

**EXECUTIVE DOCUMENT SUMMARY**

State Form 41221 (R10/4-06)

Instructions for completing the EDS and the contract process.

- Received**  
**AUG 26 ENT**  
**DOA Contracts**
1. Please read the guidelines on the back of this form.
  2. Please type all information.
  3. Check all boxes that apply.
  4. For amendments / renewals, attach original contract.
  5. Attach additional pages if necessary.

1. EDS Number: A70-4-070531  
2. Date prepared: 6/26/2014

**3. CONTRACTS & LEASES**

— Professional/Personal Services — Contract for procured Services  
☒ Grant — Maintenance  
— Lease — License Agreement  
— Attorney ☒ Amendment# 1  
— MOU — Renewal #  
— QPA — Other

**FISCAL INFORMATION**

4. Account Number: 61900-30700.573100  
5. Account Name: ISDH DOAg Fund  
6. Total amount this action: \$65,510.04  
7. New contract total: 1,164,454.71  
8. Revenue generated this action: \$0.00  
9. Revenue generated total contract: \$0.00  
10. New total amount for each fiscal year:  
Year 2014 \$1,098,944.67  
Year 2015 \$65,510.04  
Year \$  
Year \$

**TIME PERIOD COVERED IN THIS EDS**

11. From (month, day, year): 10/1/2013  
12. To (month, day, year): 9/30/2014  
13. Method of source selection: Bid/Quotation Emergency Negotiated  
☒ RFP# 12-50 Other (specify) Special Procurement

35. Will the attached document involve data processing or telecommunications systems(s)? Yes: IOT or Delegate has signed off on contract

36. Statutory Authority (Cite applicable Indiana or Federal Codes):  
42 U.S.C. 1786

37. Description of work and justification for spending money. (Please give a brief description of the scope of work included in this agreement.)  
The vendor administers the Women, Infants, and Children's (WIC) program in St. Joseph County. The Indiana Supplemental Food Program for Women, Infants and Children provides nutritious supplemental foods, nutrition education, breastfeeding support, and health care referrals to women, infants and children up to the age of five who are at nutritional risk and meet federal income guidelines (up to 185% of poverty)

38. Justification of vendor selection and determination of price reasonableness:  
This entity was awarded the contract through the State procurement bid process, RFP #12-50. Budgets were negotiated by ISDH and the vendor. The vendor has implemented cost containment measures. Funding for staffing is allocated based on participant caseload and funding for supplies is based on a flat rate per participant.

39. If this contract is submitted late, please explain why: (Required if more than 30 days late.)

40. Agency fiscal officer or representative approval: *Jared Interm...*  
41. Date Approved: 8/21/14  
42. Budget agency approval: *[Signature]*  
43. Date Approved: 9/5/14  
44. Attorney General's Office approval: *NMS*  
45. Date Approved: 9.9.14  
46. Agency representative receiving from AG: *[Signature]*  
47. Date Approved:

AUG 27 2014

20382 JLC

**AGENCY INFORMATION**

14. Name of agency: Department of Health  
15. Requisition Number: 0000026136  
16. Address: 2 N. Meridian Street  
Indianapolis, IN 46204

**AGENCY CONTACT INFORMATION**

17. Name: Steve Gale  
18. Telephone #: 317/233-9243  
19. E-mail address: sgale1@isdh.in.gov

**COURIER INFORMATION**

20. Name: Michael P. Mendyk  
21. Telephone #: 317-233-7853  
22. E-mail address: mmendyk@isdh.in.gov

**VENDOR INFORMATION**

23. Vendor ID #: 0000000039  
24. Name: MEMORIAL HOSPITAL OF SOUTH BEND  
25. Telephone #: (574) 647-3549  
26. Address: MEMORIAL HOSP OF SOUTH BEND  
615 N MICHIGAN ST  
SOUTH BEND, IN 46601  
27. E-mail address: jcostello@beaconhealthsystem.org

28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) ☒ Yes ☐ No

29. Primary Vendor: M/WBE/IN-Veteran  
Minority: ☐ Yes ☒ No  
Women: ☐ Yes ☒ No  
IN-Veteran: ☐ Yes ☒ No  
30. Primary Vendor Percentages  
100.0 %

31. Sub Vendor: M/WBE/IN-Veteran  
Minority: ☐ Yes ☒ No  
Women: ☐ Yes ☒ No  
IN-Veteran: ☐ Yes ☒ No  
32. If yes, list the %:  
Minority: %  
Women: %  
IN-Veteran: %

33. Is there Renewal Language in the document? ☒ Yes ☐ No  
34. Is there a "Termination for Convenience" clause in the document? ☒ Yes ☐ No

**RECEIVED**

SEP 08 2014

**OAG-ADVISORY**

73972-001

# REQUISITION

**Ship To:** State Department of Health  
Section 2-C  
2 N MERIDIAN ST  
INDIANAPOLIS IN 46204

**Bill to:** State Department of Health  
Section 2-C  
2 N MERIDIAN ST  
INDIANAPOLIS IN 46204

<b>Requisition No.</b>	<b>Date</b>	<b>Required Date</b>	<b>Page</b>
0000026136	07/23/2014		1 of 1
<b>Fund/Account:</b> 61900 / 573100			
<b>Dept Number:</b> 195070			
<b>Project Number:</b> 40010557WICAD14			
<b>Requisition Number:</b> 0000026136			
<b>Requestor:</b> GALLEN Allen, Gary-400			
<b>Agency Number:</b> 00400 Department of Health			
<b>Facility:</b>			

## MUST COMPLETE FOR ICPR

☐ Print REQ  
☐ Streamline Eligible

Line	Item	Description	Quantity	UOM	Unit Price	Ext Amt
This entity was awarded the contract through the State procurement bid process, RFP #12-50. Budgets were negotiated by ISDH and the vendor in order to implement cost containment measures. Funding for staffing is allocated based on participant caseload and funding for supplies is based on a flat rate per participant.						
1-1		Amend #1 A70-4-070531, 10/1/13-9/30/14	1.0000	LO	65,510.0400	65,510.04

Vendor: 0000000039 MEMORIAL HOSPITAL OF SOUTH BEND

<< PLEASE SEE ATTACHED CONTRACT  
CONTRACT DATE 10/1/13-9/30/14  
CONTRACT AMOUNT \$65,510.04

EXISTING PURCHASE ORDER # 14528000 >>

The following UN/CEFACT Unit of Measure  
Common Codes are used in this document:  
LO Lot

**Requisition Total \$ 65,510.04**

<b>Requestor Signature</b>	<b>I certify that the item[s] requested is [are] necessary for the operation of this State Agency.</b>	
	<b>Printed Name of Agency Head or Authorized Employee</b>	<b>Authorized Signature</b>

SP

**Amendment No. 1  
EDS Number A70-4-070531 (WIC)**

This is an Amendment to the existing U.S.D.A. WIC Grant Agreement entered into by and between the **Indiana State Department of Health** (hereinafter referred to as the "State") and **Memorial Hospital of South Bend Inc** (hereinafter referred to as the "Grantee") for the period from **October 1, 2013** through **September 30, 2014**, in the amount of **\$1,098,944.67**.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:

The amount of the Grant Agreement is being increased by **\$65,510.04** making the new total of the Grant Agreement **\$1,164,454.71**. The additional funds will be used to **support personnel, fringe, nutrition education activities, outreach activities, travel, other needs for St. Joseph County**. See Attachment B1, attached hereto, which replaces Attachment B, made a part hereof, and incorporated herein by reference as a part of this Grant Agreement.

All other matters previously agreed to and set forth in the original Grant Agreement and not affected by this Amendment shall remain in full force and effect.

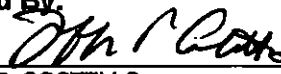
**Non-Collusion and Acceptance**

The undersigned attests, subject to the penalties of perjury, that he/she is the Grantee, or that he/she is the properly authorized representative, agent, member or officer of the Grantee, that he/she has not, nor has any other member, employee, representative, agent or officer of the Grantee, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid any sum of money or other consideration for the execution of this Grant Agreement other than that which appears upon the face hereof.

**The rest of this page has been left blank intentionally.**

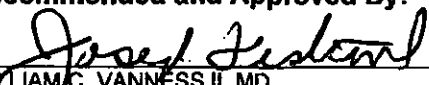
In Witness Whereof, the Grantee and the State of Indiana have, through duly authorized representatives, entered into this Grant Agreement Amendment. The parties having read and understanding the foregoing terms of the Grant Agreement Amendment do by their respective signatures dated below agree to the terms thereof.

Accepted By:

  
JEFFREY P. COSTELLO  
CFO  
MEMORIAL HOSPITAL OF SOUTH BEND INC

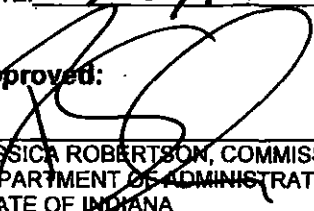
DATE: 7/22/14

Recommended and Approved By:

  
WILLIAM C. VANNESS II, MD  
STATE HEALTH COMMISSIONER  
INDIANA STATE DEPARTMENT OF HEALTH

DATE: 8/21/14

Approved:

  
JESSICA ROBERTSON, COMMISSIONER  
DEPARTMENT OF ADMINISTRATION  
STATE OF INDIANA

DATE: 8/27/14

Approved:

  
BRIAN E. BAILEY, DIRECTOR  
STATE BUDGET AGENCY  
STATE OF INDIANA

DATE: 9/5/14

Approved as to Form and Legality:

  
GREGORY F. ZOELLER  
ATTORNEY GENERAL OF INDIANA

DATE: 9.9.14

Attachment B1



Indiana State  
Department of Health

**INDIANA WIC**  
Local Agency Budget

Name of Organization:	Memorial Hospital of South Bend, Inc.		
Employer ID Number (EIN)	350868132		
Breastfeeding Region	White	Federal Fiscal Year	2014

Address:	615 North Michigan Street		
City:	South Bend	State:	Indiana
		Zip:	46601-9986

Phone:	(574) 647-2173	Fax:	(574) 647-2230
Website:	qualityoflife.org		

Name of Chief Executive:	Margo DeMont, Ph.D.		
Title:	Executive Director	Phone:	574-647-1356
Email:	mdemont@beaconhealthsystem.org		

Name of Program Contact:	Patti Meunick		
Title:	WIC Coordinator	Phone:	574-647-2184
Email:	pmeuninck@beaconhealthsystem.org		

Clinic Operation Caseload	7020	Breastfeeding Promotion Caseload	1119
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<b>WIC Nutrition Services &amp; Admin (NSA) Total Costs:</b>	<b>\$</b>	<b>1,164,454.71</b>
<b>Breastfeeding Promotion Costs:</b>	<b>\$</b>	<b>40,117.87</b>
Personnel - Salary:	\$	27,570.40
Personnel - Fringe:	\$	10,771.19
Travel:	\$	1,776.28
<b>Clinic Operations Costs:</b>	<b>\$</b>	<b>1,124,336.84</b>
Personnel - Salary:	\$	749,697.77
Personnel - Fringe:	\$	217,519.72
Travel - Clinic Services:	\$	3,440.22
Travel - Nutrition Education:	\$	1,758.66
Supplies:	\$	30,980.44
Communication:	\$	7,559.77
Contract Services:	\$	26,139.00
Space Costs:	\$	87,241.26