ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Hamilton Rural Health Village		
Street Address:	1599 Keokuk Street		
City and Zip Code:	Hamilton, IL 62341		
County: Hancock	Health Service Area: III	Health Planning Area: E-05	

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

Exact Legal Name:	Memorial Hospital Association
Street Address:	1454 North County Road 2050
City and Zip Code:	Carthage, IL 62321
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South LaSalle Street Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Ada Bair
CEO Street Address:	1454 North County Road 2050
CEO City and Zip Code:	Carthage, IL 62321
CEO Telephone Number:	217/357-8500

Type of Ownership of Applicants

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 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org.** **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**. NOTE: A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☐ Substantive

X Non-substantive

2. Narrative Description

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

The applicant is proposing the development of a healthcare campus, to be known as Hamilton Rural Health Village ("HRHV") through the renovation of a former long-term care facility. Hancock County was originally designated by the Health Resources and Services Administration as a shortage area for primary care and mental health care in 2011, and re-designated as such in 2021.

It is intended that a broad spectrum of services, addressing existing shortages, will be provided at HRHV, including:

- offices for physicians and other clinicians, including primary care, selective medical and surgical specialists, and behavioral medicine specialists
- general radiology
- laboratory
- an older adult assessment and care planning program
- diabetic and nutritional counseling
- a food pharmacy and distribution program
- a kitchen and dining area
- community educational programming
- after school programs.

The applicant, Memorial Hospital Association ("Memorial Hospital") is a critical access hospital located in Carthage, Illinois, and the only hospital in Hancock County. Hamilton, also located in Hancock County, is located approximately fourteen miles to the west of Memorial Hospital, directly across the Mississippi River from Keokuk, Iowa.

Memorial Hospital will operate HRHV, and a Certificate of Need is required solely because the associated capital expenditure exceeds the review threshold for hospitals.

The applicant has filed a request for a Hospital and Healthcare Transformation Grant to fund the proposed project, and is, as of the filing of this Certificate of Need application, awaiting a decision from the Illinois Department of Healthcare and Family Services ("DHFS") on whether or not that grant will be issued. There is no timetable for a decision by DHFS on the application. Therefore, and due to that uncertainty, this CON application proposes the funding of the project through Memorial Hospital cash reserves and a conventional loan. Should the requested grant be issued at some point following the filing of this CON application, a modification or alteration will be filed with the HFSRB. If the grant is not issued and "internal" funding sources are used, the project will be phased over a 3½ -year period. If the grant is issued, the project will progress to completion without delay. A summary of the anticipated phasing plan is provided on the following page.

This is a "non-substantive" project because facilities of the type being proposed are not licensed by IDPH.

Hamilton Rural Health Village
Anticipated Phasing Plan

Phase 1
- Physicians' Offices-Medical
- Facility Operations
- Integrative Medicine
- Lab
- Lobbies/Public Areas
- Mechanical
- PT/OT/Rehab

Phase 2
- Clinicians' Offices-Behavioral Health
- Community Ed./Wellness
- County Ambulance
- Facility Operations
- Lobbies/Public Areas
- Mechanical

Phase 3
- Facility Operations
- Food Service/Cafeteria
- Imaging
- Lobbies/Public Areas
- Mechanical

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

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

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PLEASE SEE FOLLOWING PAGE

PROJECT COST AND SOURCES OF FUNDS

	Clinical	Non-Clinical	Total
Project Cost:			
Preplanning Costs	$ 35,000	$ 115,000	$ 150,000
Site Survey and Soil Investigation			
Site Preparation	$ 100,000	$ 325,000	$ 425,000
Off Site Work			
New Construction Contracts			
Modernization Contracts	$ 2,052,105	$ 6,023,025	$ 8,075,130
Contingencies	$ 154,440	$ 292,650	$ 439,080
Architectural/Engineering Fees	$ 150,000	$ 445,000	$ 595,000
Consulting and Other Fees	$ 401,700	$ 1,143,300	$ 1,545,000
Movable and Other Equipment (not in construction contracts)	$ 1,962,000	$ 2,943,000	$ 4,905,000
Net Interest Expense During Construction Period			
Fair Market Value of Space			
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized	$ 267,540	$ 761,460	$ 1,029,000
Acquisition of Building or Other Property	$ 65,000	$ 185,000	$ 250,000
TOTAL USES OF FUNDS	**$ 5,187,785**	**$ 12,233,435**	**$ 17,413,210**
Sources of Funds:			
Cash and Securities	$ 1,040,000	$ 2,960,000	$ 4,000,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	$ 3,487,435	$ 9,925,775	$ 13,413,210
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 4,527,435**	**$ 12,885,775**	**$ 17,413,210**

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: *means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON-REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Related Project Costs
Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project X Yes ☐ No
Purchase Price: $__250,000_____
Fair Market Value: $__250,000_____ included with purchase of the building

The project involves the establishment of a new facility or a new category of service
☐ Yes X No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 100,000

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
X Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___June 30, 2027_____

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
X Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?
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 for permit being deemed incomplete.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Memorial Hospital		**CITY: Carthage, IL**			
REPORTING PERIOD DATES:		**From: January 1, 2022**	**to: December 31, 2022**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	17	396	1,579	none	17
Obstetrics					
Pediatrics					
Intensive Care	1	0	0	none	1
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	18	396	1,579	none	18

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

SIGNATURE	SIGNATURE
Ada Bair	Teresa Smith
PRINTED NAME	PRINTED NAME
Chief Executive Officer	**Chief Financial Officer**
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 9th day of May	Notarization: Subscribed and sworn to before me this 9th day of May 2023
Signature of Notary	Signature of Notary
Seal	Seal

OFFICIAL SEAL
BRENDA K LOWMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 04/17/2027

OFFICIAL SEAL
TAMMY POTTER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 12/14/2025

*Insert the EXACT legal name of the applicant

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

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

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.**

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

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost.

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions, or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

not applicable, no shell space included in project

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

not applicable, no shell space included in project

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **General Radiology**	**0**	**1**
☐		
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) - Need Determination - Establishment
Service Modernization	(c)(1) - Deteriorated Facilities
	AND/OR
	(c)(2) - Necessary Expansion
	PLUS
	(c)(3)(A) - Utilization - Major Medical Equipment
	OR
	(c)(3)(B) - Utilization - Service or Facility
1APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

___$4,000.000____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment.
$13,413,210		

	5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent. f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt. g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$17,413,210	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding, or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:	2020	2021	2022	2026
Current Ratio	1.74	3.19	44.8	2.91
Net Margin Percentage	3.2	21	4.5	4.5
Percent Debt to Total Capitalization	61.24	44.31	41.02	36.15
Projected Debt Service Coverage	2.07	6.60	2.78	2.68
Days Cash on Hand	235	216	169	155
Cushion Ratio				8.26

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available.

2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

not applicable

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

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

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

Safety Net Impact Statements shall also include all 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 37.

not applicable

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 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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

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

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

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

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	$29,278,525	$30,730,788	$43,191,462
Amount of Charity Care (charges)	$827,741	$446,538	$1,260,533
Cost of Charity Care	$408,000	$174,707	$499,999

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: memorial Hospital Associateion---Hamilton Rural Health Village (Name) 1454 North County Road 2050 (Address)
(City) Carthage (State) IL (ZIP Code) 62321 (Telephone Number) 217/357-8500

2. Project Location: 1599 keokuk Street (Address) Hamilton, IL (City) (State)
Hancock (County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No __X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number: Please see ATTACHMENT 6 Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

#23-026

File Number 2982-629-3

STATE OF ILLINOIS

OFFICE OF

THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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 HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 26, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 28TH *day of* MARCH *A.D.* 2023 .

SEAL OF THE STATE OF ILLINOIS — AUG. 26TH 1818

Authentication #: 2308701980 verifiable until 03/28/2024

Authenticate at: https://www.ilsos.gov

Alexi Giannoulias

SECRETARY OF STATE ~~ATTACH~~MENT 1

26

SITE OWNERSHIP

With the signatures on the Certification page of this Certificate of Need application, the applicant attests that the site of the proposed project, that being 1599 Keokuk Street in Hamilton, Illinois is controlled by the applicant through MHARE, LLC, which is wholly-owned by the applicant.

ATTACHMENT 2

#23-026

File Number 2982-629-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

***I,* Alexi Giannoulias,** *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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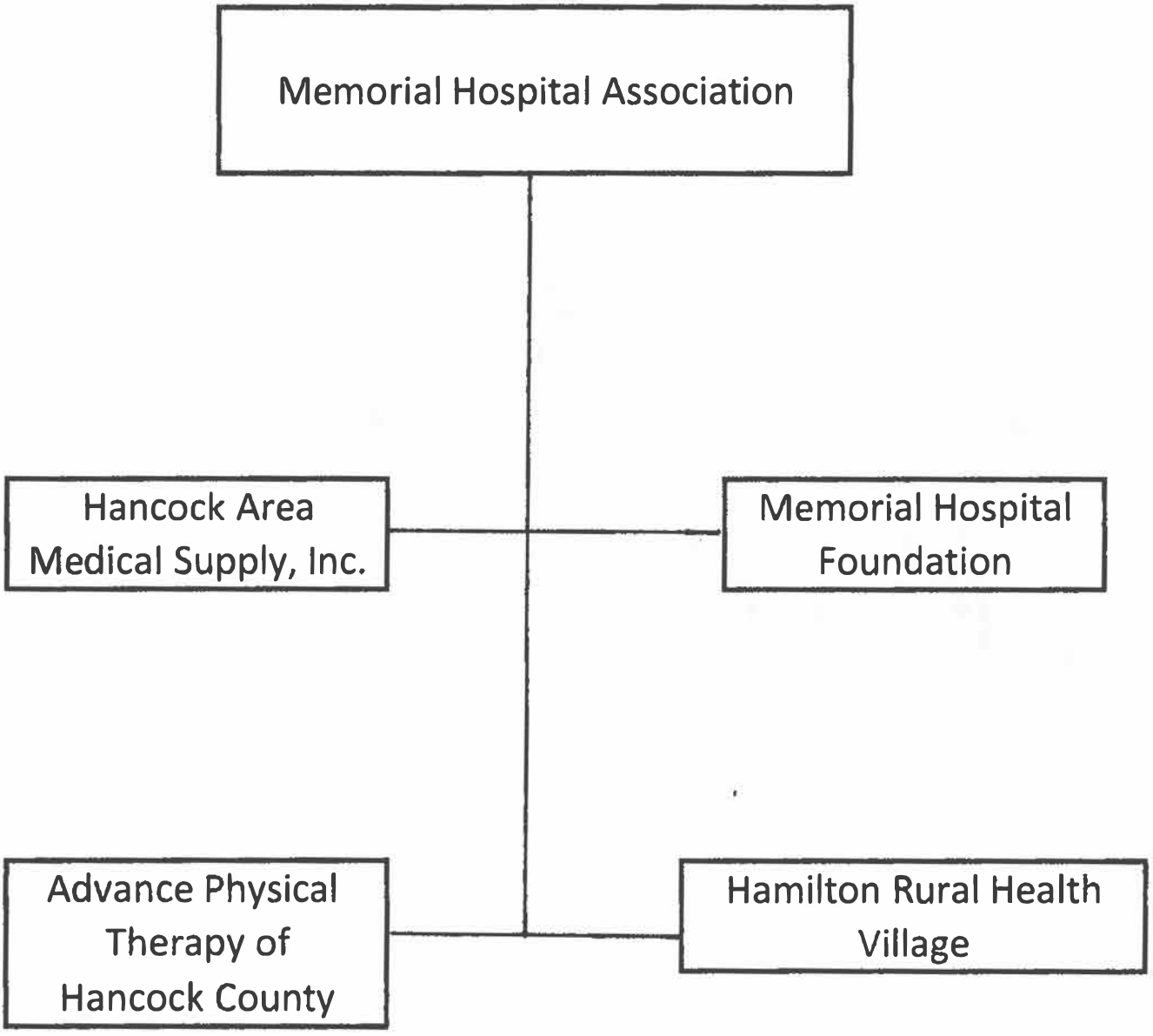
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 28TH *day of* MARCH ***A.D.*** 2023 .

Authentication #: 2308701980 verifiable until 03/28/2024
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 3

ORGANIZATIONAL CHART



ATTACHMENT 4

FLOOD PLAIN REQUIREMENTS

With the signatures provided on the Certification page of this Certificate of Need application, the applicant confirms that the project addressed thorough this Certificate of Need application, that being the establishment of an outpatient facility to be located at 1599 Keokok Street in Hamilton, Illinois, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA is attached.

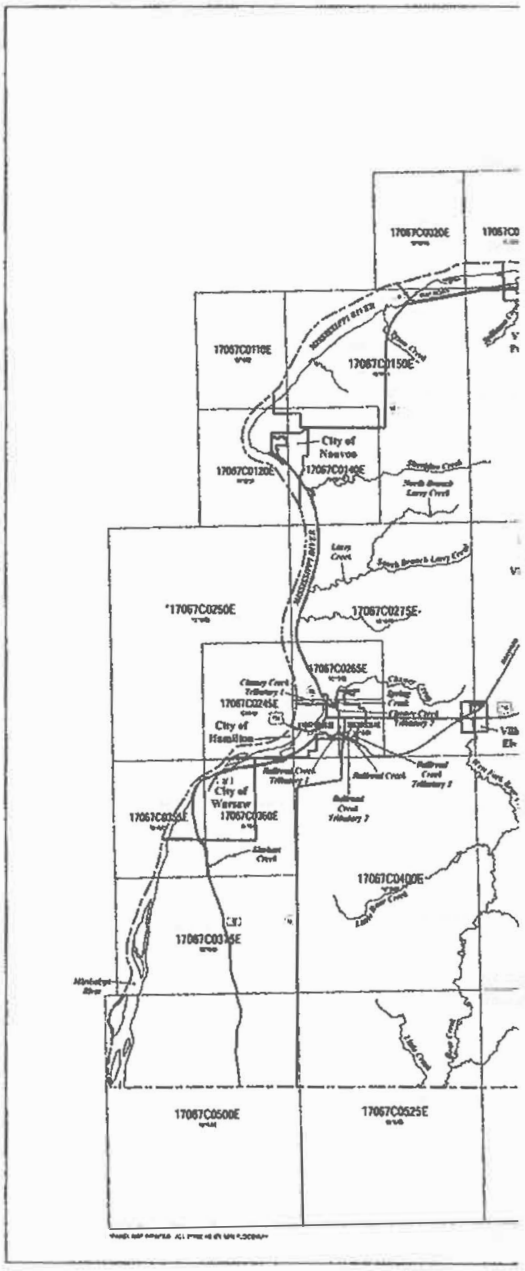
ATTACHMENT 5

#23-026

FEMA Flood Map Service Center: FIRMette Web

Help

CREATE A FIRMETTE



MAX ZOOM

ATTACHMENT 5

#23-026

Memorial Hospital

1454 North County Road 2050
P.O. Box 160 • Carthage, IL 62321
(217) 357-8500 • MHTLC.ORG

April 3, 2023

Illinois Dept. of Natural Resources
Illinois State Historic Preservation Office
ATTN: Review and Compliance/Old State Capitol
1 Natural Resources Way
Springfield, IL 62702-1271

RE: Proposed Outpatient Facility Hamilton, IL

To Whom It May Concern:

I am in the process of developing a Certificate of Need application, to be filed with the Illinois Health Facilities Services and Review Board, and I am in need of a determination of applicability from your agency.

The project proposes the development of an outpatient facility in a former nursing home, located at 1599 Keokuk Street in Hamilton, Illinois. There are no structures that appear to be of historical significance approximate to the site, which is primarily a residential area.

I have provided a map of the site and photographs of the building to be used as the future Hamilton Rural Health Village, as well as surrounding structures.

A letter from your office, confirming that the Preservation Act is not applicable to this project would be greatly appreciated.

Should you have any questions, I may be reached at the phone number below.

Sincerely,

Ada Bair

Ada Bair
CEO

attachments

cc J. Axel

ATTACHMENT 6

PROJECT COSTS and
SOURCES OF FUNDS

PROJECT COSTS

Preplanning Costs		
Evaluation of Alternatives	$	180,000
Misc./Other	$	50,000
Site Preparation		
Driveways and Walkways	$	150,000
Parking	$	180,000
Exterior Signage	$	20,000
Misc./Other	$	50,000
Modernization Contracts		
Contingencies (Modernization)		
Architectural and Engineering		
Design	$	470,000
Document Preparation	$	20,000
Interface With Agencies	$	25,000
Project Monitoring	$	30,000
Misc./Other	$	25,000
Consulting and Other Fees		
Legal	$	50,000
CON-Related	$	50,000
Project Management	$	425,000
Interior Design	$	90,000
Mktg/Public Relations	$	30,000
Grant-Related	$	75,000
Insurance	$	40,000
IT-Related Consulting	$	75,000
Commissioning	$	50,000
Equipment Planning	$	45,000
Financial Consulting	$	75,000
Environmental Assessment	$	10,000
Accounting	$	25,000

ATTACHMENT 7

Local Permits	$	30,000	
Appraisal	$	20,000	
Cost Estimating	$	45,000	
Real Estate-Related	$	30,000	
Opening Activities	$	50,000	
Elec. and AH Upgrades	$	100,000	
Misc./Other	$	200,000	
			$ 1,515,000
Acquisition of Building			$ 250,000
Movable Equipment			
Imaging	$	520,000	
Lab	$	190,000	
Clinical Offices	$	1,700,000	
PT/OT/Rehab	$	380,000	
Integrative Medicine	$	290,000	
Community Ed.	$	325,000	
Food Service/Cafeteria	$	750,000	
Other/Misc.	$	750,000	
			$ 4,905,000
Other Costs			
Phasing	$	564,000	
Artwork	$	25,000	
Interior Signage	$	20,000	
System Testing	$	30,000	
Security Systems	$	125,000	
IT-Relate	$	65,000	
Other/Misc.	$	200,000	
			$ 1,029,000
TOTAL USES OF FUNDS			$ 17,084,635
SOURCES OF FUNDS			
Cash from MHA Reserves	$	4,000,000	
Bank Loan	$	13,084,635	
TOTAL SOURCES OF FUNDS			$ 17,084,635

5/52/23

ATTACHMENT 7

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet That is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
Imaging	$ 1,528,034		1,250		1,250		
Lab	$ 1,269,045		1,468		1,468		
PT/OT/Rehab	$ 1,294,944		2,969		2,969		
Intergrative Medicine	$ 1,087,753		2,002		2,002		
	$ 5,179,775		7,689		7,689		
Non-Reviewable							
Physicians' Offices-Medical	$ 3,461,746		4,748		4,748		
Clinicians' Offices-Behav. H	$ 3,090,845		4,278		4,278		
Community Ed./Wellness	$ 741,803		1,277		1,277		
Facil. Operations	$ 865,437		1,800		1,800		
Lobbies/Public Areas	$ 123,634		313		313		
Food Service/Cafeteria	$ 2,719,943		4,465		4,465		
County Ambulance	$ 618,169		1,437		1,437		
Mechanical	$ 741,803		1,192		1,192		
	$ 12,233,435		19,510		19,510		
TOTAL	**$ 17,413,210**		**27,199**		**27,199**		

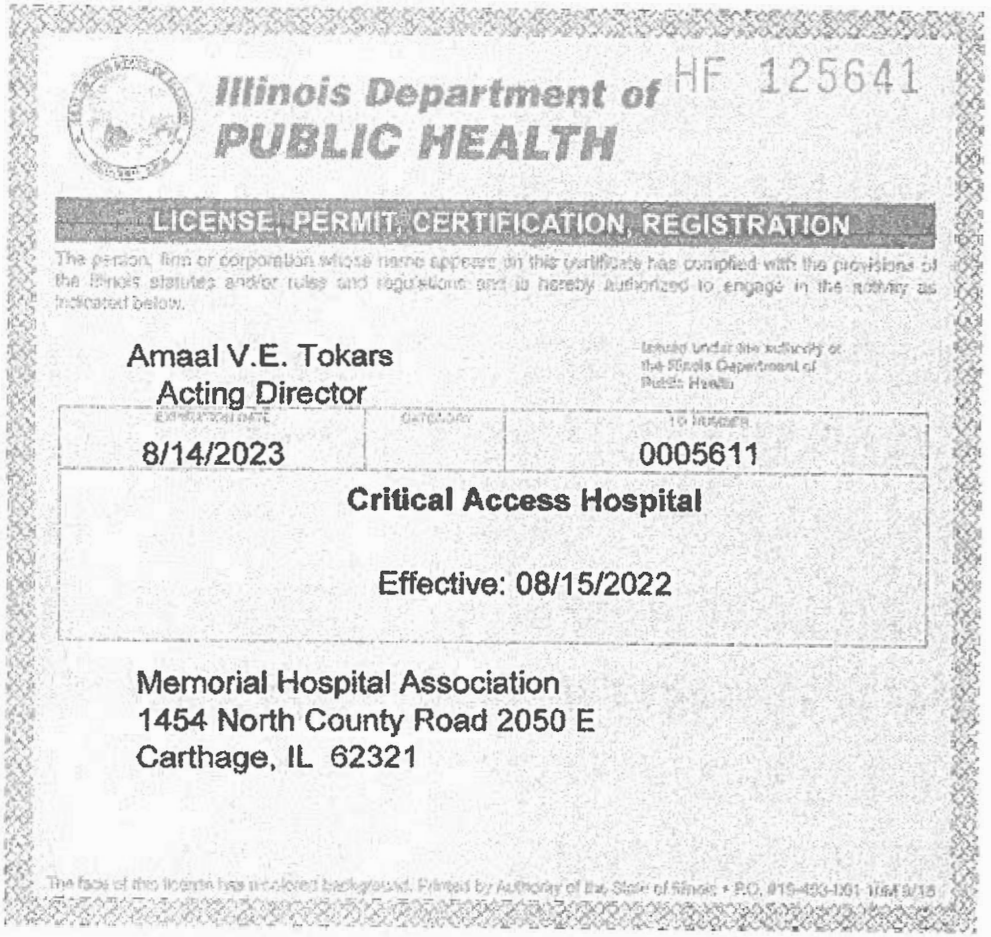
BACKGRFOUND OF THE APPLICANT

Memorial Hospital Association, located in Carthage, Illinois is the only IDPH-licensed health care facility owned and/or operated. by the applicant; and the proposed outpatient facility will be owned and operated by Memorial Hospital Association, the applicant.

With the signatures on the Certification page of this Certificate of Need application, the applicant certifies that no adverse action has been taken against the applicant named in this Certificate of Need application, directly or indirectly, over the past three years; and authorizes HFSRB and IDPH to access any documentation which it finds necessary to verify any information submitted, including, but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

ATTACHMENTY 11

#23-026



Illinois Department of PUBLIC HEALTH

HF 125641

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Amaal V.E. Tokars
Acting Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	DATE ISSUED	ID NUMBER
8/14/2023		0005611

Critical Access Hospital

Effective: 08/15/2022

Memorial Hospital Association
1454 North County Road 2050 E
Carthage, IL 62321

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #16-493-1301 1/64 9/15

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 8/14/2023

Lic Number 0005611

Date Printed 6/1/2022

Memorial Hospital Association

1454 North County Road 2050 E
Carthage, IL 62321

FEE RECEIPT NO.

ATTACHMENTY 11

#23-026

The Joint Commission

May 10, 2021

Ada Bair
CEO
Memorial Hospital Association
1454 North County Road 2050
Carthage, IL 62321

Re: # 351912
CCN: # 14-1305
Deemed Program: Critical Access Hospital
Accreditation Expiration Date: March 5, 2024

Dear Ms. Bair:

This letter confirms that your March 2, 2021 - March 4, 2021 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for critical access hospitals, including your swing bed service through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on May 4, 2021. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of March 5, 2021.

The Joint Commission is also recommending your organization for continued Medicare certification effective March 5, 2021. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

Please note, if your survey was conducted off-site (virtually): In accordance with CMS directives, your organization will be required to undergo a full on-site survey once conditions are appropriate to resume on-site activity. This survey will include all applicable Conditions of Participation (CoPs) and/or Conditions for Coverage (CfCs) as appropriate.

This recommendation applies to the following location(s):

Memorial Hospital Association
1454 NCR 2050, Carthage, IL, 62321

Evergreen Center
1450 NCR 2050, Carthage, IL, 62321

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

ATTACHMENTY 11

3P

The Joint Commission

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 5 /Survey and Certification Staff

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

ATTACHMENTY 11

PURPOSE OF THE PROJECT

The purpose of the proposed project is to improve the general health care equity of the residents of Hamilton and the surrounding communities and rural areas in western Hancock County. As such, Hamilton Rural Health Village ("HRHV") will improve the health care and well-being of the area.

Consistent with Section 1100.510.4), the HFSRB-designated service area includes those Illinois ZIP Codes located within 21 miles of the proposed site:

ZIP	City	County
62341	HAMILTON	HANCOCK
62334	ELVASTON	HANCOCK
62354	NAUVOO	HANCOCK
62379	WARSAW	HANCOCK
62336	FERRIS	HANCOCK
62313	BASCO	HANCOCK
62358	NIOTA	HANCOCK
62373	SUTTER	HANCOCK
62321	CARTHAGE	HANCOCK
62380	WEST POINT	HANCOCK
62329	COLUSA	HANCOCK
62330	DALLAS CITY	HANCOCK
62348	LIMA	ADAMS
62316	BOWEN	HANCOCK
62349	LORAINE	ADAMS
61450	LA HARPE	HANCOCK
62374	TENNESSEE	MCDONOUGH

The population of the service area identified above, per Seachbug, is approximately 16,000. Hamilton/ZIP code 62341 has the second largest population in the service area.

HRHV will provide a community-based setting for a variety of health care and well-being services, as described in the Narrative Description of this application, many of which are

preventive in nature, and that are not easily accessible to area residents. In addition, the locating of physicians and other clinicians in HRHV will reduce the service area population's reliance on physicians and other health care-related services across the river in Iowa.

The goal of this project is to have the proposed services available, consistent with the project schedule.

ALTERNATIVES

Given the applicant's goal of improving access to selective programming in the Hamilton area, two reasonable alternatives to the proposed project appear available: the re-use of another existing building or the construction of a new building to house the proposed services.

Assuming that the alternative were located in or near Hamilton, accessibility for area residents would be virtually identical to that of the proposed project, were either of the alternatives identified above selected. The capital cost associated with the two alternatives would likely differ from those of the proposed project, with the difference being based on either the facility to be acquired and/or the size and design of a building to be constructed, neither of which can be determined at this time. However, it would be anticipated that the capital costs associated with the construction of a new building would exceed those anticipated to be incurred through renovation by 35-40%. Last, it is believed that the operating costs associated with either of the alternatives, as well as the quality of care to be provided, would be very similar to those of the proposed project.

SIZE

The only area in the proposed project having an HFSRB-adopted space standard is the imaging area, which will provide one general x-ray unit. That area has been planned consistent with the HFSRB space standard.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Gen'l Radiology	1,250	1,300	(50)	YES

ATTACHMENT 14

PROJECT SERVICES UTILIZATION

The proposed project includes a single clinical service for which the HFSRB has established a utilization standard, that being general radiology.

Based on utilization of the service at Memorial Hospital, the applicant projects that, by the second year following the proposed project's completion, approximately 2,548 annual procedures will be performed on the single proposed general radiology unit. Consistent with the HFSRB's past practice of reviewing utilization of a service when only one piece of equipment is to be provided, whether or not the applicant meets the standard is not relevant.

Dept./ Service	2014 Historical Utilization* (examinations)	PROJECTED UTILIZATION* (examinations)		STATE STANDARD	MET STANDARD?
		YEAR 1	YEAR 2		
general radiology	N/A	2,000	2,548	8,000	N/A

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project will include one clinical service having a HFSRB-adopted utilization standard, that being general radiology.

The primary purpose of this clinical service is to improve the manner in which general radiology services can be provided to the patients of clinicians having offices and seeing patients in the building.

A utilization projection is provided in ATTACHMENT 15, and is based on the applicant's hospital experience. The first year following the service's opening will include a ramp-up period, with that ramp-up period anticipated to conclude approximately four months following the initiation of the service.

The general radiology service is intended to support the practices of the clinicians officed in the facility, and no material impact on other providers, with the potential excerption of Memorial Hospital, is anticipated.

#23-026

Enter Historical and/or Projected Years:		Standard	Historical 3 Years			Projected
			2020	2021	2022	2026
Current Ration	Current Assets/Current Liabilities	2.0 >	1.74	3.19	4.48	2.91
Net Margin %	(Net Income/Operating Revenues)x100	3.0% >	3.2	21	4.5	4.5
Percentage of Debt to Total Capitalization	(LT Debt/LT Debt + Net Assets)x100	<50%	61.24	44.31	41.02	36.15%
Projected Debt Service Coverage	(Net Income + I,D,A)/(Principal Pymts + Int Exp for Year of Max Debt Service after Completion)	2.50 >				2.68
Days Cash on Hand	(Total Cash all Sources/((Operating Exp less Deprec)/365)	75 >	235	216	169	155
Cushion Ratio	(Total Cash all Sources/(Annual Principal Payments + Annnual Interest Exp) for year of Max debt service afte	7.0 >				8.26

Current Ration	Total Current Assets (2020 pg 41, 2021 pg 41, 2022 pg 40)	$20,819,664	$25,325,583	$23,634,934	$19,634,934
Current Ration	Total Current Liabilities (2020 pg 42, 2021 pg 42, 2022 pg 41)	$11,963,585	$7,930,268	$5,274,921	$6,757,406
Current Ration		1.74	3.19	4.48	2.91
Net Margin %	Net Income (2020 pg 43, 2021 pg 43, 2022 pg 42)	$1,045,284	$10,140,710	$2,070,727	$2,455,187
Net Margin %	Operating Revenue (2020 pg 43, 2021 pg 43, 2022 pg 42)	$33,095,827	$48,337,687	$45,818,496	$54,163,652
Net Margin %		3.2	21.0	4.5	4.5
Percentage of Debt to Total Capitalization	Long-Term Debt (2020 pg 42, 2021 pg 42, 2022 pg 41)	$20,272,534	$19,005,767	$17,853,712	$25,570,511
Percentage of Debt to Total Capitalization					
Percentage of Debt to Total Capitalization	Long-Term Debt (2020 pg 42, 2021 pg 42, 2022 pg 41)	$20,272,534	$19,005,767	$17,853,712	$25,570,511
Percentage of Debt to Total Capitalization	Net Assets (2020 pg 42, 2021 pg 42, 2022 pg 41)	$12,831,030	$23,889,503	$25,666,137	$45,166,137
Percentage of Debt to Total Capitalization		$33,103,564	$42,895,270	$43,519,849	$70,736,648
Percentage of Debt to Total Capitalization					
Percentage of Debt to Total Capitalization		61.24%	44.31%	41.02%	36.15%
Projected Debt Service Coverage	Net Income (2020 pg 43, 2021 pg 43, 2022 pg 42)	$1,045,284	$10,140,710	$2,070,727	$2,455,187
Projected Debt Service Coverage	Interest, Depreciation & Amortization (2020 pg 43, 2021 pg 43, 2022 pg 42)	$2,813,572	$2,811,323	$2,820,889	$4,046,556
Projected Debt Service Coverage	Investment Income (2020 pg 43, 2021 pg 43, 2022 pg 42)	$329,820	$674,220	-$528,033	$330,000
Projected Debt Service Coverage	less Unrealized Gain/Loss (GL # 51660000)	-$159,760	-$243,462	$714,537	$0
Projected Debt Service Coverage		$4,028,916	$13,382,791	$5,078,120	$6,831,742
Projected Debt Service Coverage					
Projected Debt Service Coverage	Principal Payments (2020 pg 45, 2021 pg 45, 2022 pg 44)	$1,137,456	$1,279,844	$1,164,475	$1,482,485
Projected Debt Service Coverage	Interest Expense (2020 pg 43, 2021 pg 43, 2022 pg 42)	$806,843	$748,664	$663,897	$1,064,706
Projected Debt Service Coverage		$1,944,299	$2,028,508	$1,828,372	$2,547,191
Projected Debt Service Coverage					
Projected Debt Service Coverage		2.07	6.60	2.78	2.68
Days Cash on Hand	Cash and Cash equivalents (2020 pg 41, 2021 pg 41, 2022 pg 40)	$13,284,018	$15,218,771	$13,620,293	$15,111,293
Days Cash on Hand	Assets limited by board or donor (2020 pg 41, 2021 pg41, 2022 pg 40)	$6,089,146	$6,193,706	$5,583,777	$5,933,780
Days Cash on Hand	Total Cash all sources	$19,373,164	$21,412,477	$19,204,070	$21,045,073
Days Cash on Hand					
Days Cash on Hand	Total Expenses (2020 pg 43, 2021 pg 43, 2022 pg 42)	$32,050,543	$38,196,977	$43,747,769	$52,558,466
Days Cash on Hand	less Depreciation (2020 pg 43, 2021 pg43, 2022 pg 42)	-$2,006,729	-$2,062,659	-$2,156,992	-$2,981,849
Days Cash on Hand	Net Expenses	$30,043,814	$36,134,318	$41,590,777	$49,576,616
Days Cash on Hand		365	365	365	365
Days Cash on Hand	Expense per day	$82,311.82	$98,998.13	$113,947.33	$135,826.35
Days Cash on Hand		235	216	169	155

Cushion Ratio	(Total Cash all Sources	$21,045,073
	/(Annual Principal Payments + Annnual Interest Exp) for year of Max debt service after project completion	$2,547,191

ATTACHMENT 36

Board Presentation

1.74	3.19	4.48
3.2	21	4.5
61.9	44.9	41.4
2.1	6.81	2.79
238	216	169

2022 less $4M owner's contribution + Cash from Operations 23,24,25 $5.491M
2022 plus Current Portion of LT Debt 26 $1,482,485

Increased Net Income per forecast
Increased Revenue for new Revenues per forecast

Current LTD - 3 Years Payments $1.15M annual +$14M new LTD per debt sch

Current LTD - 3 Years Payments $1.15M annual +$14M new LTD per debt sch
Existing plus new Capital $19.5M

per Forecast
Avg of 20,21,22

Per debt payment sch 2026
Per debt payment sch 2026

22 Cash + Cash from operations 23,24,25(+$5,491,000)-$4,000,000

per Forecast
per Forecast

per debt sch

#23-026

Memorial Hospital

1454 North County Road 2050
P.O. Box 160 • Carthage, IL 62321
(217) 357-8500 • MHTLC.ORG

Illinois Health Facilities and
Services Review Board
Springfield, Illinois

RE: Hamilton Rural Health Village
Reasonableness of Financing Arrangements

The project, as presented in this Certificate of Need application, is proposed to be funded through a loan (mortgage) from a local bank (accounting for approximately 77% of the estimated project cost), with Memorial Hospital Association providing the balance of the project's funding through its cash reserves.

As presented in the Narrative Description section of the Certificate of Need application, a Hospital and Healthcare Transformation grant has been applied for, and a decision from the Illinois Department of Healthcare and Family Services is pending. Should that grant be issued, either during the CON application's review or following, and consistent with guidance provided by HFSRB staff, appropriate documentation will be provided to address funding through the requested grant.

Both funding alternatives described above are reasonable. Borrowing, if undertaken, is believed by the applicant to less costly and more prudent than the liquidation of additional assets; and an Audited Financial Statement will be provided to HFSRB staff, upon request. The applicant does, however, have the ability to convert existing investments into cash or to retire debt within a 60-day period.

The conditions of debt, if any is to be used, will be at the lowest net cost reasonably available to the applicant at the time that the debt is incurred.

Sincerely,

Ada Bair
Chief Executive Officer

Notarized:

OFFICIAL SEAL
BRENDA K LOWMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 04/17/2027

Brenda K Lowman

ATTACHMENT 37

4B

#23-026

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Cost/Sq. Ft.		DGSF		DGSF				
	New	Mod.	New	Circ.	Mod.	Circ.	New Const. $	Modernization $	Total Cost
Reviewable									
Imaging		$ 280.00			1,900			$ 532,000	$ 532,000
Lab		$ 240.00			2,118			$ 508,320	$ 508,320
PT/OT/Rehab		$ 155.00			3,619			$ 560,945	$ 560,945
Intergrative Medicine		$ 170.00			2,652			$ 450,840	$ 450,840
contingency		$ 15.00						$ 154,335	$ 154,335
		$ 214.45			10,289			$ 2,206,440	$ 2,206,440
Non-Reviewable									
Physicians' Offices-Medical		$ 350.00			4,748			$ 1,661,800	$ 1,661,800
Clinicians' Offices-Behav. H.		$ 350.00			4,278			$ 1,497,300	$ 1,497,300
Community Ed./Wellness		$ 275.00			1,277			$ 351,175	$ 351,175
Facil. Operations		$ 250.00			1,800			$ 450,000	$ 450,000
Lobbies/Public Areas		$ 250.00			313			$ 78,250	$ 78,250
Food Service/Cafeteria		$ 300.00			4,465			$ 1,339,500	$ 1,339,500
County Ambulance		$ 200.00			1,437			$ 287,400	$ 287,400
Mechanical		$ 300.00			1,192			$ 357,600	$ 357,600
contingency		$ 15.00						$ 292,650	$ 292,650
		$ 323.71			19,510			$ 6,315,675	$ 6,315,675
TOTAL		**$ 285.99**			**29,799**			**$ 8,522,115**	**$ 8,522,115**

ATTACHMENT 37

Projected Operating Costs and
Total Effect of the Project on Capital Costs

HAMILTON RURAL HEALTH VILLAGE--YEAR 2

Projected Outpatient Visits:		43,638
Operating Cost per Patient Visit:		
Staffing:	$ 2,373,898	$ 54.40
Med. Supplies:	$ 236,399	$ 5.42
		$ 59.82
Capital Cost per Patient Visit		
Depreciation, Interest and Amortization	$ 1,714,095	$ 39.28

ATTACHMENT 37

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

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