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.

ORIGINAL

Facility/Project Identification

Facility Name: Community Memorial Hospital Association d/b/a Community Hospital of Staunton
Street Address: 400 North Caldwell St.
City and Zip Code: Staunton 62088
County: Macoupin Health Service Area 3 Health Planning Area: E-02

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

Exact Legal Name: Community Memorial Hospital Association
Street Address: 400 North Caldwell St.
City and Zip Code: Staunton 62088
Name of Registered Agent: Sue E. Campbell
Registered Agent Street Address: 400 North Caldwell St.
Registered Agent City and Zip Code: Staunton 62088
Name of Chief Executive Officer: Sue E. Campbell
CEO Street Address: 400 North Caldwell St.
CEO City and Zip Code: Staunton 62088
CEO Telephone Number: 618-635-4241

RECEIVED
JUL 23 2018
HEALTH FACILITIES & SERVICES REVIEW BOARD

Type of Ownership of Applicants

- [x] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] 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: Sue E. Campbell
Title: Chief Executive Officer
Company Name: Community Memorial Hospital Association
Address: 400 North Caldwell St.
Telephone Number: 618-635-4241
E-mail Address: scampbell@stauntonhospital.org
Fax Number: 618-635-4244

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

Name: John S. Howard
Title: Attorney
Company Name: Thompson Coburn, LLP

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: Community Memorial Hospital Association d/b/a Community Hospital of Staunton
Street Address: 400 North Caldwell St.
City and Zip Code: Staunton 62088
County: Macoupin Health Service Area 3 Health Planning Area: E-02

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

Exact Legal Name: Southwestern Illinois Health Facilities, Inc.
Street Address: 6800 State Route 162
City and Zip Code: Maryville 62062
Name of Registered Agent: Keith A. Page
Registered Agent Street Address: 6800 State Route 162
Registered Agent City and Zip Code: Maryville 62062
Name of Chief Executive Officer: Keith A. Page
CEO Street Address: 6800 State Route 162
CEO City and Zip Code: Maryville 62062
CEO Telephone Number: 618-391-6406

Type of Ownership of Applicants

- [x] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] 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: Sue E. Campbell
Title: Chief Executive Officer
Company Name: Community Memorial Hospital Association
Address: 400 North Caldwell St., Staunton, IL 62088
Telephone Number: 618-635-4241
E-mail Address: scampbell@stauntonhospital.org
Fax Number: 618-635-4244

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

Name: John S. Howard
Title: Attorney
Company Name: Thompson Coburn, LLP

Address: 505 N. 7th St., St. Louis, MO 63101
Telephone Number: 314-552-6093
E-mail Address: JHoward@thompsoncoburn.com
Fax Number: 314-552-7000

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: Sue E. Campbell
Title: Chief Executive Officer
Company Name: Community Hospital of Staunton
Address: 400 North Caldwell St., Staunton, IL 62088
Telephone Number: 618-635-4241
E-mail Address: scampbell@stauntonhospital.org
Fax Number: 618-635-4244

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Community Memorial Hospital Association
Address of Site Owner: 400 North Caldwell St., Staunton, IL 62088
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: Community Memorial Hospital Association	
Address: 400 Caldwell St.	
☒ 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.

Discontinuation Only, Section Does Not Apply
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).

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.

This Certificate of Exemption Permit application seeks approval to discontinue one category of service at Community Memorial Hospital Association. Approval of this application would result in four (4) intensive care unit ("ICU") beds being discontinued and replaced with four (4) medical-surgical beds, resulting in the hospital remaining a 25 bed facility.

The project does not include any construction, modernization, demolition of any exiting structures, or equipment. There are no project costs associated with this application.

The project is classified as substantive based on 77 IL ADC 1110.20, because it involves a discontinuation of a category of service (i.e., the discontinuation of the intensive care category of service).

Discontinuation Only, Section Does Not Apply
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	N/A	N/A	N/A
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	N/A	N/A	N/A
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	N/A	N/A	N/A
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	N/A	N/A	N/A
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	N/A	N/A	N/A
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	N/A	N/A	N/A
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Discontinuation Only, Section Does Not Apply

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: $ N/A
Fair Market Value: $ N/A

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 $ N/A.

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): _____

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

☐ 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 Community Memorial Hospital Association * **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.**

Sue Campbell	
SIGNATURE	SIGNATURE
Sue E. Campbell	Brian Engelke
PRINTED NAME	PRINTED NAME
CEO	CFO
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 9th day of July, 2018	Notarization: Subscribed and sworn to before me this 9 day of July, 2018
Shannon Sarti	Shannon Sarti
Signature of Notary	Signature of Notary
Seal: OFFICIAL SEAL SHANNON SARTI NOTARY PUBLIC STATE OF ILLINOIS My Commission Expires 06-30-2020	Seal: OFFICIAL SEAL SHANNON SARTI NOTARY PUBLIC STATE OF ILLINOIS My Commission Expires 06-30-2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- 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 Southwestern Illinois Health Facilities, Inc. * **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

Keith A. Page
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 12th day of July, 2018

Signature of Notary

Seal

OFFICIAL SEAL
BETH A COULTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:08/13/19

SIGNATURE

Michael M. Marshall
PRINTED NAME

Vice President of Finance/CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 12th day of July, 2018

Signature of Notary

Seal

OFFICIAL SEAL
BETH A COULTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:08/13/19

*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.

Discontinuation Only, Section Does Not Apply as there are no project costs.

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.

Discontinuation Only, Section Does Not Apply
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.

Discontinuation Only, Section Does Not Apply
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 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.

Discontinuation Only, Section Does Not Apply

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.

Discontinuation Only, Section Does Not Apply

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.

Discontinuation Only, Section Does Not Apply

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 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	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
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	N/A
6	Historic Preservation Act Requirements	N/A
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	30-37
11	Background of the Applicant	N/A
12	Purpose of the Project	N/A
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
21	Charity Care Information	39

Attachment 1
Supporting Documentation for Section I - Type of Ownership

File Number 2880-427-0

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

COMMUNITY MEMORIAL HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 26, 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* 21ST *day of* JUNE *A.D.* 2018 .

Authentication #: 1817201790 verifiable until 06/21/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

File Number 2038-756-4

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

SOUTHWESTERN ILLINOIS HEALTH FACILITIES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 20, 1929, 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* 21ST *day of* JUNE *A.D.* 2018 .

Authentication #: 1817201852 verifiable until 06/21/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Community Hospital
OF STAUNTON

July 9, 2018

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

RE: Site Ownership of Community Memorial Hospital Association

Dear Ms. Avery:

The letter attests that Community Memorial Hospital Association d/b/a Community Hospital of Staunton is the owner of the hospital located at 400 North Caldwell Street, Staunton, IL 62088. As a non-profit corporation, Community Hospital of Staunton is controlled by its sole member Southwestern Illinois Health Facilities, Inc.

Southwestern Illinois Health Facilities, Inc. is located at 6800 State Route 162, Maryville, IL 62062.

Please contact me at (618) 635-4241 or scampbell@stauntonhospital.org if you have any questions.

Sincerely,

Sue Campbell

Sue Campbell
CEO
Community Hospital of Staunton

Notarization

STATE OF ILLINOIS)
)
COUNTY OF Macoupin)

Subscribed and attested before me on this 9th day of July, 2018.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official Seal in the county and State aforesaid, the day and year first above written.

OFFICIAL SEAL
SHANNON SARTI
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 06-30-2020

Shannon Sarti
Notary Public

My Commission Expires:

Attachment 3
Supporting Documentation for Section I - Operating Identity/Licensee

File Number 2880-427-0

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

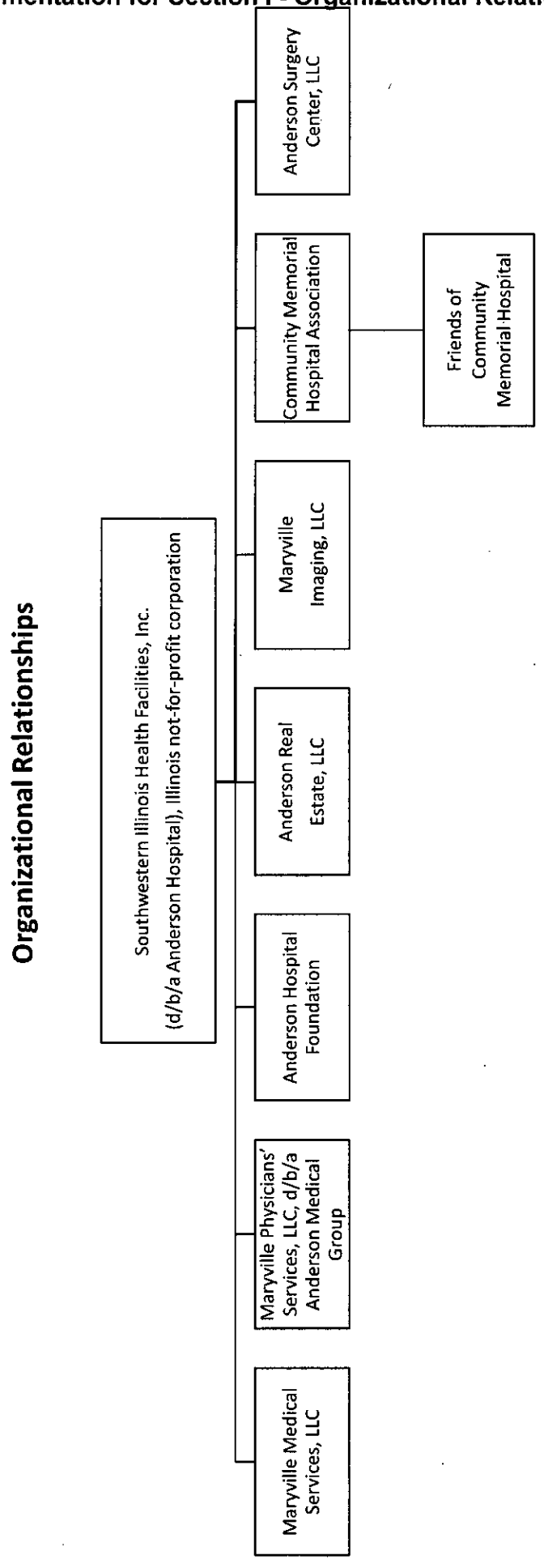
I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

COMMUNITY MEMORIAL HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 26, 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* 21ST *day of* JUNE *A.D.* 2018 .

Authentication #: 1817201790 verifiable until 06/21/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE


Organizational Relationships
Southwestern Illinois Health Facilities, Inc.
(d/b/a Anderson Hospital), Illinois not-for-profit corporation
Anderson Surgery Center, LLC
Community Memorial Hospital Association
Friends of Community Memorial Hospital
Maryville Imaging, LLC
Anderson Real Estate, LLC
Anderson Hospital Foundation
Maryville Physicians' Services, LLC, d/b/a Anderson Medical Group
Maryville Medical Services, LLC

Attachment 10
Response to Criterion 1110.130 - Section II Discontinuation Questions

GENERAL INFORMATION REQUIREMENTS

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

   The intensive care category of service is being discontinued. This discontinuation will result in four (4) ICU beds being discontinued and re-categorized as four (4) medical-surgical beds.

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

   No other clinical services are to be discontinued.

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

   The anticipated date of discontinuation will be no later than 30 days after the Illinois Health Facilities and Services Review Board approves the Certificate of Exemption.

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

   The four (4) ICU beds that are discontinued will be re-categorized as four (4) medical-surgical beds.

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. Community Memorial Hospital Association will retain all medical records pertaining to the services being discontinued and will retain such records for the length of time required by applicable law.

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 is not applicable. This application involves the discontinuation of a service (i.e., intensive care) and not the discontinuation of an entire facility.

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.

Community Hospital
OF STAUNTON

July 9, 2018

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Re: Media Notification

Dear Ms. Avery:

This letter attests that Community Memorial Hospital Association d/b/a Community Hospital of Staunton provided the required notice of the discontinuation of our four ICU beds to local media that the hospital would routinely notify about events. The notice was published in the Staunton Star Times newspaper on June 27, 2018. Please find supporting documentation of this notification enclosed with this letter.

Please contact me at (618) 63504241 or scampbell@stauntonhospital.org if you have any questions.

Sincerely,

Sue Campbell

Sue Campbell
CEO
Community Hospital of Staunton

Enclosures

LEGAL NOTICE
State of Illinois
Department of Agriculture

Notice is hereby given that the grain dealer license of Center Grain LLC, 600 Mason Ridge Center Drive, St. Louis, MO 63141 has been voluntarily surrendered. This company has given formal notice to the Illinois Department of Agriculture of their election to voluntarily cease purchasing grain from producers. Under the requirements of this voluntary election, grain cannot be received, picked up, or contracted for purchase after May 25, 2018.

If you have any questions, please notify the Illinois Department of Agriculture, Bureau of Warehouses, State Fairgrounds, P.O. Box 19281, Springfield, Illinois 62794-9281 on or before August 23, 2018.

Raymond Poe
Director
Illinois Department of Agriculture
51-3

NOTICE TO PUBLIC

Per requirements of Illinois Department of Public Health, this Public Notice is hereby given that Community Memorial Hospital Association, dba Community Hospital of Staunton, will be filing a Certificate of Exemption Permit ("COE") application with the Illinois Health Facilities and Services Review Board to discontinue four ICU beds and to reclassify those beds as medical-surgical beds. Community Hospital of Staunton intends to discontinue its ICU service within 30 days of the Illinois Health Facilities and Services Review Board's approval of our application. For additional information regarding this Notice, please contact Sue Campbell, CEO, Community Hospital of Staunton, 400 North Caldwell Street, Staunton, IL 62088, (618) 635-4241.

STATE OF ILLINOIS
CIRCUIT COURT
MACOUPIN COUNTY

PUBLICATION NOTICE

Of Court Date for Request for name Change (Minor Child)

Case Number 18MR84

Filed June 19, 2018: Lee Ross, Clerk of the Circuit Court, Macoupin County, IL

Request of: Sandra Kay Loveless by Teresa Williams (mother) to change name of minor child.

Current name of Minor Child:
Sandra Kay Loveless

Proposed New Name of Minor Child
Sandra Kay Williams

Court Date: July 20, 2018;
Time: 9:30 a.m.
Address: 201 East Main, Carlinville, IL, Courtroom: A

Teresa Williams
1-3p

PREVAILING WAGE
NOTICE 2018 ---03

TAKE NOTICE that Dorchester Township and Road District of Macoupin County, Illinois, pursuant to "An Act regulating wages of laborers, mechanics, and other workers employed in any public works by the State, county, city or any public body or any political subdivision or by anyone under contract for public

TAX DEED NO. 2018TX25
FILED June 8, 2018

TAKE NOTICE

TO: PETE DUNCAN, MACOUPIN COUNTY CLERK; KEITH B. PESAVENTO; OCCUPANT; UNKNOWN OWNERS OR PARTIES INTERESTED; AND NONRECORD CLAIMANTS.

This is NOTICE of the filing of the Petition for Tax Deed on the following described property:

Part of the West Half of the Northeast Quarter of the Northeast Quarter of Section 17, Township 7 North, Range 6 West of the Third Principal Meridian, described as follows: Beginning at the Southwest corner of the East Half of the Northwest Quarter of the Northeast Quarter of said Section 17, thence East 1109 feet to the point of beginning, thence East 165 feet, thence North 465 feet, thence West 60 feet, thence Southwesterly 472 feet to the point of beginning. Situated in the County of Macoupin, State of Illinois.

Property Index Number 02-000-432-01

On November 9, 2018 at 9:30 A.M. the Petitioner intends to make application for an order on the petition that a Tax Deed be issued. The real estate was sold on December 1, 2015 for general taxes of the year 2014. The period of redemption will expire October 15, 2018.

Kathleen A. Kyndberg,
Attorney for Petitioner
(618) 457-4586
51-3

STATE OF ILLINOIS
IN THE CIRCUIT COURT
OF THE SEVENTH JDICIAL
CIRCUIT MACOUPIN COUNTY
- IN PROBATE

IN THE MATTER OF THE ESTATE OF CONSTANCE A. BUCHHOLZ, Deceased
No. 2018P57
NOTICE FOR PUBLICATION - CLAIMS

Notice is given of the death of CONSTANCE A. BUCHHOLZ of Staunton, Macoupin County, Illinois. Letters of Office were issued on May 14, 2018 to Elizabeth A. Sirko, 57 Deer Run Estates Lane, New Douglas, Illinois 62074, whose attorney is Gina Verticchio of the law firm Verticchio & Verticchio, 100 East Chestnut Street, P.O. Box 87, Gillespie, Illinois 62033.

Claims against the estate may be filed in the office of the clerk of the court at the Macoupin County Courthouse in Carlinville, Illinois, or with the representative, or both, within six months from the date of the first publication of this Notice and any claim not filed within that period is barred. Copies filed with the Clerk must be mailed or delivered to the representative and to the attorney within (10) days after it has been filed.

Dated this 4th day of June, 2018
ELIZABETH A. SIRKO, Administrator
by Gina M. Verticchio,
One of her attorneys

GINA VERTICCHIO
VERTICCHIO & VERTICCHO,
Attorneys at Law
100 East Chestnut street
P.O. Box 87
Gillespie, IL 62033
Telephone: (217) 839-4411
Attorney Registration #6301101

Staunton, IL. 62088
Telephone: 618-635-5250
e-mail: jgiuffre@dmbdlaw.com
Service: admin@dmbdlaw.com

#E-043-18

1-3

ADVERTISEMENT OF SALE

A public sale of storage unit contents will be held on the 14th day of July 2018 at 10:00 AM located at 400 Harris, Staunton, IL.

The contents are located at Staunton Public Storage located at 400 Harris, Staunton, IL in Unit #27 under the name of Brenda Mangum.

The sale shall be held in an auction style format with all items being sold as one lot. All items must be removed from storage unit on day of sale.

1-3

Amore to host Benld Public Library fundraiser

JoDanni's Amore will sponsor a fundraiser on Thursday, July 19, to benefit the Frank Bertetti Benld Public Library. On that day, from 4:30 to 8:30 p.m., Amore will donate to the library 15 percent of all proceeds from dine-in, delivery, and carry-out food orders as long as the customer mentions the Benld Library fundraiser.

Amore is located at 2422 Staunton Road in Benld. For more information or to order, call (217) 835-4397.

Cookout at Randy's Market

The Coal Country Sports Complex Foundation will hold a cookout at Randy's Market in Gillespie on Saturday, June 30th. Serving starts at 10 a.m. and continues until all sandwiches are sold. Porkburgers, butterfly pork chops, water and soda will be sold.

"That's another reason for older people to have ups," Katz says. "Yo check for signs of oral those visits."

Dry mouth caused by Most older Americans scription and over-the- many of which can cau Reduced saliva flow inc of cavities. Saliva helps decay, gum disease and b also lubricates the mou easier to eat, swallow, s food. "Sometimes dry just cause mild discomfo "At other times it can l cant oral disease that ca the person's health, diet quality of life."

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.

Community Memorial Hospital Association strives to provide the highest level of care to its patients. Over time, as the utilization of its ICU decreased and as the training and competency requirements for intensive care services increased, the facility had difficulty maintaining the competency of its staff and the quality of ICU care provided to its patients. Rather than risk providing less than the highest level of care to its patients, Community Memorial Hospital Association has transferred patients in need of high-acuity, intensive care services and stopped actively managing its four (4) ICU beds (i.e., the intensive care category of service). The decision to stop actively managing the ICU beds was based on the increased ability to monitor patients in medical-surgical beds, the decreased need for ventilator support and ICU care at the facility, and the clinical decision-making of the physicians determining that it would be best to transfer patients requiring ICU services to a facility providing a higher level of care. To ensure the high quality of care provided to patients and the ability to provide services to low income patients, the hospital has decided that it would be best to discontinue the four (4) ICU beds and to reclassify them as medical-surgical beds. By doing this, Community Memorial Hospital Association's would designate all of its 25 beds as medical-surgical beds, which is most appropriate given the hospital's Critical Access Hospital designation and scope of services. The chart below shows the steady decline of the already low occupancy rates of the ICU beds from 2011 to 2017 which resulted in difficulty maintaining the intensive care competencies of the staff and the provision of high quality services to its patients.

Occupancy of ICU Beds					
Year	Authorized ICU Beds	Direct Admissions to Intensive Care	Patient Days Direct Admissions to Intensive Care	Intensive Care Peak Census	ICU Occupancy Rate
2011	4	70	185	1	12.7%
2012	4	54	135	1	9.2%
2013	4	47	110	3	7.5%
2014	4	27	27	0	1.8%
2015	4	0	0	0	0%
2016	4	0	0	0	0%
2017	4	0	0	0	0%

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.

The discontinuation will not have an adverse effect upon access to care for residents of the facility's market area. Community Memorial Hospital Association is located in Hospital Planning Area E-02. The bed need for Hospital Planning Area E-02 is noted in the table below.

Bed Need per the 2017 Inventory of Health Care Facilities and Services and Need Determinations			
Service	**E-02 Hospital Planning Area Beds**	**Community Memorial Hospital**	**E-02 Planning Area Bed Calculation Excess (Need)**
Medical-Surgical	89	21	28
Intensive Care Beds	8	4	6

HSHS St. Francis Hospital is the only hospital within 21 miles of Community Memorial Hospital Association that provides intensive care services. Please see the table below for the distance, ICU beds, and ICU occupancy rate for HSHS St. Francis Hospital.

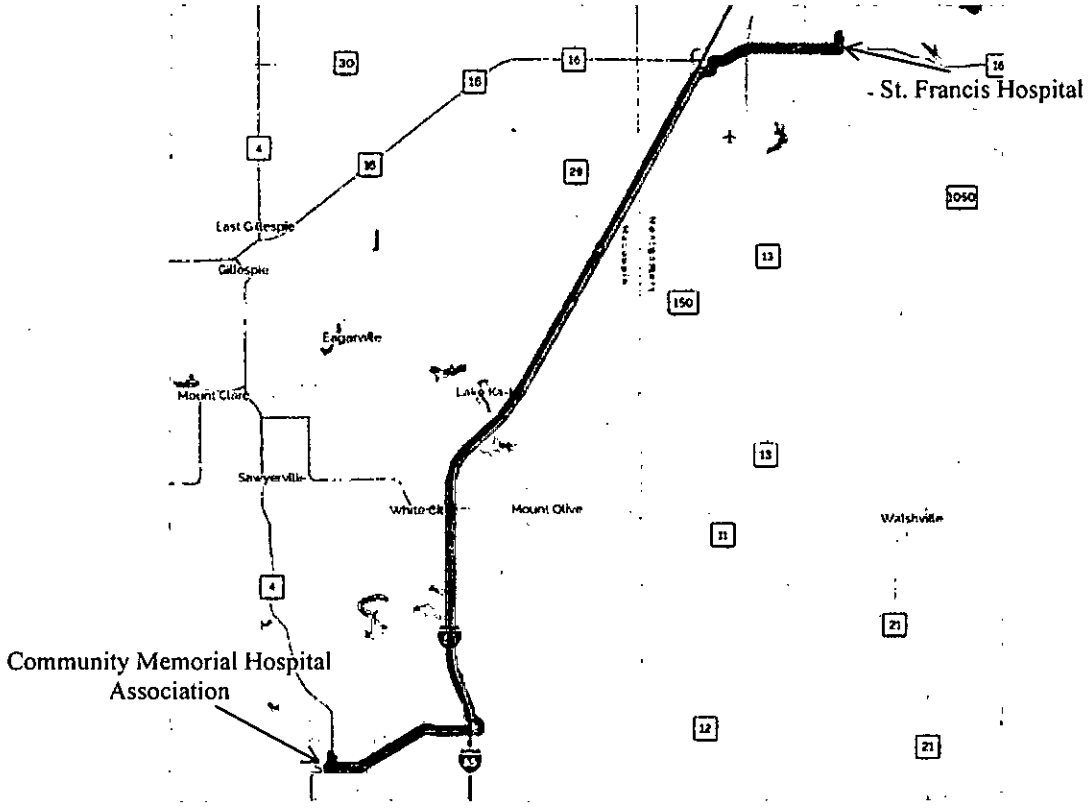
Facilities within 21 miles of Community Memorial Hospital Association				
Facility	**City**	**Distance**	**ICU Beds**	**ICU Occupancy Rate**
HSHS St. Francis Hospital	Litchfield	17.2 miles	4	50.9%

Community Memorial Hospital Association will continue to serve its own patient population in the re-categorized medical-surgical beds and pending reclassification of the ICU beds will continue to address the ICU care needs of the patients. In this interim period, such patients will be sent to higher acuity facilities that will be better able to provide high quality ICU care to patients. As can be seen by the above charts, there are more ICU beds available in the facility's Hospital Planning Area than are currently needed and the only hospital within 21 miles of the facility has an occupancy rate of 50.9%. Therefore, the closure and re-categorization of the four (4) ICU beds will not have an adverse impact on the resident's in the facility's market area and will not result in an ICU bed shortage. If a resident presents to Community Memorial Hospital Association requiring ICU services, the patient will be transferred to another facility for the higher level of care.

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.

Per 77 IL ADC 1110.290(d) and 77 IL ADC 1100.510(d), the facility must provide copies of the notification letters sent to health care facilities that provide the same services that are located within 21 miles of the facility. HSHS St. Francis Hospital (Litchfield) is the only hospital providing ICU services within 21 miles of Community Memorial Hospital Association. A map showing HSHS St. Francis Hospital and its distance from the Community Memorial Hospital Association is also included. (Source: MapQuest)

Map Showing Distance from Memorial Community Hospital Association to St. Francis Hospital



YOUR TRIP TO:

St. Francis Hospital
1215 Franciscan Dr
23 MIN | 17.2 MI

Community Hospital
OF STAUNTON

June 20, 2018

Mr. Kevin Seely
HSHS St. Francis Hospital
1215 Franciscan Drive
Litchfield, IL 62056

RE: Discontinuation of four ICU beds

Dear Mr. Seely,

I am writing to inform you that Community Hospital of Staunton will soon be filing a Certificate of Exemption Permit ("COE") application with the Illinois Health Facilities and Services Review Board to discontinue four ICU beds and to re-classify those beds as medical-surgical beds. Community Hospital of Staunton intends to discontinue its ICU service within 30 days of the Illinois Health Facilities and Services Review Board's approval of our application. The COE application requires that we request letters from each hospital located within 21 miles from our hospital requesting what impact closing our unit may have on your facility. The discontinuation of the ICU category of service will have no impact on access to care in the Macoupin County market area as Community Hospital of Staunton will continue to serve the same patient population in the re-categorized medical-surgical beds. Furthermore, the discontinuation should not have any negative impact on your facility because we have not admitted any patients requiring intensive care services since 2015.

Enclosed is a sample letter that we prepared for your reference and editing, as appropriate. For us to include your letter in our COE application, please return it in the enclosed stamped envelope on your facility's letterhead by June 30, 2018. If you do not respond, we will assume the discontinuation has no impact on your facility.

If you have question, please contact me at (618) 635-4241 or scampbell@stauntonhospital.org. Thank you.

Sincerely,

Sue Campbell

Sue Campbell, CEO
Community Hospital of Staunton

Enclosures

[HSHS St. Francis Letterhead]

_____, 2018

Sue Campbell
CEO
Community Hospital of Staunton
400 North Caldwell St.
Stanton, IL 62088

Re: Discontinuation of four ICU beds

Dear Ms. Campbell:

I am writing in response to your letter regarding the planned discontinuation of four (4) ICU beds at Community Hospital of Staunton.

HSHS St. Francis Hospital has sufficient capacity to accommodate the needs of any patients requiring ICU care that may be impacted by the closure of Community Hospital of Staunton's four ICU beds. Our facility can meet this need without restriction or limitations that would preclude us from providing other inpatient services to residents of the Macoupin County market area.

If you have any questions, please contact me at [Insert Phone Number and email address].

Sincerely,

Kevin Seely
President and CEO
HSHS St. Francis Hospital

Attachment 20
Supporting Documentation for Section IX - Safety Net Impact Statement

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 of ICU service and the reclassification of the four ICU beds to medical-surgical beds will have a positive impact on the essential safety net services in the community. Community Memorial Hospital Association is a safety net and Critical Access Hospital serving the residents of Macoupin County. Community Memorial Hospital Association provides a wide range of quality health care services to poor, uninsured and underinsured patients. This project will enhance Community Memorial Hospital Association's ability to serve the community as a safety net hospital.

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.

Community Memorial Hospital Association is unaware of any impact the project would have on the ability of another provider or health care system to cross-subsidize safety net 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.

Community Memorial Hospital Association is unaware of any impact the discontinuation of its ICU service might impact the remaining safety net providers in the community.

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2015**	**2016**	**2017**
Inpatient	2	0	1
Outpatient	13	11	26
Total	**15**	**11**	**27**
Charity (cost In dollars)			
Inpatient	$1,227	$153	$2,723
Outpatient	$38,773	$14,892	$50,203
Total	**$40,000**	**$15,045**	**$52,926**
MEDICAID			
Medicaid (# of patients)	**2015**	**2016**	**2017**
Inpatient	23	28	19
Outpatient	4359	4573	4689
Total	**4382**	**4601**	**4708**
Medicaid (revenue)			
Inpatient	$33,900	$59,350	$49,179
Outpatient	$2,114,100	$2,910,650	$2,751,539
Total	**$2,148,000**	**$2,970,000**	**$2,800,718**

By the signatures on this application, Community Memorial Hospital Association certifies the following:

- The charity care information provided in this application was prepared in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act.
- The Medicaid information provided in this application was prepared in a manner consistent with the information reported each year to the Illinois Department of Public Health 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.

Attachment 21
Supporting Documentation for Section X - Charity Care Information

The amount of charity care provided by Community Memorial Hospital Association and Southwestern Illinois Health Facilities, Inc. 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.

COMMUNITY MEMORIAL HOSPITAL ASSOCIATION CHARITY CARE			
	7/1/2015 - 6/30/2016	**7/1/2016 - 12/31/2016***	**1/1/2017 – 12/31/2017**
Net Patient Revenue	**$17,143,957**	**$9,607,797**	**$17,421,599**
Amount of Charity Care (charges)**	$31,048	$18,127	$297,008
Cost of Charity Care	$15,000	$9,000	$148,000
Ratio of Charity Care Cost to Net Patient Revenue	.09%	.09%	.85%

***Note**: Community Memorial Hospital Association changed its fiscal year from a June 30th year end to a December 31st year end following Southwestern Illinois Health Facilities becoming its sole member.*

SOUTHWESTERN ILLINOIS HEALTH FACILITIES, INC. CHARITY CARE			
	2015	**2016**	**2017**
Net Patient Revenue	**$132,623,000**	**$131,793,000**	**$145,275,000**
Amount of Charity Care (charges)	$4,309,000	$4,706,000	$7,464,000
Cost of Charity Care	$1,130,000	$1,251,000	$1,814,000
Ratio of Charity Care Cost to Net Patient Revenue	.85%	.95%	1.25%

#E-043-18

THOMPSON COBURN LLP

One US Bank Plaza
St. Louis, MO 63101

314 552 6000 main
314 552 7000 fax
thompsoncoburn.com

John S. Howard
314 552 6093 direct
jhoward@thompsoncoburn.com

July 19, 2018

VIA CERTIFIED MAIL

Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

RE: Community Memorial Hospital Association Discontinuation of ICU Category of Service

Dear Ms. Avery:

We represent Community Memorial Hospital Association and are submitting the enclosed Certificate of Exemption Permit application for consideration by the Illinois Health Facilities and Review Board. Enclosed, please find the following:

1. An original and one (1) copy of an application for an exemption permit to discontinue four (4) intensive care beds and to re-categorize those beds to four (4) medical-surgical beds, resulting in 25 beds at Community Memorial Hospital Association; and

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

This application complies with the applicable standards and criteria of Part 1130 of the Illinois Planning Act. Please advise me if you require anything further to consider the enclosed application complete.

Sincerely,

Thompson Coburn LLP

By

John S. Howard
Partner

JSH/ark

Enclosures