ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: St. Mary's Hospital		
Street Address: 400 N. Pleasant Ave		
City and Zip Code: Centralia, IL. 62801		
County: Marion	Health Service Area: 5	Health Planning Area: F-4

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

Exact Legal Name: St. Mary's Hospital Center, a Missouri nonprofit corporation, d/b/a SSM Health St. Mary's Hospital
Street Address: 400 N. Pleasant Ave
City and Zip Code: Centralia, IL. 62801
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 So LaSalle St, Suite 814
Registered Agent City and Zip Code: Chicago, IL 60604
Name of Chief Executive Officer: Damon Harbison
CEO Street Address: 400 N. Pleasant
CEO City and Zip Code: Centralia, IL. 62801
CEO Telephone Number: (618) 436-6525

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which 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

Name: Damon Harbison
Title: President St. Mary's Hospital
Company Name: SSM Health – St. Mary's Hospital
Address: 400 N. Pleasant, Mt. Vernon, IL. 62801
Telephone Number: (618) 436-6525
E-mail Address: Damon.R.Harbison@ssmhealth.com
Fax Number: (618) 436-8038

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

Name: Jenny Sims
Title: Director, Strategy & Business Development
Company Name: SSM Health -Illinois
Address: 1 Good Samaritan Way / Mt. Vernon, IL 62864
Telephone Number: (618) 899-2499
E-mail Address: Jennifer.sims@ssmhealth.com
Fax Number: (618) 899-4702

Post Exemption Contact
THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name: Jenny Sims	
Title: Director, Strategy & Business Development	
Company Name: SSM Health -Illinois	
Address: 1 Good Samaritan Way / Mt. Vernon, IL 62864	
Telephone Number: (618) 899-2499	
E-mail Address: Jennifer.sims@ssmhealth.com	
Fax Number: (618) 899-4702	

Site Ownership

Exact Legal Name of Site Owner: SSM Health Care Corporation d/b/a SSM Health
Address of Site Owner: 10101 Woodfield Lane, St. Louis MO 63132
Street Address or Legal Description of the Site: 400 N. Pleasant Centralia, IL. 62801
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee:

n/a (SSM Health St. Mary's is only applicant)

Exact Legal Name:
Address:
☐ 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.

n/a

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.

Per Section 1130.525 of the Health Facilities & Services Review Board rules, this application is being submitted to **permanently discontinue procedures and remove the cardiac catheterization lab** at SSM Health St. Mary's Hospital in Centralia, IL.

Cardiac catheterization is considered to be a substantive service based on the IHFSRB definition of substantive projects "...Projects proposing a new service or discontinuation of a service, which shall be reviewed by the board ..."

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?

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.

n/a

Anticipated exemption completion date (refer to Part 1130.570): n/a

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 Yes.
☒ All reports regarding outstanding permits n/a – no 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:

- X in the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of:
St. Mary's Hospital
a Missouri nonprofit corporation, d/b/a SSM Health St. Mary's 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.

Damon Harbison
President

Mike Bowers
Chief Operating Officer

Notarization:
Subscribed and sworn to before me
this 15 day of December 2020

Signature of Notary

Seal

RHONDA EDMONSON
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
January 08, 2024

Notarization:
Subscribed and sworn to before me
this 15 day of December 2020

Signature of Notary

Seal

RHONDA EDMONSON
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
January 08, 2024

*Insert the EXACT legal name of the applicant

St. Mary's Hospital
a Missouri nonprofit corporation, d/b/a SSM Health St. Mary's Hospital

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.

   Category of Service: Cardiac Catheterization
   (No impact to bed count.)

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

   Discontinuation is limited to cardiac catheterization, and services that could result from a cardiac catheterization such as coronary angiogram or balloon angioplasty.

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

   1/31/2021

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

   This space is being evaluated for use as a sleep lab or a vein clinic.

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.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2017**	**2018**	**2019**
Inpatient	157	128	133
Outpatient	958	803	874
Total	**1,115**	**931**	**1,007**
Charity (cost in dollars)			
Inpatient	506,428	399,033	315,345
Outpatient	827,195	594,029	660,300
Total	**1,333,623**	**933,062**	**975,645**
MEDICAID			
Medicaid (# of patients)	**2017**	**2018**	**2019**
Inpatient	1,602	1,504	1,767
Outpatient	18,442	16,587	17,563
Total	**20,044**	**18,091**	**19,320**
Medicaid (revenue)			
Inpatient	25,873,249	24,975,388	25,076,871
Outpatient	57,548,982	54,867,179	56,057,379
Total	**83,422,231**	**79,842,567**	**81,134,250**

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

✓ Done

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			
SSM Health – SM Hospital	**2017**	**2018**	**2019**
Net Patient Revenue (total hospital)	**$104,806,700**	**$105,761,211**	**$108,144,154**
Amount of Charity Care (charges)	$2,730,230	$3,211,469	$4,334,377
Cost of Charity Care	$1,333,623	$993,062	$975,645

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

✓ **Done**

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	13
2	Site Ownership	14
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	n/a
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	16
5	Discontinuation General Information Requirements	17
6	Reasons for Discontinuation	18
7	Impact on Access	19
8	Background of the Applicant	20-21
9	Safety Net Impact Statement	23
10	Charity Care Information	24
	Fee (check included)	

ATTACHMENT 1: ILLINOIS CERTIFICATE OF GOOD STANDING

File Number 3006-038-5

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

ST. MARY'S HOSPITAL, CENTRALIA, ILLINOIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1947, 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. 26 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* NOVEMBER *A.D.* 2020 .

Authentication # 2031002542 verifiable until 11/05/2021
Authenticate at: http://www.cyberdrivenillinois.com

Jesse White
SECRETARY OF STATE

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION- 08/2019 Edition

ATTACHMENT 2: SITE OWNERSHIP

GARY L.PURCELL
MARION COUNTY TREASURER
PO BOX 1025
SALEM IL 62881
marionil.devnetwedge.com

PROPERTY INDEX NUMBER
14-17-100-008

1ST DUE DATE	07/30/2020	2ND DUE DATE	09/30/2020
1ST INSTALLMENT	$66,129.77	2ND INSTALLMENT	$66,129.77

REAL ESTATE TAX BILL (2019 PAYABLE 2020)

Late Payment Schedule

Postmarked after:	PAY	Postmarked after:	PAY
09/30/2020	$0.00	09/30/2020	$67,121.72
10/30/2020	$0.00	10/30/2020	$68,113.66
11/30/2020	$0.00	11/30/2020	$69,105.61
12/15/2020	Contact the Collector's office	12/15/2020	Contact the Collector's office
Incorrect payments will be returned.		Incorrect payments will be returned.	

DUPLICATE

NAME: ST MARYS HOSPITAL
400 N PLEASANT AVE
CENTRALIA IL 62881

FIRST INSTALLMENT PAID	SECOND INSTALLMENT PAID
1	2

PRIOR YEAR TAX	$134,521.96
TIF EAV	0
1977 EAV	0
FREEZE BASE VALUE	0
COUNTY MULTIPLIER	1.0000
FAIR CASH VALUE	3,899,340
LAND VALUE	32,980
+ BUILDING VALUE	1,266,670
- HOME IMPROVE EXEMP	0
= TOTAL VALUE	1,299,650
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	1,299,650
- SR FREEZE EXEMPTION	0
- RETURN VET / MISC EX	0
- OWNER OCCUPIED EX	0
- SR HOMESTEAD EXEMP	0
-DISABLED / D. VET EX	0
+ FARM LAND VALUE	0
- DRAINAGE ABATEMENT	0
+ FARM BUILDINGS VALUE	0
= TAXABLE VALUE	1,299,650
x TAX RATE	10.17655
= CURRENT TAX	$132,259.54
- ENTERPRISE ZONE	$0.00
+ BACK TAX	$0.00
= TAX BILLED	$132,259.54
- TAX PAID	$66,129.77
= TOTAL TAX DUE	$66,129.77

TOWNSHIP NAME	TAX CODE	TOTAL PAID	TOTAL PAID
Centralia Township	14001		

Taxing Body	Current Rate	% Of Total	Current Tax	Prior Year Tax	Pension Amount	Library Amount
COUNTY TAX	1.03137	10.13	$13,404.20	$13,452.80	$2,313.51	$0.00
CENTRALIA GRADE SCHOOL	2.74679	26.99	$35,698.66	$35,618.73	$2,334.05	$0.00
CENTRALIA HIGH SCHOOL	2.55210	25.08	$33,168.37	$33,206.19	$941.58	$0.00
KASKASKIA COLLEGE 501	0.56854	5.59	$7,389.03	$8,625.39	$0.00	$0.00
CENTRALIA REG LIB	0.25371	2.49	$3,297.34	$3,363.36	$387.95	$0.00
CENTRALIA TWP RD&BR	0.37043	3.64	$4,814.29	$4,904.36	$0.00	$0.00
CENTRALIA TOWNSHIP	0.29228	2.87	$3,798.62	$3,921.43	$117.23	$0.00
CENTRALIA CITY	2.36133	23.20	$30,689.03	$31,429.70	$24,334.01	$0.00
Totals	**10.17655**		**$132,259.54**			

LEGAL DESCRIPTION	TAX FOR	TOTAL ACRES
PT NE NW 10-61-27 Womens Center 13.2% exempt Orthopedic Center 93% exempt Cancer Center 89.6% exempt Medical Office 1054 MLK taxable	Commercial	26.96
	PROPERTY ADDRESS: 400 N PLEASANT, CENTRALIA, IL 62881	
OWNER: ST MARYS HOSPITAL		

$1.00 FEE FOR EACH DUPLICATE BILL

REVIEW PAYMENT OPTIONS AND COLLECTION POLICIES ON THE BACK OF THIS BILL

RETURN THIS STUB WITH 1ST INSTALLMENT PAYMENT

PAY TO: MARION COUNTY COLLECTOR
PO BOX 1025
SALEM IL 62881

Property Index Number	14-17-100-008
1st Due Date	07/30/2020
Back Tax	$0.00
1st Installment	$66,129.77
1st Installment Paid	$66,129.77
1st Installment Balance Due	

☐ CHECK ☐ CASH ☐ BANK ☐ CREDIT/DEBIT

Incorrect payments will be returned.

ST MARYS HOSPITAL
400 N PLEASANT AVE
CENTRALIA IL 62881

PAID

DUPLICATE

1

RETURN THIS STUB WITH 2ND INSTALLMENT PAYMENT

PAY TO: MARION COUNTY COLLECTOR
PO BOX 1025
SALEM IL 62881

Property Index Number	14-17-100-008
2nd Due Date	09/30/2020
Total Tax	$132,259.54
2nd Installment	$66,129.77
2nd Installment Paid	
2nd Installment Balance Due	$66,129.77

☐ CHECK ☐ CASH ☐ BANK ☐ CREDIT/DEBIT

Incorrect payments will be returned.

ST MARYS HOSPITAL
400 N PLEASANT AVE
CENTRALIA IL 62881

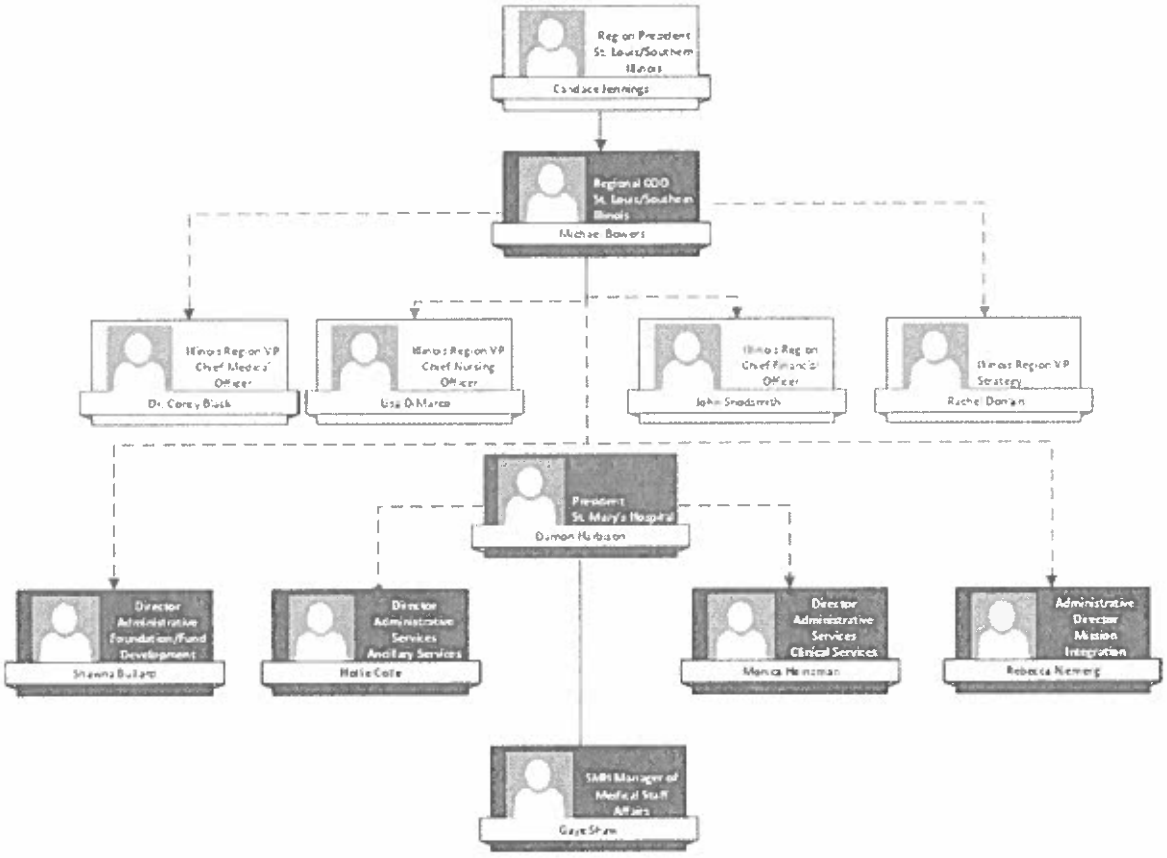
BALANCE DUE

DUPLICATE

2

ATTACHMENT 3:
n/a

ATTACHMENT 4: ORGANIZATIONAL CHART



ATTACHMENT 5: NOTICE OF DISCONTINUATION

100 Legals

Notice

Notice is hereby given that SSM Health St. Mary's Hospital will close the Cardiac Catheterization Lab on January 31, 2021. Cardiac Cath procedures are still available in the region at SSM Good Samaritan Hospital.

The following services will still be provided at SSM Health St. Mary's Hospital.

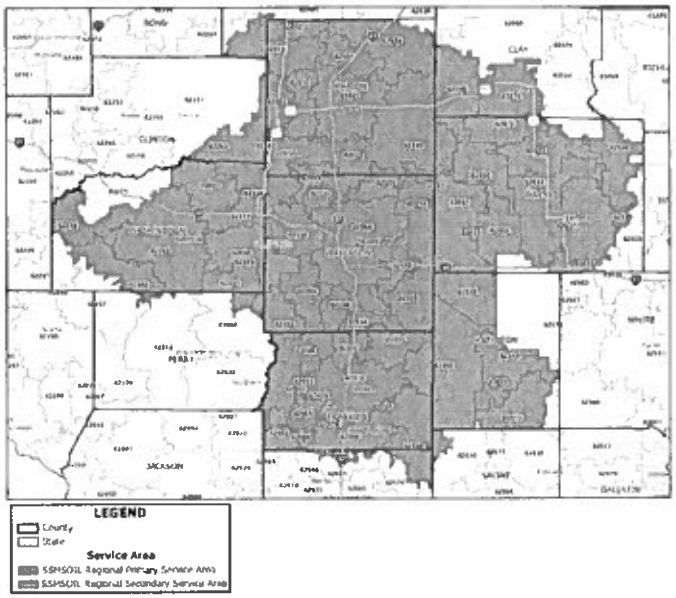
Inpatient/Outpatient:
Cardiology Consultations, Electrocardiogram (EKG), Holter Monitors, Event Monitors, Stress Testing, Echocardiograms, Transesophageal Echocardiograms (TEE), Peripheral Vascular Testing, and Nuclear Cardiology.

Outpatient:
Cardiac Rehab Program/ Services

ATTACHMENT 6: REASONS FOR DISCONTINUATION

1. Low volume:

In the service area defined by SSM Health-Illinois as its Primary & Secondary Service Area (PSA/SSA), St. Mary's hospital has seen a significant decline in the volume of cardiac catheterization procedures. This decline has made it difficult to maintain staff competency and efficient operations, including the cost of staffing, supplies and annual preventive maintenance on equipment. Good Samaritan has been the provider of over 90% of cardiac catheterization procedures over that last 5 years, increasing to 99% YTD 2020. This is a duplicative service that is not sustainable in our region.



So IL discharges Jan 2016 - Sept 2020
11/3/2020
Source: September Masterfile

Dschg Yr Qtr	(All)
Payor Group	(All)
Fine Product	(All)
Heart Cath Flag	Y

Entity	Discharge Year	IP	OP	Grand Total
GSAM	2016	494	457	951
	2017	550	484	1,034
	2018	508	422	930
	2019	467	480	947
	2020	357	321	678
SMC	2016	34	46	80
	2017	9	24	33
	2018	20	36	56
	2019	2	15	17
	2020	3	3	6

ATTACHMENT 7: IMPACT ON ACCESS

As stated in "Reasons for Discontinuation", the total volume of cardiac catheterization in the defined service area is low for St. Mary's. From the defined market, St. Mary's sister hospital Good Samaritan has a historical market share for these services of over 90%. Therefore, the majority of cases from the defined service area are being performed at Good Samaritan. Residents in the region also have access to these services at Southern Illinois Healthcare and HSHS St. Elizabeth's in O'Fallon. All of these programs are higher-volume with the capacity to ensure 24/7 access.

No Impact on Cardiology Access / Care:
Residents of the service area continue to have 24/7 access to a full range of cardiology services, including STEMI care. Good Samaritan operates a strong, full-service cardiology program.

ATTACHMENT 8: BACKGROUND INFORMATION

8-1:
In addition to SSM Health St. Mary's Hospital, the following is a list of assumed names that St. Mary's has filed for the entity from the Illinois Secretary of State's website.

Assumed Name	
INACTIVE	IRVINGTON RURAL HEALTH CENTER
INACTIVE	SALEM RURAL HEALTH CENTER
INACTIVE	VANDALIA RURAL HEALTH CENTER
INACTIVE	FAMILY HEALTH CENTER OF ST. MARY'S
ACTIVE	SSM HEALTH ST MARY'S HOSPITAL - CENTRALIA

8-2:

SSM Health St. Mary's Hospital has no adverse actions filed by Illinois Health facilities & Services Review Board.

8.3:

SSMHealth
In partnership with the Felician Sisters

St. Mary's Hospital
Centralia
400 N. Pleasant Ave
Centralia, IL 62801
phone: 618-436-8000
ssmhealthIllinois.com

November 6, 2020

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

Dear Ms. Avery,
I am writing to formally grant the IHFSRB access to any documents needed to validate the background information contained in our Discontinuation Exemption Application specific to cardiac catheterization at SSM Health St. Mary's Hospital.

If you should have any questions, please feel free to call me at (618) 436-6525

Sincerely,

Damon Harbison, President
SSM Health-St. Mary's Hospital

8.4:
n/a

ATTACHMENT 9: SAFETY NET IMPACT STATEMENT

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2017**	**2018**	**2019**
Inpatient	157	128	133
Outpatient	958	803	874
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ATTACHMENT 10: CHARITY CARE INFORMATION

CHARITY CARE			
SSM Health – SM Hospital	**2017**	**2018**	**2019**
Net Patient Revenue (total hospital)	**$104,806,700**	**$105,761,211**	**$108,144,154**
Amount of Charity Care (charges)	$2,730,230	$3,211,469	$4,334,377
Cost of Charity Care	$1,333,623	$993,062	$975,645

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

DISCONTINUATION CERTIFICATE OF EXEMPTION APPLICATION

AUGUST 2019 EDITION

TABLE OF CONTENTS

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2nd FLOOR
SPRINGFIELD, ILLINOIS 62761
(217) 782-3516

INSTRUCTIONS

GENERAL

- The application for exemption (Application) must be completed for all transactions proposing a discontinuation of a single category of service in a 6-month period.
- The persons preparing the Application are advised to refer to the Planning Act, as well as the rules promulgated there under (77 Ill. Adm. Codes 1100, 1110 and 1130) for more information. Applicants should refer to 77 IAC 1130.140 for definitions of a discontinuation of a category of service.
- Applicants should also refer to 77 IAC 1130.220(a) for information on who the applicant(s) should be.
- 77 IAC 1130.525(a) prohibits any person from discontinuing a health care facility or category of service prior to receiving approval from the State Board.
- It is noted that all applications for exemption for the discontinuation of a single category of service in a 6-month period are subject to the opportunity for a public hearing and public hearing requirements (77 IAC 1130.525(c)).
- **The Application does not supersede any of the above-cited rules and requirements.**
- The Application is organized into several sections.
- Questions concerning completion of this form may be directed to Health Facilities and Services Review Board staff at (217) 782-3516.
- Copies of the Application form are available on the Health Facilities and Services Review Board website www.illinois.gov/sites/hfsrb.

SPECIFIC

- Use the Application as written and formatted.
- **ALL APPLICABLE CRITERIA** for each applicable section must be addressed. **If a criterion is NOT APPLICABLE, label it as such and state the reason why**.
- **ALL PAGES ARE TO BE NUMBERED CONSECUTIVELY BEGINNING WITH PAGE 1 OF THE APPLICATION. DO NOT INCLUDE INSTRUCTIONS AS PART OF THE APPLICATION OR IN NUMBERING THE PAGES IN THE APPLICATION.**
- Unless otherwise stated, attachments for each Section should be appended after the last page of the Application.
- Begin each attachment on a separate 8 1/2" x 11" sheet of paper and print or type the attachment identification in the lower right-hand corner of each attached page.
- Information to be considered must be included with the applicable Section attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
- The Application must be signed by the authorized representative(s) of each applicant entity.

Provide an original Application and one copy, both **unbound**. **Label the copy** that contains the original signatures **original (put the label on the Application).**

Failure to follow these requirements WILL result in the Application being declared incomplete. In addition, failure to provide certain required information (e.g., not providing a site for the proposed project or having an invalid entity listed as the applicant) may result in the Application being declared null and void.

ADDITIONAL REQUIREMENTS

SAFETY NET IMPACT STATEMENT

A SAFETY NET IMPACT STATEMENT must be submitted for **ALL DISCONTINUATION PROJECTS**. **SEE SECTION IV** OF THE APPLICATION.

CHARITY CARE INFORMATION

CHARITY CARE INFORMATION must be provided for **ALL** substantive projects. **SEE SECTION V** OF THE APPLICATION.

FEE

An application-processing fee of $2,500 MUST be submitted with the application. **The application will not be deemed complete and review will not be initiated until the entire processing fee is submitted. Payment may be made by check or money order and must be made payable to the Illinois Department of Public Health**.

APPLICATION SUBMISSION

Submit an original and one copy of all Sections of the application, including all necessary attachments. **The original must contain original signatures in the certification portions of this form.** Submit all copies to:

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761