#E-018-21

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name: Fayette County Hospital – Discontinue Intensive Care Beds		
Street Address:650 West Taylor Street		
City and Zip Code: Vandalia, 62471		
County: Fayette	Health Service Area 5	Health Planning Area: F-02

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

Exact Legal Name: Fayette County Hospital District
Street Address: 650 West Taylor Street
City and Zip Code: Vandalia, 62471
Name of Registered Agent: Gregory D Starnes
Registered Agent Street Address: 650 West Taylor Street
Registered Agent City and Zip Code: Vandalia, 62471
Name of Chief Executive Officer: Gregory D Starnes
CEO Street Address: 650 West Taylor Street
CEO City and Zip Code: Vandalia, 62471
CEO Telephone Number: 618-283-5400

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Gregory D. Starnes
Title: CEO
Company Name: Fayette County Hospital
Address: 650 West Taylor Street, Vandalia, IL 62471
Telephone Number: 618-283-5400
E-mail Address: Greg.Starnes@sblfch.org
Fax Number:

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

Name: Kim Uphoff
Title: Board Secretary
Company Name: Heartland Health System, Inc
Address: 1000 Health Center Drive, Mattoon IL 61938
Telephone Number:217-258-2163
E-mail Address:kuphoff@sblhs.org
Fax Number:

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: Gregory D Starnes
Title:CEO
Company Name: Fayette County Hospital
Address:650 West Taylor Street, Vandalia, IL 62471
Telephone Number: 618-283-5400
E-mail Address:Greg.Starnes@sblfch.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Fayette County Hospital District
Address of Site Owner: 650 West Taylor Street, Vandalia, IL 62471
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: Heartland Health System, Inc
Address: 1000 Health Center Drive, Mattoon, IL 61938

X	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.

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.

Fayette County Hospital is discontinuing its intensive care category of hospital beds. It has two intensive care beds and would like to add those two beds to its medical surgical beds.

Upon approval, Fayette County Hospital would then be authorized for a total of 25 medical surgical beds, and would have no authorized beds in the Intensive Care category of service.

There would be no change to any other categories of service.

The hospital is located at 650 West Taylor Street, Vandalia, IL 62471.

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 __ No _X_. 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.

_____

_____

_____

_____

_____

Anticipated exemption completion date (refer to Part 1130.570): _____

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X 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 _the Fayette County Hospital District*

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

Gregory D. Starnes
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of June, 2021

Sheri R. Hopkins
Signature of Notary

Seal

OFFICIAL SEAL
SHERI R HOPKINS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/11/22

SIGNATURE

Nancy L. Pryor
PRINTED NAME

Chair
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of June, 2021

Jill Magnus
Signature of Notary

Seal

OFFICIAL SEAL
JILL MAGNUS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:10/24/21

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

X	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

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Site Ownership

Fayette County Hospital District owns the property of 650 W. Taylor St., Vandalia, IL where the hospital is located.

Gregory D. Starnes, CEO

Subscribed and sworn to before me
This 2nd day of April, 2021

OFFICIAL SEAL
SHERI R HOPKINS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/11/22

AHACHMENT 3

#E-018-21

File Number 7205-154-8

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

HEARTLAND HEALTH SYSTEM, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 01, 2019, 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* 8TH *day of* MARCH *A.D.* 2021 .

Jesse White

SECRETARY OF STATE

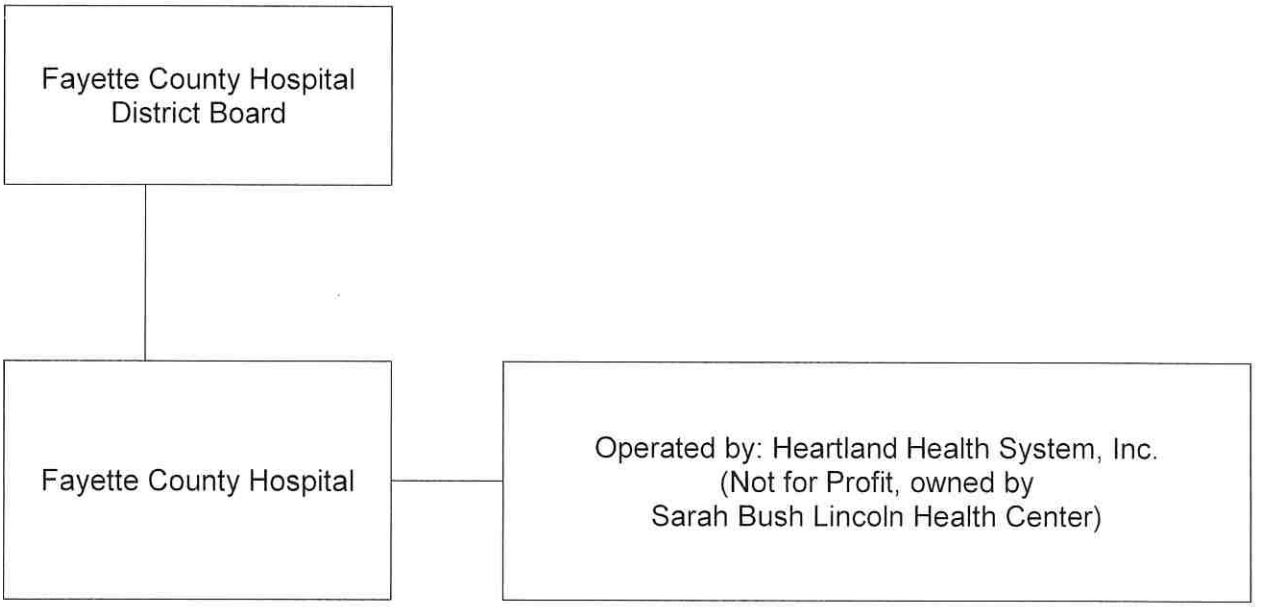
Authentication #: 2106702618 verifiable until 03/08/2022

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

ATTACHMENT 4

Fayette County Hospital

Organizational Chart



ATTACHMENT 5
GENERAL INFORMATION REQUIREMENTS

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

   Fayette County Hospital proposes to discontinue its Intensive Care category of hospital beds. There are two beds in this category.

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

   No other clinical services will be discontinued.

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

   Anticipated date of discontinuation will be the date this request is approved.

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

   Fayette County Hospital proposes to use these two beds as medical surgical beds, and increase its authorized medical surgical beds from 23 to 25.

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.**

   See attached

ATTACHMENT 5

#E-018-21

Certificate of Publication

STATE OF ILLINOIS
COUNTY OF FAYETTE

THIS IS TO CERTIFY, that the notice of which a printed copy is hereto annexed, was published once a week for One Successive week(s) in the Vandalia Leader-Union, a newspaper of general circulation, published in the city of Vandalia in said County and State, by Greg A. Hoskins, its publisher, and that the first insertion was made in the paper published on the 17th Day of June, A.D., 2021, and the last paper published on the 17th Day of June, A.D., 2021, and said newspaper was regularly published for six months prior to date of the first publication of said notice.

Legal 2746
First Publication
June 17 2021
LEGAL NOTICE
Public Notice is hereby given that Fayette County Hospital District is discontinuing service of intensive care beds of which it has two beds in the category. The hospital plans to use these two beds for medical and surgical services.

Patty Peterson
Director of Communications
Sarah Bush Lincoln
1000 Health Center Drive

Subscribed and sworn before me, this date:

P Atkinson

Paula Atkinson
Agent of the Vandalia Leader-Union
Vandalia, IL

June 17th, A. D., 2021

ATTACHMENT 6

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.

Insufficient volume or demand for service is the reason for discontinuation. Data indicates that there have been no intensive care patient days in this hospital for the past 5 years.

Because this is a critical access hospital with only 25 total beds, there is also a lack of sufficient staff to adequately provide this level of service.

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.**

   This discontinuation will have no adverse effect upon access to care. Due to the rural location and small size of this critical access hospital, these two beds have not been used for intensive care patients for the past 5 years.

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.**

   There are no healthcare facilities located within the normal travel radius of 21 miles from Fayette County Hospital, which is the distance requirement outlined in f77 Ill. Adm. Code 1100.510(d). Therefore, no notification letters were sent.

   HSHS Saint Anthony's Memorial Hospital is located 34 miles from the applicant and is the nearest facility with intensive care beds. The Hospital Profile report shows HSHS Saint Anthony's Memorial Hospital has 10 intensive care beds and is at 53% capacity.

   There have been zero patients who have received intensive care services at Fayette County Hospital in the last 5 years.

   The anticipated date of discontinuation will be effective upon approval of this application.

ATTACHMENT 8

Background of Applicant

Fayette County Hospital attests that the background information which was previously provided in the Exemption Application #E-005-21 – Fayette County Hospital, and approved on April 27, 2021, remains in effect and has not changed.

Fayette County Hospital certifies that no changes have occurred since that time.

Gregory D. Starnes, CEO

Subscribed and sworn to before me

This 29th day of June, 2021

Sheri R. Hopkins

OFFICIAL SEAL
SHERI R HOPKINS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/11/22

ATTACHMENT 9

Safety Net Impact Statement

The discontinuation of two Intensive Care beds will not have any impact on essential safety net services and will not impact any racial or health care disparities in the community.

This discontinuation project will not negatively impact other safety net providers and will not affect the ability of other providers to provide safety net services.

Charity Care	2018	2019	2020
# of Patients			
Inpatient	6	18	11
Outpatient	81	968	163
Total	87	986	174
Cost In $s			
Inpatient	11,219.21	21,586.14	10,026.09
Outpatient	115,636.59	637,157.70	160,594.91
Total	126,855.80	658,743.84	170,621.00

Medicaid			
# of Patients	21,195	22,699	20,885
Gross Revenues			
Inpatient	467,074	1,627,372	1,061,068
Outpatient	21,680,998	23,455,764	26,717,269
Total	22,148,072	25,083,136	27,778,337

ATTACHMENT 10

CHARITY CARE - Fayette County Hospital			
	2018	**2019**	**2020**
Net Patient Revenue	26,555,946	28,443,396	27,674,308
Amount of Charity Care (charges)	373,369	686,654	1,693,577
Cost of Charity Care	131,389	258,457	711,810