E-027-18

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

MAY 01 2018

This Section must be completed for all projects.

HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Memorial Medical Center		
Street Address: 701 N. First Street		
City and Zip Code: Springfield 62781		
County: Sangamon	Health Service Area 3	Health Planning Area: 3

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

Exact Legal Name: Memorial Medical Center
Street Address: 701 N. First Street
City and Zip Code: Springfield 62781
Name of Registered Agent: Anna N. Evans, General Counsel & VP of Internal Audit and Compliance
Registered Agent Street Address: 701 N. First Street
Registered Agent City and Zip Code: Springfield 62781
Name of Chief Executive Officer: Edgar J. Curtis
CEO Street Address: 701 N. First Street
CEO City and Zip Code: Springfield 62781
CEO Telephone Number: 217-788-3340

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: Michael A. Curtis
Title: Administrator, Business Development and Strategic Planning
Company Name: Memorial Health System
Address: 701 N. First Street, Springfield, IL 62781
Telephone Number: 217-757-4281
E-mail Address: Curtis.michael@mhsil.com
Fax Number: 217-788-5520

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

Name: Michael Copelin
Title: President
Company Name: Copelin Helathcare Consulting
Address: 42 Birch Lake Drive, Sherman, IL 62684
Telephone Number: 217-496-3712
E-mail Address: micball1@aol.com
Fax Number: 217-496-3097

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.

Facility/Project Identification

Facility Name: Memorial Medical Center
Street Address: 701 North First Street
City and Zip Code: Springfield 62781
County: Christian Health Service Area : 3 Health Planning Area: 3

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Exact Legal Name: Memorial Health System
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City and Zip Code: Springfield 62781
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Telephone Number: 217-496-3712
E-mail Address: micball1@aol.com
Fax Number: 217-496-3097

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: Michael A. Curtis
Title: Administrator, Business Development and Strategic Planning
Company Name: Memorial Health System
Address: 701 N. First Street, Springfield, IL 62781
Telephone Number: 217-757-4281
E-mail Address: curtis.michael@mhsil.com
Fax Number: 217-788-5520

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 62781
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
Address: 701 N. First Street, Springfield, IL 62702

☒ 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.

Flood Plain Requirements Not Applicable

[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).

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

Historic Resources Preservation Act Requirements Not Applicable

[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.

Memorial Medical Center ("MMC") intends to permanently discontinue its 6-station outpatient chronic renal dialysis service. MMC operates its Chronic Dialysis program under the CMS certification number (14-2315). MMC seeks to discontinue the service due to low utilization. Since the beginning of 2015, less than 10 patients have been treated through the Chronic Dialysis program. MMC refers outpatient chronic renal dialysis patients to other facilities offering this service in the area. Patients whom need dialysis services while at MMC for other services including, but not limited to outpatient surgery, interventional radiology procedures and emergency care will still be able to be treated under the acute renal dialysis program (CMS certification number 14-0148). In the future, patients will continue to be referred to the local area dialysis facilities. The intent is to keep these stations in operation for use in the acute dialysis program.

This project is discontinuation of outpatient chronic renal dialysis services and does not have any related project costs.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only) Not Applicable

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

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 $ **Not Applicable**.

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): _Estimated May 31, 2018, or shortly after exemption is issued_____

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 representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of Memorial Health System* 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

Edgar J. Curtis
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of April, 2018

Signature of Notary

Seal

CINDY APPENZELLER
OFFICIAL SEAL
Notary Public State of Illinois
My Commission Expires
August 12, 2021

SIGNATURE

Robert W. Kay
PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of April, 2018

Signature of Notary

Seal

CINDY APPENZELLER
OFFICIAL SEAL
Notary Public - State of Illinois
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*Insert the EXACT legal name of the applicant

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PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

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*Insert the EXACT legal name of the applicant

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 Not Applicable – discontinuation only with no project costs

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) Not Applicable

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) Not Applicable

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 compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(2) - A statement as to the anticipated benefits of	X

the proposed changes in ownership to the community	
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)

Not Applicable

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 Not Applicable

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 Not Applicable

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 New	Cost/Square Foot 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	24-25
2	Site Ownership	26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	27-28
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
9	Cost Space Requirements	
10	Discontinuation	30-36
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
18	Financial Viability	
19	Economic Feasibility	
20	Safety Net Impact Statement	37-38
21	Charity Care Information	39

File Number 5248-617-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that 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, 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* 27TH *day of* APRIL *A.D.* 2018 .

Authentication #: 1811700392 verifiable until 04/27/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

24

Att-1, 1062

File Number 0751-757-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that 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, 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* 27TH *day of* APRIL *A.D.* 2018 .

Authentication #: 1811700306 verifiable until 04/27/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

25

ATT-1, 2012

Memorial
HEALTH SYSTEM

701 North First Street • Springfield, Illinois 62781-0001
www.memorialmedical.com • **Phone (217) 788-3000**

May 1, 2018

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62702

Re: Site Ownership of Memorial Medical Center

Dear Ms. Avery:

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

Memorial Health System's address is 701 N. 1st Street, Springfield, Illinois 62781.

Please contact me at 217-788-3340 or curtis.ed@mhsil.com if you have any questions.

Sincerely,

Edgar J. Curtis
President
Chief Executive Officer
Memorial Health System

ATT - 2

File Number 0751-757-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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Authentication #: 1811700306 verifiable until 04/27/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

27

ATT3, 1of2

File Number 5248-617-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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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* 27TH *day of* APRIL *A.D.* 2018 .

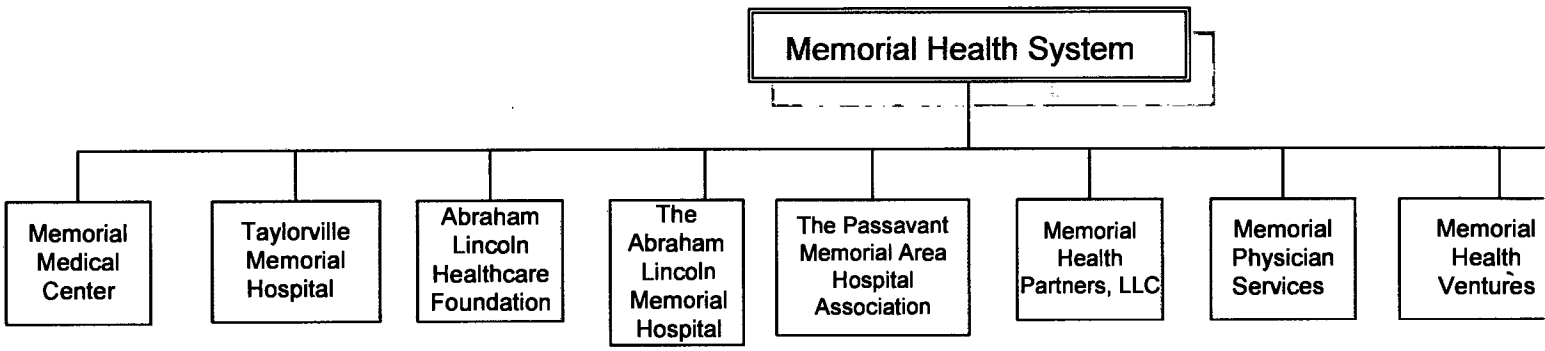
Authentication #: 1811700392 verifiable until 04/27/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATT-3; 2 of 2

Organizational Relationships



ATT - 4

SECTION II. DISCONTINUATION

Criterion 1110.130 – Discontinuation (State-Owned Facilities and Relocation of ESRD's)

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

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 whether or not the discontinuation of each service or of the entire facility 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.

GENERAL INFORMATION REQUIREMENTS

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

   No beds are being discontinued. ESRD chronic outpatient program is being discontinued as noted in requirement # 2.

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

Six (6) chronic end stage renal dialysis stations are being discontinued to be re-categorized and utilized as part of Memorial Medical Center's acute dialysis program.

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

   The anticipated date of discontinuation of the chronic ESRD program is 5/31/2018 or upon the approval of this exemption permit application by the Illinois Health Facilities and Services Review Board.

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

   The current stations used in the chronic program will remain operational and will be used by the acute dialysis program as needed.

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.

   This is not applicable. The hospital will retain all the medical records pertaining to patients formerly treated in the chronic ESRD program and will care for these patients in the acute dialysis program in the future if and when the need arises.

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

   This is not applicable. Only the chronic outpatient ESRD services are being discontinued and there are plenty of other providers in the are to meet these needs. Any patients at Memorial Medical Center for other services or for emergent needs can be treated in the same stations under the acute dialysis program.

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.

The reason for the discontinuation of the chronic ESRD program is due to extremely low utilization with less than 10 patients being served in this program since 2015. There are several other providers in the immediate area that can meet the needs of these patients, including one facility less than a mile from Memorial Medical Center. It is the intent, that the existing stations will remain operational as part of the hospital's acute dialysis program. Memorial believes patients at the hospital for other services or on an emergent basis can be treated appropriately in the acute dialysis program. The cost to maintain a medical director and staff time needed to remain compliant with the separate CMS certification number requirements for the chronic program is not justified given the low utilization of this program.

IMPACT ON ACCESS

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

The applicant is located in Health Services Area 3. The In-Center Hemodialysis category of service need for this planning area as identified in the 9/1/2017 Inventory of Health Care Facilities and Services Needs Determination is summarized in the table below.

Station Need with Discontinuation of MMC Chronic Stations					
Service	**2015 Existing Stations**	**2020 Projected Station Need**	**Calculation Excess (Need) - Current**	**MMC Stations to be Discontinued**	**Calculation Excess (Need) – After MMC Discontinuation**
HSA 3 Planning Area In-Center Hemodialysis Stations	179	155	24	(6)	18

This certificate of exemption permit application seeks to discontinue chronic ESRD program, but to leave the stations operational to be utilized in the acute dialysis program. As the table above shows, it is projected this health service area will still have excess stations to meet the projected patient needs. There are 13 other facilities providing ESRD services located within 45 minutes of the applicant (note some facilities are in HSA 4 and not just 3). These facilities and distance / minutes from Memorial Medical Center are listed in the tables below:

Facilities within 45 miles or minutes of Memorial Medical Center		
Facilities	**Minutes**	**Miles**
DaVita Springfield Central Dialysis, 600 N Grand Ave W, Springfield, IL 62702	4	1
FMC – West Centre West Springfield, 1112 Centre West Dr., Springfield, IL 62704	12	3.7
DaVita Springfield South Dialysis, 2930 S 6th Street, Springfield, IL 62703	12	4
DaVita Springfield South At Home, 2930 S 6th Street, Springfield, IL 62703	12	4
DaVita Springfield Montvale Dialysis, 2930 Montvale Dr, Ste A, Springfield, IL 62704	14	4.9
DaVita Taylorville Dialysis, 901 W Spresser St, Taylorville, IL 62568	36	27.8
DaVita Lincoln Dialysis, 2100 5th Street, Lincoln, IL 62656	33	30.1
DaVita Jacksonville Dialysis, 1515 W Walnut St, Jacksonville, IL 62650	51	40
DaVita Decatur East Wood Dialysis, 794 E Wood St, Decatur, IL 62523	45	40
DaVita Decatur East Wood At Home, 794 E Wood St, Decatur, IL 62523	45	40
FMC – Decatur Home, 441 W Hay St, Ste B, Decatur, IL 62526	45	40.2
DaVita Macon County Dialysis, 1090 W Mckinley Ave, Decatur, IL 62526	43	41.5
FMC – Decatur, 1830 S 44th St, Decatur, IL 62521	52	43.5

The discontinuation of the chronic outpatient ESRD service at Memorial Medical Center will have no impact on access to care for residents of the facility's market area because the hospital will continue to serve its own patient population in the existing stations to be utilized by the hospital's acute dialysis program and there is an excess number of stations for outpatient ESRD services in the 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.

See copies of the letters on the following pages along with the certified mail receipts for the 13 facilities noted above.

Memorial
MEDICAL CENTER

701 North First Street • Springfield, Illinois 62781-0001
www.memorialmedical.com • **Phone (217) 788-3000**
A Memorial Health System Affiliate

April 12, 2018

(Certified/Return Receipt: 7015 3010 0000 0677 1316)
DaVita
3 West Hawthorn Parkway #410 & #290
Vernon Hills, IL 60061

RE: Discontinuation of Six (6) Chronic Renal Dialysis Stations

To Whom It May Concern:

I am writing to inform you that Memorial Medical Center {"MMC") will soon be filing a Certificate of Exemption Permit {COEP) Application with the Illinois Health Facilities and Services Review Board {"IHFSRB") to discontinue its chronic renal dialysis program ("chronic program") operated under CMS certification number 14-2315. We anticipate closing the chronic program after approval by the IHFSRB, and hope we will receive such approval on or before the end of May 2018. Since 2015, less than 10 patients have utilized MMC's chronic program. MMC also operates an acute renal dialysis program ("acute program") to meet the dialysis needs of patients receiving other services at MMC. There are 11 dialysis stations at MMC, including the 6 approved under the chronic program's CMS certification number. Our desire is to continue to utilize all 11 dialysis stations in operation to meet the needs of MMC's acute program. MMC only seeks to terminate outpatient chronic dialysis services for individuals not needing any other services at MMC, and believes other providers in the community can meet the needs of these patients.

The COEP application requires that we request letters, from each facility providing the same services located within 45 minutes travel time from our hospital, stating what impact closing our unit may have on your facility. The discontinuation of chronic renal dialysis category of service at MMC will have no impact on access to care in the surrounding area. MMC will continue to serve the same patients currently receiving services in the acute program and, should not have any negative impact on your facility.

The following facilities of yours maybe impacted based on their location:

DaVita Springfield Central Dialysis, 600 N Grand Ave W, Springfield, IL 62702
DaVita Springfield South Dialysis, 2930 S 6th Street, Springfield, IL 62703
DaVita Springfield South At Home, 2930 S 6th Street, Springfield, IL 62703
DaVita Springfield Montvale Dialysis, 2930 Montvale Dr., Ste A, Springfield, IL 62704
DaVita Taylorville Dialysis, 901 W Spresser Street, Taylorville, IL 62568
DaVita Lincoln Dialysis, 2100 5th Street, Lincoln, IL 62656
DaVita Jacksonville Dialysis, 1515 W Walnut Street, Jacksonville, IL 62650
DaVita Decatur East Wood Dialysis, 794 E Wood Street, Decatur, IL 62523
DaVita Decatur East Wood At Home, 794 E Wood Street, Decatur, IL 62523
DaVita Macon County Dialysis, 1090 W McKinley Ave, Decatur, IL 62526

Enclosed is a sample letter that we prepared for your reference and editing, as appropriate. Please return your letter in the enclosed stamped envelope on your facility's letterhead by May 12, in order for us to include your letter in our COEP application. If you do not respond, we will assume the discontinuation has no impact on your facility. Should you have any questions, please contact me at 217.757.4281 or Curtis.michael@mhsil.com.

Sincerely,

Mike Curtis

Michael A. Curtis
Administrator
Business Development & Strategic Planning

Memorial MEDICAL CENTER
701 North First Street • Springfield, Illinois 62781-0001
www.memorialmedical.com • **Phone (217) 788-3000**
A Memorial Health System Affiliate

April 12, 2018

Certified/Return Receipt: 7016 0910 0000 9107 6966
Fresenius Medical Care North America
920 Winter Street
Waltham, MA 02451-1457

RE: Discontinuation of Six (6) Chronic Renal Dialysis Stations

To Whom It May Concern:

I am writing to inform you that Memorial Medical Center ("MMC") will soon be filing a Certificate of Exemption Permit (COEP) Application with the Illinois Health Facilities and Services Review Board ("IHFSRB") to discontinue its chronic renal dialysis program ("chronic program") operated under CMS certification number 14-2315. We anticipate closing the chronic program after approval by the IHFSRB, and hope we will receive such approval on or before the end of May 2018. Since 2015, less than 10 patients have utilized MMC's chronic program. MMC also operates an acute renal dialysis program ("acute program") to meet the dialysis needs of patients receiving other services at MMC. There are 11 dialysis stations at MMC, including the 6 approved under the chronic program's CMS certification number. Our desire is to continue to utilize all 11 dialysis stations in operation to meet the needs of MMC's acute program. MMC only seeks to terminate outpatient chronic dialysis services for individuals not needing any other services at MMC, and believes other providers in the community can meet the needs of these patients.

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FMC – West Centre West Springfield, 1112 Centre West Dr., Springfield, IL 62704
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FMC – Decatur, 1830 S 44th St., Decatur, IL 62521

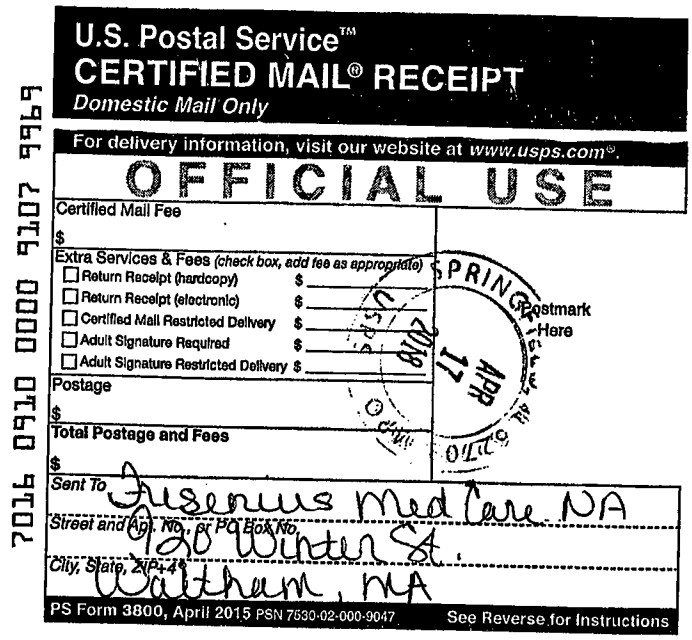
Enclosed is a sample letter that we prepared for your reference and editing, as appropriate. Please return your letter in the enclosed stamped envelope on your facility's letterhead by May 12, in order for us to include your letter in our COEP application. If you do not respond, we will assume the discontinuation has no impact on your facility.

If you have aby questions, please feel free to contact me at 217.757.4281 or curtis.michael@mhsil.com.

Sincerely,

Mike Curtis

Michael A. Curtis
Administrator
Business Development & Strategic Planning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SAFETY NET IMPACT STATEMENT – ATTACHMENT 20

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.

This project will either have no material impact or a positive impact on essential safety net services in the community. Memorial Medical Center is a safety-net hospital serving as a Level 1 Trauma hospital in the Southern Illinois Trauma Center, the only regional burn center in downstate Illinois and a full-service community hospital. Memorial Medical Center provides a wide range of services to poor, uninsured and underinsured persons.

Health Safety Net Services have been defined as services provided to patients who are low-income and otherwise vulnerable, including those uninsured and covered by Medicaid. (Agency for Healthcare Research and Quality, Public Health Service, U.S. Department of Health and Human Services, "The Safety Net Monitoring Initiative," AHRQ Pub. No. 03-P011, August, 2003)

This project only seeks to discontinue chronic ESRD services. The existing stations will remain operational to support the acute dialysis program of Memorial Medical Center. There are several other local providers of ESRD services and an excess of stations in the surrounding area as discussed in Attachment 10. Other safety-net services will not be affected and Memorial Medical Center will continue to serve all patients currently being served prior to this discontinuation. Memorial Medical Center serves all patients, including the uninsured and underinsured residents of Planning Area E-01, the State-defined planning area in which the hospital is located.

Planning Area E-01 includes Sangamon, Logan, Menard, Mason, Christian, and Cass Counties and selected townships within Brown and Schuyler Counties.

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.

This project will have no impact on the ability of other providers or health care systems to cross-subsidize safety net services in the community.

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.

The permanent discontinuation of the dialysis category of service will not impact the remaining safety net providers in the community. Dialysis, while a lifesaving service, is not a safety net service as it is primarily covered by Medicare or commercial insurance. There is capacity in the community to access dialysis services through other providers, all of which accept, to Memorial Medical Center's knowledge, Medicaid and/or undocumented patients.

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

1. The amount of charity care provided by Memorial Medical Center for the 3 fiscal years prior to submission of the CON application was:

CHARITY CARE			
Charity (# of patients)	**Year 2015**	**Year 2016**	**Year 2017**
Inpatient	512	536	673
Outpatient	2,600	2,183	3,129
Total	3,112	2,719	3,802
Charity (cost in dollars)			
Inpatient	2,517,046	2,590,123	3,668,897
Outpatient	2,053,567	1,542,388	2,510,377
Total	4,570,613	4,132,511	6,179,274

This amount was calculated in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act.

2. The amount of care provided by Memorial Medical Center to Medicaid patients for the 3 fiscal years prior to submission of the CON application was:

MEDICAID			
Medicaid (# of patients)	**Year 2015**	**Year 2016**	**Year 2017**
Inpatient	3,989	4,453	4,418
Outpatient	98,641	100,903	98,165
Total	102,630	105,356	102,583
Medicaid (revenue)			
Inpatient	32,096,720	33,396,259	33,356,589
Outpatient	14,344,634	18,523,136	14,866,655
Total	46,441,354	51,919,395	48,223,244

This amount was provided 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 Illinois Health Facilities and Services Review Board under Section 13 of the Illinois Health Facilities Act and published in the Annual Hospital Profile.

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

Memorial Medical Center is a teaching and research hospital affiliated with Southern Illinois University School of Medicine. MMC works with local colleges and nursing schools to provide ongoing training. Additional information on the community benefit services provided by MMC can be found in the annual reports here: https://www.memorialmedical.com/about/community-benefit.

Charity Care Information – ATTACHMENT – 21

The amount of charity care provided by Memorial Medical Center 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 – Memorial Medical Center			
	Fiscal Year 2015	**Fiscal Year 2016**	**Fiscal Year 2017**
Net Patient Revenue	**$563,186,911**	**$593,032,278**	**$572,791,762**
Amount of Charity Care (charges)	$17,512,548	$15,463,228	$24,338,424
Cost of Charity Care	$4,570,613	$4,132,511	$6,179,274
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.81%	0.70%	1.08%

Memorial
HEALTH SYSTEM

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May 1, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Memorial Medical Center Discontinuation of Chronic ESRD Services

Dear Ms. Avery,

I am submitting the enclosed Certificate of Exemption Permit application for consideration by the Illinois Health Facilities and Services Review Board. Please find the following:

1. An original and 1 copy of an application for permit to discontinue six (6) chronic end stage renal dialysis stations and to convert their use solely to the acute dialysis program at Memorial Medical Center; and

2. A filing fee of $2,500 payable to the Illinois Department of Public Health.

I believe this application conforms with the applicable standards and criteria of Part 1130 of the Board's regulations. Please advise me if you require anything further to deem the enclosed application complete.

Sincerely,

Michael A. Curtis
Administrator, Business Development and Strategic Planning

Enclosures