

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Springfield Memorial Hospital – Comprehensive Rehabilitation Bed Discontinuation		
Street Address: 701 N First Street		
City and Zip Code: Springfield 62781		
County: Sangamon	Health Service Area 3	Health Planning Area: E-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Memorial Medical Center d/b/a Springfield Memorial Hospital
Street Address: 701 N First Street
City and Zip Code: Springfield 62781
Name of Registered Agent: Zach Dinardo
Registered Agent Street Address: 340 W Miller Street
Registered Agent City and Zip Code: Springfield 62702
Name of Chief Executive Officer: Evan Davis
CEO Street Address: 701 N First Street
CEO City and Zip Code: Springfield 62781
CEO Telephone Number: 217-899-4011

Type of Ownership of Applicants

☒ 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Dana Mollohan
Title: System Director – Business Development and Planning
Company Name: Memorial Health
Address: 340 W Miller Street, Springfield, IL 62702
Telephone Number: 217-788-4263
E-mail Address: mollohan.dana@mhsil.com
Fax Number: 217-527-3267

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Springfield Memorial Hospital – Comprehensive Rehabilitation Bed Discontinuation			
Street Address: 701 N First Street			
City and Zip Code: Springfield 62781			
County: Sangamon	Health Service Area	3	Health Planning Area: E-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Memorial Health System
Street Address: 340 W Miller Street
City and Zip Code: Springfield 62702
Name of Registered Agent: Zach Dinardo
Registered Agent Street Address: 340 W Miller Street
Registered Agent City and Zip Code: Springfield 62702
Name of Chief Executive Officer: Mandy Eaton
CEO Street Address: 340 W Miller Street
CEO City and Zip Code: Springfield 62702
CEO Telephone Number: 217-788-4440

Type of Ownership of Applicants

☒ 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.	

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Name: Dana Mollohan
Title: System Director – Business Development and Planning
Company Name: Memorial Health
Address: 340 W Miller Street, Springfield, IL 62702
Telephone Number: 217-788-4263
E-mail Address: mollohan.dana@mhsil.com
Fax Number: 217-527-3267

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

Name: Robert Ellison
Title: Vice President – Business Development and Strategy Execution
Company Name: Memorial Health
Address: 340 W Miller, Springfield, IL 62702
Telephone Number: 217-757-2402
E-mail Address: Ellison.robert@mhsil.com
Fax Number:

Post Exemption Contact

[Person to receive all correspondence subsequent to exemption issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Dana Mollohan
Title: System Director – Business Development and Planning
Company Name: Memorial Health
Address: 340 W. Miller Street, Springfield, IL 62702
Telephone Number: 217-788-4263
E-mail Address: mollohan.dana@mhsil.com
Fax Number: 217-527-3267

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Memorial Health System
Address of Site Owner: 701 N First Street, Springfield IL
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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 ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Memorial Medical Center d/b/a Springfield Memorial Hospital	
Address: 701 N. First Street, Springfield, IL 62781	
☒ 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.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

Provide (for each 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.

Narrative Description

In the space below, provide 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.

Memorial Medical Center d/b/a Springfield Memorial Hospital (SMH) located at 701 North First Street, Springfield, Illinois is proposing to discontinue its existing 30-bed comprehensive rehabilitation unit. The discontinuation is planned to coincide with the licensing and opening of the proposed 60-bed Rehabilitation Institute of Springfield, LLC (RIS). The discontinuation is being delayed until the new hospital is opened to avoid any disruption in access to rehabilitation services. SMH plans to relinquish 10 beds with this COE and to convert 20 of the discontinued beds to the medical/surgical category of service.

RIS is a joint venture entity between Encompass Health Springfield Holdings, LLC and Memorial Health Ventures (MHV). Memorial Health System d/b/a Memorial Health is the parent company of both SMH and MHV. RIS is filing a certificate of need application to establish a freestanding 60-bed comprehensive rehabilitation hospital to be located at 4685 Wabash Avenue, **Identified as PIN 21-11.0-300-030** and **PIN 21-11.0-300-034** in Springfield, Illinois. RIS is expected to be open and accepting of patients on January 1, 2029.

This project is substantive as it involves the discontinuation of a category of service.

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes ___ No X___. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

Anticipated exemption completion date (refer to Part 1130.570): January 1, 2029

State Agency Submittals [Section 1130.620(c)]

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 being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of ____

Memorial Medical Center d/b/a Springfield 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 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 fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

Drew M. Early
PRINTED NAME

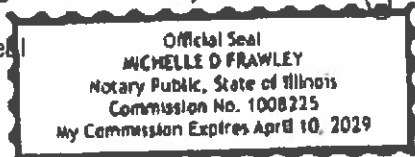
Interim President, SMH
PRINTED TITLE

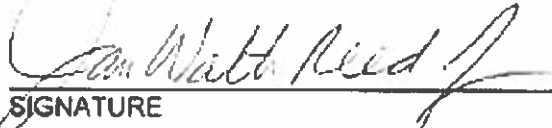
Notarization:

Subscribed and sworn to before me
this 27 day of August


Signature of Notary

Seal




SIGNATURE

James W. Reed Jr
PRINTED NAME

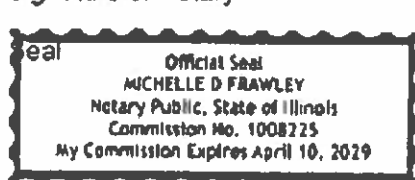
Chairperson of the Board of Directors
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 27 day of August


Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of Memorial Health System d/b/a Memorial Health.

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 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 fee required for this application is sent herewith or will be paid upon request.

Mandy C Eaton
SIGNATURE

Mandy C. Eaton
PRINTED NAME

President and CEO
PRINTED TITLE

Cheryl S. Martin
SIGNATURE

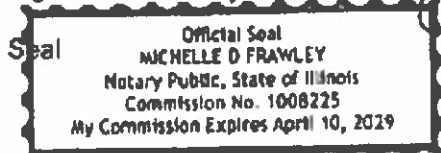
Cheryl S. Martin
PRINTED NAME

Chairperson of the Board of Directors
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 27 day of August, 2020

Michelle D Frawley
Signature of Notary



Notarization:

Subscribed and sworn to before me
this 27 day of August 2020

Michelle D Frawley
Signature of Notary



*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

☒ Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the category of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide attestation that the facility provided the required notice of the category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

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

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.
2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A CATEGORY OF SERVICE [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community **including the impact on racial and health care disparities 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 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 9.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION- 02/2024 Edition

	Medicaid (revenue)			
	Inpatient			
	Outpatient			
	Total			

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

SECTION V. CHARITY CARE INFORMATION

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 10.

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

APPEND DOCUMENTATION AS ATTACHMENT 10, 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 included attachments:

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		16-18
2	Site Ownership		19
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		20-22
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		23
5	Discontinuation General Information Requirements		24-25
6	Reasons for Discontinuation		26
7	Impact on Access		27-30
8	Background of the Applicant		31-34
9	Safety Net Impact Statement		35-36
10	Charity Care Information		37

ATTACHMENT 1

Applicant Information

The Certificates of Good Standing for Memorial Medical Center d/b/a Springfield Memorial Hospital and Memorial Health System are attached at ATTACHMENT 1.

File Number

0751-757-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

MEMORIAL MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 19, 1897, ADOPTED THE ASSUMED NAME SPRINGFIELD MEMORIAL HOSPITAL ON MAY 25, 2021, 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 4TH day of AUGUST A.D. 2026 .

Authentication # 2621600674 verifiable until 08/04/2027
Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulis
SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

MEMORIAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 21, 1981, ADOPTED THE ASSUMED NAME MEMORIAL HEALTH ON SEPTEMBER 27, 2016, 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 4TH day of AUGUST A.D. 2026 .

Authentication #: 2621600782 verifiable until 08/04/2027
Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulas
SECRETARY OF STATE



August 31, 2026

John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

Re: Site Ownership of Memorial Medical Center d/b/a Springfield Memorial Hospital

Dear Mr. Kniery:

This letter attests to Memorial Health System's site ownership and control of Memorial Medical Center d/b/a Springfield Memorial Hospital located at 701 N. 1st Street, Springfield, Illinois 62781.

Memorial Health System's address is 340 W. Miller Street, Springfield, Illinois 62702.

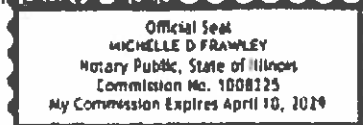
Please contact me at 217-788-4440 or eaton.mandy@mhsil.com if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Mandy C. Eaton".

Mandy C. Eaton
President and Chief Executive Officer
Memorial Health

SUBSCRIBED AND SWORN
To before me this 31 day of August, 2026

A handwritten signature in black ink that reads "Michelle D. Frawley".
Notary Public

340 W. Miller St.
Springfield, IL 62702

217.788.3000

memorial.health

ATTACHMENT 3

Persons with 5% or greater ownership interest

The Certificates of Good Standing for Springfield Memorial Hospital and Memorial Health System are attached at ATTACHMENT 3.

Ownership > 5%

The following Persons own a 5% or greater interest in Memorial Medical Center d/b/a Springfield Memorial Hospital:

Name	Percentage Interest
Memorial Health System	100%

The following Persons own a 5% or greater interest in Memorial Health System:

Name	Percentage Interest
Memorial Health System	100%

Memorial Medical Center d/b/a Springfield Memorial Hospital is the operating licensee:



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp Date 12/31/2026

Lic Number 0001487

Date Printed 12/15/2025

Validation Num

Memorial Medical Center
dba Springfield Memorial Hospital
701 N First St
Springfield, IL 62781

FEE RECEIPT NO

File Number

0751-757-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

MEMORIAL MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 19, 1897, ADOPTED THE ASSUMED NAME SPRINGFIELD MEMORIAL HOSPITAL ON MAY 25, 2021, 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.



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Authentication # 2621600674 verifiable until 08/04/2027
Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulis
SECRETARY OF STATE



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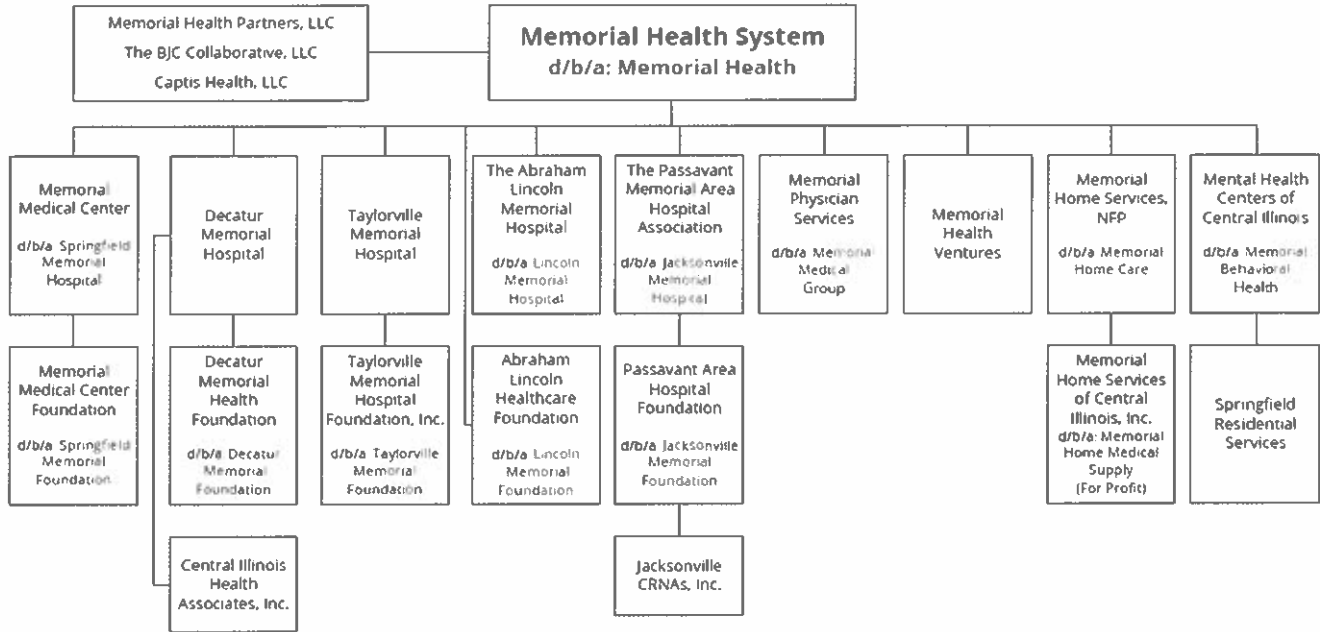
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MEMORIAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 21, 1981, ADOPTED THE ASSUMED NAME MEMORIAL HEALTH ON SEPTEMBER 27, 2016, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT 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 4TH day of AUGUST A.D. 2026 .

CORPORATE STRUCTURE



ATTACHMENT 5

General Information Requirements

- 1. Identify the category of service and the number of beds, if any, that are to be discontinued.**

The applicant proposes to discontinue its 30-bed comprehensive rehabilitation unit. The applicant intends to relinquish ten of these beds, but will convert 20 of them to the medical / surgical category of service.

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

No clinical services besides those directly related to the inpatient comprehensive rehabilitation services are being discontinued.

- 3. Provide the anticipated date of discontinuation for each identified service.**

The applicant plans to discontinue inpatient comprehensive rehabilitation services upon the opening and licensing of the Rehabilitation Institute of Springfield (RIS) hospital on West Wabash in Springfield, Illinois. This proposed freestanding 60-bed rehabilitation hospital is planned to open on January 1, 2029. The applicant does not wish to discontinue the inpatient comprehensive rehabilitation beds at Springfield Memorial Hospital prior to the proposed opening of RIS to ensure continuity and access of care.

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

The applicant will convert 20 of the existing comprehensive rehabilitation beds to medical/ surgical beds and will relinquish the other 10 beds. The current space and equipment will be retained for use in support of future patient care needs.

- 5. Provide attestation that the facility provided the required notice of the category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.**

By their signatures to this application, the applicants attest that the following notice is being provided in the Springfield State Journal Register. A copy of the newspaper public notice is included with this ATTACHMENT 5. Wording for the newspaper public notice is as follows:

Memorial Medical Center d/b/a Springfield Memorial Hospital located at 701 N First Street, Springfield, Illinois, intends to close its 30-bed comprehensive rehabilitation inpatient unit upon the opening and licensing of the proposed Rehabilitation Institute of Springfield hospital and after receiving approval by the Illinois Health Facilities and Services Review Board (IHFSRB). The hospital plans to submit the required Certificate of Exemption (COE) application on or around September 8, 2026. After submission, a copy of the COE application and information about the discontinuation of the unit may be found on the IHFSRB website at [Illinois.gov/sites/hfsrb](https://illinois.gov/sites/hfsrb). You may also contact Dana Mollohan at 217-788-4263 at Memorial Health with any questions or concerns.

Attachment 5 – Newspaper Public Notice

Will run September 8 to September 15, 2026 in the Springfield State-Journal Registrar.

Ad Preview

Memorial Medical Center d/b/a Springfield Memorial Hospital located at 701 N First Street, Springfield, Illinois, intends to close its 30-bed comprehensive rehabilitation inpatient unit upon the opening and licensing of the proposed Rehabilitation Institute of Springfield hospital and after receiving approval by the Illinois Health Facilities and Services Review Board (IHFSRB). The hospital plans to submit the required Certificate of Exemption (COE) application on or around September 8, 2026. After submission, a copy of the COE application and information about the discontinuation of the unit may be found on the IHFSRB website at [illinois.gov/sites/hfsrb](https://www.illinois.gov/sites/hfsrb). You may also contact Dana Mollohan at 217-788-4263 at Memorial Health with any questions or concerns.

Attachment 6

Reasons for Discontinuation

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action.

The reasons for discontinuation are: (1) the proposed freestanding Rehabilitation Institute of Springfield (RIS) will have a 60-bed state of the art facility that can meet the inpatient rehabilitation needs of the community and thus the service at Springfield Memorial (SMH) will not be needed (2) the current 30-bed inpatient rehabilitation unit at Springfield Memorial Hospital (SMH) is in an older building on the SMH campus that was not designed to meet current rehabilitation room standards. By relinquishing 10 of the comprehensive rehabilitation beds and converting 20 of the beds to the medical / surgical category of service, the current space occupied by the inpatient rehabilitation will be utilized for future patient care needs.

The discontinuation at SMH is proposed to coincide with the opening of RIS and will allow for an orderly transition of services and will not create any gaps in access or patient care. The proposed new facility will be better equipped to meet the comprehensive rehabilitation needs of the community and will improve access to care while simultaneously allowing for better utilization of necessary services at SMH.

Attachment 7

Impact on Access

- 1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.**

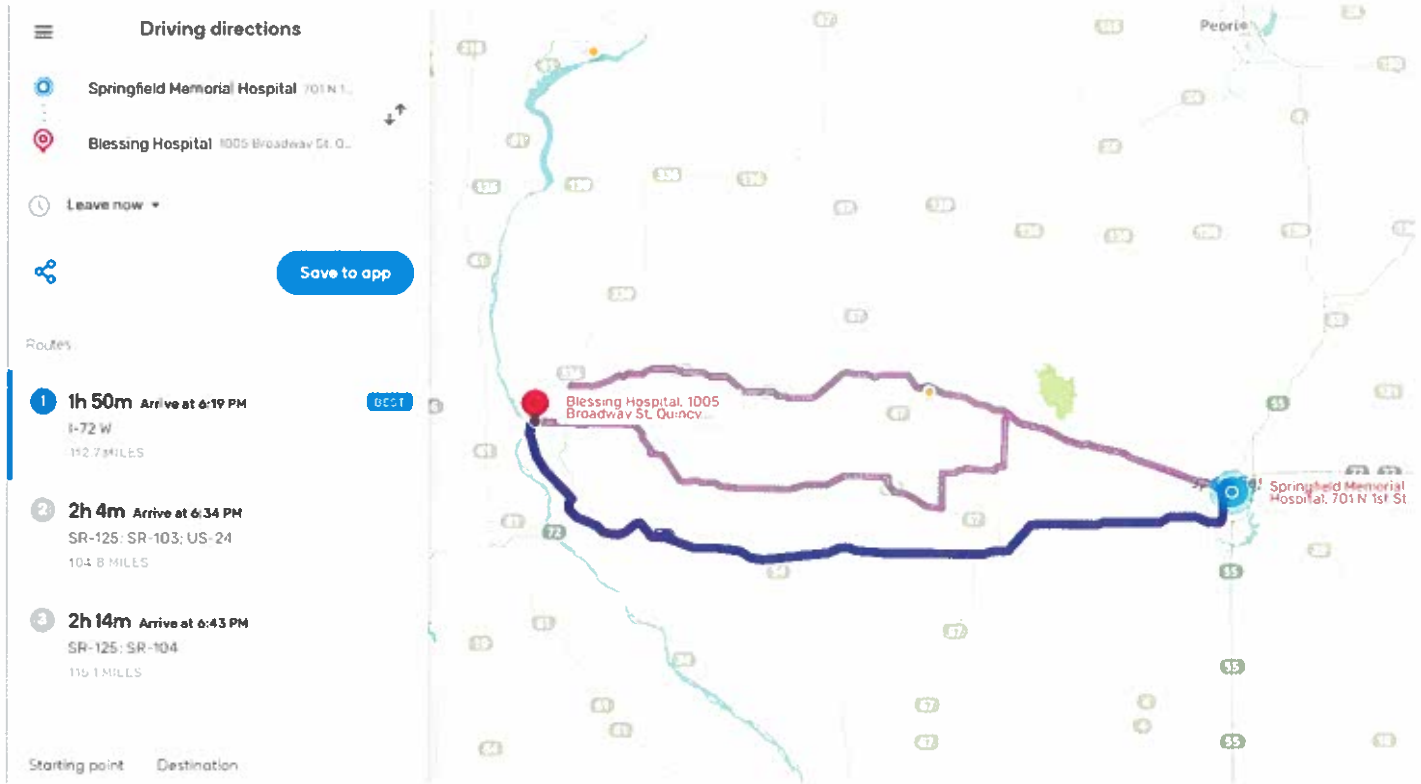
The discontinuation will not have an adverse effect upon access to care for the residents of the facility's market area. The beds are only being discontinued to coincide with the opening and licensing of the proposed 60-bed freestanding rehabilitation hospital to be operated by Rehabilitation Institute of Springfield, LLC. The opening of this facility will further increase the access to comprehensive rehabilitation beds in the area. Blessing Hospital in Quincy is 112 miles to the west of Springfield Memorial Hospital (SMH) and is the only other hospital providing comprehensive rehabilitation beds in health service area 3 (HSA-3). Per the Inventory of Health Care Facilities and Services 2025 Edition (IHCFS), HSA-3 has a surplus of 14 comprehensive physical rehabilitation beds; however, the current set up at SMH is not ideal for a rehabilitation unit due to facility limitations and thus only 21 of the 30 beds are currently being staffed and set up. Several of the rooms are not private rooms (12), which is the current standard of care. Decatur Memorial Hospital (DMH) is 42 miles to the east of SMH and is also owned by the parent company of SMH, Memorial Health System. DMH routinely refers rehabilitation patients to SMH.

- 2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.**

There are not any facilities within 17 miles that currently provide comprehensive physical rehabilitation services. As noted above, Blessing Hospital in Quincy is in the same HSA and as such, a notification letter has been provided to them. Notification letter and proof of mailing is attached at ATTACHMENT 7.

ATTACHMENT 7 – Drive time /Distance Maps

Springfield Memorial to Blessing Hospital





August 31, 2026

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED

Mike Trachta
President and CEO
Blessing Hospital
PO Box 7005
Quincy, IL 62305

Re: Discontinuation of Comprehensive Rehabilitation Beds at Springfield Memorial Hospital

Dear Mr. Trachta:

I am writing to inform you that Springfield Memorial Hospital (SMH) will soon be filing a Certificate of Exemption (COE) Application with the Illinois Health Facilities and Services Review Board to discontinue its 30-bed comprehensive rehabilitation unit. The discontinuation is anticipated to occur upon the opening of the Rehabilitation Institute of Springfield, LLC rehabilitation hospital to be located on West Wabash in Springfield, IL. The new facility is expected to open and start accepting patients on January 1, 2029.

We are aware of no adverse impact to patients or related access due to the discontinuation as the new facility will have the capacity to accept patients that would have been treated at SMH.

Pursuant to the Health Facilities Planning Act, we are providing this notice and would ask that you respond in writing if you anticipate an adverse impact on your facility due to the proposed discontinuation at SMH.

Please contact me at 217-788-4440 or eaton.mandy@mhsil.com if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Mandy C. Eaton".

Mandy C. Eaton
President and Chief Executive Officer
Memorial Health

340 W. Miller St.
Springfield, IL 62702

217-788-3000

memorial health

ATTACHMENT 7 - Return Receipt/Proof of Mailing

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
■ Complete items 1, 2, and 3. ■ 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 ☐ Agent ☐ Addressee	
1. Article Addressed to: <i>Mike Trachten, RED</i> <i>Blessing Hospital</i> <i>PO Box 7005</i> <i>Quincy, IL 62305</i>  9590 9402 7309 2028 2589 63		B. Received by (Printed Name) C. Date of Delivery	
2. Article Number (Transfer from service label) 7022 0410 0003 4930 8304		D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No	
3. Service Type ☐ Adult Signature ☐ Adult Signature Restricted Delivery ☐ Certified Mail® ☐ Certified Mail Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500)		☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Signature Confirmation™ ☐ Signature Confirmation Restricted Delivery	

Attachment 8

Background of Applicant

- 1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

Memorial Medical Center d/b/a Springfield Memorial Hospital (SMH) is hospital with 500 beds located in Springfield, Illinois. SMH is a fully owned affiliate of Memorial Health System (MHS). After the proposed discontinuation SMH will be a 490 bed facility.

MHS is an Illinois Not for Profit corporation and is the sole corporate member of the following Illinois health care facilities, as defined under the Illinois Health Facilities Planning Act (20 ILCS 3960/3).

The identification numbers of each of these health care facilities is shown below, along with their names and locations.

Name and Location of Facility	Identification Numbers
Passavant Area Hospital (DBA Jacksonville Memorial Hospital) Jacksonville, Illinois	Illinois License ID # 1792 Joint Commission ID # 7362
Memorial Medical Center (DBA Springfield Memorial Hospital) Springfield, Illinois	Illinois License ID # 1487 Joint Commission ID # 7431
Abraham Lincoln Hospital (DBA Lincoln Memorial Hospital) Lincoln, Illinois	Illinois License ID # 5728 Joint Commission ID # 7373
Taylorville Memorial Hospital Taylorville, Illinois	Illinois License ID # 5447 Joint Commission ID # 4745
Decatur Memorial Hospital Decatur, Illinois	Illinois License ID # 0471 Joint Commission ID # 4632

- 2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.**

There have been no adverse actions taken against any facility owned or operated in Illinois by SMH or MHS in the three (3) year period prior to the filing of this Application.

- 3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

Letters certifying the above information and granting access to the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health are included in ATTACHMENT 8.

4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

SMH has not submitted another CON or COE application in the last calendar year. MHS is a co-applicant on the related Rehabilitation Institute of Springfield proposed freestanding hospital. This CON application is being submitted concurrently with this COE and all information in the application is accurate.



August 31, 2026

John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

Re: Authorization to Access Information and Statement of No Adverse Action

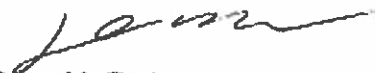
Dear Mr. Kniery:

Pursuant to 77 Ill. Admin. Code Section 1110.230, I hereby authorize the Illinois Health Facilities & Services Review Board (the "Board") and the Illinois Department of Public Health ("IDPH") to access all information necessary to verify any documentation or information submitted by Memorial Health System with this application. I further authorize the Board and IDPH to obtain any additional documentation or information which the Board or IDPH finds pertinent and necessary to process this application.

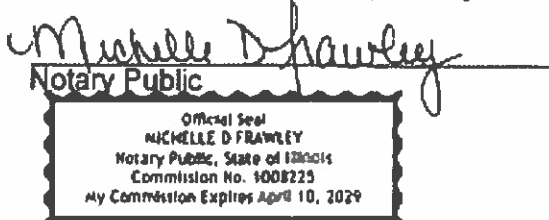
I also certify that there has been no adverse action taken against any Illinois facility owned and/or operated by the Springfield Memorial Hospital in the three years prior to the filing of this application for a Certificate of Exemption Permit.

Please contact me at 217-588-5295 or early.drew@mhsil.com if you have any questions.

Sincerely,


Drew M. Early
Interim President, Springfield Memorial Hospital
Senior Vice President and Chief Operating Officer
Memorial Health

SUBSCRIBED AND SWORN
To before me this 27 day of August 2026



340 W. Miller St.
Springfield, IL 62702

217.788.3000

memorial.health



August 31, 2026

John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

Re: Authorization to Access Information and Statement of No Adverse Action

Dear Mr. Kniery:

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I also certify that there has been no adverse action taken against any Illinois facility owned and/or operated by the Memorial Health System in the three years prior to the filing of this application for a Certificate of Exemption Permit.

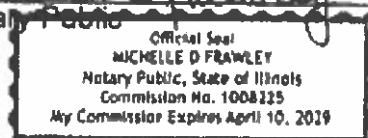
Please contact me at 217-788-4440 or eaton.mandy@mhsil.com if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Mandy C. Eaton".

Mandy C. Eaton
President and Chief Executive Officer
Memorial Health

SUBSCRIBED AND SWORN
To before me this 27 day of August, 2026

A handwritten signature in black ink that reads "Michelle D. Frawley".
Notary Public

340 W. Miller St.
Springfield, IL 62702

217-788-3000

memorial.health

Attachment 9

Safety Net Impact Statement

1. The project's material impact, if any, on essential safety net services in the community *including the impact on racial and health care disparities in the community*, to the extent that it is feasible for an applicant to have such knowledge.

Springfield Memorial Hospital (SMH) does not believe the discontinuation will have any impact on safety net services nor on racial and health care disparities in the community. The discontinuation is only taking place in conjunction with the opening of the proposed freestanding 60-bed Rehabilitation Institute of Springfield that will offer greater access to comprehensive rehabilitation services to the local community and will simultaneously allow SMH to streamline other needed inpatient services.

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.

SMH does not believe this project will materially impact the ability of the other providers or health care systems to cross subsidize safety net services. As mentioned in ATTACHMENT 7 number 1, the only other hospital offering the same services in HSA-3 is Blessing Hospital, 113 miles to the west in Quincy. The discontinuation would not affect any other type of safety net services.

3. How the discontinuation of a service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

There should not be any impact to the community or other providers as the beds discontinued by this project will be offset by the opening of the proposed Rehabilitation Institute of Springfield.

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.

Please see the table below in ATTACHMENT 9.

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.

Please see the table below in ATTACHMENT 9.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

Springfield Memorial Hospital and Memorial Health System believe related proposed Rehabilitation Institute of Springfield project will improve access to this important service while also allowing SMH to streamline other essential patient care services. This project is not expected to have any impact on safety net services or other health care services in the area.

Safety Net Information per PA 96-0031			
Springfield Memorial Hospital			
FY '23 thru FY '25			
	Charity Care		
	FY 2023	FY 2024	FY 2025
Charity (# of patients)			
Inpatient	125	135	118
Outpatient	1,253	1,470	833
Total	1,378	1,605	951
Charity (Cost in \$\$)			
Inpatient	1,495,880	2,537,215	4,345,877
Outpatient	1,043,733	1,929,394	2,265,169
Total	2,539,613	4,466,609	6,611,046
	Medicaid		
	FY 2023	FY 2024	FY 2025
Medicaid (# of patients)			
Inpatient	3,994	3,714	3,880
Outpatient	121,349	104,120	91,330
Total	125,343	107,834	95,210
Medicaid (Revenue)			
Inpatient	58,497,024	58,422,866	71,871,283
Outpatient	77,304,360	63,259,344	99,333,563
Total	135,801,384	121,682,210	171,204,846

Attachment 10

Charity Care Springfield Memorial Hospital

The amount of charity care provided by Springfield Memorial Hospital for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below. 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 – Springfield Memorial Hospital			
	FY 2023	FY 2024	FY 2025
Net Patient Service Revenue	\$ 783,578,091	\$ 815,445,499	\$ 889,212,969
Amount of Charity Care (charges)	\$ 10,553,179	\$ 20,184,399	\$ 28,836,211
Cost of Charity Care	\$ 2,539,613	\$ 4,466,609	\$ 6,611,046
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.32%	0.55%	0.74%

Charity Care – Memorial Health

The amount of charity care provided by Memorial Health Affiliates - Decatur Memorial Hospital, Springfield Memorial Hospital, Taylorville Memorial Hospital, Lincoln Memorial Hospital and Jacksonville Memorial Hospital - for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below.

CHARITY CARE - Memorial Health System			
	FY 2023	FY 2024	FY 2025
Net Patient Service Revenue	\$ 1,325,133,895	\$ 1,404,245,444	\$ 1,517,746,002
Amount of Charity Care (charges)	\$ 14,100,043	\$ 26,259,884	\$ 46,446,003
Cost of Charity Care	\$ 3,592,478	\$ 5,672,394	\$ 10,564,011
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.27%	0.40%	0.70%