ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Passavant Area Hospital
Street Address: 1600 West Walnut Street
City and Zip Code: Jacksonville, IL 62650
County: Morgan Health Service Area AMI 3 Health Planning Area: AMI 3

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

Exact Legal Name: The Passavant Memorial Area Hospital Association
Street Address: 1600 West Walnut Street
City and Zip Code: Jacksonville, IL 62650
Name of Registered Agent: Anna Evans
Registered Agent Street Address: 701 N First Street
Registered Agent City and Zip Code: Springfield, IL 62781
Name of Chief Executive Officer: Scott Boston, MD
CEO Street Address: 1600 West Walnut Street
CEO City and Zip Code: Jacksonville, IL 62650
CEO Telephone Number: 217-479-5523

Type of Ownership of Applicants

- ☒ 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: Dana Mollohan
Title: System Director, Business Development and Planning
Company Name: Memorial Health System
Address: 701 North First Street, Springfield, IL 62781
Telephone Number: 217-788-4263
E-mail Address: mollohan.dana@mhsil.com
Fax Number: 217-527-3267

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

Name: Michael Copelin
Title: President
Company Name: Copelin Healthcare Consulting
Address: 42 Birch Lake Drive, Sherman, IL 62684
Telephone Number: 217-496-3712
E-mail Address: micball1@aol.com
Fax Number: 217-788-5520

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Passavant Area Hospital
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City and Zip Code: Jacksonville, IL 62650
County: Morgan Health Service Area AMI 3 Health Planning Area: AMI 3

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

Exact Legal Name: Memorial Health System
Street Address: 701 N First Street
City and Zip Code: Springfield, IL 62781
Name of Registered Agent: Anna Evans
Registered Agent Street Address: 701 N First Street
Registered Agent City and Zip Code: Springfield, IL 62781
Name of Chief Executive Officer: Edgar Curtis
CEO Street Address: 701 N First Street Street
CEO City and Zip Code: Springfield, IL 62781
CEO Telephone Number: 217-788-3340

Type of Ownership of Applicants

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

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Company Name: Memorial Health System
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Name: Michael Copelin
Title: President
Company Name: Copelin Healthcare Consulting
Address: 42 Birch Lake Drive, Sherman, IL 62684
Telephone Number: 217-496-3712
E-mail Address: micball1@aol.com
Fax Number: 217-788-5520

Post Exemption Contact

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

Name: Dana Mollohan
Title: System Director Business Development and Planning
Company Name: Memorial Health System
Address: 701 N First Street
Telephone Number: 217-788-4263
E-mail Address: mollohan.dana@mhsil.com
Fax Number: 217-527-3267

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Memorial Health System
Address of Site Owner: 701 North 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: The Passavant Memorial Area Hospital Association
Address: 1600 West Walnut Street, Jacksonville, IL 62650
☒ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o 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. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Passavant Area Hospital (PAH) located at 1600 West Walnut Street Jacksonville, IL 62650 proposes the discontinuation of its 10-bed Acute Mental Illness (AMI) unit. The discontinuation will be effective after approval is received from the Illinois Health Facilities and Review Board.

PAH provided notice to the Illinois Health Facilities and Review Board on February 22, 2019 that the AMI unit would temporarily suspend inpatient psychiatry services. Monthly status reports have been provided as required.

This project does not include the construction, demolition or modernization of any existing buildings and there are not any costs associated with the project.

This is a substantive project because it proposes the discontinuation of a designated category of service.

Project Status and Completion Schedules

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

Memorial Health System is a co-applicant on the Taylorville Memorial Hospital Facility Modernization Project (Permit 18-003), That project is on-going and will not be completed by the time this exemption application is filed.

Anticipated exemption completion date (refer to Part 1130.570): June 30, 2022

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

- ☒ Cancer Registry
- ☒ APORS
- ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
- ☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the Application being deemed incomplete.

CERTIFICATION

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

- 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 Passavant Area Hospital*

in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

W. Scott Boston, MD
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of March

Beth Kesselring
Signature of Notary

Seal

OFFICIAL SEAL
BETH DIANN KESSELRING
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES MAR. 28, 2022

SIGNATURE

Thomas L. Veith
PRINTED NAME

Chair of the Board of Directors
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of March

Beth Kesselring
Signature of Notary

Seal

OFFICIAL SEAL
BETH DIANN KESSELRING
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES MAR. 28, 2022

*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 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 31st day of March 2020

Signature of Notary

Seal

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

SIGNATURE

Dean E. Robert Jr.
PRINTED NAME

Chair of the Board of Directors
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 31st day of March 2020

Signature of Notary

Seal

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

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

☒	Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

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

REASONS FOR DISCONTINUATION

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

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

IMPACT ON ACCESS

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

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

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

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

SECTION IV. SAFETY NET IMPACT STATEMENT

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

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

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

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

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

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

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

A table in the following format must be provided as part of Attachment 9.

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

Inpatient			
Outpatient			
Total			

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

SECTION V. CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 10.

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

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

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
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ATTACHMENT 1

Applicant Information

The Certificates of Good Standing for Passavant Area Hospital and Memorial Health System are attached at ATTACHMENT 1.

File Number 0991-754-3

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

THE PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1906, 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* 1ST *day of* FEBRUARY *A.D.* 2020 .

Authentication #: 2003200350 verifiable until 02/01/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

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.

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 2003200342 verifiable until 02/01/2021

Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 1ST *day of* FEBRUARY *A.D.* 2020 .

Jesse White

SECRETARY OF STATE

Memorial HEALTH SYSTEM

701 N. First St. • Springfield, Illinois 62781-0001
ChooseMemorial.org • Phone 217-788-3000

March 31, 2020

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

Re: Site Ownership of Passavant Area Hospital

Dear Ms. Avery:

This letter attests to Memorial Health System's site ownership and control of Passavant Area Hospital located at 1600 West Walnut Street, Jacksonville, IL 62650.

Memorial Health System's address is 701 North First Street, Springfield, IL 62781.

Please contact me at 217-788-3340 if you have any questions.

Sincerely,

Edgar J. Curtis
President and Chief Executive Officer
Memorial Health System

SUBSCRIBED AND SWORN
To before me this 31st day of March, 2020

Notary Public

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

ATTACHMENT 3

Persons with 5% or greater ownership interest

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

Ownership > 5%

The following Persons own a 5% or greater interest in Passavant Area Hospital:

Name	Percentage Interest
Memorial Health System	100%

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

Name	Percentage Interest
Memorial Health System	100%

File Number 0991-754-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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THE PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1906, 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* 1ST *day of* FEBRUARY *A.D.* 2020 .

Authentication #: 2003200350 verifiable until 02/01/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

File Number 5248-617-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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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* 1ST *day of* FEBRUARY *A.D.* 2020 .

Authentication #: 2003200342 verifiable until 02/01/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Organizational Relationships

ATTACHMENT 5

Discontinuation – General Information Requirements

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

   Passavant Area Hospital is discontinuing their 10 bed Acute Mental Illness Unit.

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

   The related Partial Hospitalization Program will also permanently be closed. Beyond this, no other clinical services are being discontinued.

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

   The decision to temporarily suspend the Acute Mental Illness Unit and the Partial Hospitalization occurred on February 19, 2019. Notice was provided to the Illinois Health Facilities and Services Review Board on February 22, 2019 and monthly status reports have been filed as required. Permanent discontinuation of these services will occur as soon as approval is received from the Review Board and is anticipated to occur no later than April 7, 2020.

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

   All medical records will be retained in the electronic health record system and retained for the length of time required by licensing entities. All existing equipment will be utilized in other clinical areas and the current space will be used for storage and maintained for future clinical needs.

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

   Passavant Area Hospital provided notice on March 24, 2020 in the State Journal Register. A copy of the notice is provided as part of ATTACHMENT 5.

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Misc

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Steph Shobe, Director of Human Resources
Dimond Bros Insurance LLC
928 Clinton Road, PO Box 1090
Paris, IL 61944
steph.shobe@dimondbros.com

Misc

We have an immediate opening for a

Miscellaneous Items

NOTICE

Pasavant Area Hospital in Jacksonville intends to close its 10 bed acute mental illness unit after receiving approval by the Illinois Health Facilities and Services Review Board (IHFSRB). The service was temporarily discontinued in the unit in February 2019 and after thorough review, the hospital has decided to make that discontinuation permanent due to lack of available psychiatric physician resources. The hospital intends to submit the required Certificate of Exemption (COE) on or around March 31, 2020. After submission, a copy of the COE and information about the discontinuation of the unit may be found on the IHFSRB website at Illinois.gov/sites/hfsrb. You may also contact Robert Ellison at 217 757 2402 at Memorial Health System with any questions or concerns.

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WEST KOKE MILL VILLAGE

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For more info

ATTACHMENT 6

Reason 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.

Passavant Area Hospital made the decision to discontinue the 10 bed Acute Mental Illness unit and related Partial Hospitalization Program on February 19, 2019. The area lacked adequate physician resources to safely operate the unit and related program. Passavant has actively been working with area healthcare groups to recruit the needed physician resources to reopen the unit. Unfortunately even after a year of recruitment efforts, the nationwide shortage of psychiatrists has made recruitment efforts unsuccessful. It is anticipated that it will be 2021 at the earliest before adequate physician resources can be recruited. Based on this, Passavant has decided to proceed with discontinuing the 10 bed AMI unit and the Partial Hospitalization Program instead of seeking to continue the temporary closure period.

ATTACHMENT 7

Impact on Access

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

   Passavant Area Hospital does not believe the discontinuation will have an adverse effect upon access to care for patients in its market area. The Inventory of Health Care Facilities and Services and Need Determinations report date September 1, 2019 indicated an excess of 44 AMI beds in Health Service Area 3. This excess did include the 32 bed AMI unit at St. John's Hospital that subsequently closed; however, even with discontinuing the Passavant 10 bed unit, the Health Service Area 3 will still have an excess of 2 beds.

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

   According to section 1100.510(d), Passavant Area Hospital would have to provide notices to health care facilities providing similar services within a 21 mile radius. There are not any health facilities providing similar services in this radius.

   Passavant treated 775 patients in the 24 months prior to the temporary closure in February 2019. The three closest health facilities providing similar services are all 40 miles or more away. Illini Community Hospital in Pittsfield has a 10 bed AMI unit, but specialized in geriatric patients and thus was not a direct competitor of Passavant. Likewise, Lincoln Prairie Behavioral Health specializes in pediatric AMI services and is not a competitor of Passavant. Memorial Health System is the only health facility providing the exact same services as Passavant and is a co-applicant to this project.

ATTACHMENT 8

Background of the Applicant

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

   Passavant Area Hospital is a community hospital with 58-staffed acute beds (131 authorized beds) located in Jacksonville, Illinois. Passavant Area Hospital is a fully owned affiliate of Memorial Health System (MHS)

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

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

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

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

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

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

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

Passavant
AREA HOSPITAL
A Memorial Health System Affiliate
1600 West Walnut | Jacksonville, IL 62650 | 217-245-9541 | PassavantHospital.com

March 25, 2020

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

Mr. Michael Constantino
Supervisor, Project Review Section
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

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

Dear Ms. Avery and Mr. Constantino:

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

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

Please contact me at 217-479-5523 if you have any questions.

Sincerely,

W. Scott Boston, MD
President and Chief Executive Officer
Passavant Area Hospital

SUBSCRIBED AND SWORN
To before me this 25 day of March, 2020

Beth Kesselring
Notary Public

Memorial HEALTH SYSTEM

701 N. First St. • Springfield, Illinois 62781-0001
ChooseMemorial.org • Phone 217-788-3000

March 31, 2020

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

Mr. Michael Constantino
Supervisor, Project Review Section
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

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

Dear Ms. Avery and Mr. Constantino:

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

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

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

Sincerely,

Edgar J. Curtis
President and Chief Executive Officer
Memorial Health System

SUBSCRIBED AND SWORN
To before me this 31st day of March, 2020

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

Notary Public

ATTACHMENT 9

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

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

Passavant Area Hospital does not believe the discontinuation will have an adverse effect upon access to care for patients in its market area. The Inventory of Health Care Facilities and Services and Need Determinations report date September 1, 2019 indicated an excess of 44 AMI beds in Health Service Area 3. This excess did include the 32 bed AMI unit at St. John's Hospital that subsequently closed; however, even with discontinuing the Passavant 10 bed unit, the Health Service Area 3 will still have an excess of 2 beds.

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 not materially impact the ability of other providers or health care systems to subsidize safety net services. The Acute Mental Illness service at Passavant Area Hospital has been temporarily suspended since February 19, 2019 with no noticeable adverse impact on safety net providers.

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

Passavant Area Hospital and Memorial Health System remain committed to serving this patient population by continuing to offer services at other Health System affiliate hospitals and by maintaining ties with other heath providers in our community. As mentioned above, the 10 bed AMI unit at Passavant has been temporarily closed since February 19, 2019 with no noticeable impact on safety net providers.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

Please see the table below in ATTACHMENT 9.

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

Please see the table below in ATTACHMENT 9.

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

Passavant Area Hospital and Memorial Health System there are sufficient AMI resources in the local area and that patients will continue to have access to care. This project is not expected to have any impact on safety net services or other health care services in the area.

A table in the following format must be provided as part of Attachment 9.

Safety Net Information per PA 96-0031 – Passavant Area Hospital			
CHARITY CARE			
Charity (# of patients)	**Year 2016**	**Year 2017**	**Year 2018**
Inpatient	49	113	476
Outpatient	1,292	2,168	6,897
Total	**1,341**	**2,281**	**7,373**
Charity (cost In dollars)			
Inpatient	$ 14,147	$ 35,583	$ 67,613
Outpatient	373,018	682,682	905,833
Total	**$ 387,165**	**$ 718,265**	**$ 973,446**
MEDICAID			
Medicaid (# of patients)	**Year 2016**	**Year 2017**	**Year 2018**
Inpatient	630	769	716
Outpatient	22,787	23,133	22,110
Total	23,417	23,902	22,826
Medicaid (revenue)			
Inpatient	$ 1,543,608	$ 1,668,753	$ 5,230,894
Outpatient	4,274,097	4,007,487	15,449,509
Total	$ 5,817,705	$5,676,240	$ 20,680,403

ATTACHMENT 10

Charity Care – Passavant Area Hospital

The amount of charity care provided by Passavant Hospital for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below. Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3).

CHARITY CARE – Passavant Area Hospital			
	Fiscal Year 2016	**Fiscal Year 2017**	**Fiscal Year 2018**
Net Patient Revenue	**$90,777,366**	**$101,842,950**	**$104,709,239**
Amount of Charity Care (charges)	$4,409,235	$6,758,901	$6,985,714
Cost of Charity Care	$1,096,291	$1,697,205	$1,735,849
Ratio of Cost of Charity Care to Net Patient Service Revenue	1.21%	1.67%	1.66%

Charity Care – Memorial Health System

The amount of charity care provided by Memorial Health System Affiliates (excluding Passavant Area Hospital) – Memorial Medical Center, Taylorville Memorial Hospital, Abraham Lincoln Memorial Hospital and Decatur Memorial Hospital - for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below.

CHARITY CARE – Memorial Medical Center			
	Fiscal Year 2016	**Fiscal Year 2017**	**Fiscal Year 2018**
Net Patient Revenue	**$593,032,278**	**$572,791,762**	**$602,680,285**
Amount of Charity Care (charges)	$15,463,228	$24,338,424	$25,976,165
Cost of Charity Care	$4,132,511	$6,179,274	$6,464,059
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.70%	1.08%	1.07%

CHARITY CARE – Abraham Lincoln Memorial Hospital			
	Fiscal Year 2016	**Fiscal Year 2017**	**Fiscal Year 2018**
Net Patient Revenue	**$46,748,549**	**$45,460,509**	**$48,023,865**
Amount of Charity Care (charges)	$1,692,716	$2,140,061	$2,418,202
Cost of Charity Care	$506,055	$664,590	$729,845
Ratio of Cost of Charity Care to Net Patient Service Revenue	1.08%	1.46%	1.52%

CHARITY CARE – Taylorville Memorial Hospital			
	Fiscal Year 2016	**Fiscal Year 2017**	**Fiscal Year 2018**
Net Patient Revenue	**$42,441,416**	**$41,553,636**	**$42,081,576**
Amount of Charity Care (charges)	$1,589,421	$1,347,644	$2,095,273
Cost of Charity Care	$474,305	$399,084	$639,523
Ratio of Cost of Charity Care to Net Patient Service Revenue	1.12%	0.96%	1.52%

CHARITY CARE – Decatur Memorial Hospital			
	Fiscal Year 2016	**Fiscal Year 2017**	**Fiscal Year 2018**
Net Patient Revenue	**$ 254,244,029**	**$275,946,863**	**$296,433,641**
Amount of Charity Care (charges)	$7,522,012	$8,748,999	$10,405,063
Cost of Charity Care	$2,491,560	$2,739,107	$3,237,596
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.98%	0.99%	1.09%