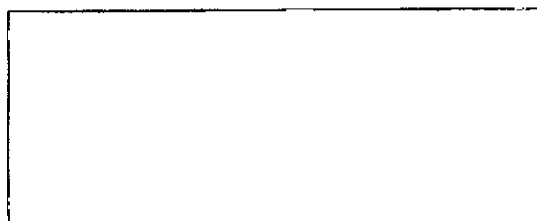
MAPQUEST.

Trip to Christian Village











1507 7th St, Lincoln, IL 62656 - (217) 735-4500

33.85 miles - about 50 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|---|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.2 mi |
|  | 3. Turn LEFT onto W MCKINLEY AVE. | go 0.2 mi |
|  | 4. Turn RIGHT onto N MONROE ST. | go 0.5 mi |
|  |  5. Turn LEFT onto IL-121 N / IL-48 S. Continue to follow IL-121 N. | go 31.3 mi |
|  | 6. Turn LEFT onto N LOGAN ST / I-55-BL. | go 0.6 mi |
|  | 7. Turn SLIGHT RIGHT onto I-55-BL / 5TH ST. | go 0.9 mi |
|  | 8. Turn RIGHT onto S MAIN ST. | go 0.1 mi |
|  | 9. Turn LEFT onto 7TH ST. | go 0.0 mi |

END

10. 1507 7TH ST is on the LEFT.

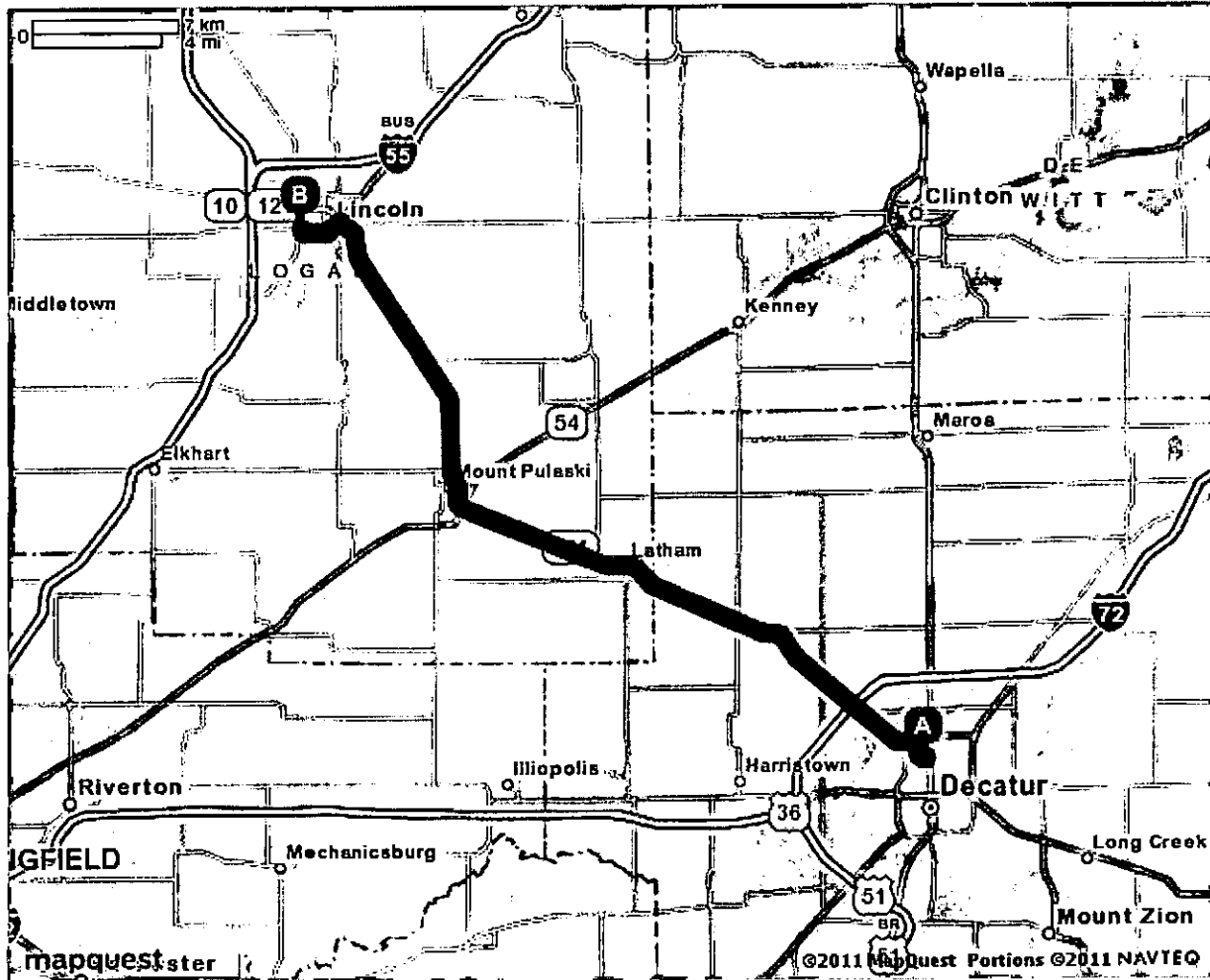
go 0.0 mi



Christian Village - (217) 735-4500
1507 7th St, Lincoln, IL 62656

Total Travel Estimate : 33.85 miles - about 50 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature X <i>Carol Goodman</i> <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee	
1. Article Addressed to: Michelle Boyer-Eyrse Maple Ridge Care Center 2202 N. Kickapoo Lincoln, IL 62656	B. Received by (Printed Name) <i>A Goodman</i>	C. Date of Delivery <i>4-28-11</i>
2. Article Number (Transfer from service label)	D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No 3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D. 4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
7009 2250 0003 2946 3536		

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

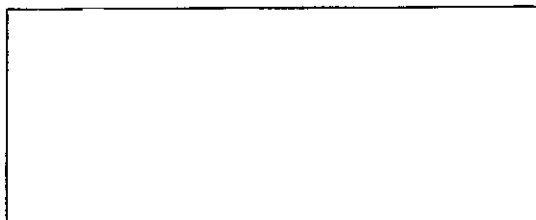
Trip to Maple Ridge Care Center

2202 N Kickapoo St, Lincoln, IL 62656 -

(217) 735-1538

33.20 miles - about 46 minutes

Notes



A Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.2 mi



3. Turn **LEFT** onto **W MCKINLEY AVE.**

go 0.2 mi



4. Turn **RIGHT** onto **N MONROE ST.**

go 0.5 mi



5. Turn **LEFT** onto **IL-121 N / IL-48 S**. Continue to follow **IL-121 N.**

go 31.1 mi



6. Turn **RIGHT** onto **N KICKAPOO ST / I-55-BL.**

go 1.2 mi



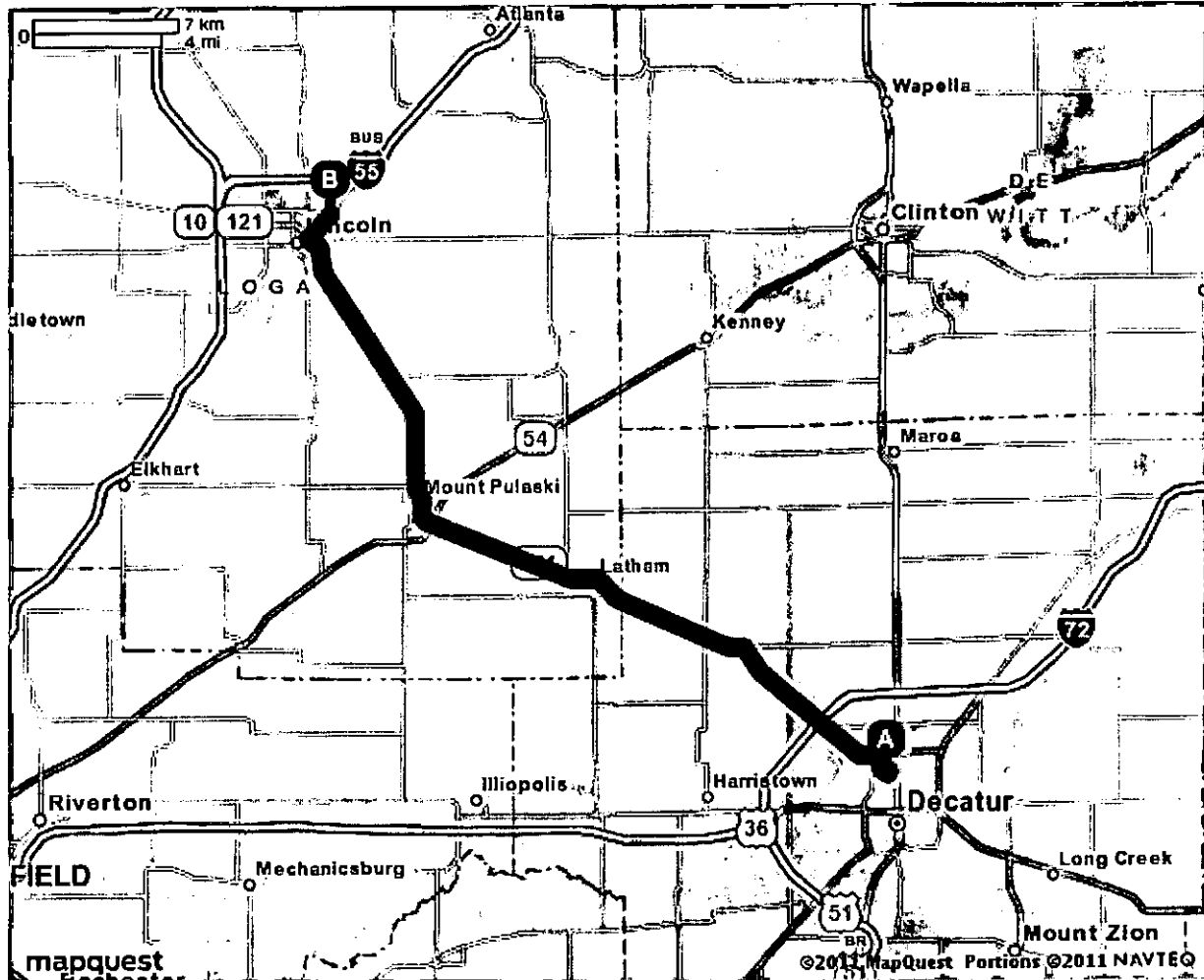
7. **2202 N KICKAPOO ST** is on the **RIGHT.**

go 0.0 mi

B Maple Ridge Care Center - (217) 735-1538 2202 N Kickapoo St, Lincoln, IL 62656

Total Travel Estimate : 33.20 miles - about 46 minutes

Route Map [Hide](#)



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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature x <i>Susan M. Boyd</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: Frank Shepke St. Clara's Manor 200 5th St. Lincoln, IL 62656	B. Received by (Printed Name) <i>Susan M. Boyd</i>	C. Date of Delivery <i>4/28/11</i>
2. Article Number (Transfer from service label)	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
	3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
	7009 2250 0003 2946 3545	

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



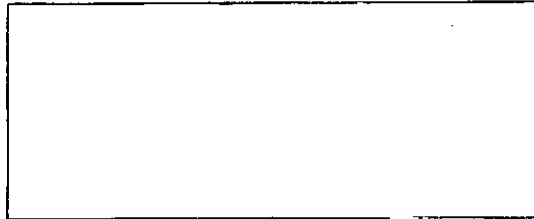
MAPQUEST.

Trip to St Clara's Manor Inc










200 5th St, Lincoln, IL 62656 - (217) 735-1507

32.88 miles - about 47 minutes

Notes



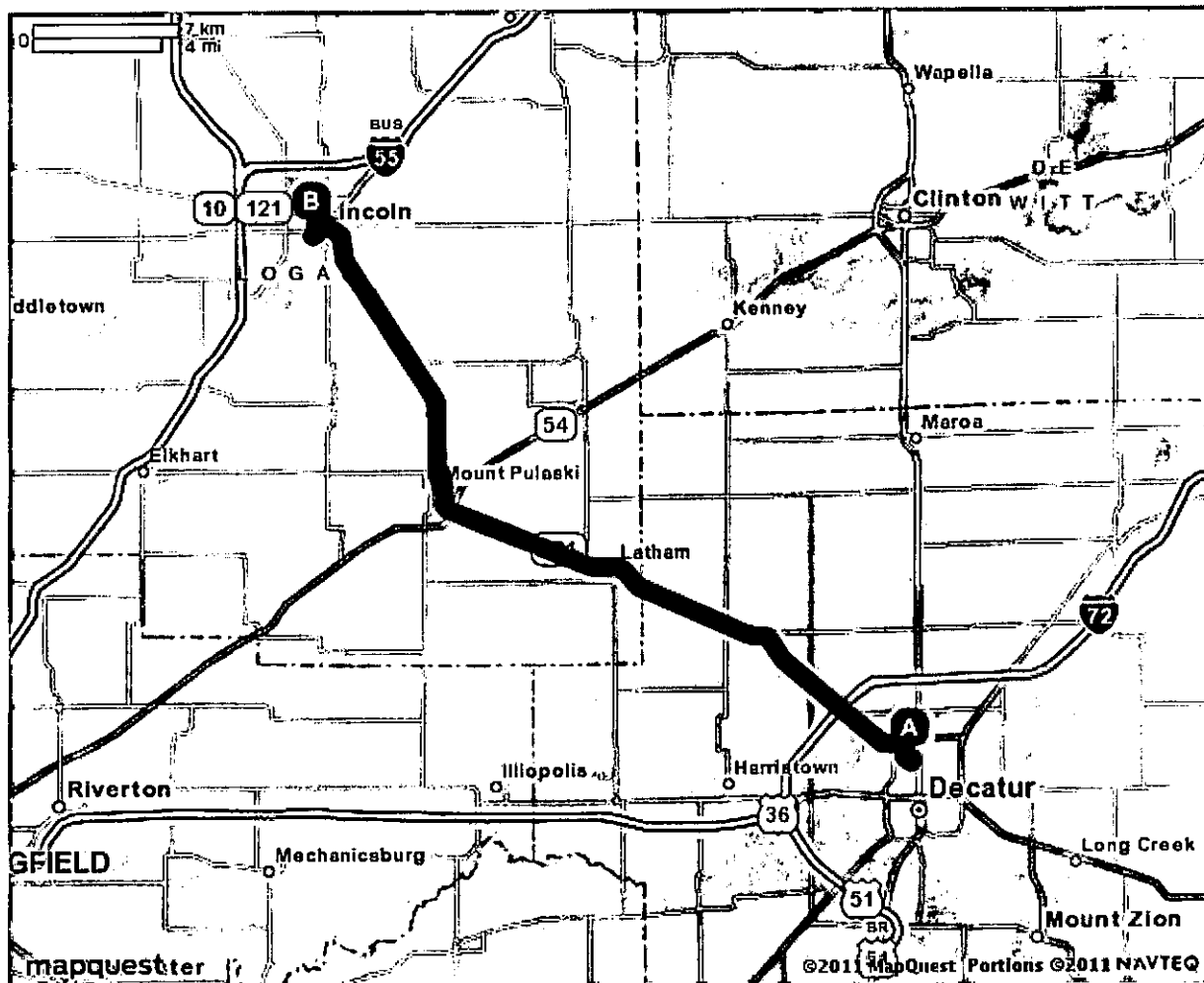
A Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.2 mi |
|  | 3. Turn LEFT onto W MCKINLEY AVE. | go 0.2 mi |
|  | 4. Turn RIGHT onto N MONROE ST. | go 0.5 mi |
|   | 5. Turn LEFT onto IL-121 N / IL-48 S. Continue to follow IL-121 N. | go 31.3 mi |
|  | 6. Turn LEFT onto N LOGAN ST / I-55-BL. | go 0.6 mi |
|  | 7. Turn SLIGHT RIGHT onto I-55-BL / 5TH ST. | go 0.1 mi |
|  | 8. 200 5TH ST. | go 0.0 mi |

B St Clara's Manor Inc - (217) 735-1507 200 5th St, Lincoln, IL 62656

Total Travel Estimate : 32.88 miles - about 47 minutes

Route Map [Hide](#)



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- 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:
 Jo Hilliard
 Vonderlieth Living Center
 1120 Topper Dr.
 Mt. Pulaski, IL 62548

2. Article Number
 (Transfer from service label)

7009 2250 0003 2946 3552

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X K Fletcher Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
K. Fletcher *4/27/11*

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

3. Service Type
 Certified Mail Express Mail *This was a letter only*
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes



MAPQUEST.

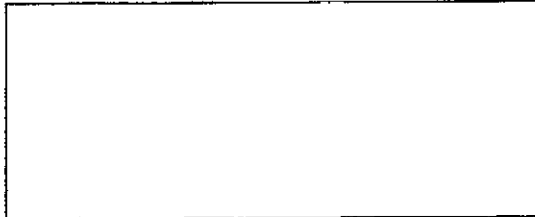
Trip to Vonderlieth Living Center

1120 N Topper Dr, Mt Pulaski, IL 62548 -

(217) 792-3218

21.68 miles - about 29 minutes

Notes



A Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going EAST on N EDWARD ST toward N UNION ST.

go 0.0 mi



2. Turn LEFT onto N UNION ST.

go 0.2 mi



3. Turn LEFT onto W MCKINLEY AVE.

go 0.2 mi



4. Turn RIGHT onto N MONROE ST.

go 0.5 mi



5. Turn LEFT onto IL-121 N / IL-48 S. Continue to follow IL-121 N.

go 20.7 mi



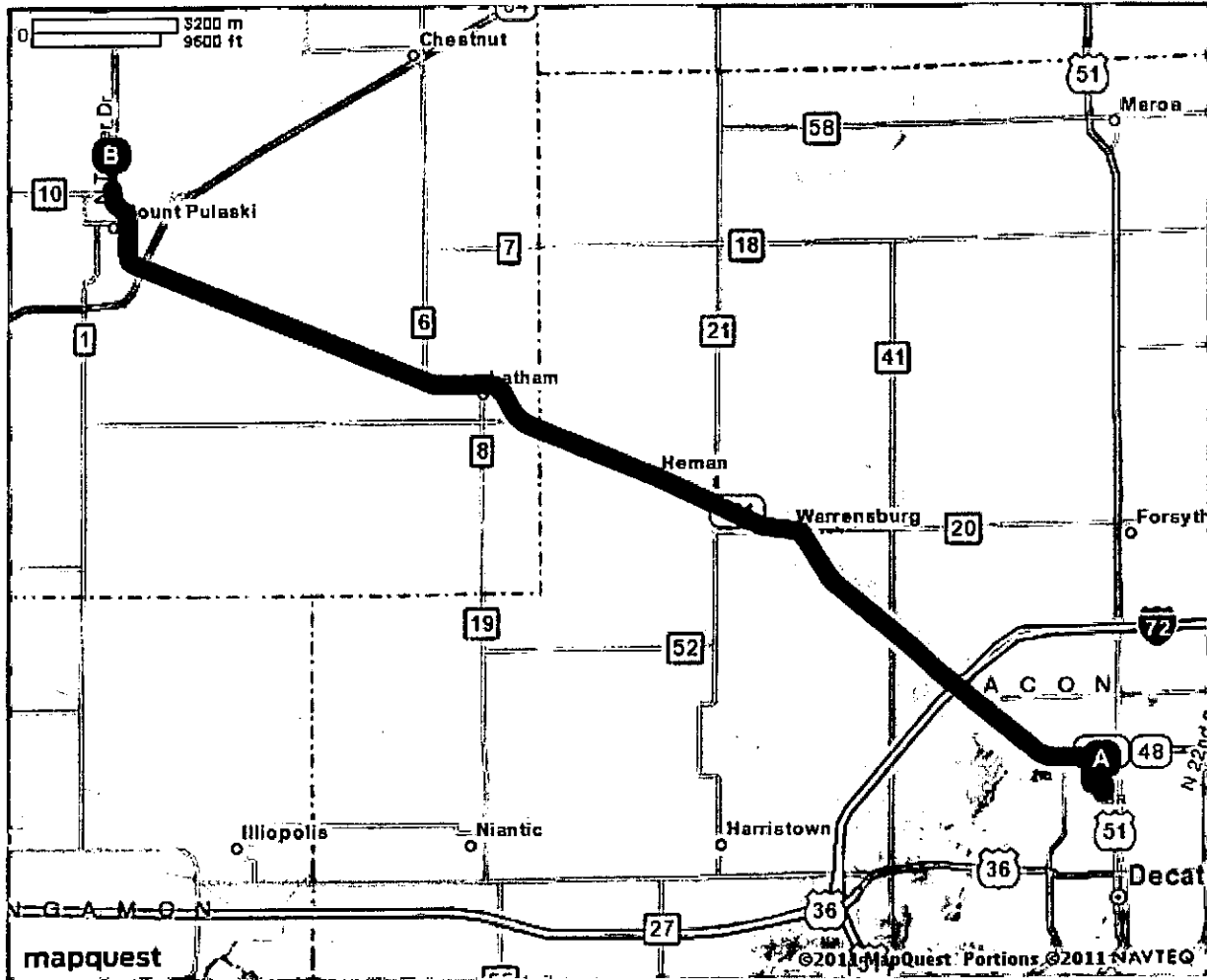
6. 1120 N TOPPER DR is on the LEFT.

go 0.0 mi

B Vonderlieth Living Center - (217) 792-3218 1120 N Topper Dr, Mt Pulaski, IL 62548

Total Travel Estimate : 21.68 miles - about 29 minutes

Route Map [Hide](#)



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- 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:

Shannon Moore
Shelbyville Rehab & Health Center
2116 S. 3rd Dr.
Shelbyville, IL 62565

COMPLETE THIS SECTION ON DELIVERY

A. Signature

Shannon Moore

Agent

Addressee

B. Received by (Printed Name)

Shannon Moore

C. Date of Delivery

4-28-11

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)

7009 2250 0003 2946 3569

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Shelbyville Health Care Center

2116 W South 3rd St, Shelbyville, IL 62565
 - (217) 774-2128
 38.46 miles - about 52 minutes

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|--|---|------------|
| | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
| | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
| | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
| | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. | go 1.5 mi |
| | 5. Turn LEFT onto US-36 / E ELDORADO ST. Continue to follow US-36 E. | go 8.2 mi |
| | 6. Turn RIGHT onto CR-57 / 2130 E / 85TH ST / DALTON CITY RD. Continue to follow CR-57. | go 6.0 mi |
| | 7. CR-57 becomes IL-128. | go 21.7 mi |
| | 8. Turn RIGHT onto W MAIN ST / IL-128 / IL-16 / 1300 N. | go 0.7 mi |
| | 9. Turn LEFT onto DACEY DR. | go 0.1 mi |



10. Turn LEFT onto W SOUTH 3RD ST.

go 0.0 mi



11. 2116 W SOUTH 3RD ST is on the RIGHT.

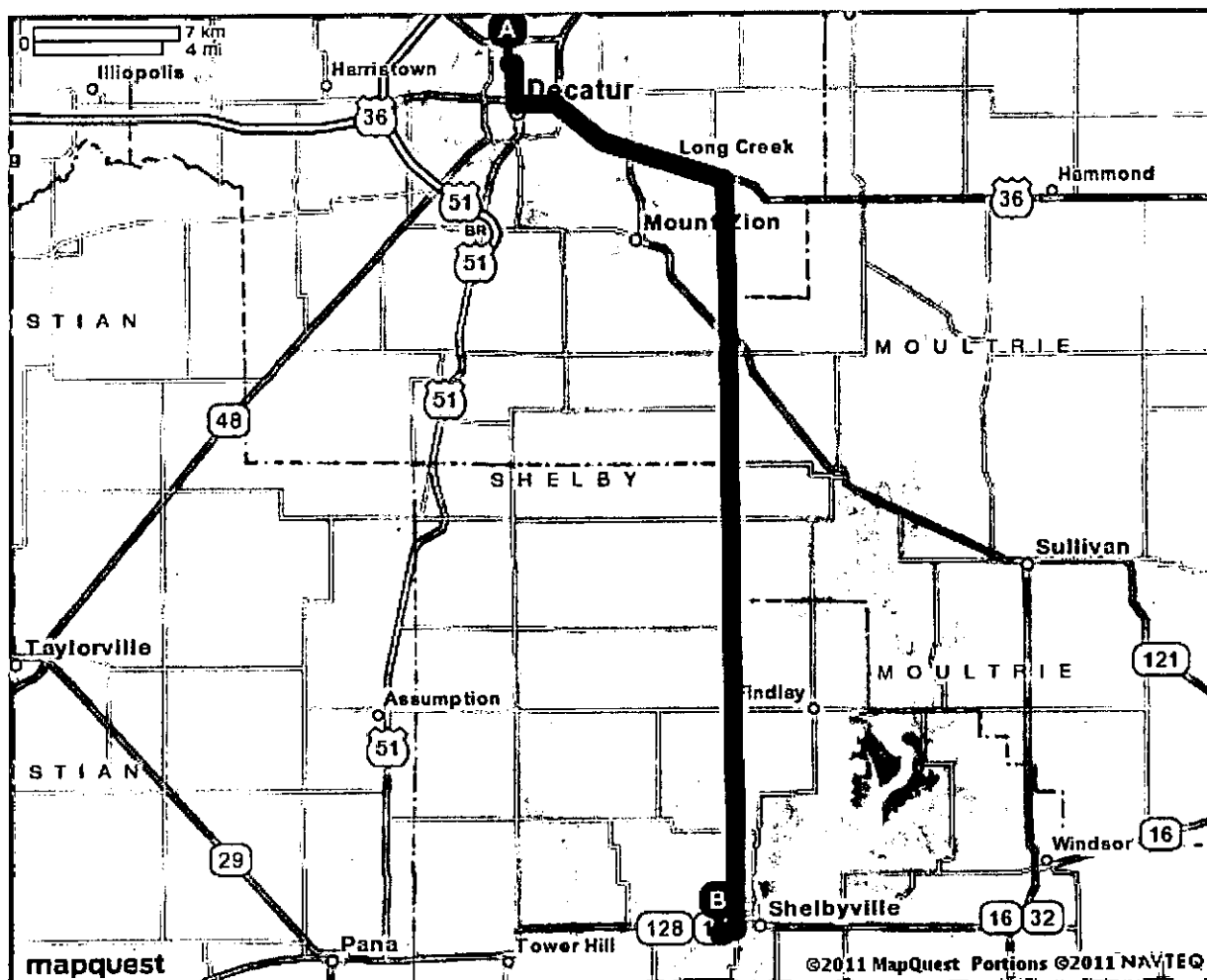
go 0.0 mi



Shelbyville Health Care Center - (217) 774-2128
2116 W South 3rd St, Shelbyville, IL 62565

Total Travel Estimate : 38.46 miles - about 52 minutes

Route Map [Hide](#)



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- 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
Shelbyville Manor

N. Route 128
Shelbyville, IL 62565

→ Please use correct address:

1111WN124b

COMPLETE THIS SECTION ON DELIVERY

A. Signature

[Handwritten Signature]

Agent

Addressee

B. Received by (Printed Name)

Wendell Lee

C. Date of Delivery

4/28/11

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)

7009 2250 0003 2946 3415

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

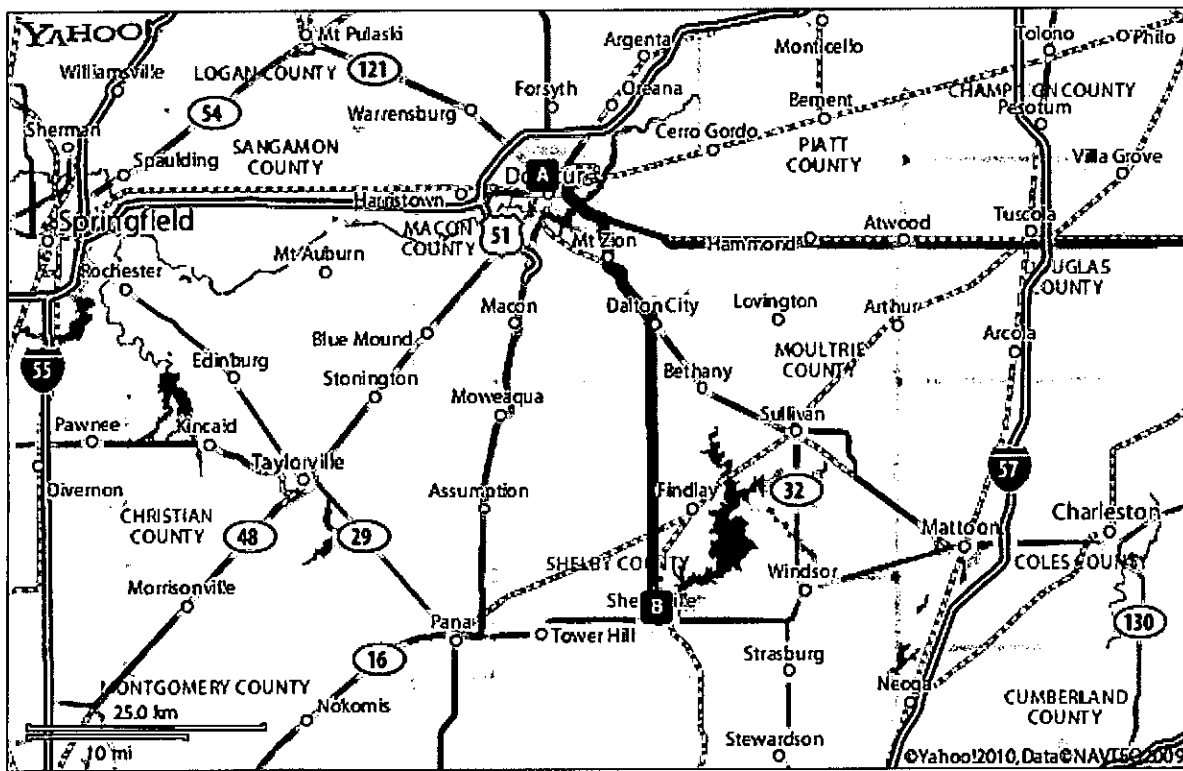
Directions to 799 W North 12th St, Shelbyville, IL 62565



Total Time: 54 mins, Total Distance: 36.13 mi

	Distance
A 1. Start at 2300 N EDWARD ST, DECATUR going toward N UNION ST	go 30 ft
2. Turn L on N UNION ST	go 213 ft
3. Turn R on W KENWOOD AVE	go 0.16 mi
4. Turn R on N MAIN ST(US-51-BR S)	go 0.37 mi
5. Turn L on E GARFIELD AVE	go 1.5 mi
6. Turn R on N 21ST ST	go 0.14 mi
7. Turn L on E OLIVE ST	go 410 ft
8. Bear R on N 22ND ST(IL-121)	go 0.28 mi
9. Continue to follow IL-121	go 0.82 mi
10. Bear L on US-36	go 3.09 mi
11. Turn R on S MOUNT ZION RD(IL-121)	go 318 ft
12. Continue to follow IL-121	go 8.54 mi
13. Turn R on IL-128	go 20.79 mi
14. Turn L on W NORTH 12TH ST	go 0.25 mi
B 15. Arrive at 799 W NORTH 12TH ST, SHELBYVILLE, on the L	

Time: 54 mins, Distance: 36.13 mi



When using any driving directions or map, it's a good idea to do a reality check and make sure the road still exists, watch out for construction, and follow all traffic safety precautions. This is only to be used as an aid in planning.

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
Hawthorne Inn
SW Park St.
Clinton, IL 61727

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
Shelia McCh...

B. Received by (Printed Name) C. Date of Delivery
Shelia McCh... *7-28-11*

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 7009 2250 0003 2946 3484
(Transfer from service label)

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



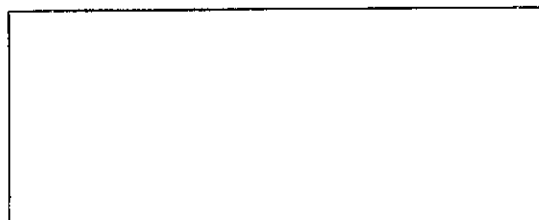
MAPQUEST.

Trip to Hawthorne Inn












1 Park Ln W, Clinton, IL 61727 - (217) 935-8500

20.03 miles - about 26 minutes

Notes

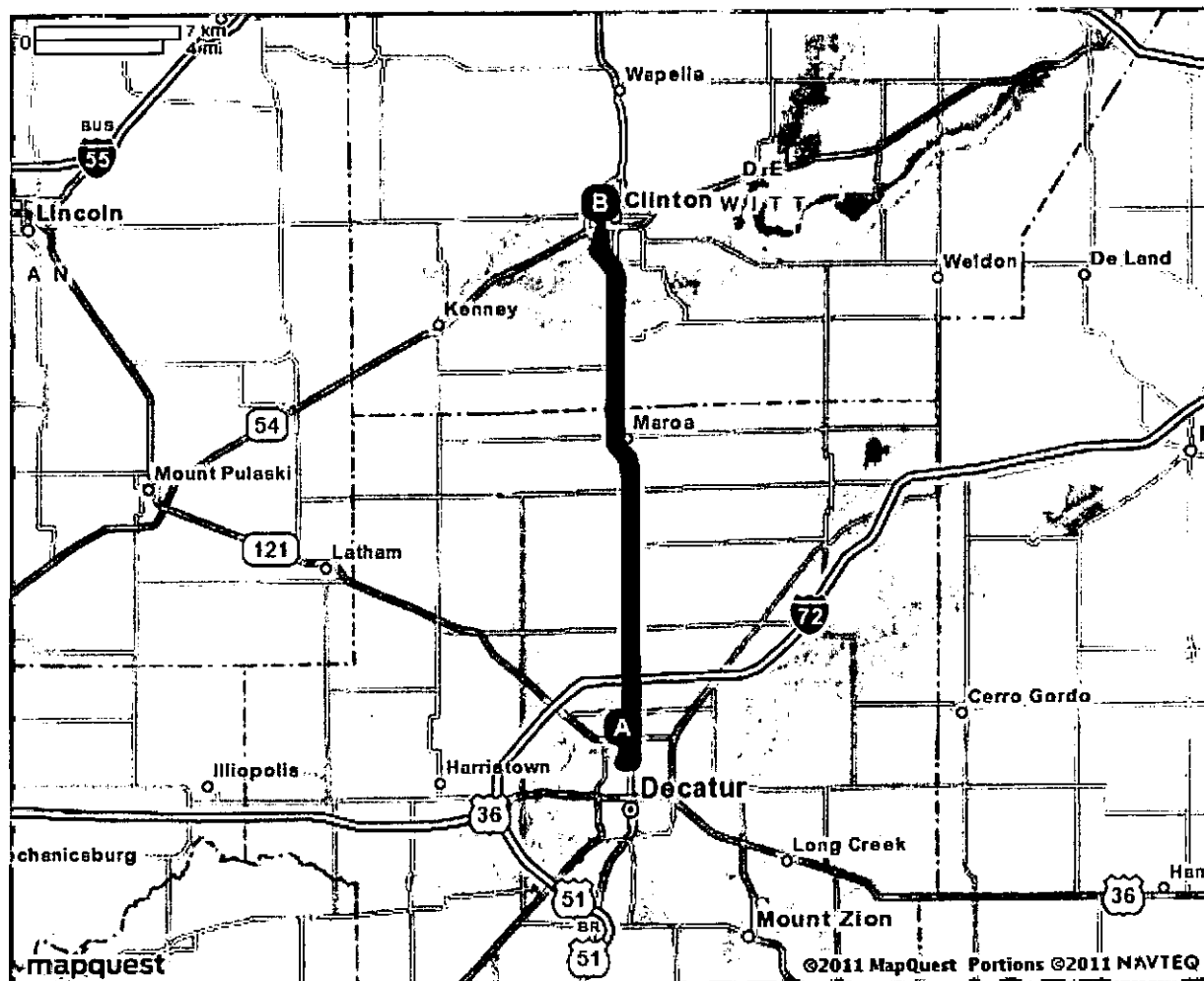


Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn LEFT onto US-51-BR N / N WATER ST. Continue to follow US-51-BR N. | go 2.8 mi |
|   | 5. US-51-BR N becomes US-51 N. | go 16.4 mi |
|  | 6. Turn RIGHT onto KLEEMAN DR. | go 0.2 mi |
|  | 7. Turn LEFT onto ILLINI DR. | go 0.4 mi |
|  | 8. Turn RIGHT onto PARK LN W. | go 0.0 mi |
|  | 9. 1 PARK LN W is on the RIGHT. | go 0.0 mi |

B Hawthorne Inn - (217) 935-8500
1 Park Ln W, Clinton, IL 61727
Total Travel Estimate : 20.03 miles - about 26 minutes

Route Map [Hide](#)



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1. Article Addressed to:

Administrator
Farmer City Rehab & Healthcare
404 Brookview Dr.
Farmer City, IL 61842

2. Article Number
(Transfer from service label)

7009 2250 0003 2946 3507

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

M. Hirsbrunner

Agent

Addressee

B. Received by (Printed Name)

Mary Hirsbrunner

C. Date of Delivery

1/28/11

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

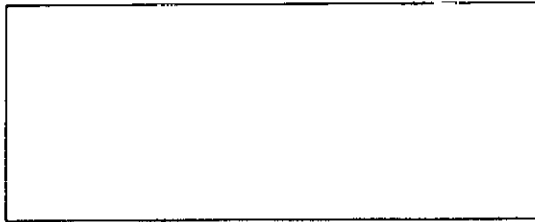


MAPQUEST.












Trip to Farmer City Rehab-Health Care

404 Brookview Dr, Farmer City, IL 61842 -
 (309) 928-2118
 37.78 miles - about 48 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn LEFT onto US-51-BR N / N WATER ST. Continue to follow US-51-BR N. | go 2.5 mi |
|   | 5. Merge onto I-72 E toward CHAMPAIGN. | go 14.6 mi |
|  | 6. Take the IL-48 exit, EXIT 156 , toward WELDON / CISCO. | go 0.3 mi |
|  | 7. Take the exit on the LEFT toward WELDON. | go 0.0 mi |
|   | 8. Turn LEFT onto IL-48 N. | go 13.5 mi |
| | 9. Turn RIGHT onto 1175 N / IL-54. Continue to follow IL- | go 5.8 mi |



54.



10. Turn LEFT onto S JOHN ST.

go 0.3 mi



11. Turn LEFT onto W HIGH ST.

go 0.2 mi



12. Turn RIGHT onto BROOKVIEW DR.

go 0.1 mi



13. 404 BROOKVIEW DR is on the LEFT.

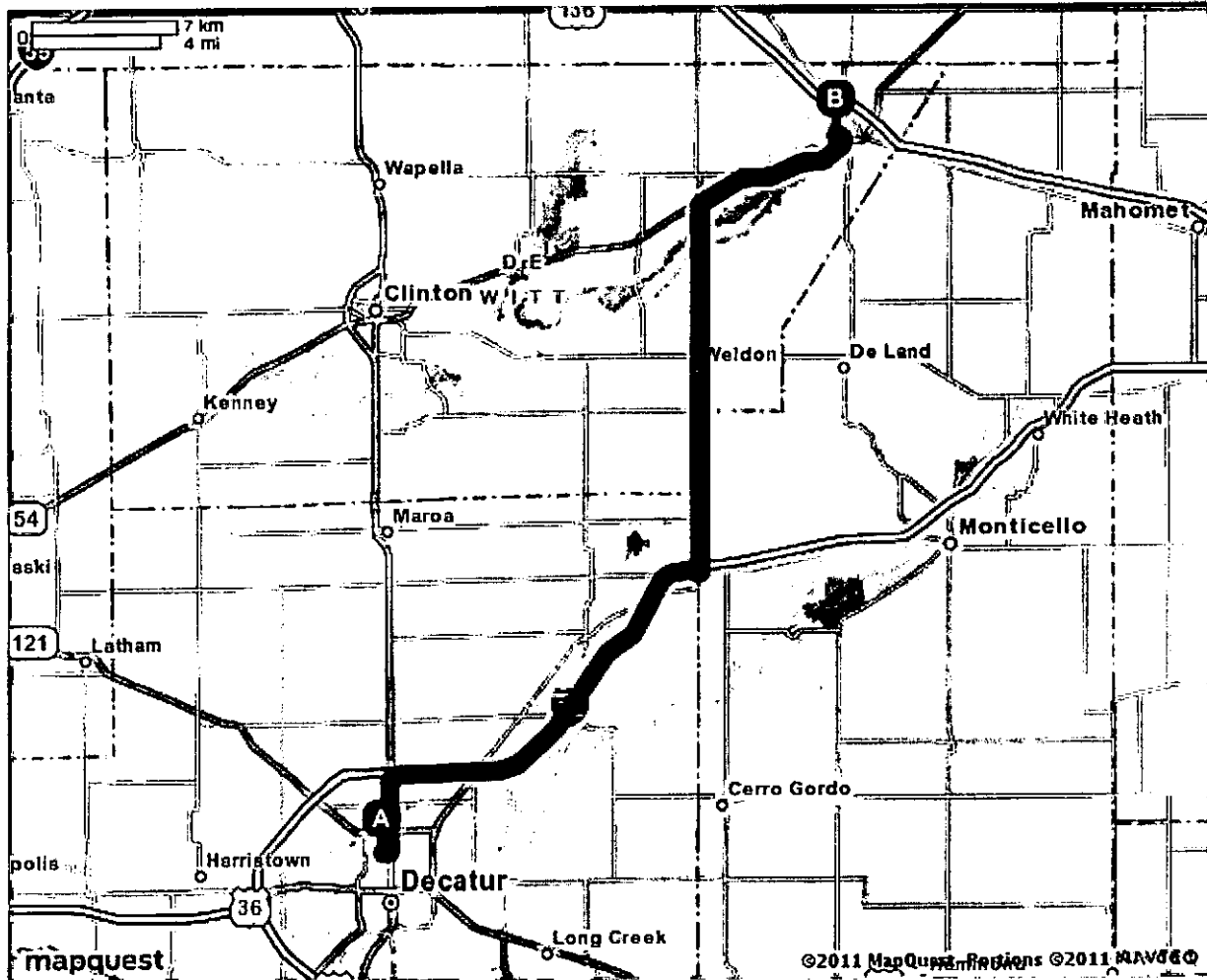
go 0.0 mi



Farmer City Rehab-Health Care - (309) 928-2118
404 Brookview Dr, Farmer City, IL 61842

Total Travel Estimate : 37.78 miles - about 48 minutes

Route Map [Hide](#)



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- 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
Taylorville Care Center
600 S. Houston
Taylorville, IL 62568

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Agent
 Addressee
X Rhonda Baker

B. Received by (Printed Name)
Rhonda Baker

C. Date of Delivery
4/28/11

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)

7009 2250 0003 2946 3477



MAPQUEST.

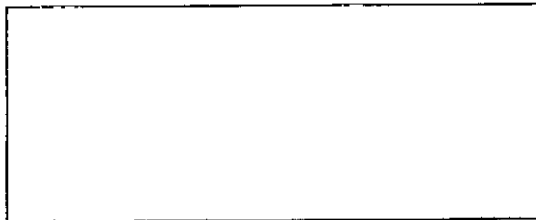
Trip to Taylorville Care Center

600 S Houston St, Taylorville, IL 62568 -













(217) 824-9636

32.42 miles - about 49 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|---|--|------------|
|  | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
|  | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
|  | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
|   | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 3.0 mi |
|  | 5. Turn SLIGHT RIGHT. | go 0.3 mi |
|   | 6. Turn SLIGHT RIGHT onto W SOUTHSIDE DR / IL-105 W. | go 0.8 mi |
|   | 7. Turn LEFT onto IL-48 S. | go 26.8 mi |
|  | 8. Turn RIGHT onto S SHUMWAY ST. | go 0.7 mi |
|  | 9. Turn LEFT onto W PRAIRIE ST. | go 0.5 mi |



10. Turn RIGHT onto S HOUSTON ST.

go 0.1 mi



11. 600 S HOUSTON ST is on the RIGHT.

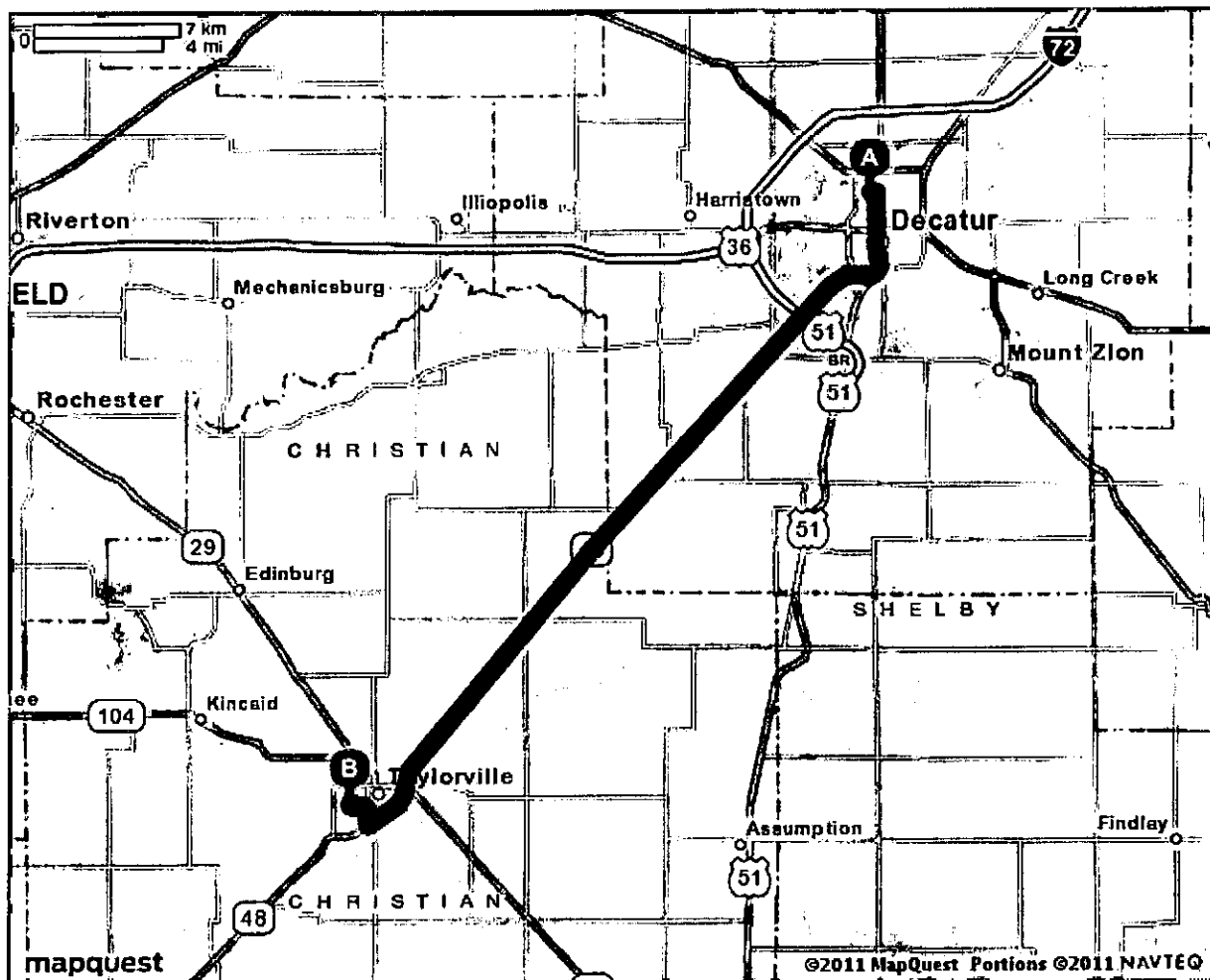
go 0.0 mi



Taylorville Care Center - (217) 824-9636
600 S Houston St, Taylorville, IL 62568

Total Travel Estimate : 32.42 miles - about 49 minutes

Route Map [Hide](#)



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- 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
Leroy Manor
509 Buck Rd.
LeRoy, IL 61752

2. Article Number

(Transfer from service)

7009 2250 0003 2946 3248

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

Julia Smith

Agent

Addressee

B. Received by (Printed Name)

Julia Smith

C. Date of Delivery

4-28-11

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



MAPQUEST.

Trip to Le Roy Manor

509 S Buck Rd, Le Roy, IL 61752 - (309)

962-5000

42.07 miles - about 53 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121
2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.0 mi



3. Turn **RIGHT** onto **W KENWOOD AVE.**

go 0.2 mi



4. Turn **LEFT** onto **US-51-BR N / N WATER ST.** Continue to follow **US-51-BR N.**

go 2.5 mi



5. Merge onto **I-72 E** toward **CHAMPAIGN.**

go 14.6 mi



6. Take the **IL-48** exit, **EXIT 156**, toward **WELDON / CISCO.**

go 0.3 mi



7. Take the exit on the **LEFT** toward **WELDON.**

go 0.0 mi



8. Turn **LEFT** onto **IL-48 N.**

go 13.5 mi



9. **IL-48 N** becomes **2100 E / CR-2.**

go 1.0 mi

10. Turn **LEFT** onto **CR-10**.

go 0.1 mi

11. Turn **RIGHT** onto **2100 E / CR-8**.

go 4.0 mi

12. **2100 E / CR-8** becomes **CR-21**.

go 4.4 mi

13. Turn **RIGHT** onto **CR-21 / N 2600 EAST RD / S CHESTNUT ST**. Continue to follow **CR-21 / S CHESTNUT ST**.

go 0.7 mi

14. Turn **LEFT** onto **E VINE ST**.

go 0.3 mi

15. Turn **LEFT** onto **S BUCK RD**.

go 0.1 mi

16. **509 S BUCK RD** is on the **LEFT**.

go 0.0 mi

**Le Roy Manor - (309) 962-5000**
509 S Buck Rd, Le Roy, IL 61752

Total Travel Estimate : 42.07 miles - about 53 minutes

Route Map [Hide](#)

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. Theresa Rutherford, COO
 St. Mary's Hospital
 1000 E. Lakeshore Dr.
 Decatur, IL 62521

2. Article Number

(Transfer from service label)

7009 2250 0003 2946 3347

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-15

COMPLETE THIS SECTION ON DELIVERY

A. Signature

Lloyd E. Brumett Agent
 Address

B. Received by (Printed Name)

C. Date of Delivery

LOYD E BRUMETT 5-10-11

- 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



MAPQUEST.

Trip to St Mary's Hospital

1800 E Lake Shore Dr, Decatur, IL 62521 -
(217) 464-2966

4.21 miles - about 10 minutes

Notes

Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526



1. Start out going **EAST** on **N EDWARD ST** toward **N UNION ST.**

go 0.0 mi



2. Turn **LEFT** onto **N UNION ST.**

go 0.0 mi



3. Turn **RIGHT** onto **W KENWOOD AVE.**

go 0.2 mi



4. Turn **RIGHT** onto **US-51-BR S / N MAIN ST.**

go 2.6 mi



5. Merge onto **IL-105 E / E LAKE SHORE DR.**

go 1.4 mi



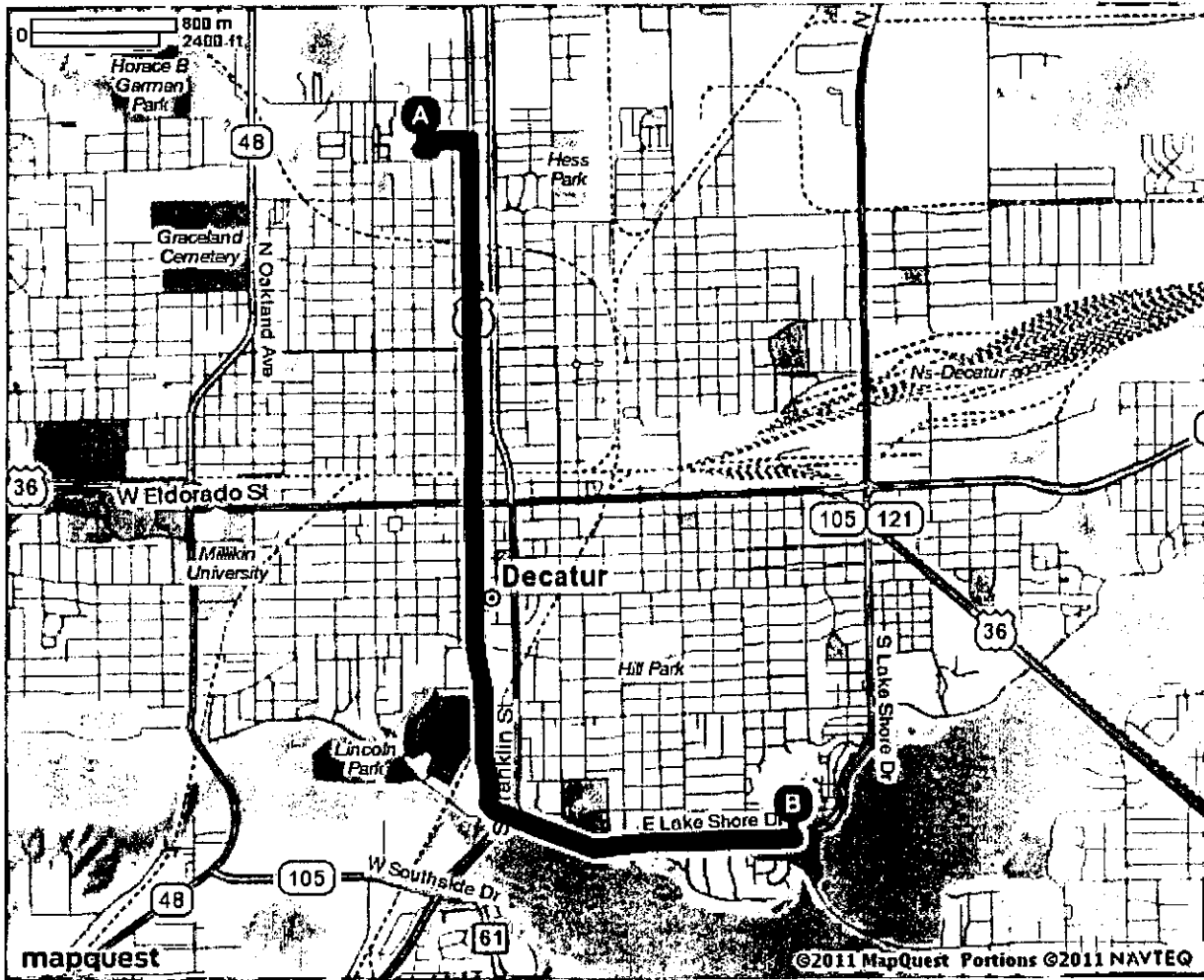
6. 1800 E LAKE SHORE DR is on the **LEFT.**

go 0.0 mi

St Mary's Hospital - (217) 464-2966 1800 E Lake Shore Dr, Decatur, IL 62521

Total Travel Estimate : 4.21 miles - about 10 minutes

Route Map [Hide](#)



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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:

Chief Nursing Officer
 Taylorville Memorial Hospital
 201 E. Pleasant
 Taylorville, IL 62568

COMPLETE THIS SECTION ON DELIVERY

A. Signature

x Debra E. Hodson Agent Addressee

B. Received by (Printed Name)

Debra E. Hodson

C. Date of Delivery

5-6-11

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)

7009 2250 0003 2946 3330

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540



MAPQUEST.

Trip to Taylorville Memorial Hospital

201 E Pleasant St, Taylorville, IL 62568 -
(217) 824-3331

30.28 miles - about 47 minutes

Notes



Decatur Memorial Hospital - (217) 876-8121 2300 N Edward St, Decatur, IL 62526

- | | | |
|--|---|------------|
| | 1. Start out going EAST on N EDWARD ST toward N UNION ST. | go 0.0 mi |
| | 2. Turn LEFT onto N UNION ST. | go 0.0 mi |
| | 3. Turn RIGHT onto W KENWOOD AVE. | go 0.2 mi |
| | 4. Turn RIGHT onto US-51-BR S / N MAIN ST. Continue to follow US-51-BR S. | go 3.0 mi |
| | 5. Turn SLIGHT RIGHT. | go 0.3 mi |
| | 6. Turn SLIGHT RIGHT onto W SOUTHSIDE DR / IL-105 W. | go 0.8 mi |
| | 7. Turn LEFT onto IL-48 S. | go 24.7 mi |
| | 8. Turn RIGHT onto LINCOLN TRL. | go 0.2 mi |
| | 9. Turn RIGHT onto E PARK ST / IL-29 N. | go 0.9 mi |



10. Turn **RIGHT** onto **WALNUT ST / N WALNUT ST.**

go 0.1 mi



11. Turn **RIGHT** onto **E PLEASANT ST.**

go 0.0 mi



12. **201 E PLEASANT ST** is on the **LEFT.**

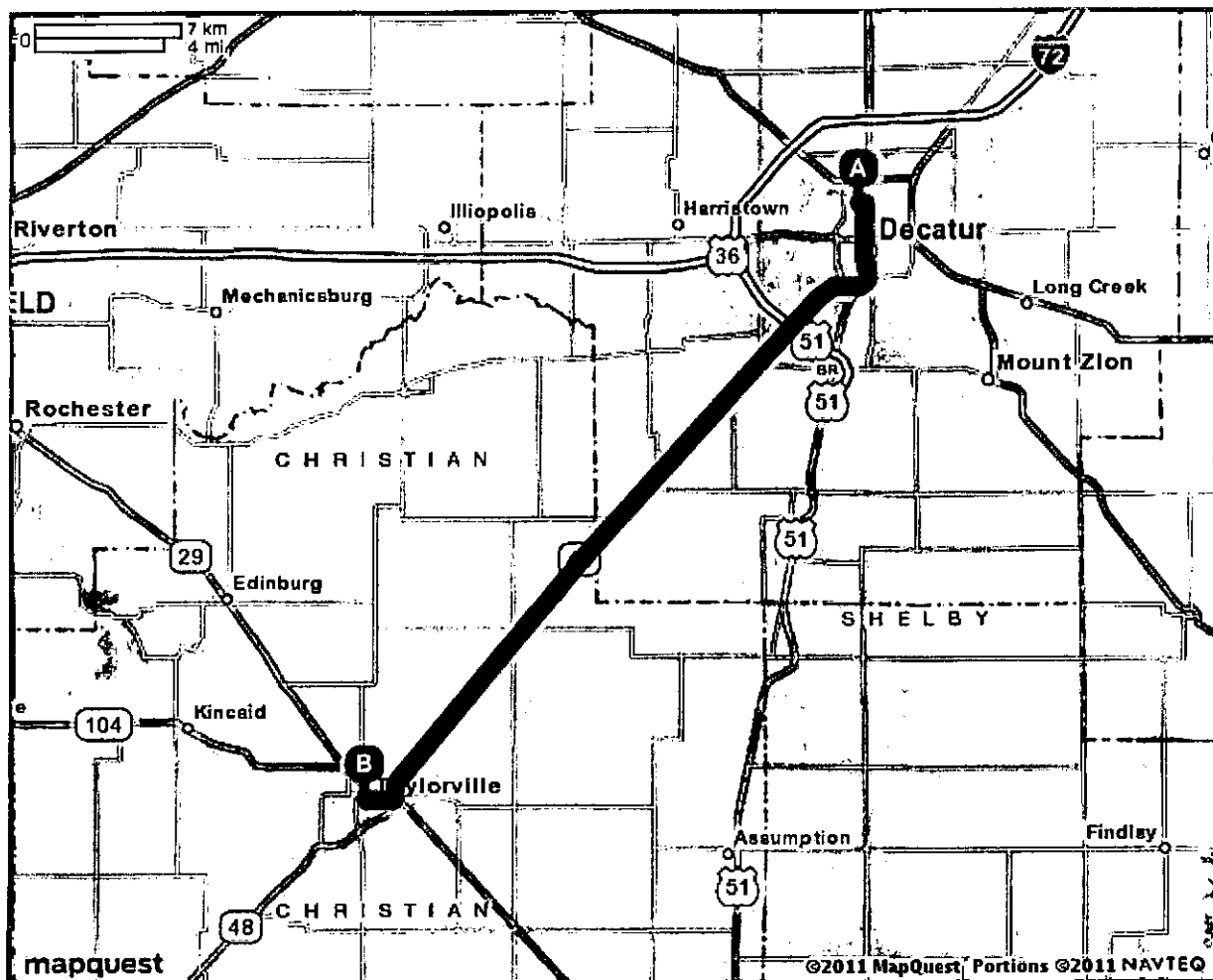
go 0.0 mi



Taylorville Memorial Hospital - (217) 824-3331
201 E Pleasant St, Taylorville, IL 62568

Total Travel Estimate : 30.28 miles - about 47 minutes

Route Map [Hide](#)



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Living Center

SKILLED CARE

180 West Imboden Drive Decatur, IL 62521

217.422.6464 Fax 217.422.6526 www.imbodencreek.com

May 9, 2011

Dear Linda,

Thank you for the notification regarding your skilled nursing facility closing. Imboden Creek Living Center is indeed a licensed skilled nursing facility, capable of providing care to a wide variety of individuals. Often times, it is the long term care facility's who have specific staff that spend much of their time at the hospital that are chosen as the most viable option for placement of these individuals. Imboden Creek would love the opportunity to serve any of these skilled residents who may need further care upon the discontinuation of your services. As a skilled facility, we have no specific limitations or conditions that restrict admissions.

Again, thank you for the notification. If we can be assistance during this time of transition, please feel free to contact me. We wish you well in your future endeavors.

Sincerely,

Molly A Carpenter, BA
Administrator



May 5, 2011

Linda Fahey
Decatur Memorial Hospital
2300 N. Edward St.
Decatur, IL 62526

Dear Ms. Fahey:

I would like to let you know how much we appreciate you contacting us in regards to you discontinuing your Skilled Nursing Services. Our facility is able to assist you at the time when you discontinue your services. At this time we have two available beds, but due to many of our Resident's plans for returning home, it is uncertain what our bed availability will be in mid June. Heritage Manor has no restrictions or limitations and able to handle your caseload without conditions, limitations or discrimination.

Thank you in advance for entrusting Heritage Manor with your Residents.

Sincerely,

Kayce Hanscel SSD
Social Service Director

Appendix 111

May 4, 2011

Linda Fahey, RN, MSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

Dear Ms. Fahey

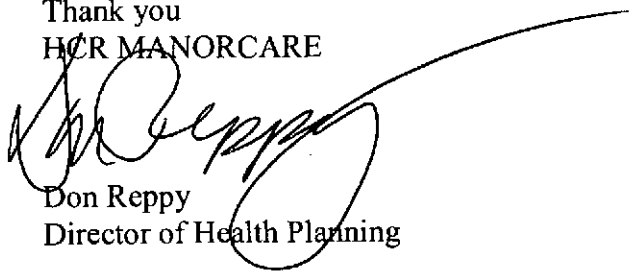
Thank you for your letter of April 26 to Rachel Cassella, Administrator of Heartland of Decatur.

HCR-ManorCare is in full support of your efforts to discontinue skilled nursing services. Heartland of Decatur has the capacity to accommodate the additional skilled nursing patients necessary to prevent any interruption of services in Decatur.

We expect that the impact of this discontinuation will be an increase in admissions to our facility and other skilled nursing centers in the area. Heartland of Decatur will admit these additional patients without conditions, limitations, or discrimination.

If we can be of any further assistance in this matter, please do not hesitate to contact me. We look forward to a continuing positive relationship.

Thank you
HCR MANORCARE


Don Reppy
Director of Health Planning



May 4, 2011

Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

Dear Ms. Fahey:

I see no adverse effect on my facility from your discontinuing your Skilled Nursing Service. Heritage is willing and able to absorb part of your caseload. Each resident must be prescreened by my staff for appropriateness of placement and to ascertain our ability to meet their individual needs.

Sincerely,

Nancy L. Pryor LNHA
Administrator

TAYLORVILLE CARE CENTER
600 S. HOUSTON
TAYLORVILLE, IL 62568
(217) 824-9636

May 2, 2011

Decatur Memorial Hospital
Linda Fahey, RN, MSN
2300 North Edward Street
Decatur, IL 62526

Regarding: Skilled Nursing Service

Dear Mrs. Fahey,

Please accept this letter as notice to you that Taylorville Care Center does have the capacity available to accommodate a portion of your skilled nursing caseload. We are also willing and able to absorb part of your caseload without conditions, limitations or discrimination.

If you have any questions, please contact me at (217) 824-9636.

Thank you for your attention to this notice.

Sincerely,

A handwritten signature in cursive script that reads "Rhonda Baker". The signature is written in black ink and is positioned above the typed name and title.

Rhonda Baker, Administrator
TAYLORVILLE CARE CENTER



1925 South Main
Bloomington, IL 61704
Phone: 309-829-4348
Fax: 309-827-4570

Bloomington
REHABILITATION &
HEALTH CARE CENTER

"Caring With a Hometown Touch"

April 28, 2011

Linda Fahey, RN MSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

Dear Linda,

This letter is in response to your letter dated April 26, 2011, requesting an impact statement and availability at our facility for your case load.

The submittal of your CON application to discontinue your Skilled Nursing Service will not have an adverse impact on our facility.

Our facility is willing and able to absorb your case load up to the number of beds we are licensed for. Our current open beds include 15 regular/general population. Our only limitation includes identified sex offenders

If you have any questions or we can help in any way, please contact me at 309-829-4348

Sincerely,

Janice Kindred,
Administrator
Bloomington Rehabilitation and Health Care Center

MOWEAQUA NURSING & RETIREMENT CENTER
525 South Macon Street
Moweaqua, IL 62550
(217) 768-3951

May 2, 2011

Linda Fahey, RN, MSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

RE: CON Application

Dear Ms. Fahey:

In response to your letter dated April 26, 2011, my facility has capacity available to handle your skilled caseload. Closing your unit would not have an impact on this facility.

Moweaqua Nursing Center is a licensed-skilled, 70 bed facility, by the Illinois Department of Public Health. We are Medicaid Certified and Private Pay and Private Insurance. We have our own in-house skilled therapy (Whitestar) and Medicare is billed for the therapy.

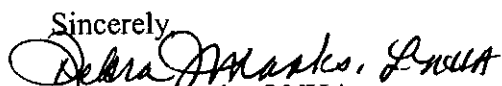
We are a small privately owned facility and we are fully staffed.

We have an independent living facility attached to our Nursing Facility so we have rehabilitated many residents and sent them back home. We also have rehabilitated Residents of Moweaqua and they have returned to their homes in the community.

Recently we contracted with Anthony McCormack, MD as our Medical Director and we use DMH as our lab.

Please feel free to give me a call if you have any questions or if I can be of further assistance.

Sincerely,


Debra J. Maaks, LNHA
Administrator



Shelbyville Manor

May 2, 2011

Linda Fahey, RN, MSN
Decatur Memorial Hospital
2300 North Edward Street
Decatur, Illinois 62526

Dear Ms. Fahey:

This letter is in response to your letter sent April 26, 2011, regarding the discontinuation of your Skilled Nursing Service. We have enjoyed a positive working relationship with Decatur Memorial Hospital for the last several years and look forward to working together in the future.

Shelbyville Manor is a skilled nursing facility that has been providing rehabilitative and extended care service to seniors in Shelbyville and the surrounding area since 1991. It would be a privilege to provide care to the residents of your Skilled Nursing Service, based on our ability to meet their care needs. Shelbyville Manor does not discriminate based on race, creed or color. The facility is Medicare/Medicaid certified. We accept insurance as well as private pay.

We anticipate the impact of the closure of your Skilled Nursing Service to be a positive one for Shelbyville Manor. It will provide the opportunity to serve even more seniors needing our specialized care.

Sincerely,

Alma P. Smart

Alma P. Smart

Marketing Director

169

April 28, 2011

Linda Fahey
Decatur Memorial Hospital
2300 N. Edward St.
Decatur, IL 62526

Dear Ms. Fahey:

Thank you for your April 26th letter notifying us of your intent to discontinue Skilled Nursing Services. Our facility will not be negatively impacted by this decision. Currently, we are fortunate to have very few empty beds, however, that is not always the case. In such times that we have open beds, we are more than willing to accept referrals.

I must add, Ms. Fahey, that I am very grateful to DMH for the effort made by those performing discharging and the nurses on the halls who give report. We have had several referrals recently and the process has been so smooth, any questions we have are quickly answered, and the nurse's report comes without fail. Please, if you can, pass on our gratitude in making what is sometimes a difficult adjustment for a resident and their family a successful joint process. We are always pleased to have a DMH referral.

Respectfully,



Jo Hilliard
Administrator



Prairie Rose
HEALTH CARE CENTER
"Caring with a Hometown Touch"

900 South Chestnut
Pana, Illinois 62557
Phone: (217) 562-3996
Fax: (217) 562-4005
www.petersenhealthcare.net

April 28, 2011

Linda Fahey, RN MSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

Dear Linda,

This letter is in response to your letter dated April 26, 2011, requesting an impact statement and availability at our facility for your case load.

The submittal of your CON application to discontinue your Skilled Nursing Service will not have an adverse impact on our facility.

Our facility is willing and able to absorb your case load up to the number of beds we are licensed for. Our current open beds include 15 regular/general population and 5 (3 male and 2 female) beds on our Special Care Unit for ambulatory residents with Alzheimer's or Dementia. Our only limitation includes identified sex offenders due to our close proximity of a school.

If you have any questions or we can help in any way, please contact me at 217-562-3996.

Sincerely,

Laura R. Morrell
Administrator
Prairie Rose Health Care Center

Appendix 119

April 29, 2011

Ms. Linda Fahey

Decatur Memorial Hospital

2300 North Edward Street

Decatur, IL 62526

Dear Ms. Fahey:

Both facilities Aspen Ridge Care Centre and McKinley Court Care Centre will have the capacity to accommodate the skilled nursing case load available due to the discontinuation of your services.

Our facilities will be available to screen and accept these potential patients as per the regulations without discrimination.

Our facilities will be available 24 hours a day to meet the community needs and assist your facility as needed to accommodate the patients.

If you have any questions, please feel free to contact me at 217-737-9462.

Sincerely,



Lisa Trudeau, RN ILNHA

Senior Administrator

Appendix 120

the
ARTHUR HOME



*Operated by Community Retirement, Inc.
423 Eberhardt Dr
Arthur, IL 61911
217-543-2103*

April 29, 2011

Linda Fahey, RN, BSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526

Dear Ms. Fahey,

We have received notification that Decatur Memorial Hospital is proposing to discontinue its licensed bed Skilled Nursing Unit (long-term care nursing beds).

The Arthur Home will be able to accommodate a portion of Decatur Memorial Hospital's long-term care nursing case load. The Arthur Home does, however, have a very few self-imposed restrictions or limitations in the acceptance of our Residents. It is my belief that these restrictions are not vastly different from other long-term care nursing facilities in the area. If you need details regarding the type of restrictions that are currently in place, we will be happy to provide those upon request.

If you require any further information, or The Arthur Home can provide any assistance to you throughout this process, please do not hesitate to let us know how we may help.

Sincerely,

David Eversole
Administrator



601 North Morgan
Bement, Illinois 61813
Phone: 217.678.2191
Fax: 217.678.3602

Bement
HEALTH CARE CENTER

"Caring With a Hometown Touch"

April 28, 2011

Linda Fahey, RN MSN
Vice President of Nursing
Decatur Memorial Hospital
2300 North Edward Street
Decatur, Il 62526

Dear Linda,

This letter is in response to your letter dated April 26, 2011, requesting an impact statement and availability at our facility for your case load.

The submittal of your CON application to discontinue your Skilled Nursing Service will not have an adverse impact on our facility.

Our facility is willing and able to absorb your case load up to the number of beds we are licensed for. Our current open beds as of 4/28/11 include 3 male beds 10 female beds 2 private rooms and 4 Medicare beds (2 male & 2 female).

If you have any questions or we can help in any way, please contact me at 217-678-2191.

Sincerely,

Adam Pullen
Administrator

Appendix 122



Titus Manor

At Wyman Park

513 North Worth Street Sullivan, IL 61951

Phone: 217/728-4725 Fax: 217/728-4770

Administrator: *Kathy Hawbaker*

April 28, 2011

Ms. Linda Fahey, RN, MSN

DMH

2300 North Edward Street

Decatur, IL 62526

Dear Ms. Fahey:

Thank you for your letter of April 26, 2011 regarding the discontinuation of your skilled nursing service. Please be advised that we are a Shelter Care Home for Ladies. We are not licensed for skilled care. Under the Shelter Care regulations we are able to assist our ladies with bathing, dressing and medication distribution. Our ladies ambulate either with or without the aid of a cane or walker. If you have any further questions with regard to our facility, please do not hesitate to contact me at (217) 728-4725. I have enclosed our latest brochure with regard to our home.

Sincerely,

Kathy Hawbaker, Administrator

Titus Manor at Wyman Park

(217) 728-4725

(217) 728-4770 - fax

175

Appendix 123



May 5, 2011

Linda Fahey

2300 N. Edward St. Decatur

62526

Dear Linda:

St. Clara's Manor will be happy to screen any residents' you will need placement for. We are licensed for 140 residents, but are setup for 131. Currently we have 103 residents, and do have open bed as you can see. We are unable to accept Trach. Patients. We do accept patients with IV's, tube feeding, and wound vacs. All beds are Medicare/Medicaid certified. Please feel free to contact me with any patients(s) you will need placement for. We will gladly accept patients we can meet the needs of.

Mike Eads



(Administrator)

Info: Facility phone # (217)-735-1507

Fax:-217-732-3188

Address 200 5th street Lincoln ll

62656

Email:meads@heritageofcare.com

Admissions: Susan Boyd

DON: Teresa Rekart

Adon: Glenda Beatty