

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	Touchette Regional Hospital, Inc.—discontinuation of intensive care category of service		
Street Address:	5900 Bond Avenue		
City and Zip Code:	Centreville, IL 62207		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

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

Exact Legal Name:	Touchette Regional Hospital, Inc
Street Address:	5900 Bond Avenue
City and Zip Code:	Centreville, IL 62207
Name of Registered Agent:	Illinois Corporation Service C
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Larry McCulley
CEO Street Address:	5900 Bond Avenue
CEO City and Zip Code:	Centreville, IL 62207
CEO Telephone Number:	618/332-3060

Type of Ownership of Applicants

☒ 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:	675 North Court, Suite 210
Telephone Number:	Palatine, IL 60067
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

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Street Address:	5900 Bond Avenue		
City and Zip Code:	Centreville, IL 62207		
County:	St. Clair	Health Service Area	XI Health Planning Area: F-01

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

Exact Legal Name:	Southern Illinois Health Care Foundation, Inc.
Street Address:	2041 Goose Lake Road
City and Zip Code:	Sauget, IL 62206
Name of Registered Agent:	Pete Thomas
Street Address:	2041 Goose Lake Road
City and Zip Code:	Sauget, IL 62206
Name of Chief Executive Officer:	Larry McCulley
CEO Street Address:	2041 Goose Lake Road
CEO City and Zip Code:	Sauget, IL 62206
CEO Telephone Number:	618/332-0694

Type of Ownership of Applicants

☒ 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:	675 North Court, Suite 210
Telephone Number:	Palatine, IL 60067
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
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:	Larry McCulley
Title:	Chief Executive Officer & President
Company Name:	Touchette Regional Hospital, Inc.
Address:	5900 Bond Avenue Centreville, IL 62207
Telephone Number:	618/332-3060
E-mail Address:	LMcCulley@sihf.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Touchette Regional Hospital, Inc.
Address of Site Owner:	5900 Bond Avenue Centreville, IL 62207
Street Address or Legal Description of the Site:	5900 Bond Avenue Centreville, IL 62207
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:	Touchette Regional Hospital, Inc.		
Address:	5900 Bond Avenue Centreville, IL 62207		
☒ Non-profit Corporation	☐ Partnership		
☐ For-profit Corporation	☐ Governmental		
☐ Limited Liability Company	☐ Sole Proprietorship	☐	
Other			
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Narrative Description

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

The proposed project is limited to the discontinuation of the 8-bed intensive care ("ICU") category of service at Touchette Regional Hospital ("TRH"), located in Centreville, Illinois. The discontinuation will occur within thirty days following approval of this Certificate of Exemption application.

During 2021, 33 patients were admitted to the hospital's ICU, and the average daily census in its ICU was 0.48 patients.

A full range of ICU services are available to area residents at Memorial Hospital-Belleville (10 miles), HSHS St. Elizabeth's Hospital in O'Fallon (14 miles) and Memorial Hospital-Shiloh (16 miles), as well as numerous hospitals immediately across the Mississippi River in Missouri. As a result, reasonable access to intensive care services for area residents will be maintained.

The hospital will "convert" its current 8-bed ICU into an 8-bed "intermediate care" unit, designed for the care of patients needing a higher level of care than is typically provided on the hospital's medical/surgical units, but a lower level of care than is typically provided in an ICU. The "intermediate care" beds will be categorized as medical/surgical beds for IDPH and HFSRB reporting purposes, increasing the hospital's number of "approved" medical/surgical beds from 66 to 74. The hospital's total number of "approved" beds will not change.

TRH currently operates an emergency department, classified as "basic" by IDPH, and has in place patient transfer agreements with area hospitals providing ICU services.

This is a "substantive" project, because it addresses the discontinuation of a HFSRB-designated category of service.

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes ___ 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): ___ within 30 days of the approval of the COE application _____

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:

- o In the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o In the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

Ellie Henderson

PRINTED NAME

President

PRINTED TITLE

SIGNATURE

Zach York

PRINTED NAME

Chief Operating Officer

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of March, 2023

Tracy Satterfield
Signature of Notary

Seal



Notarization:

Subscribed and sworn to before me
this 9th day of March, 2023

Tracy Satterfield
Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

John Jeffries
SIGNATURE

John Jeffries
PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of March 2023

Tracy Satterfield
Signature of Notary

Seal



Pete Thomas
SIGNATURE

Pete Thomas
PRINTED NAME

Corp. VP of Compliance
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of March 2023

Tracy Satterfield
Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION**Type of Discontinuation**

☒ Discontinuation of a single category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

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

REASONS FOR DISCONTINUATION

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

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

IMPACT ON ACCESS

1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.
2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

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

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

SECTION IV. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

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

SECTION V. CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE			
	2019	2020	2021
Net Patient Revenue	52,329,932	49,333,023	54,820,007
Amount of Charity Care (charges)	3,515,189	2,589,3936	2,553,830
Cost of Charity Care	2,674,707	2,090,159	2,381,957

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

File Number

5710-868-1



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

TOUCHETTE REGIONAL HOSPITAL, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 18, 1992, 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 27TH
day of JUNE A.D. 2022 .**

Authentication #: 2217802188 verifiable until 06/27/2023

Authenticate at: <http://www.ilsos.gov>

Jesse White
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SECRETARY OF STATE ATTACHMENT 1

File Number

5328-855-3



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

SOUTHERN ILLINOIS HEALTH CARE FOUNDATION, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 09, 1983, 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 JUNE A.D. 2022 .**

Jesse White

Authentication #: 2217900944 verifiable until 06/28/2023
Authenticate at: <http://www.lisos.gov>

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SECRETARY OF STATE ATTACHMENT 1

SITE OWNERSHIP

With the signatures affixed to the "Certification" pages of this Certificate of Need application, the applicants attest to the fact that the site of the proposed project, that being 5900 Bond Avenue in Centreville, Illinois, is owned by Touchette Regional Hospital, Inc.

File Number

5710-868-1



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

TOUCHETTE REGIONAL HOSPITAL, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 18, 1992, 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 27TH
day of JUNE A.D. 2022 .**

Authentication #: 2217802188 verifiable until 06/27/2023

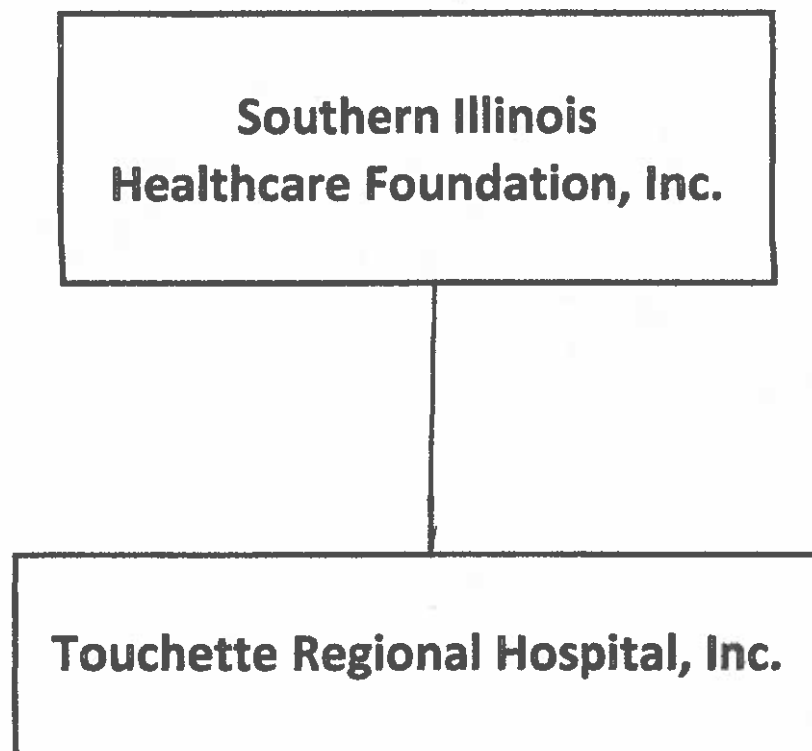
Authenticate at: <http://www.lisos.gov>

Jesse White

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SECRETARY OF STATE ATTACHMENT 3

ORGANIZATIONAL RELATIONSHIP



DISCONTINUATION

1. This Certificate of Exemption ("COE") application addresses the discontinuation of the applicant hospital's intensive care category of service, which includes 8 authorized beds. The category of service will be replaced by an "intermediate care unit".
2. The proposed discontinuation will not impact any other areas of the hospital.
3. The hospital's intensive care unit ("ICU") will be discontinued within 30 days following receipt of the requested COE Permit. Discontinuation will occur via formal notification to the HFSRB and IDPH..
4. As of the filing of this COE application, the applicant has no intended use to the space occupied by the ICU. Hospital personnel allocated to the ICU either have, or will be offered other positions at the hospital. Equipment will be used in other areas of the hospital, as appropriate, sold, donated, or discarded.
5. The required legal notice was published in the *Belleville News-Democrat* on February 22, 2023. Proof of publication is attached.



Deseret Gazette
Belleville News-Democrat
Bellingham Herald
Burlington Herald
Centre Daily Times
Charlotte Observer
Columbus Ledger-Enquirer
Fresno Bee

The Herald - Rock Hill
Herald-Sun - Durham
Idaho Statesman
Island Packet
Kansas City Star
Lexington Herald Leader
Merced Sun-Star
Miami Herald

el Nuevo Herald - Miami
Modesto Bee
Raleigh News & Observer
The Olympian
Sacramento Bee
Fort Worth Star-Telegram
The State - Columbia
Sun Herald - Biloxi

Sun News - Myrtle Beach
The News-Tribune-Tacoma
The Telegraph - Macon
San Luis Obispo Tribune
Tri-City Herald
Wichita Eagle

AFFIDAVIT OF PUBLICATION

Account #	Order Number	Identification	Order PO	Amount	Cols	Depth
38751	386238	Print Legal Ad-IPL01107930 - IPL0110793		\$81.24	1	18 L

Attention: Lori Sasse
SIHF HEALTHCARE
2041 GOOSE LAKE RD.
EAST SAINT LOUIS, IL 62206

LEGAL NOTICE

Touchette Regional Hospital intends to cease the operations of its intensive care unit ("ICU") following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("HFSRB"). It is anticipated that the discontinuation will occur before April 30, 2023. The hospital intends to file the required Certificate of Exemption application with the HFSRB by February 28, 2023; after which time additional information relating to the proposed discontinuation can be found on the HFSRB's website at hfsrb.illinois.gov.
IPL0110793
Feb 22 2023

STATE OF ILLINOIS)
COUNTIES OF
MADISON, MONROE & ST. CLAIR) SS

This is to certify that the undersigned Jeffry Couch is the Editor and General Manager of the Belleville News-Democrat, in MADISON, MONROE & ST. CLAIR COUNTIES a public and English secular newspaper of general circulation, which has been regularly published daily in the cities of Belleville, Waterloo, Collinsville & Highland, Counties of Madison, Monroe & St. Clair, State of Illinois, for at least one year prior to the first publication of the notice hereinafter mentioned, and that a notice of which the annexed is a true printed copy, has been published in said newspaper, issues of:

1 insertion(s) published on:

02/22/23

"It is further certified that said newspaper is a newspaper as defined in 'an Act to revise the law in relation to notices' as amended by Act approved July 17, 1959 - Ill. Revised Statutes, Chap. 100, Para. 1 & 5."

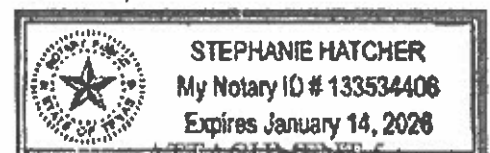
And further certifies that the face of type in which each publication of said notice was made was the same as the body type used in the classified advertising in the issue of said newspaper which said publication was made.

Julie Ambry

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Stephanie Hatcher

Notary Public In and for the state of Texas, residing in Dallas County



Extra charge for lost or duplicate affidavits.
Legal document please do not destroy!

REASON FOR DISCONTINUATION

The applicants are proposing the discontinuation of Touchette Regional Hospital's 8-bed intensive unit ("ICU") category of service as a result of the service's low utilization, particularly since 2019. During calendar 2021 the ICU utilization declined to an average daily census ("ADC") of only 0.48 patients...less than 3.4 patient days per week. The table below documents the ICU's low utilization in recent years.

	ICU Patient Days
2021	177
2020	260
2019	213
2018	668
2017	1,019
2016	950
2015	1,335

IMPACT ON ACCESS

The proposed discontinuation of ICU services will not have a material impact on the ability of area residents to access ICU services because of the availability of those services at other area hospitals.

On February 22, 2023, notification letters were sent by the applicants to the other providers of ICU services in the HFSRB-designated geographic service area. A sample of that letter is attached. As of the filing of this application, no responses have been received. However, should any responses be received, they will be forwarded to HFSRB staff.

Touchette
REGIONAL HOSPITAL

February 15, 2023

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

**RE: Touchette Regional Hospital
Proposed Discontinuation of ICU
Category of Service**

**Mr. Michael McManus
President
Memorial Hospital
4500 Memorial Dr.
Belleville, IL 62226**

Dear Mr. McManus:

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

Touchette Regional Hospital ("TRH") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (HFSRB") to discontinue the hospital's 8-bed intensive care category of service, and the formal discontinuation of that service will occur within thirty days following the HFSRB's approval of that application.

During calendar 2021 and 2022, a total of 36 patients were admitted to the hospital's ICU, and 74 patient days of care were provided.

Admissions to TRH's intensive care category of service have been suspended, and that status remains.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing obstetrical services to residents from our service area. Any impact statement received will be forwarded to the HFSRB. If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,



**Larry McCulley
CEO**

SENDER COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY			
☐ Complete items 1, 2, and 3. ☐ Print your name and address on the reverse so that we can return the card to you. ☐ Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: MR. MICHAEL MUMFORD PRESIDENT MEMORIAL HOSPITAL 4500 MEMORIAL DR. BIRMINGHAM, AL 35226  9590 9402 4225 8121 6591 48 2. Article Number (Transfer from service label) 7006 2150 0003 9980 0022		A. Signature X ☐ Agent ☐ Addressee B. Received by (Printed Name) C. Date of Delivery D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No 3. Service Type <table border="0"> <tr> <td> ☒ Adult Signature ☐ Adult Signature Restricted Delivery ☒ Certified Mail® ☐ Certified Mail Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500) </td> <td> ☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Return Receipt for Merchandise ☐ Signature Confirmation™ ☐ Signature Confirmation Restricted Delivery </td> </tr> </table>		☒ Adult Signature ☐ Adult Signature Restricted Delivery ☒ Certified Mail® ☐ Certified Mail Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500)	☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Return Receipt for Merchandise ☐ Signature Confirmation™ ☐ Signature Confirmation Restricted Delivery
☒ Adult Signature ☐ Adult Signature Restricted Delivery ☒ Certified Mail® ☐ Certified Mail Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500)	☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Return Receipt for Merchandise ☐ Signature Confirmation™ ☐ Signature Confirmation Restricted Delivery				

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ATTACHMENT 7

24

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United States
Postal Service

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PETE THOMAS
2041 GAOSE LAKE RD
SAUGEY, IL 62240

6-282241



ATTACHMENT 7

25

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☒ Complete items 1, 2, and 3. ☒ Print your name and address on the reverse so that we can return the card to you. ☒ Attach this card to the back of the mailpiece, or on the front if space permits.		A. Signature ☒ <i>[Signature]</i> ☐ Agent ☐ Addressee	
1. Article Addressed to: MR. CHRIS KLAN PRESIDENT AND CEO 1515 ST. ELIZABETH'S HOSPITAL ONE ST. ELIZABETH'S BLVD O'FALLON, IL 62269		B. Received by (Printed Name) <i>[Signature]</i> C. Date of Delivery <i>[Signature]</i> D. Is delivery address different from item 1? ☐ Yes ☒ No If YES, enter delivery address below:	
 9590 9402 7478 2055 1725 45		3. Service Type ☒ Adult Signature ☐ Priority Mail Express® ☐ Adult Signature Restricted Delivery ☐ Registered Mail™ ☐ Certified Mail® ☐ Registered Mail Restricted Delivery ☐ Certified Mail Restricted Delivery ☐ Signature Confirmation ☐ Collect on Delivery ☐ Signature Confirmation Restricted Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500)	
2. Article Number (Transfer from service label) 7011 2000 0001 5412 3579		Domestic Return Receipt	

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USPS TRACKING #



First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

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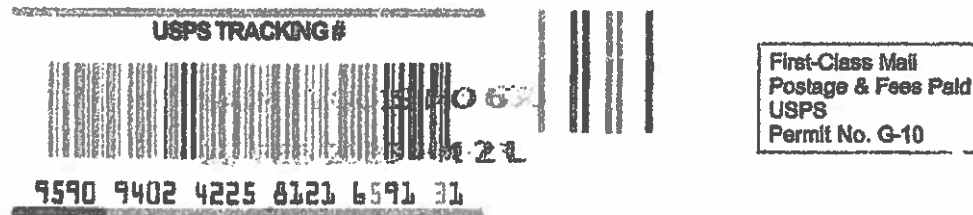
United States
Postal Service

• Sender: Please print your name, address, and ZIP+4® in this box•

PETE THOMAS
2041 GOOSE LAKE RD
SAUGET, IL 62206



SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
☐ Complete items 1, 2, and 3. ☐ Print your name and address on the reverse so that we can return the card to you. ☐ Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: MR. MICHAEL MCMAHON PRESIDENT MEMORIAL HOSPITAL 1404 CROSS STREET CHICAGO, IL 60612  9590 9402 4225 8121 6591 31 2. Article Number (Transfer from service label) 7006 2150 0003 9980 0039		A. Signature X ☐ Agent ☐ Address B. Received by (Printed Name) C. Date of Delivery D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No	
3. Service Type ☐ Registered Mail® ☐ Registered Mail Restricted Delivery ☒ Certified Mail® ☐ Certified Mail Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Insured Mail Restricted Delivery (over \$500)		☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Return Receipt for Merchandise ☐ Signature Confirmation ☐ Signature Confirmation Restricted Delivery	
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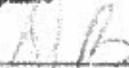
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Postal Service

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PETE THOMAS
2041 GOOSE LAKE DR.
SAUGET, IL 62206

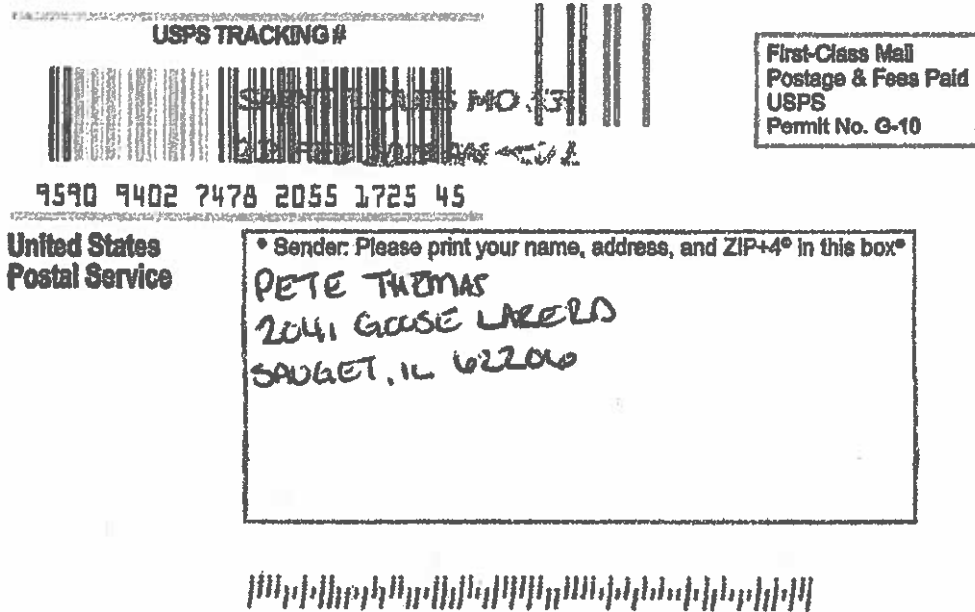
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SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY		
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BACKGROUND OF APPLICANT

Touchette Regional Hospital, Inc. is the only IDPH-licensed facility owned and/or operated by applicant Southern Illinois Health Care Foundation, Inc. By virtue of the signatures on the Certification pages of this Certificate of Exemption application, the applicants attest to the fact that no "adverse action" has been taken against Touchette Regional Hospital, Inc. during the three years prior to the filing of this application.

SAFETY NET IMPACT STATEMENT

As noted in ATTACHMENT 7, the proposed discontinuation of intensive care services at Touchette Regional Hospital ("the hospital") will have minimal impact on access to that service for residents in the communities the hospital, because of 1) the ability for patients to access other intensive care services in the area, and 2) extraordinarily low utilization of the hospital's ICU in recent years.

The following Illinois providers of ICU services are located within seventeen miles of the hospital, the HFSRB's identified geographic service area: HSHS St. Elizabeth's Hospital in O'Fallon, Gateway Regional Medical Center in Granite City, Memorial Hospital in Belleville, and Memorial Hospital-East in Shiloh. In addition, there are numerous hospitals in Missouri that provide ICU services, located within seventeen miles of the hospital.

During 2020, only 67 patients were admitted to the hospital's ICU, and in 2021 that number dropped to 33.

The required table, addressing charity care and care provided to Medicaid recipients is provided on the following page.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2019	2020	2021
Inpatient	147	106	96
Outpatient	1,989	1,230	1,348
Total	2,136	1,336	1,444
Charity (cost in dollars)			
Inpatient	\$1,308,322	\$752,496	\$756,603
Outpatient	\$2,206,867	\$1,662,676	\$1,625,397
Total	\$3,515,189	\$2,415,172	\$2,382,000
MEDICAID			
Medicaid (# of patients)	2019	2020	2021
Inpatient	1,216	1,036	1,200
Outpatient	24,721	19,426	28,117
Total	25,937	20,462	29,317
Medicaid (revenue)			
Inpatient	\$7,874,935	\$6,623,751	\$8,498,939
Outpatient	\$26,596,094	\$23,156,567	\$29,374,596
Total	\$34,471,029	\$29,780,318	\$37,873,535

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	14
2	Site Ownership	16
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	17
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	18
5	Discontinuation General Information Requirements	19
6	Reasons for Discontinuation	21
7	Impact on Access	22
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10	Charity Care Information	13

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEx

March 9, 2023

Mr. John Kniery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear John:

Enclosed please find two copies of a Certificate of Exemption ("COE") application addressing the discontinuation of the intensive care unit ("ICU") category of service at Touchette Regional Hospital in Centreville, Illinois.

The application is accompanied by a check, in the amount of \$2,500.00, as a filing fee.

A notice of suspension has been filed with both IDPH and the HFSRB.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,



Jacob M. Axel
President

enclosures