

E-025-18 [ORIGINAL]

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**This Section must be completed for all projects.****RECEIVED**

APR 30 2018

HEALTH FACILITIES &
SERVICES REVIEW BOARD**Facility/Project Identification**

Facility Name: Carle Richland Memorial Hospital		
Street Address: 800 E. Locust Street		
City and Zip Code: Olney, IL 62450		
County: Richland	Health Service Area: HSA-5	Health Planning Area: F-03

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

Exact Legal Name: Richland Memorial Hospital, Inc. dba Carle Richland Memorial Hospital	
Street Address: 800 E. Locust St.	
City and Zip Code: Olney, IL 62450	
Name of Registered Agent: James C. Leonard, MD	
Registered Agent Street Address: 611 West Park Street	
Registered Agent City and Zip Code: Urbana, IL 61801	
Name of Chief Executive Officer: Jennifer Emmons	
CEO Street Address: 800 E. Locust St.	
CEO City and Zip Code: Olney, IL 62450	
CEO Telephone Number: (618) 395-2131	

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: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation
Address: 611 W. Park St. Urbana, IL 61801
Telephone Number: 217-902-5521
E-mail Address: Collin.Anderson@Carle.com
Fax Number:

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 150 N. Riverside Plaza, Ste. 3000 Chicago, IL 60606
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Name of Chief Executive Officer: James C. Leonard, MD
CEO Street Address: 611 W. Park St.
CEO City and Zip Code: Urbana, IL 61801
CEO Telephone Number: 217-383-3311

Type of Ownership of Applicants

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

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Telephone Number: 217-902-5521
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Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 150 N. Riverside Plaza, Ste. 3000 Chicago, IL 60606
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

Post Exemption Permit Contact

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

Name: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation Hospital
Address: 611 W. Park St. Urbana, IL 61801
Telephone Number: 217-902-5521
E-mail Address: Collin.anderson@carle.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: n/a
Address of Site Owner: n/a
Street Address or Legal Description of the Site: 800 E. Locust St. Olney, IL 62450
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: Richland Memorial Hospital, Inc. dba Carle Richland Memorial Hospital	
Address: 800 E. Locust St. Olney, IL 62450	
☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Other	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
○ 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.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. 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.

Carle Richland Memorial Hospital ("CRMH") is requesting to discontinue its acute mental illness (AMI) category of service. CRMH is currently authorized to operate 16 AMI beds located at 800 E. Locust St. Olney, IL 62450. The discontinuation will be effective at the later of HFSRB approval or Illinois Department of Public Health approval.

There are no project costs associated with this project.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No 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

For facilities in which prior permits have been issued please provide the permit numbers.
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): <u>Upon IDPH & HFSRB approval</u>
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): not applicable ☐ Purchase orders, leases or contracts pertaining to the project have been executed. Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☐ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

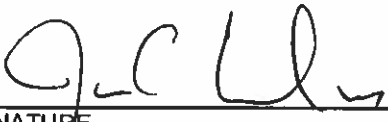
Are the following submittals up to date as applicable: ☒ Cancer Registry ☒ APORS ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

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

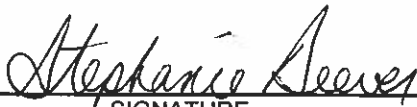
- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its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

This Application for Permit is filed on the behalf of The Carle Foundation *
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

James C. Leonard, MD
PRINTED NAME

President and CEO
PRINTED TITLE

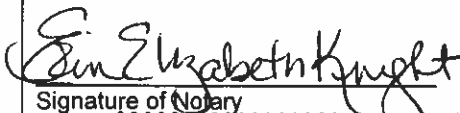

SIGNATURE

Stephanie Beever
PRINTED NAME

Executive Vice President and Chief Strategy Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 25 day of April, 2018


Signature of Notary

Seal
"OFFICIAL SEAL"
Erin Elizabeth Knight
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 04/15/21

*Insert EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 25 day of April, 2018


Signature of Notary

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Jennifer Emmons
SIGNATURE

Jennifer Emmons
PRINTED NAME

Interim Chief Executive Officer
PRINTED TITLE

Christina Bare
SIGNATURE

Christina Bare
PRINTED NAME

Director of Business Operations
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 24th day of April, 2018

Notarization:

Subscribed and sworn to before me
this 24th day of April, 2018

Cheryl J Stout
Signature of Notary

Seal

OFFICIAL SEAL
CHERYL J STOUT
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/05/20

*Insert EXACT legal name of the applicant

Cheryl J Stout
Signature of Notary

Seal

OFFICIAL SEAL
CHERYL J STOUT
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/05/20

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- | | |
|-------------------------------------|---|
| ☐ | Discontinuation of an Existing Health Care Facility |
| ☒ | Discontinuation of a category of service |

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or 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.

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.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES
- INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

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, 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 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)**PURPOSE OF PROJECT**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. SERVICE SPECIFIC REVIEW CRITERIA (Neonatal Intensive Care Services Only)

Criterion 1130.531 Requirements for Exemptions for the Establishment or Expansion of Neonatal Intensive Care Service and Beds

This Section is applicable to all projects proposing the establishment, or expansion of Neonatal Intensive Care Service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements, as well as charts for the service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). **APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Criterion 1130.531 - Neonatal Intensive Care Services

1. Applicants proposing to establish, expand and/or modernize the Neonatal Intensive Care categories of service must submit the following information:
2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Neonatal Intensive Care		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand
1130.531(a) - A description of the project that identifies the location of the neonatal intensive care unit and the number of neonatal intensive care beds proposed;	X	X
1130.531(b) - Verification that a final cost report will be submitted to the Agency no later than 90 days following the anticipated project completion date;	X	X
1130.531(c) - Verification that failure to complete the project within the 24 months after the Board approved the exemption will invalidate the exemption.	X	X

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHANGE OF OWNERSHIP (CHOW)**1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility**

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.
3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the	X

compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	
1130.520(b)(2) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

Application for Change of Ownership Among Related Persons

When a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership. [20 ILCS 3960/8.5(a)]

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

VI. 1120.120 - AVAILABILITY OF FUNDS (Neonatal Intensive Care Services only)

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
TOTAL FUNDS AVAILABLE		

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. **Variance**

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot Mod.	New Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS **ATTACHMENT 19**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the

reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

A table in the following format must be provided as part of Attachment 40.

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			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

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 41.

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

APPEND DOCUMENTATION AS **ATTACHMENT 21**, 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	25-26
2	Site Ownership	27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	28-29
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	30
5	Flood Plain Requirements	31
6	Historic Preservation Act Requirements	32
7	Project and Sources of Funds Itemization	n/a
8	Financial Commitment Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	n/a
11	Background of the Applicant	33-36
12	Purpose of the Project	37
13	Alternatives to the Project	n/a
	Service Specific:	
14	Neonatal Intensive Care Services	n/a
15	Change of Ownership	n/a
	Financial and Economic Feasibility:	
16	Availability of Funds	n/a
17	Financial Waiver	n/a
18	Financial Viability	n/a
19	Economic Feasibility	n/a
20	Safety Net Impact Statement	38-39
21	Charity Care Information	40



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, 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

RICHLAND MEMORIAL HOSPITAL, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 30, 1996, 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 APRIL A.D. 2018 .***

Jesse White

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 I am the keeper of the records of the Department of Business Services. I certify that

THE CARLE FOUNDATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1946, 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 11TH
day of JANUARY A.D. 2018 .***

Jesse White

SECRETARY OF STATE

Proof of Site Ownership

The requirement to provide proof of site ownership is not applicable to this project.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, 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

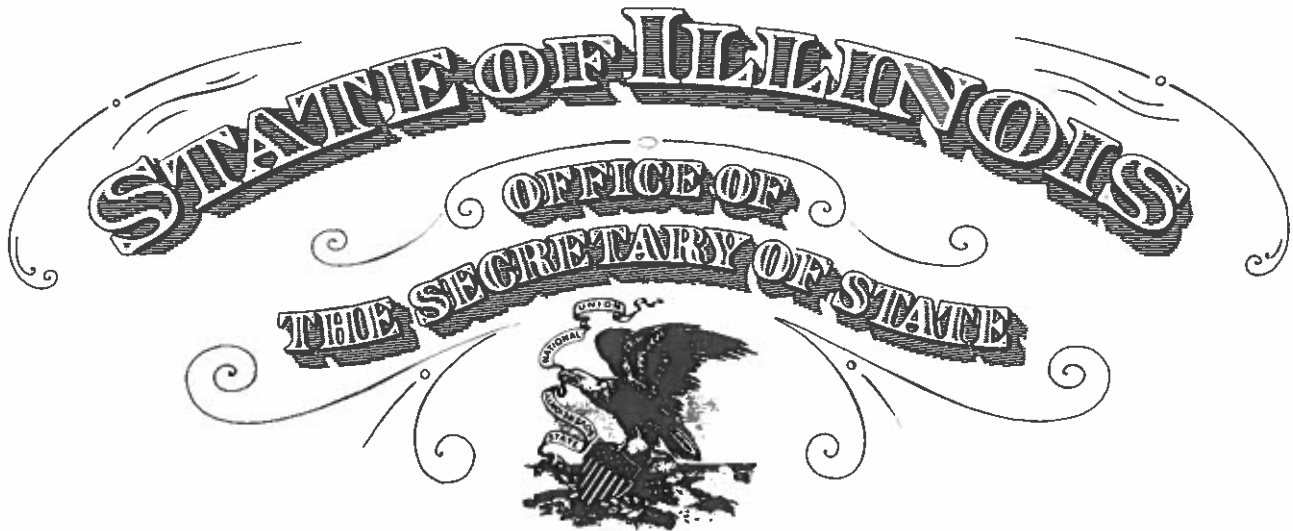
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SECRETARY OF STATE



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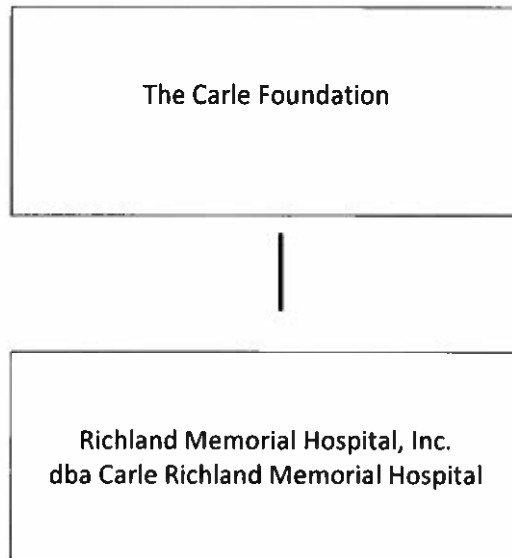


***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 11TH
day of JANUARY A.D. 2018 .***

Jesse White

SECRETARY OF STATE

Entity Chart



Flood Plain Requirements

The requirement to provide documentation that the project is not in a flood plain is not applicable because there is no construction associated with the discontinuation of the acute mental illness category of service.

Historic Resources Preservation Act Requirements

This project does not involve the demolition or other modification of buildings and will have no impact on historic resources. Thus, the requirement to obtain clearance from the Historic Preservation Agency is not applicable.

Section II, Discontinuation

Criterion 1110.130(a), General

1. **Identify the categories of service and the number of beds, if any that is to be discontinued.**

Carle Richland Memorial Hospital ("CRMH") located at 800 E. Locust St. Olney, IL 62450 proposes to discontinue its acute mental illness (AMI) category of services, which consists of 16 beds.

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

No other clinical services will be discontinued as a result of this project.

3. **Provide the anticipated date of discontinuation for each identified service or for the entire facility.**

The discontinuation will be effective at the later of HFSRB approval or Illinois Department of Public Health approval.

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

The vacated space within the AMI unit will be renovated and converted into physician exam rooms for outpatient specialty services.

Equipment that remains viable will remain in the repurposed space or be utilized in other units within the hospital.

5. **Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.**

Medical records will be maintained and available in an electronic format by CRMH for 10 years post discharge.

6. **For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.**

This section is not applicable. The proposed discontinuation is for the AMI category of service only. All questionnaires and data required to be submitted by CRMH will continue to be provided as required.

7. **Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.**

This section is not applicable. The proposed discontinuation is for the AMI category of service only.

8. **Provide attestation that the facility provided the required notice of the facility or 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.**

Documentation that the facility provided the required notice of the category of service discontinuation to local media is attached at Attachment- 10A. The notice ran in the Olney Daily Mail newspaper on April 27, 2018.

Criterion 1110.130(b), Reasons for Discontinuation

CRMH suspended operation of its AMI unit on July 26, 2017 due to a lack of physician coverage. At that time, the unit's Medical Director and sole psychiatrist in Olney began an extended medical leave. Unfortunately, it has become clear that the Medical Director will not return to work because of his medical condition.

CRMH worked with a recruitment firm for several months in an attempt to recruit a replacement psychiatrist. To date, only one candidate has been identified. Unfortunately, he withdrew himself from consideration upon discussing details of the position.

Since recommending operations would require either the current psychiatrist's return to work or successful recruitment of one or more replacement psychiatrists, CRMH has determined it must discontinue its AMI category of service.

Criterion 1110.130(c), Impact on Access

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.

The discontinuation of the AMI unit will not negatively impact access to care. The unit has temporarily suspended operations since July 2017 without having an adverse effect on access. During this time, psych patients who presented at CRMH were stabilized in the Emergency Department and either discharged with an outpatient treatment plan or transferred to an appropriate AMI provider on a case-by-case basis. This manner of addressing the needs of patients presenting to the ED with psychiatric conditions will continue following discontinuation.

Furthermore, CRMH recently hired a Psychiatric Mental Health Nurse Practitioner who will provide new outpatient behavioral health services on the CRMH campus starting summer 2018. A Carle Psychiatrist practicing in Champaign-Urbana will be the nurse practitioner's collaborating physician in order to provide local care to the Olney community. CRMH is pleased to begin offering this access to mental health services on an outpatient basis.

To ensure regional and community behavioral health and psychiatry needs are met going forward, Carle Health System has retained a consulting firm to undertake a long-term assessment and develop a system-wide strategic plan for behavioral health.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 21 miles of the applicant facility.

This section is not applicable since there are not any health care facilities within 21 miles of CRMH that offer inpatient AMI services. Attached at Attachment- 10B is a map showing a 21-mile radius around CRMH.

CERTIFICATE OF PUBLICATION

State of Illinois
County of Richland

Publisher's Fee \$ 85.68

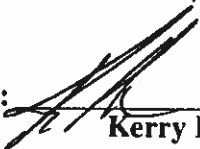
Carle Richland Memorial Hospital

Psychiatric Public Notice

This is to Certify that a Notice, a true copy of which is hereto attached, was published in the Olney Daily Mail, a secular newspaper of general circulation in Olney, in the County of Richland and the State of Illinois, by Gatehouse Media, a corporation existing under the laws of said state once a week for 1 successive weeks; that the date of the first paper containing said notice was published the 27 day of April, 20 18, and that the date of the last paper containing said notice was published the 27 day of April, 20 18.

And this is to Further Certify that said newspaper has been regularly published for 50 weeks prior to the publications of said notice therein, and that the person who signs the name of said company to this certificate is as appears by the records of said company, its duly authorized agent for such purpose.

Dated this, 27 day of April, 20 18.

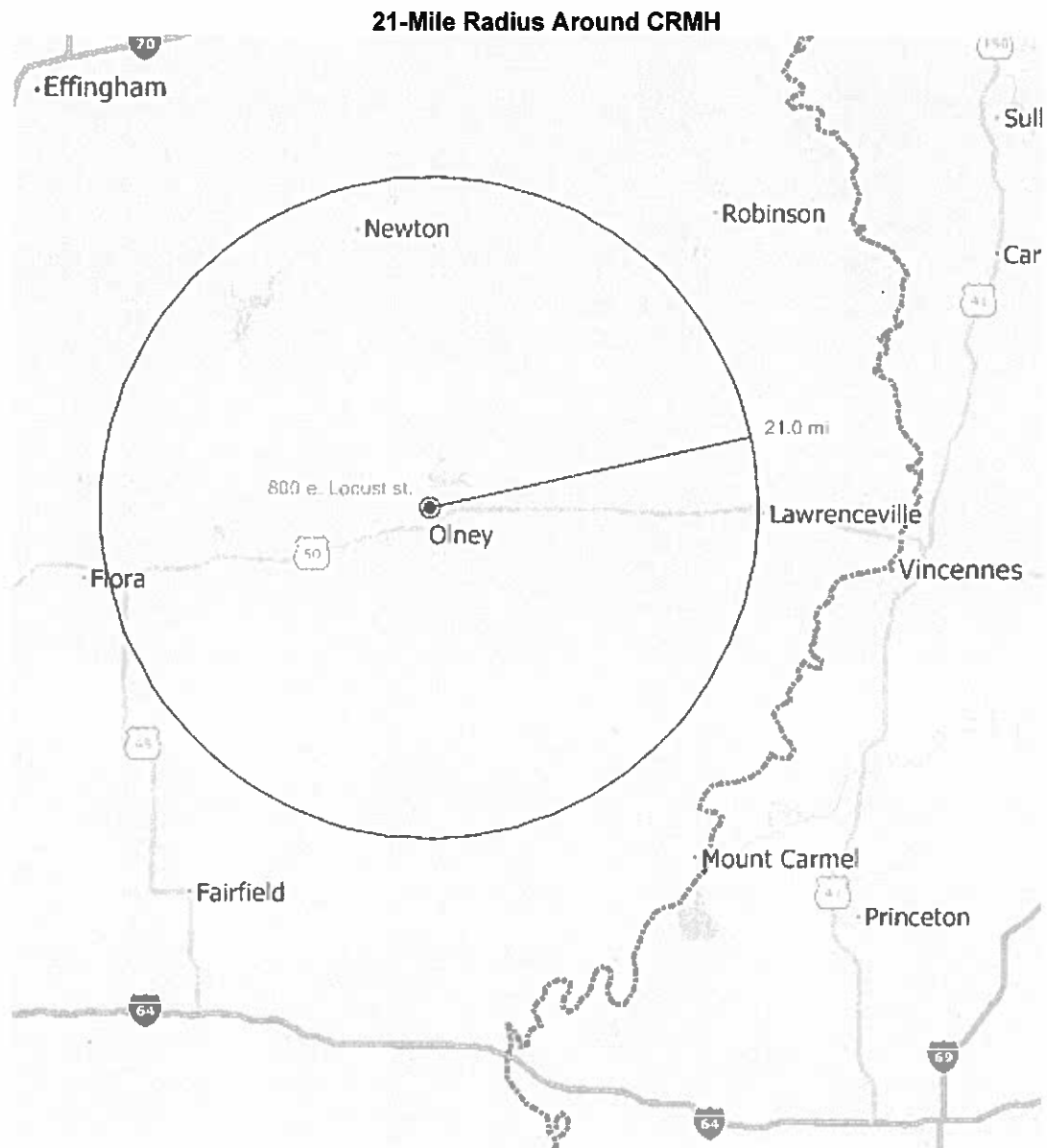
Signature: 

Kerry Kocher, Publisher

Public Notice

Pending approval from the Illinois Health Facilities and Services Review Board, Carle Richland Memorial Hospital will treat adult patients requiring mental health treatment in the outpatient and emergency department settings rather than operating a dedicated inpatient area of the hospital with a distinct acute mental illness bed category of service. While CRMH will no longer have inpatient admissions for psychiatric care, it will continue to collaborate with other psychiatric programs for necessary admissions. In Olney, CRMH will address the lower acuity mental health services needs of the community in the outpatient setting with a newly hired healthcare professional in collaboration with the mental health professionals of its partner, Carle Foundation Hospital.

Attachment- 10B



Background of Applicant

This section is not applicable to a discontinuation project with no project costs.

Safety Net Impact Statement

Carle Richland Memorial Hospital ("CRMH") is requesting to discontinue its acute mental illness (AMI) category of service. This Safety Net Impact Statement addresses the following requirements:

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

The discontinuation will not affect essential safety net services in the community. As discussed in Attachment- 10, the AMI unit has temporarily suspended operations since July 2017 without having an adverse effect on access. During this time, psych patients who presented at CRMH were stabilized in the Emergency Department and either discharged with an outpatient treatment plan or transferred to an appropriate AMI provider on a case-by-case basis. This manner of addressing the needs of patients presenting to the ED with psychiatric conditions will continue following discontinuation.

Furthermore, CRMH recently hired a Psychiatric Mental Health Nurse Practitioner who will provide new outpatient behavioral health services on the CRMH campus starting during summer 2018. A Carle Psychiatrist practicing in Champaign-Urbana will be the collaborating physician in order to provide local care to the Olney community.

- 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.**

CRMH has been transferring patients who require a higher level of acuity of inpatient psychiatric care to other facilities for a period of years. The applicants do not believe this project will impact the ability of another provider to cross-subsidize these services.

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

CRMH is the only hospital in the county, and it will continue to operate to provide the most appropriate scope of services in consideration of the community's needs and the resources available to the community.

Safety Net Impact Statements shall also include:

- 1. For the three fiscal years prior to the application, the applicant must also provide certification describing the amount of charity care provided by the applicant;**
- 2. For the three fiscal years prior to the application, a certification of the amount of charity care provided to Medicaid patients;**
- 3. Any information the applicant believes is directly relevant to safety net services.**

Safety Net Impact Statement

1. Charity Care Information (CRMH)

Charity Care (# of patients)	FY 14	FY 15	FY 16
Inpatient	84	105	90
Outpatient	1,166	1,168	1,437
Total	1,250	1,273	1,527
Charity Care (cost in dollars)	FY 14	FY 15	FY 16
Inpatient	\$374,472	\$174,609	\$182,172
Outpatient	\$833,502	\$494,391	\$616,828
Total	\$1,207,974	\$669,000	\$799,000

2. Medicaid Information (CRMH)

Medicaid (# of patients)	FY 14	FY 15	FY 16
Inpatient	679	609	542
Outpatient	12,973	12,926	13,559
Total	13,652	13,535	14,101
Medicaid (Revenue)	FY 14	FY 15	FY 16
Inpatient	\$1,965,584	\$1,546,938	\$1,425,666
Outpatient	\$4,375,010	\$4,549,321	\$5,155,903
Total	\$6,340,594	\$6,096,259	\$6,581,569

Charity Care Information

Charity care figures for Carle Richland Memorial Hospital for the latest three audited fiscal years are provided in the table below:

Carle Richland Memorial Hospital

		2015	2016	2017
1	Net Patient Revenue	\$48,418,212	\$49,518,141	\$51,520,404
2	Amount of Charity Care (charges)	\$2,300,617	\$2,703,837	\$3,343,340
3	Cost of Charity Care	\$669,000	\$799,000	\$991,000
4	Ratio of the cost of Charity Care to Net Patient Revenue	1.4%	1.6%	1.9%

F-025-18



611 West Park Street, Urbana, IL 61801-2595

Via Federal Express

Collin Anderson
(217) 902-5521
Collin.Anderson@Carle.com

Mr. Michael Constantino
Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, Illinois 62761

Re: Certificate of Need Application

Dear Mr. Constantino:

The Carle Foundation and Carle Richland Memorial Hospital, as co-applicants, hereby submit the attached Certificate of Exemption application for the discontinuation of Carle Richland Memorial Hospital's acute mental illness category of service. For your review, I have attached an original and one copy of the following documents:

1. Check for \$2,500 for the application processing fee; and
2. Completed application for Certificate of Exemption.

Thank you for your time and consideration. Please feel free to contact me if you require any additional information.

Sincerely,

A handwritten signature in blue ink, appearing to read "Collin Anderson", written over a horizontal line.

Collin Anderson
Business Development & Regulatory Coordinator
Carle Health System