Original

11-064

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

JUN 2 6 2011

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: FHN – Skilled Nursing Unit			
Street Address: 1045 West Stephenson Street			
City and Zip Code: Freeport 61032			
County: Stephenson	Health Service Area 001	Health Planning Area: B-02	

Applicant /Co-Applicant Identification

Exact Legal Name: Freeport Memorial Hospital
Address: 1045 West Stephenson Street, Freeport, IL 61032
Name of Registered Agent: Michael C. Clark
Name of Chief Executive Officer: Michael Perry, M.D.
CEO Address: 1045 West Stephenson Street, Freeport, IL 61032
Telephone Number: 815-599-6458

Type of Ownership of Applicant/Co-Applicant

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

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

Refer to Attachment 1

Primary Contact

Name: Michael Perry, M.D.
Title: President/CEO
Company Name: FHN
Address: 1045 W. Stephenson Street, Freeport, IL 61032
Telephone Number: 815-599-6458
E-mail Address: mperry@fhn.org
Fax Number: 815-599-6868

Additional Contact

Name: Nancy Cutler
Title: Vice President of Patient Services & CNO
Company Name: FHN
Address: 1045 West Stephenson Street, Freeport, IL 61032
Telephone Number: 815-599-6335
E-mail Address: ncutler@fhn.org
Fax Number: 815-599-6868

Post Permit Contact

Name: Sharon Summers
Title: COO
Company Name: FHN
Address: 1045 West Stephenson Street, Freeport, IL 61032
Telephone Number: 815-599-6151
E-mail Address: ssummers@fhn.org
Fax Number: 815-599-6868

Site Ownership

Exact Legal Name of Site Owner: Freeport Regional Healthcare Foundation
Address of Site Owner: 1045 West Stephenson Street, Freeport, IL 61032
Street Address or Legal Description of Site: Refer to Attachment 2

Operating Identity/Licensee

Exact Legal Name: Freeport Memorial Hospital
Address: 1045 West Stephenson Street, Freeport, IL 61032

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

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

Refer to Attachment 3

Organizational Relationships

Refer to Attachment 4 – Organizational Chart for Freeport Regional Healthcare Foundation

Flood Plain Requirements

Not applicable for the discontinuation of a category of service.

Historic Resources Preservation Act Requirements

Not applicable for the discontinuation of a category of service.

DESCRIPTION OF PROJECT

1. Project Classification

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

2. Narrative Description

This application is for a non-substantive project review for the discontinuation of a category of service. The discontinuation of 26 beds inventoried by IDPH as General Long-Term Care. This project has no projected cost and therefore Part 1120 is not applicable for this reason.

Project Costs and Sources of Funds

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

Refer to Attachment 7

Related Project Costs

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

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

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

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

Refer to Attachment 8 – Not Applicable

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

N/A ☐ All reports regarding outstanding permits - No outstanding permits exist

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE	-0-						
Medical Surgical	-0-						
Intensive Care	-0-						
Diagnostic Radiology	-0-						
MRI	-0-						
Total Clinical	-0-	10,300					10,300
	-0-						
NON REVIEWABLE	-0-						
Administrative	-0-						
Parking	-0-						
Gift Shop	-0-						
	-0-						
Total Non-clinical	-0-	3,800					3,800
TOTAL		**14,100**					**14,100**

Refer to Attachment 9

Facility Bed Capacity and Utilization

FACILITY NAME: Freeport Memorial Hospital		CITY: Freeport			
REPORTING PERIOD DATES:		From: 01/01/10		to: 12/31/10	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	109	5,620	17,206		109
Obstetrics	14	563	1,162		14
Pediatrics	15	356	679		15
Intensive Care	18	457	1,454		18
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	26	440	5,729	26	0
Specialized Long Term Care					
Long Term Acute Care					
Other (identify)					
TOTALS:	172	7,436	26,230	26	0

CERTIFICATION

This Application for Permit is filed on the behalf of _Freeport 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.

SIGNATURE

__Mike Perry_____
PRINTED NAME

__President/CEO_____
PRINTED TITLE

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

Signature of Notary

Seal

"OFFICIAL SEAL"
TAMMY EDLER
Notary Public, State of Illinois
My Commission Expires 3-11-16

SIGNATURE

_____Gary Quinn_____
PRINTED NAME

_____Chairman of the Board_____
PRINTED TITLE

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

Signature of Notary

Seal

"OFFICIAL SEAL"
TAMMY EDLER
Notary Public, State of Illinois
My Commission Expires 3-11-16

SECTION II. DISCONTINUATION

Criterion 1110.130 - Discontinuation

GENERAL INFORMATION REQUIREMENTS

1. This is a non-substantive request to discontinue the category of Skilled Nursing Services and the decertification of 26 General Long Term Care Beds at FHN Memorial Hospital, Freeport, Illinois 61032.
2. Clinical services that are projected to be discontinued as a result of discontinuation of the Skilled Nursing Unit include Physical therapy, Occupational therapy and Speech therapy specific to the Skilled Unit.
   Specific activities coordinated by the activities director will also be discontinued on this unit.
3. The anticipated date of discontinuation for the Skilled Nursing Unit will occur when the Health Facilities Planning Board issues the permit for discontinuation of services. This is projected to be sometime in October following the HFSRB meeting.
4. At this time, there are no immediate plans for the use of the physical plant vacated by the skilled nursing unit. There is a possibility of utilizing the rooms for medical/surgical patients in the future as a means to convert semi-private rooms to private rooms throughout the Hospital.
5. All medical records are currently integrated with the other Hospital medical records and will be kept the required 7 years per policy.
6. All questionnaires and data required by HFSRB or DPH will be provided through the date of discontinuation, and required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

1. The past several years have demonstrated a decline in demand for Skilled Nursing Services at FHN. At one time, census exceeded 35 patients per day with a length of stay greater than 16 days. However, over the past several years census has declined to the current average daily census of 11.9 with a length of stay of 13 days. Data below demonstrates the past three years of volume:

	2008	2009	2010	2011
Avg. Census	14.5	15.1	14.9	11.9
Avg. Pt. Stay	11.9	10.9	11	13.2

2. The service is not economically feasible and continuation impairs the facility's financial viability. Below demonstrates the previous three years of financial data:

	2008	2009	2010
SNF Net Revenue	2,350,593	2,254,066	2,225,510
SNF Expenses	2,860,872	2,914,686	2,850,110
SNF Net Operating Loss	(635,362)	(660,620)	(499,517)

IMPACT ON ACCESS

There are currently twenty-one (21) Long Term Care facilities offering Skilled Nursing within a 45 minute travel time within the FHN Service Area. This represents approximately 2033 Skilled Nursing beds within the 45 minute travel distance.

The following facilities received the attached written request for an impact statement:

- Freeport Rehabilitation and Health Care Center, 900 s. Kiwanis Dr. Freeport, Il
- Good Samaritan Nursing Home, 1006 N Lowden Rd. Mt Carroll, Il
- Lena Living Center, 1010 s. Logan, Lena, Illinois
- Medina Nursing Center, 402 s. Center, Durand Illinois
- Monroe manor Nursing and Rehab Center, 516 26th Ave, Monroe, Wisconsin 53566
- Stockton health Center, Stockton, Il 61085
- Oregon healthcare Center 811 S. 10th, Oregon, Il 61061
- Parkview Home, 1234 S. Park Blvd, Freeport, Il 61032
- Pine Crest Manor 414 South Wesley Ave. Mt. Morris, Il 61054
- Polo Rehabilitation and Health Care Center 701 e. Buffalo, Polo, Il 61064
- Provena St Joseph Center 659 Jefferson Freeport, Il. 61032
- Stephenson Nursing Center 2946 SD. Walnut Rd. Freeport, Il 61032
- Woods Crossing 401 23rd St. Broadhead, Wisconsin 53520
- P A Peterson Center, Rockford, Illinois
- Willows Hearth Center, Rockford, Illinois
- Rockford Nursing and Rehabilitation, Rockford, Il.
- River Bluff, Rockford, Illinois
- Alden Park Strathmoor, Rockford, Illinois
- Alden Alma Nelson Manor, Rockford, Illinois
- Amberwood Care Center, Rockford, Illinois
- Rosewood Care Center, Rockford, Illinois

Responses from these centers will be forwarded to the Health Facilities Planning Board when they are received.

Refer to Attachment 10

XI. Safety Net Impact Statement

Refer to Attachment 43.

XII. Charity Care Information

Refer to Attachment 44

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11	Background of the Applicant	N/A
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
14	Size of the Project	N/A
15	Project Service Utilization	N/A
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	N/A
27	Non-Hospital Based Ambulatory Surgery	N/A
28	General Long Term Care	N/A
29	Specialized Long Term Care	N/A
30	Selected Organ Transplantation	N/A
31	Kidney Transplantation	N/A
32	Subacute Care Hospital Model	N/A
33	Post Surgical Recovery Care Center	N/A
34	Children's Community-Based Health Care Center	N/A
35	Community-Based Residential Rehabilitation Center	N/A
36	Long Term Acute Care Hospital	N/A
37	Clinical Service Areas Other than Categories of Service	N/A
38	Freestanding Emergency Center Medical Services	N/A
		N/A
	Financial and Economic Feasibility:	
39	Availability of Funds	N/A
40	Financial Waiver	N/A
41	Financial Viability	N/A
42	Economic Feasibility	N/A
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File Number 2569-316-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

FREEPORT MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 10, 1938, 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 18TH *day of* JULY *A.D.* 2011

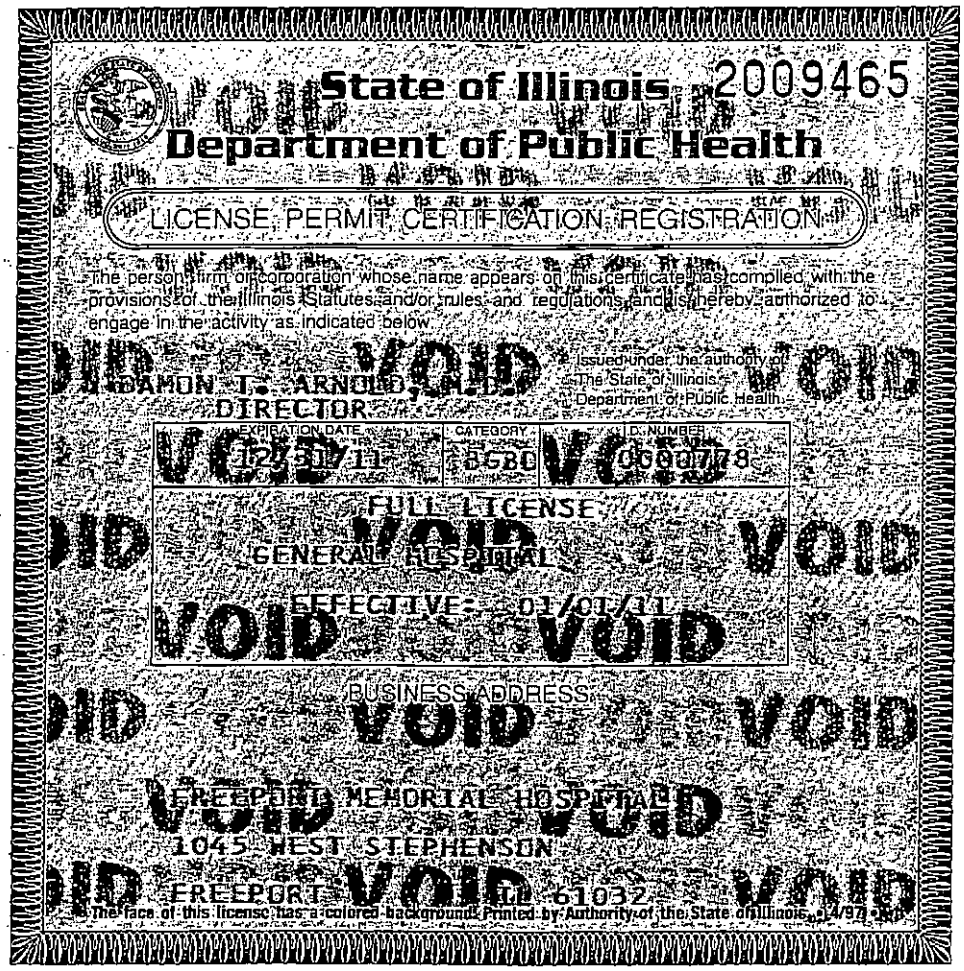
Jesse

SECRETARY OF

Authentication #: 1119901272

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

Attachment 1



State of Illinois 2009465
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/11	8680	0000778

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/11

BUSINESS ADDRESS:
FREEPORT MEMORIAL HOSPITAL
1045 WEST STEPHENSON
FREEPORT IL 61032

The face of this license has a colored background. Printed by Authority of the State of Illinois 4/97

VOID

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Attachment 2

Internal Revenue Service
District Director

Department of the Treasury

Date: 24 JUL 1985

Employer Identification Number: 36-3290904

Accounting Period Ending: July 31

Form 990 Required: ☒ Yes ☐ No

Person to Contact: A. Bucek

Contact Telephone Number: 312-886-1278

Freeport Health Care Foundation
1045 West Stephenson Street
Freeport, IL 61032

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of section 509(a) of the Code, because you are an organization described in section 509 (a)(3).

If your sources of support, or your purposes, character, or method of operation change, please let us know so we can consider the effect of the change on your exempt status and foundation status. Also, you should inform us of all changes in your name or address.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have any questions about excise, employment, or other Federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

The box checked in the heading of this letter shows whether you must file Form 990, Return of Organization Exempt from Income Tax. If Yes is checked, you are required to file Form 990 only if your gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late, unless there is reasonable cause for the delay.

Page (over) 16

Attachment 2

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

J. R. Starkey

District Director

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Attachment 2

File Number 2569-316-7

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OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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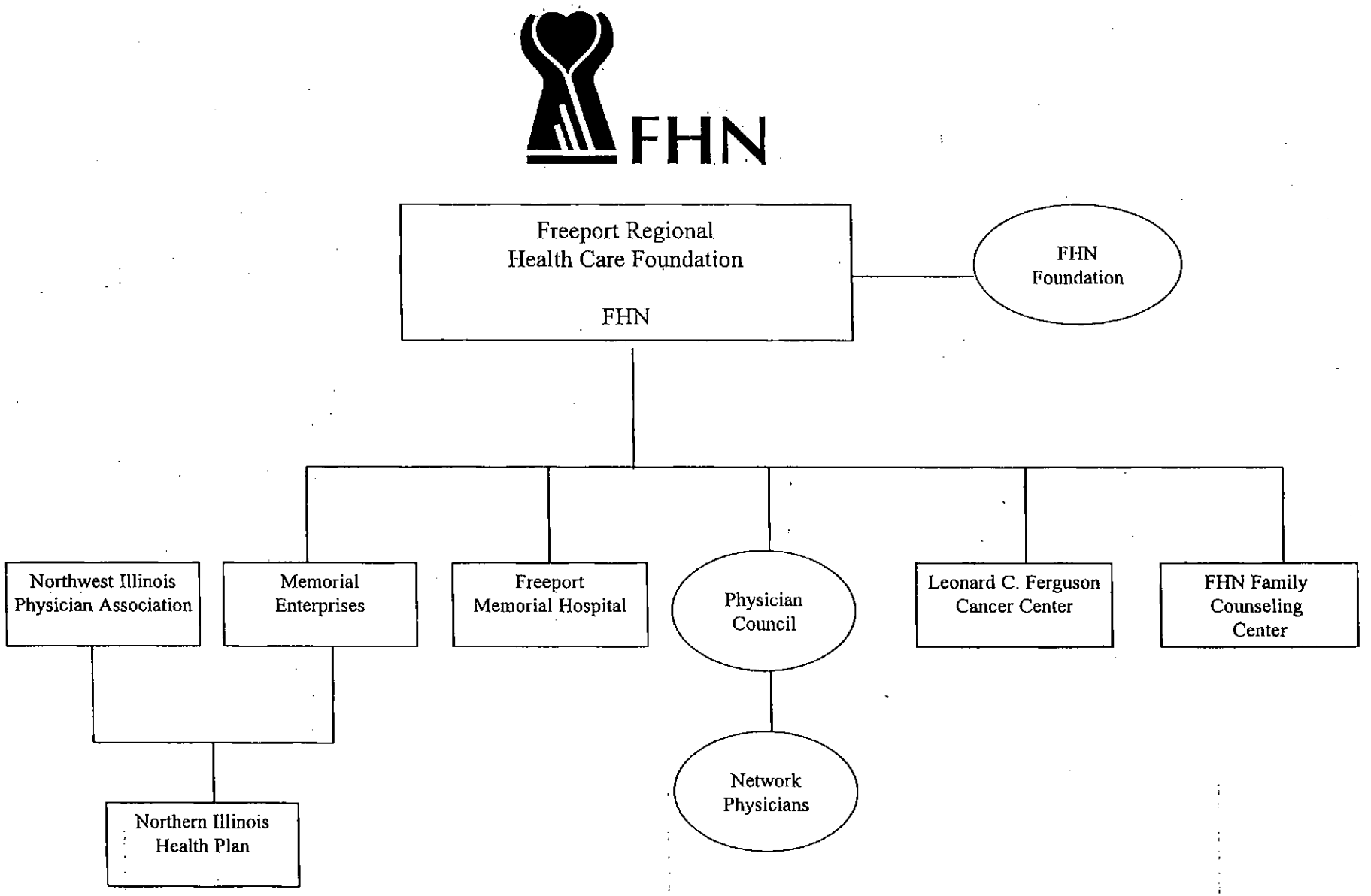
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 18TH *day of* JULY *A.D.* 2011

Jesse

SECRETARY OF

Authentication #: 1119901272

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



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Attachment 4

DLH:rw
12/05

Project Costs and Sources of Funds

There are no project costs or sources of funds related to this application for discontinuation for category of service.

Project Status and Completion Schedules

There are no project expenditures or obligations for an application for discontinuation of this category of service.

Cost Space Requirements

The DGSF of the discontinued category of service is 14,100. There have been preliminary discussions to utilize some of the vacated space as Medical Surgical beds in order to create all private rooms within FHN Memorial Hospital. No decisions have been made to move forward. No DGSF has been discussed or determined related to this potential use of the vacated space.

FHN

July 19, 2011

SAMPLE

Dear Nursing Home Administrator:

FHN Memorial Hospital is in the process of completing a Certificate of Need application for the Illinois Health Facilities Planning Board to discontinue its Skilled Nursing Unit/Services. FHN has experienced reduced demand for Skilled Nursing services over the past several years and has made the decision to discontinue the services given the adequate capacity to deliver Skilled Care in the communities we serve.

One of the Health Facilities Planning Board requirements is documentation from all facilities within 45 minutes travel time quantifying the impact of our proposal on discontinuing this service. Specifically, we need a letter from your facility stating the number of skilled beds at your facility and any negative impact of our proposal on your existing capacity to provide Skilled Nursing Care.

FHN's Skilled Nursing Unit had 440 admissions and 5,727 patient days in 2010; 442 admissions and 6,404 patient days in 2009; and 199 admissions and 2,589 patient days year-to-date. Please indicate if your facility will have the capacity to accommodate any and/or all of future skilled nursing demand for service once FHN closes its unit and/or if any restrictions or limitations would preclude providing service to residents in the FHN market area.

We anticipate the discontinuation of Skilled Nursing Services once the Health Facilities Planning Board issues a permit. The Health Facilities Planning Board meets in early October.

Thank you in advance for providing the information necessary to complete our application. If you have any questions or need additional information, please do not hesitate to contact me at 599-6151. We would appreciate a reply as early as possible.

Sincerely,

Sharon Summers
Executive Vice President/Chief Operating Officer

Attachment 10

1045 West Stephenson Street, Freeport, IL 61032
Phone: 815-599-6000 Toll Free: 800-747-4131
Website: www.fhn.org

NDER: 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.

Article Addressed to:

ernice Marinelli
ockford Nursing + Rehab
920 N. Main Street
ockford, IL 61103

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Dawn Spillare ☑ Agent ☐ Addressee

B. Received by (Printed Name) Dawn Spillare C. Date of Delivery 7/21/11

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

Article Number (Transfer from service label) 7008 0500 0000 0550 6299

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Michelle Lindeman
Provena St. Joseph Ctr.
659 E. Jefferson St
Dixon, IL 61032

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Mary Kay Braun ☒ Agent ☐ Addressee

B. Received by (Printed Name) MK Braun C. Date of Delivery 7/21/11

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

Attachment 10

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 0500 0000 0550 6237

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

DER: COMPLETE THIS SECTION

mplete items 1, 2, and 3. Also complete
m 4 if Restricted Delivery is desired.
int your name and address on the reverse
that we can return the card to you.
tach this card to the back of the mailpiece,
on the front if space permits.

ticle Addressed to:

rnell Forthey
phenson Nursing Ctr.
746 S. Walnut Rd
eport, IL 61032

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C Snyder ☐ Agent ☐ Addressee

B. Received by (Printed Name) C Snyder C. Date of Delivery 7-21-11

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

ticle Number (ansfer from service label) 7008 0500 0000 0550 6220

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Deb Sitz
Parkview Home
1234 S. Park Blvd.
Freeport, IL 61032

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Debra Sitz ☐ Agent ☐ Addressee

B. Received by (Printed Name) DeDra Sitz C. Date of Delivery 7-21-11

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 0500 0000 0550 6213

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

Attachment 10

NDER: 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.

Article Addressed to:

Peggy Holt
'A Peterson Center
311 Parkview Ave
Rockford, IL 61107

COMPLETE THIS SECTION ON DELIVERY

A. Signature X Shawn Cremer ☒ Agent ☐ Addressee

B. Received by (Printed Name) SHAWN CREMER C. Date of Delivery 7-21-11

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

NEW TOWNE ROCKFORD IL 61 JUL 21 2011 USPS 801

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label) 7008 0500 0000 0550 6275

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Debra Ford Adkins
Willows Health Center
4054 Albright Lane
Rockford, IL 61103

COMPLETE THIS SECTION ON DELIVERY

A. Signature X ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 7-21-11

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) 7008 0500 0000 0550 6282

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

ER: COMPLETE THIS SECTION

- plete items 1, 2, and 3. Also complete 4 if Restricted Delivery is desired.
- your name and address on the reverse hat we can return the card to you.
- ch this card to the back of the mailpiece, n the front if space permits.

le Addressed to:

resa Blair
o Rehab + Health Care
13 E. Buffalo
lo, IL 61064

COMPLETE THIS SECTION ON DELIVERY

A. Signature X Rose Bass ☐ Agent ☐ Addressee

B. Received by (Printed Name) ROSE BASS C. Date of Delivery 7-21

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

cle Number (Transfer from service label) 7008 0500 0000 0550 6244

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Julie Logan
Amberwood Care Ctr
2313 N. Rockton Ave.
Rockford, IL 61103

COMPLETE THIS SECTION ON DELIVERY

A. Signature X Chesney Cates ☐ Agent ☐ Addressee

B. Received by (Printed Name) Chesney Cates C. Date of Delivery 7-21-11

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) 7008 0500 0000 0550 6336

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

ENDER: 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.

Article Addressed to:

Heath Schiesler
Alden Alma Nelson No
550 S. Mulford Ave
Rockford. IL 61108

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Sue Tom ☐ Agent ☐ Addressee

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

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

USPS ROCKFORD IL 61104 JUL 21 2011

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service la) 7008 0500 0000 0550 6329

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Pamela Bertner
River Bluff Nursing Home
4401 North Main St
Rockford. IL 61103

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 7-21-11

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

Attachment 10

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 0500 0000 0550 6305

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-154(

NDER: 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.

Article Addressed to:

Dana Payton
Regon Healthcare Centr
11 S. 10th Street
Regon. IL 61061

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) DANA S. PAYTON | C. Date of Delivery 7-21-2011

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

Article Number (Transfer from service label) 7008 0500 0000 0546 5756

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Bart Becker
Rosewood Care Ctr
1660 S. Mulford Rd
Rockford. IL
61108

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 7/21/11

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

USPS ROCKFORD IL 61108 JUL 21 2011

Page 24

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 0500 0000 0550 6343

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

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

Holger Oksnevad
Medina Nursing Center
402 S. Center Street
Durand, Ill. 61024

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Pat Sarver ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Pat Sarver

C. Date of Delivery 7/21/11

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) 7005 3110 0000 3989 0789

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

Page 27 Attachment 10

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:

Anthony Valentino
Elder Park Strathmoor
3668 Strathmoor Dr.
Rockford, IL 61107

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 7/21/11

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

ROCKFORD IL 61108 JUL 21 2011 USPS

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7008 0500 0000 0550 6312

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Lori Steele
Stockton Health Center
PO Box 38
Stockton, IL 61085

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Dolores Downs ☐ Agent ☐ Addressee

B. Received by (Printed Name) Dolores Downs C. Date of Delivery 7-21-11

D. Is delivery address different from item 1? ☒ Yes
If YES, enter delivery address below: ☐ No
501 E. Front Ave.
Stockton IL 61085

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) 7005 3110 0000 3988 8625

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

Attachment 10

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:

Carol Labash
Pine Crest Manor
414 South Wesley Ave
Mt. Morris, IL 61054

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X C. Black ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Black C. Date of Delivery 7-21-11

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) 7008 0500 0000 0550 6251

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Laurie Alumbaugh
Lena Living Center
1010 S. Logan Street
Lena, IL 61048

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jennifer Mulligan ☐ Agent ☐ Addressee

B. Received by (Printed Name) Jennifer Mulligan C. Date of Delivery 7-21-11

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) 7005 3110 0000 3989 0772

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

Page 28

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:

Lee Gunderson
Woods Crossing
E401 23rd St
Brodhead, WI 53520

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☒ Addressee

B. Received by (Printed Name) Lee Gunderson
C. Date of Delivery 7/22/11

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) 7008 0500 0000 0550 6268

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

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Deanna Kruse
Monroe Manor Housing
516 26th Avenue
Monroe, Wisconsin
53566

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Tammy Blumer ☐ Agent ☐ Addressee

B. Received by (Printed Name) Tammy Blumer
C. Date of Delivery 7/22/11

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) 7005 3110 0000 3988 8618

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

Pinecrest Community

JUL 2 5 2011

July 21, 2011

Sharon Summers
Executive Vice President/Chief Operating Officer
FHN Memorial Hospital
1045 West Stephenson Street
Freeport, IL 61032

Dear Ms. Summers,

Thank you for your letter dated July 19, 2011 informing Pinecrest Community of FHN Memorial Hospital's Certificate of Need application with the Illinois Health Facilities Planning Board to discontinue its Skilled Nursing Unit/Services. We do not anticipate any negative impact on our existing capacity to provide Skilled Nursing Care as a result of your proposal.

Pinecrest Manor is licensed for 57 skilled beds and 68 intermediate beds. Seven of our skilled beds are located within our specialized Alzheimer's and dementia unit and fourteen skilled beds are located on our short term rehab wing. We anticipate that we would be in a position to accept additional referrals to our nursing facility that might result from the closing of FHN Memorial Hospital's Skilled Nursing Unit/Services.

If you have any questions or need additional information, please do not hesitate to contact me at 815-734-4103.

Best regards,

Ferol J. Labash

Ferol J. Labash
Chief Executive Officer

414 S. Wesley Ave. ◆ Mt. Morris ◆ Illinois ◆ 61054 ◆ 815-734-4103 ◆ fax 815-734-7318
www.pinecrestcommunity.org

659 E. Jefferson St.
Freeport, IL 61032
815 232-6181 Tel
815 232-6143 Fax

PROVENA
St. Joseph Center

July 21, 2011

Sharon Summers
FHN Memorial Hospital
1045 West Stephenson Street
Freeport, IL 61032

Dear Sharon,

Provena St. Joseph Center has 120 Medicare certified beds and is operating with only an average daily census of 18 Medicare. There is currently a project underway at the ministry for an addition of 16 private Medicare rooms along with the conversion of 14 current semi-private rooms. This will significantly expand the access to private rooms for short stay Medicare rehab and nursing in the community.

Please let me know if you require any additional information or have any questions.

Sincerely,

Michelle Lindeman
Administrator

Stephenson Nursing Center

2946 South Walnut Street • Freeport, Illinois 61032

July 22, 2011

Sharon Stone
Executive Vice President/Chief Operating Officer
1045 West Stephenson Street
Freeport, Illinois 61032

Dear Sharon:

It is with deep regret that FHN Skilled Nursing Services will be discontinuing its service. FHN Skilled Nursing Unit/Service has been the cornerstone to every nursing home in the Stephenson County area. Due to the influx of assisted living, home health care services and supportive living facilities, long term care facilities have also suffered a reduction in admissions. Stephenson Nursing Center continues to strive due to your Skilled Nursing Services' support. If the service discontinues, it would limit our admission efforts.

Two years ago we got dually certified for Medicare/Medicaid beds. However, we have 44 beds that we have set aside for skilled Medicare admissions only. We currently have registered nurses on all three shifts to address skill care needs. In addition, because of your proposal, I am being proactive and will be providing in-service training for our register nurses to refresh their skills on services such as, IV, TPN and Tracheotomy. As you well know, these are services we currently depend on FHN Skilled Nursing Services to provide.

Thank you for sharing this information with me. Of course I wish you all the best. Please do not hesitate to contact me if you have any questions.

Sincerely,

Darnell Fortney, LHNA
SNC Administrator

page 32 Attachment 10

We Care

Telephone: 815/235-6173 • Fax: 815/235-9633
E-mail: snc@co.stephenson.il.us • Web Address: www.co.stephenson.il.us/nursing/

Documentation for Safety Net Impact Statement

Discontinuation of the General Long Term Nursing Care category of service at Freeport Memorial Hospital in Freeport, IL will not have a material impact on the safety net services in the community.

Freeport Memorial Hospital will remain able to provide safety net services for these patients.

Freeport Memorial Hospital certifies that the table below summarizes Safety Net Information per PA-96-0031 for the general Long Term Care category of service.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2010**	**Year 2009**	**Year 2008**
Inpatient	4	5	1
Outpatient	0	0	0
Total	**4**	**5**	**1**
Charity (cost in dollars)			
Inpatient	281,233	80,339	22,285
Outpatient	0	0	0
Total	**281,233**	**80,339**	**22,285**
MEDICAID			
Medicaid (# of patients)	**Year 2010**	**Year 2009**	**Year 2008**
Inpatient	24	17	13
Outpatient	0	0	0
Total	24	17	13
Medicaid (revenue)			
Inpatient	96,134	95,832	32,210
Outpatient	0	0	0
Total	96,134	95,832	32,210

Documentation of Charity Care Information

The table below summarizes Charity Care provided by Freeport Memorial Hospital and Freeport Memorial Hospital – Skilled Nursing as outlined in 20 ILCS 3960/3.

CHARITY CARE			
	Year 2010	Year 2009	Year 2008
Net Patient Revenue	**117,647,600**	**118,198,181**	**122,492,847**
Amount of Charity Care (charges)	6,339,171	5,575,587	4,668,770
Cost of Charity Care	2,001,573	1,976,540	1,554,374

Attachment 44