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HEALTH FACILITIES & SERVICES REVIEW BOARD

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:	Anderson Hospital Emergency Department Expansion
Street Address:	6800 State Rte 162
City and Zip Code:	Maryville, IL 62062
County:	Madison Health Service Area: 11 Health Planning Area: F-01

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

Exact Legal Name:	Anderson Hospital
Street Address:	6800 State Rte 162
City and Zip Code:	Maryville, IL 62062
Name of Registered Agent:	Lisa Spencer
Registered Agent Street Address:	6800 State Rte 162
Registered Agent City and Zip Code:	Maryville, IL 62062
Name of Chief Executive Officer:	Lisa Spencer
CEO Street Address:	6800 State Rte 162
CEO City and Zip Code:	Maryville, IL 62062
CEO Telephone Number:	618-391-6404

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:	Lisa Spencer
Title:	President
Company Name:	Anderson Hospital
Address:	6800 State Rte 162 Maryville, IL 62062
Telephone Number:	618-391-6404
E-mail Address:	spencerl@andersonhospital.org
Fax Number:	618-288-4088

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

Name:	Ralph Weber
Title:	CON consultant
Company Name:	Weber Alliance
Address:	920 Hoffman Lane Riverwoods, IL 60015
Telephone Number:	847-791-0830
E-mail Address:	NA
Fax Number:	

Illinois Health Facilities and Services Review Board
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Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Anderson Healthcare
Street Address:	6800 State Rte 162
City and Zip Code:	Maryville, IL 62062
Name of Registered Agent:	Michael Marshall
Registered Agent Street Address:	6800 State Rte 162
Registered Agent City and Zip Code:	Maryville, IL 62062
Name of Chief Executive Officer:	Michael Marshall
CEO Street Address:	6800 State Rte 162
CEO City and Zip Code:	Maryville, IL 62062
CEO Telephone Number:	618-391-6402

Type of Ownership of Applicants

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

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Address:	920 Hoffman Lane Riverwoods, IL 60015
Telephone Number:	847-791-0830
E-mail Address:	NA
Fax Number:	

Post Permit Contact

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

Name:	Lisa Spencer
Title:	President
Company Name:	Anderson Hospital
Address:	6800 State Rte 162 Maryville, IL 62062
Telephone Number:	618-391-6404
E-mail Address:	spencerl@andersonhospital.org
Fax Number:	618-288-4088

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Anderson Hospital

Address of Site Owner: 6800 State Rte 162 Maryville, IL 62062

Street Address or Legal Description of the Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Anderson Hospital

Address: 6800 State Rte 162 Maryville, IL 62062

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

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

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

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 project is the construction of a building addition to house the new emergency department. The new ED is located adjacent to and immediately south of the current ED, and has a footprint of approximately 24,900 sq ft. The project includes a full basement, including 18,350 sq ft of shell space, and a 1,716 sq ft interior corridor that connects the proposed ED to the existing hospital circulation system. The total sq ft of the project is 49,991 sq ft, of which 14,728 dgsf is clinical.

The project includes 26 treatment rooms, including rooms that are designed to accommodate specialized services. These include two seclusion rooms for patients with behavioral health needs, two isolation rooms, one room for sexual assault patients (OB/GYN), three larger rooms for accommodating trauma cases, and four rooms for "quick visits" and special capabilities for pediatric patients. These rooms are not restricted to these specialized uses; all 26 rooms will be in use on a daily basis, especially during peak periods.

Total capital cost of the project is $34,050,316. $11,121,175 is clinical, $22,929,141 is non-clinical.

The anticipated completion date of the project is May 30, 2027.

The project is considered non-substantive because it does not add inpatient bed capacity or establish a category of service.

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

☒ Non-substantive

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 ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ 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 $ _____.

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
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___May 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
☐ 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?
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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.

7

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.

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: Anderson Hospital		**CITY: Maryville, IL**			
REPORTING PERIOD DATES:		**From: Jan 1, 2023**	**to: Dec 31, 2023**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	108	4,287	22,813	0	108
Obstetrics	24	1,372	4,326	0	24
Pediatrics	0	0	0	0	0
Intensive Care	12	488	2,207	0	12
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)					
TOTALS:	144	6,147	29,346	0	144

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

Michael M Marshall
SIGNATURE

Lisa Spencer
SIGNATURE

Michael M. Marshall
PRINTED NAME

Lisa Spencer
PRINTED NAME

CEO
PRINTED TITLE

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16 day of December

Ranada Ridenhour
Signature of Notary

Seal

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

Notarization:
Subscribed and sworn to before me
this 16 day of December

Ranada Ridenhour
Signature of Notary

Seal

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RANADA RIDENHOUR
Notary Public, State of Illinois
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My Commission Expires
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*Insert ~~the EXACT legal name of the applicant~~

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Michael M. Marshall
SIGNATURE

Lisa Spencer
SIGNATURE

Michael M. Marshall
PRINTED NAME

Lisa Spencer
PRINTED NAME

CEO
PRINTED TITLE

President
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*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION Discontinuation is not part of this project

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this Application for Discontinuation https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm**

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

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 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the **geographic service area**.

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

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:

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:

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
☐ **Emergency Department**	**22**	**26**
☐		
☐		

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

APPEND 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]:**

$9,050,316	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.
$25,000,000	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. 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.
$34,050,316	**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:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

NO SAFETY NET IMPACT STATEMENT IS REQUIRED; THE PROJECT IS NON-SUBSTANTIVE.

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]:

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.

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

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: _____
(Name) (Address)

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

2. Project Location: _____
(Address) (City) (State)

_____
(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 ___?

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:_____ 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

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	28-29
2	Site Ownership	30
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	31
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	32
5	Flood Plain Requirements	33-36
6	Historic Preservation Act Requirements	37-38
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14	Size of the Project	58
15	Project Service Utilization	59-60
16	Unfinished or Shell Space	61
17	Assurances for Unfinished/Shell Space	62
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	NA
19	Comprehensive Physical Rehabilitation	NA
20	Acute Mental Illness	NA
21	Open Heart Surgery	NA
22	Cardiac Catheterization	NA
23	In-Center Hemodialysis	NA
24	Non-Hospital Based Ambulatory Surgery	NA
25	Selected Organ Transplantation	NA
26	Kidney Transplantation	NA
27	Subacute Care Hospital Model	NA
28	Community-Based Residential Rehabilitation Center	NA
29	Long Term Acute Care Hospital	NA
30	Clinical Service Areas Other than Categories of Service	63-65
31	Freestanding Emergency Center Medical Services	NA
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33	Availability of Funds	66-119
34	Financial Waiver	NA
35	Financial Viability	120-122
36	Economic Feasibility	123-131
37	Safety Net Impact Statement	NA
38	Charity Care Information	132
39	Flood Plain Information	133-136

File Number 7206-613-8

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*

ANDERSON HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2019, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* OCTOBER *A.D.* 2024 .

Authentication #: 2428902444 verifiable until 10/15/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

Attachment 1

File Number 2038-756-4

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*

ANDERSON HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 20, 1929, 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* 15TH *day of* OCTOBER *A.D.* 2024 .

Authentication #: 2428902430 verifiable until 10/15/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

Attachment 1

December 16 2024

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: Proof of Site Ownership

Dear Chairwoman Savage:

I hereby certify Anderson Hospital owns the property of the campus of Anderson Hospital, 6800 State Rte 162 in Maryville, Illinois. The proposed emergency department is planned as an addition to the existing hospital on this property.

If you have any questions, please contact Lisa Spencer, President, Anderson Hospital, at 618-391-6404, or spencerl@andersonhospital.org.

Sincerely,

Michael W Marshall

Michael Marshall
President
Anderson Healthcare
6800 State Rte 162
Maryville, IL 62062

NOTARY

Ranada Ridenhour
County of Madison
State of IL
12/16/2024

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

Attachment 2

File Number 2038-756-4

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*

ANDERSON HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 20, 1929, 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.

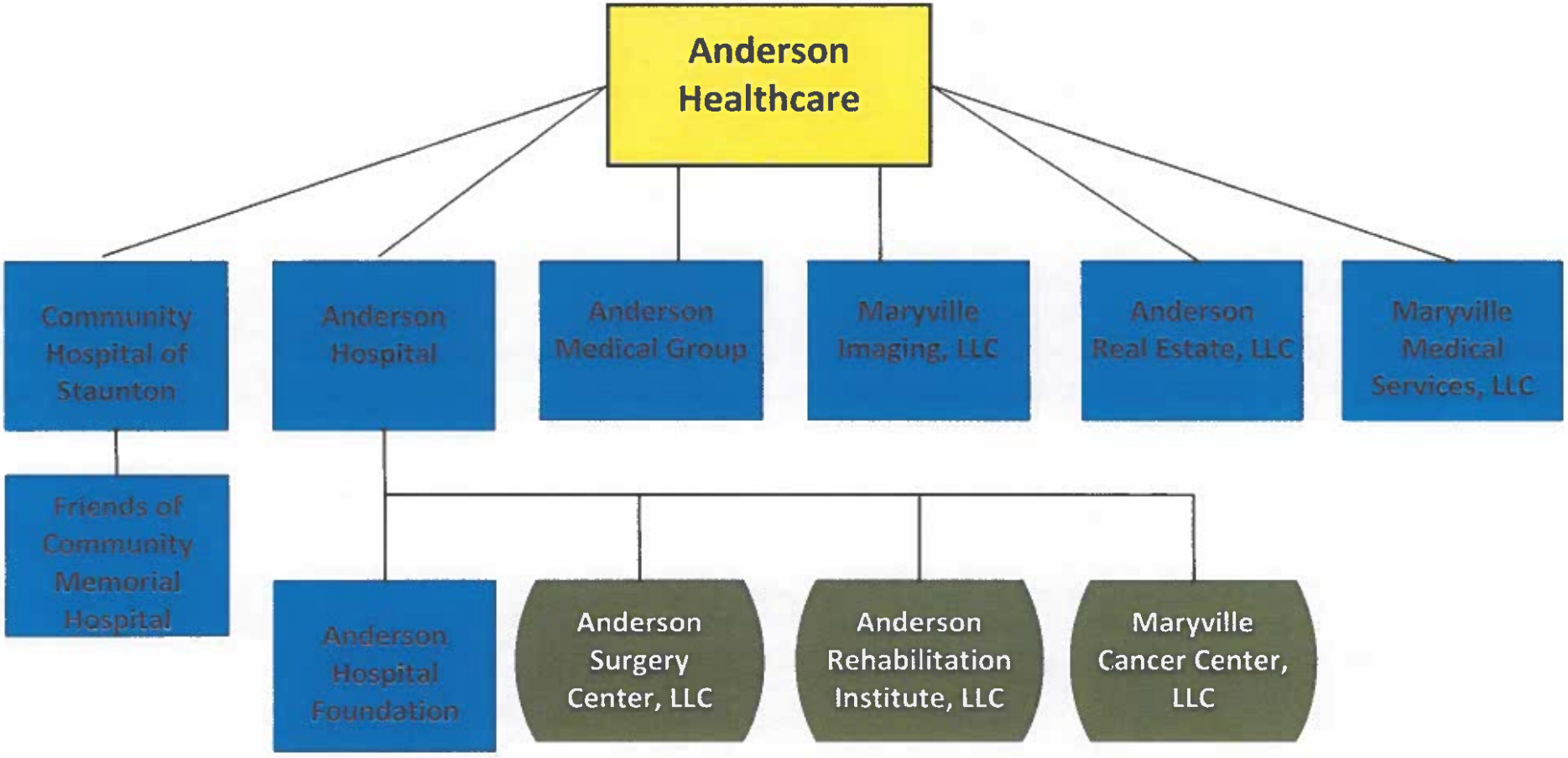
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* OCTOBER *A.D.* 2024 .

Authentication #: 2428902430 verifiable until 10/15/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

Attachment 3

Anderson Healthcare
Organizational Chart



Flood Plain Requirements

Illinois Executive Order #2006-5, "Construction Activities in Special Flood Hazard Areas" defines "Special Flood Hazard Areas" or "Floodplains" as areas subject to "100 year frequency flood and shown as such on the most current Flood Insurance Rate Map published by the Federal Emergency Management Agency."

The following pages from FEMA Flood Map Service show part of Panel 17043600958, effective on 4/15/1982. The map shows the location of the campus of Anderson Hospital in Maryville. The dotted grid on the overlay for this area indicates that no digital data are available in this classification system for the determination of susceptibility to flooding.

The instructions to this section require follow-up with the area's county or local community building or planning department for assistance when it cannot be determined whether the site is in a floodplain. The page following the FEMA aerial map includes the finding by Marc Hohlt, the Stormwater Coordinator for Madison County, that the project site is not located in a flood hazard area.

Attachment 5

FEMA (//www.fema.gov/)

FEMA Flood Map Service Center: Search By Address

Navigation

Search

- MSC Home (/portal/)
- MSC Search by Address (/portal/search)
- MSC Search All Products (/portal/advanceSearch)
- MSC Products and Tools (/portal/resources/productsandtools)
  - Hazus (/portal/resources/hazus)
  - LOMC Batch Files (/portal/resources/lomc)
  - Product Availability (/portal/productAvailability)
- MSC Frequently Asked Questions (FAQs) (/portal/resources/faq)
- MSC Email Subscriptions (/portal/subscriptionHome)
- Contact MSC Help (/portal/resources/contact)

Enter an address, place, or coordinates:

6800 State Rte 162 Maryville, IL 62062 Search

Whether you are in a high risk zone or not, you may need flood insurance (https://www.fema.gov/national-flood-insurance-program) because most homeowners insurance doesn't cover flood damage. If you live in an area with low or moderate flood risk, you are 5 times more likely to experience flood than a fire in your home over the next 30 years. For many, a National Flood Insurance Program's flood insurance policy could cost less than $400 per year. Call your insurance agent today and protect what you've built.

Learn more about steps you can take (https://www.fema.gov/what-mitigation) to reduce flood risk damage.

Search Results—Products for **MARYVILLE, VILLAGE OF**

Show ALL Products » (https://msc.fema.gov/portal/availabilitySearch?addcommunity=170299&communityName=MARYVILLE, VILLAGE OF#searchre

The flood map for the selected area is number **1704360095B**, effective on **4/15/1982**

MAP IMAGE

VIEW/PRINT FIRM (https://msc.fema.gov/portal/viewProduct?productID=1704360095B) DOWNLOAD FIRM PANEL

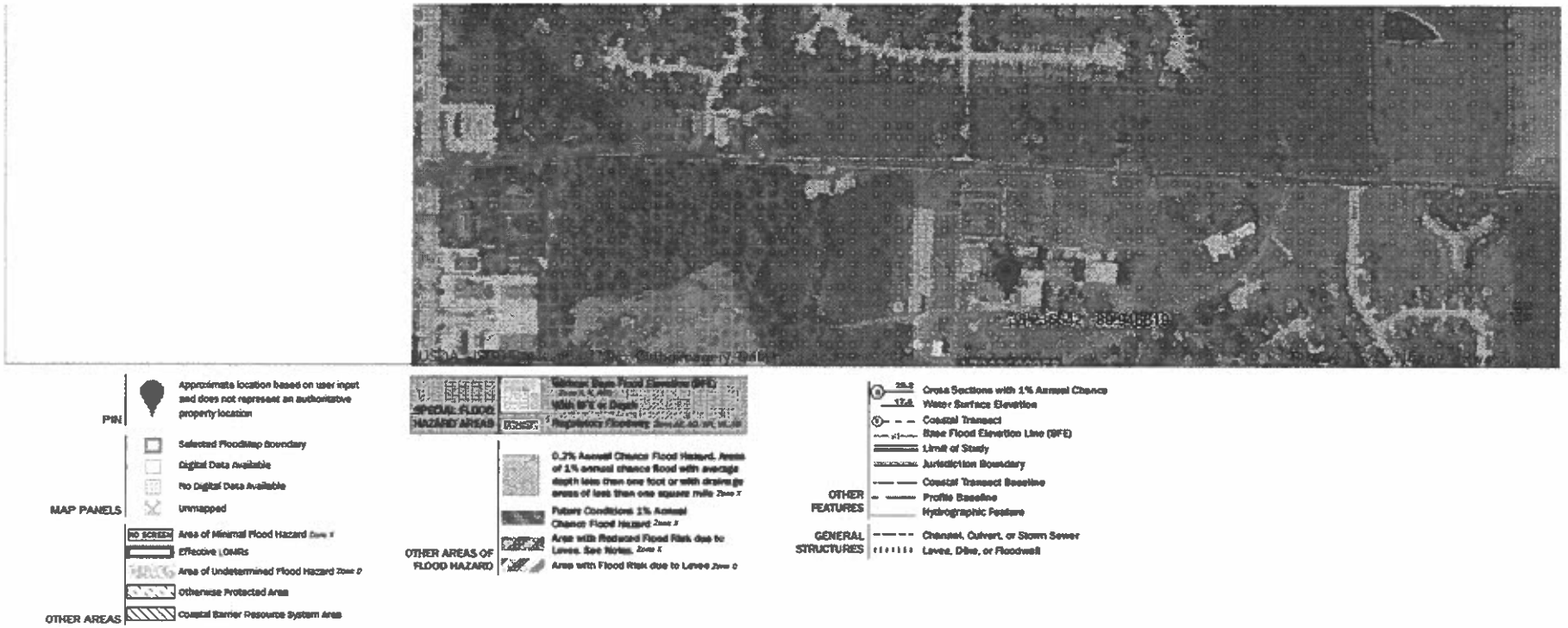
(https://msc.fema.gov/portal/downloadProduct?productTypeID=FINAL_PRODUCT&productSubTypeID=FIRM_PANEL&productID=1704360095B)

Changes to this FIRM

Revisions (0)
Amendments (3)
Revalidations (0)

You can choose a new flood map or move the location pin by selecting a different location on the locator map below or by entering a new location in the search field above. It may take a minute or more during peak hours to generate a dynamic FIRMette.

Attachment 5



35

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OIG HOTLINE Report Fraud, Waste & Abuse (https://www.oig.dhs.gov/hotline)

Official website of the Department of Homeland Security

Attachment 5

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: ANDERSON HOSPITAL (Name) 6800 STATE RTE 162 (Address)
   MARYVILLE (City) IL (State) 62062 (ZIP Code) 618 288 5711 (Telephone Number)
2. Project Location: ANDERSON HOSPITAL (Address) 6800 STATE RTE 162 MARYVILLE, IL (City) (State)
   MADISON (County) COLLINSVILLE (Township) 3N 8W S2 (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: 17043C0095B Effective Date: 4/15/1982

Name of Official: Marc Hohlt Title: Stormwater Coordinator

Business/Agency: Madison County Address: 157 N. Main St.

Edwardsville (City) IL (State) 62025 (ZIP Code) 618-296-4665 (Telephone Number)

Signature: Marc Hohlt Date: 12/10/2024

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

Historic Resources Preservation Review

The State Historic Preservation Office has completed its review and determined that there are no historic, architectural or archeological sites within the project area. Attached is the letter from the office.

Attachment 6

Madison County
Maryville
CON - New Construction, Emergency Department Expansion
6800 State Route 162

IDPH, SHPO Log #003112924

December 17, 2024

Ralph Weber
Weber Alliance
920 Hoffman Lane
Riverwoods, IL 60015

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact Steve Dasovich, Cultural Resources Manager, at 217/782-7441 or at Steve.Dasovich@illinois.gov.

Sincerely,

Carey L. Mayer

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer

Attachment 6

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	$ 13,749	$ 0	$ 13,749
Site Preparation	$ 313,264	$ 731,466	$ 1,044,730
Off Site Work			
New Construction Contracts	$ 7,323,931	$ 17,101,250	$ 24,425,181
Modernization Contracts		$ 857,024	$ 857,024
Contingencies	$ 88,000	$ 312,000	$ 400,000
Architectural/Engineering Fees	$ 403,915	$ 943,134	$ 1,347,049
Consulting and Other Fees	$ 41,000	$ 123,506	$ 164,506
Movable or Other Equipment (not in construction contracts)	$ 1,962,189	$ 1,290,396	$ 3,252,585
Bond Issuance Expense (project related)	$ 100,000	$ 215,000	$ 315,000
Net Interest Expense During Construction (project related)	$ 508,377	$ 1,186,213	$ 1,694,590
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
a) IT	$ 310,500	$ 116,200	$ 426,700
b) artwork	$ 4,250	$ 21,358	$ 25,608
c) signage	$ 52,000	$ 31,595	$ 83,595
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$ 11,121,175	$ 22,929,141	$ 34,050,316
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 3,621,175	$ 5,429,141	$ 9,050,316
Pledges			
Gifts and Bequests			
Bond Issues (project related)	$ 7,500,000	$ 17,500,000	$ 25,000,000
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$ 11,121,175	$ 22,929,141	$ 34,050,316

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

Attachment 7

Project Costs and Source of Funds

Narrative Description of Line Items.

Line 2 – Site Survey and Soil Investigation $13,749

- Subsurface Soils Investigation
- Foundation System Recommendations
- Site Topographic Survey
- Pavement and Percolation recommendations
- Site Seismic classification analysis.

Of the total amount, $13,749.00 is clinical cost.

Line 3 – Site Preparation $1,044,730

- General Site Work
  - Earth Moving
  - Import and Export of Material
  - Shoring
  - Paving
  - Concrete Curb and Gutter
  - Site Utilities
  - Stormwater management (Quality and Quantity Treatment)
- Utility Company Service work
  - Relocation of existing, temporary and permanent services for Power, Gas, Fire Water, Telecom, Cable

Of the total amount, $313,264 is clinical cost. Together with Site Survey and Soil Investigation this is 4.23% of the clinical New Construction ($7,323,931), Modernization ($0) plus Contingencies ($88,000).

Line 4 – Off Site Work $0

- Costs are included in Site Preparation above. Work includes installation of new IDOT campus entrance, minimal tie-in work offsite.

Line 5 – New Construction Contracts $24,425,181

- Project Background
  - Market Analysis
  - Feasibility Studies
  - Legal Investigation
  - Zoning Investigation
- Preconstruction Services
  - Budgeting
  - Schedule
  - Construction Phasing
  - Site Logistics
- Programing
  - Gather information for occupant space requirements.
  - Review and Analysis of space standards

    - Prepare Space Occupancy Program for Design
        - Department and Room Occupancy
        - Space systems and services requirements
        - Space level FFE concepts
- All construction contracts, cost to complete the new addition project. Construction of a new single story building addition with a basement and designed for future vertical expansion. Cost includes structure, building envelope, interior finishes and building MEP services.
- Includes contractor's markup, overhead, and profit.
- Costs are escalated to the mid-point of construction.

Of the total amount, $7,323,931 is clinical cost. At 14,728 clinical sq ft, the cost is $497.28 per clinical square foot.

Line 6 – Modernization Contracts $857,024

- All construction contracts, cost to complete the modernization scope of the project. Scope includes tie ins of select services and utilities within the existing hospital and creation of the new horizontal connector through the hospital.
- Includes contractor's markup, overhead, and profit.
- Costs are escalated to the mid-point of construction.

Of the total amount, $0 is clinical cost. The modernization cost of the connecting corridor is $499.43 per sq ft. It is a non-clinical component of the project.

Line 7 – Contingencies $400,000

- Allowance for unforeseen New Construction and Modernization Costs

Of this amount, $88,000 is allocated as a clinical cost. $88,000 is 1.2% of the clinical construction cost of $7,323,931. None of the modernization cost associated with the corridor connector component of this project is clinical. All clinical contingency is associated with new construction.

Line 8 – Architectural/ Engineering Fees $1,347,049

- Concept Design, Schematic Design, Design Development, Construction Documents services along with full engineering, Bidding and Negotiation, and construction administration.

Of the total amount, $403,915 is clinical cost. This amount is 5.52% of the total of clinical construction plus contingencies.

Line 9 - Consulting and Other Fees $164,506

- Charges for the services of various types of consulting and professional experts including:
    - Legal Fees
    - Signage/ Wayfinding Consultant
    - FF&E Consultant Fees
    - CON Consultant
    - CON Application Fee

Of the total amount, $41,000 is assigned as a clinical cost.

Line 10 - Movable Capital Equipment $3,252,585

- All furniture, furnishings, fixtures and equipment for the proposed project for clinical and support spaces.
- The Architect will be retained to provide specific expertise during equipment planning and specification, and to assist and ensure effective use of available funding. Equipment planning will be closely coordinated with architectural design.
- Freight and installation costs are also included in the estimate.

Of the total amount, $1,962,189 is clinical equipment:

Arjo lifts	$ 45,000
Cardiac Monitor Central stations	$ 1,332,396
Defibrillators	$ 113,695
Dopplers	$ 1,000
EKGs	$ 75,272
IV Poles	$ 9,200
Pyxis Auxillary	$ 12,700
Safety psych bed	$ 2,700
Safety chairs (psych rooms)	$ 2,063
Stretchers	$ 214,663
Surgical lights	$ 153,500
Other clinical equipment	

Line 11 – Bond Issuance Expense $315,000

This expense includes borrower's counsel, bond counsel, issuer's counsel, lender's counsel and the placement agency fee. It is anticipated that bonds will be issued through the Illinois Finance Authority.

Line 12 – Net Interest Expense During Construction (project related) $1,684,590

Borrowing of $25,000,000 will be used to fund part of the construction, scheduled from July 2025 through May, 2027, as well as other project costs. The cost of borrowing is offset by interest earned on the balance of principal throughout the construction period.

Line 14 – Other Costs to be Capitalized $535,903

- Information Technology
  - Premise Cabling, Computers, Switches and equipment for Telephone and Data systems.
  - Building Safety and Security Systems including Access Control, CCTV, Intrusion Detection.
- Artwork
- Signage
  - Interior wayfinding
  - Exterior Building and Site Signage.

Of the total amount, $366,750 is allocated as clinical cost.

Cost / Space Requirements
(departmental gross sq ft)
Anderson Hospital

Department/Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Sq Ft That Is:			
		Existing	Proposed	New Construction	Modernized	As Is	Vacated
Construction Costs							
CLINICAL/REVIEWABLE							
Emergency Department	$ 7,323,931	12,759	14,728	14,728			11,043
Subtotal Clinical	$ 7,323,931	12,759	14,728	14,728			11,043
NON-REVIEWABLE							
Public Areas	$ 1,286,533		2,435	2,435			
Circulation - Vertical	$ 1,288,009		1,657	1,657			
Training	$ 226,971		465	465			
Staff Offices - Administrative	$ 502,890		1,032	1,032			
Staff Support	$ 635,818		1,203	1,203			
Circulation - Horizontal	$ 1,178,326		2,675	2,675			
Building Systems	$ 2,399,817		5,550	5,550			
Connecting Corridor	$ 857,024		1,716		1,716		
Unassigned (Shell Space)	$ 9,582,885		18,530	18,530			
Subtotal Non-Clinical	$ 17,958,273	-	35,263	33,547	1716		
TOTAL CONSTRUCTION	$ 25,282,205	-	49,991	48,275	1,716		11,043

Other Proj Costs	
Preplanning Costs	$ -
Site Survey / Soil	$ 13,749
Site Preparation	$ 1,044,730
Off Site Work	$ -
Contingencies	$400,000
A/E fees	$ 1,347,049
Consulting, fees	$164,506
Moveable Equipt, Furnish	$3,252,585
Bond Issuance Expense	$315,000
Net Int Exp Dur Constr	$1,694,590
FMV leased space, eqpmnt	
Other Capital Costs	
- IT	$426,700
- artwork	$25,608
- signage	$83,595
Subtotal	$ 8,768,112
TOTAL PROJECT COSTS	$ 34,050,316

Note: Total construction of $25,282,205 includes $24,425,181 in new construction and $857,024 in modernization cost.

Attachment 9

Background of the Applicant

This attachment includes the following:

IDPH License, Anderson Hospital
Joint Commission Accreditation

Anderson Healthcare list of facilities in Illinois and license information

Letter of certification that there have been no adverse actions against Anderson Hospital or any facility owned or operated by Anderson Healthcare; authorization of access to information.

Attachment 11

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF130388

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.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2024		0004119

General Hospital

Effective: 01/01/2024

Anderson Hospital
6800 State Route 162
Maryville, IL 62062

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4422001 10M 3/22

Attachment 11

45

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2024

Lic Number 0004119

Date Printed 11/17/2023

Anderson Hospital

6800 State Route 162
Maryville, IL 62062

FEE RECEIPT NO.

Anderson Hospital

Maryville, IL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

March 23, 2024

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7380
Print/Reprint Date: 05/24/2024

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Attachment 11

Anderson Healthcare – Licensed Facilities in Illinois

Anderson Hospital
6800 State Route 162
Maryville, IL 62062
IDPH License # 0004119; expiration 12/31/2025
Joint Commission certification: TJC#7380/CCN#140289; duration 3/23/24-3/23/27

Anderson Surgery Center
3403 Anderson Healthcare Drive, Suite A
Edwardsville, IL 62025
IDPH License # 7003235; expiration 7/22/2025
Certification (AAAHC): 000130446O/CCN#130446; duration 6/25/24-6/24/2027

Anderson Rehabilitation Institute
3402 Anderson Healthcare Drive
Edwardsville, IL 62025
IDPH License # 0006239; expiration 7/21/25
Joint Commission or other certification; TJC#664984/CCN#143029; duration 4/26/24-4/26/27

Maryville Imaging - Goshen
3417 Anderson Healthcare Dr – Suite 101
Edwardsville, IL 62025
Illinois IEMA License # 9265184
American College of Radiology for CT duration 9/14/22-9/14/25
American College of Radiology for MRI; duration 9/24/22-9/27/25

Maryville Imaging - Maryville
2023 Vadalabene Dr – Suite 100
Maryville, IL 62062
Illinois IEMA License # 9253473
IDPH Mammography License # 152827; expiration 4/7/25
American College of Radiology for CT duration 3/23/23-5/23/26
American College of Radiology for MRI; duration 3/2/22-7/12/25
American College of Radiology for Mammography; duration 1/24/22-4/7/25

Community Hospital of Staunton
400 N Caldwell St
Staunton, IL 62088
IDPH License # 0000414; expiration 6/30/25
CMS certification; CCN141306; duration 10/27/22-10/27/25

December 16, 2024

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: No Adverse Actions / Authorized Access to Information

Dear Chairwoman Savage:

I hereby certify that no adverse action has been taken against Anderson Hospital or Anderson Healthcare or any facility owned or operated by the Anderson Healthcare directly or indirectly, within three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.

I hereby authorize the Health Facilities and Services Review Board ("Board") and the Illinois Department of Public Health ("IDPH") to access any documentation they find necessary to verify any documentation or information submitted, including but not limited to official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations. I further authorize the Board and IDPH to obtain any additional documentation or information that Board or IDPH deems necessary to process the application.

If you have any questions, please contact Lisa Spencer, President, Anderson Hospital, at 618-391-6404, or spencerl@andersonhospital.org.

Sincerely,

Michael Marshall

Michael Marshall
President
Anderson Healthcare
6800 State Rte 162
Maryville, IL 62062

NOTARY

Ranada Ridenhour
County of Madison
State of Illinois
12/16/2024

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

Attachment 11

PURPOSE OF THE PROJECT

1. Document that the project will provide health care services that improve the health care or well-being of the market population to be served.

The project is the modernization and expansion of the emergency department at Anderson Hospital. The current emergency department is located in part of the hospital that was built in 1977. Like most other emergency departments of that era, the ED has several facility deficiencies and operational inefficiencies. For example, there is no dedicated procedure room and only one room to accommodate behavioral health patients, which is often insufficient. There is no special room or space for sexual assault patients, resuscitation bays for patients meeting certain trauma codes, or rooms to accommodate patients that are awaiting transfer to other hospitals for tertiary care services. There is no work space for staff handling patient registration. There is limited workspace separated from patients and families for physicians, and for EMS charting and uploading reports. There is insufficient space for equipment and supplies storage. The arrangement of space within the department is not an efficient layout compared to modern Emergency Departments.

Capacity is also an issue, especially during the peak times. Anticipating 36,907 visits this year (extrapolated from 30,756 through the month of October), ED visits increased by 3,489 over the past three years, an annual increase of 1,163 visits. Apart from this growth, the 22 stations are not able to accommodate daily peaks in service. 55% of patient volume is seen between the 9 hours from 9:00 AM to 6:00 PM (38% of the daily hours). Capacity issues resulted in over 2,000 LWBS patients (Left Without Being Seen) last year. Calculations in other sections of this permit application show that up to 27 treatment stations or rooms are needed to accommodate this patient volume during the peak 9 hours.

The project addresses these issues by constructing a new emergency department increasing the number of treatment stations from the existing 22 treatment stations to 26 rooms. Each of these 26 will be used for general patient treatment. However, two of the rooms will be seclusion rooms for behavioral health patients (2), two isolation rooms (2), one room to accommodate sexual assault patients (OB/GYN room) (1), three larger rooms with specialized equipment to treat patients with trauma conditions (3), and four rooms for "quick visits" and special capability for pediatric patients (4). There will be a holding area with three recliners for patients awaiting transfer or discharge. The 26 rooms will better accommodate ED patients during the peak hours.

2. Define the planning area or market area, or other relevant area, per the applicant's definition.

The table on the next two pages presents patient origin information based on the residence of patients visiting the Anderson Hospital emergency department. Zip codes with more than 10 residents who were ED patients at Anderson Hospital in CY 2023 are displayed on the table. 73% of all visits are from 7 zip codes in Madison County containing Collinsville, Granite City, Edwardsville, Glen Carbon, Troy and Maryville. No other zip code provides more than 2.0% of patient visits to the ED.

The 7 zip codes with 73% of patients constitute the planning area for the project. The 7 zip codes are the Primary Service Area (PSA). The balance of Madison County is the Secondary Service Area (SSA), adding about 12% of ED patients. Together, the PSA an SSA are the source of about 85% of Anderson Hospital ED patients.

Table - Zip Codes of Patient Residence (Year: 2023)
Anderson Hospital - Maryville campus
Emergency Deprtment Visits - not admitted
Source: Hospital Medical Records

Zip Code	Community Name	County Name	Number of Patients	Percent of total	Cumulative Percent
Primary Service Area					
62234	Collinsville	Madison	5625	19.70%	
62040	Granite City	Madison	4940	17.30%	
62025	Edwardsville (also 62026)	Madison	4354	15.20%	
62034	Glen Carbon	Madison	2171	7.60%	
62294	Troy	Madison	2158	7.60%	
62062	Maryville	Madison	1584	5.60%	
	Madison County 7 zip codes		20832	73.00%	73.00%
Secondary Service Area					
62249	Highland	Madison	500	1.80%	
62095	Wood River	Madison	374	1.30%	
62010	Bethalto	Madison	307	1.10%	
62060	Madison	Madison	277	1.00%	
62002	Alton	Madison	250	0.90%	
62097	Worden	Madison	237	0.80%	
62024	East Alton	Madison	202	0.70%	
62281	St. Jacob	Madison	184	0.60%	
62061	Marine	Madison	156	0.50%	
62046	Hamel	Madison	112	0.40%	
62001	Alhambra	Madison	104	0.40%	
62087	South Roxana	Madison	99	0.30%	
62067	Moro	Madison	89	0.30%	
62018	Cottage Hills	Madison	76	0.30%	
62035	Godfrey	Madison	75	0.30%	
62058	Livingston	Madison	65	0.20%	
62090	Venice	Madison	65	0.20%	
62084	Roxana	Madison	57	0.20%	
62074	New Douglas	Madison	46	0.20%	
62048	Hartford	Madison	43	0.20%	
62021	Dorsey	Madison	33	0.10%	
	Remaining Madison County Total		3351	11.80%	84.80%
Outside Primary and Secondary Areas					
62232	Caseyville	St. Clair	567	2.00%	
62201	East St. Louis	St. Clair	298	1.00%	
62208	Fairview Heights	St. Clair	137	0.50%	
62226	Belleville	St. Clair	129	0.50%	
62269	O'Fallon	St. Clair	117	0.40%	
62206	Cahokia	St. Clair	89	0.30%	
62221	Belleville	St. Clair	82	0.30%	
62205	East St. Louis	St. Clair	70	0.20%	
62223	Belleville	St. Clair	69	0.20%	
62220	Belleville	St. Clair	63	0.20%	
62203	Belleville	St. Clair	56	0.20%	
62254	Lebanon	St. Clair	52	0.20%	
62204	East St. Louis	St. Clair	32	0.10%	

62207	East St. Louis	St. Clair	31	0.10%	
62258	Mascoutah	St. Clair	25	0.10%	
62260	Millstadt	St. Clair	20	0.10%	
62243	Freeburg	St. Clair	11	0.04%	
	St. Clair County Total		1848	6.44%	91.24%
62088	Staunton	Macoupin	275	1.00%	
62014	Bunker Hill	Macoupin	127	0.40%	
62069	Mount Olive	Macoupin	76	0.30%	
62033	Gillispie	Macoupin	68	0.20%	
62012	Brighton	Macoupin	49	0.20%	
62009	Benid	Macoupin	35	0.10%	
62685	Shipman	Macoupin	17	0.10%	
62626	Carlinville	Macoupin	11	0.04%	
	Macoupin County Total		658	2.31%	93.55%
62275	Pocahontas	Bond	91	0.30%	
62246	Greenville	Bond	76	0.30%	
62086	Sorento	Bond	35	0.10%	
62273	Pierron	Bond	12	0.04%	
62262	Mulberry Grove	Bond	11	0.04%	
	Bond County Total		225	0.79%	94.34%
63136	St. Louis, MO	St. Louis	22	0.10%	
63031	Florrisant, MO	St. Louis	19	0.10%	
63116	St. Louis, MO	St. Louis	18	0.10%	
63033	Florrisant, MO	St. Louis	15	0.10%	
63026	Fenton, MO	St. Louis	11	0.04%	
63115	St. Louis, MO	St. Louis	11	0.04%	
63129	Oakville, MO	St. Louis	11	0.04%	
	St. Louis County Total		107	0.36%	94.70%
62293	Trenton	Clinton	25	0.10%	
62230	Breese	Clinton	18	0.10%	
62231	Carlyle	Clinton	15	0.10%	
62216	Aviston	Clinton	13	0.05%	
62265	New Baden	Clinton	12	0.04%	
	Clinton County Total		83	0.29%	94.99%
62056	Litchfield	Montgomery	48	0.20%	
62049	Hillsboro	Montgomery	13	0.05%	
	Montgomery County Total		61	0.21%	95.20%
62052	Jerseyville	Jersey	25	0.10%	
62701	Springfield	Sangamon	19	0.10%	
62236	Columbia	Monroe	15	0.10%	
63376	St. Peters, MO	St. Charles	13	0.05%	
62401	Effingham	Effingham	11	0.04%	
	Other Counties Total		83	0.29%	95.49%
Zip Codes with 10 or fewer patients			1286	4.51%	100.00%
Total Patients			28534	100.00%	100.00%

Attachment 12

3. Identify the existing problems or issues that need to be addressed as applicable or appropriate for the project.

The project is intended to address three issues that were summarized in the introduction of the Purpose of the Project section: 1) facility limitations that affect patient flow and operational performance; 2) inadequate capacity, especially during the regularly experienced peak hours; and 3) treatment facilities that don't meet current requirements for patients with special needs.

Facility limitations that affect patient flow and operational performance.

Anderson Hospital ED staff and management recognize that patients waiting for emergency care have varying degrees of anxiety, pain, fears and concerns for their well-being. Accordingly, Anderson has instituted a "Pull to Full" ED service, meaning eliminating waiting whenever possible by taking patients from the waiting area and filling all treatment bays/rooms. This means doing bed-side triage in the treatment bays/rooms. When treatment bays/rooms are filled, triage is now done in a small triage room, where the patient history and vitals are taken and EKGs and other tests administered. The current room is about 10' by 10', and is filled with a desk and chair, stand-up scale and other equipment. There is no space for a needed wheel-chair compatible scale. When this room is in use and all treatment stations filled, then triage is done in alternate areas not designed for the function, resulting in back-and-forth trips for staff doing triage and further monitoring. Bringing providers out in front to administer "waiting-room medicine" does not provide patients with the privacy they seek and draws providers away from the active emergency treatment areas.

Patient registration staff do not have an office and/or private work space. They sit near a public corridor. A properly sized designated work area is needed for the registration staff to have space that is private so computer screens cannot be viewed by others. The registration staff have an important role in the ED patient experience.

Designated space for providers is limited. Space is needed for physicians and staff to review patient information, make calls to specialists or hospitalists, and have some relief from the high level of activity of the ED. Interaction with family members of patients is critical, but some of the providers' functions require privacy and the opportunity for uninterrupted thought and communication with fellow ED staff.

The current undersized EMS space is approximately 6' by 9'. This is inadequate for the needed space to do charting. The medication refrigerator and cabinet for restocking are not as secure in the current space as necessary. On a typical day, there are 21 ambulance arrivals. Adequate space is needed for workspace for charting and restocking of paramedic supplies.

Finally, the decontamination area is undersized (approximately 6' by 10' with the shower taking up 3½ ' by 4'), hard to access, and often used to store carts and supplies in the unit, blocking access. The current unit cannot accommodate a stretcher, let alone staff working on both sides of the stretcher. A significant increase in space is needed for the decontamination area.

Inadequate capacity, especially during regularly experienced peak hours.

The "Pull to Full" operational practice described above is intended to reduce patient waiting by placement of patients in treatment rooms as soon as possible. It also enables triage to occur in the treatment rooms. The policy also results in increased utilization of the current 22 treatment bays. However, there are not enough rooms to prevent triage and sometimes treatment in the ED hallways. When high volumes occur, triage backs up into alternate locations not designed for the function.

Hourly arrival data presented elsewhere in this permit application show a concentration of arrivals between 9:00 AM and 6:00 PM. In 2023, hourly arrivals in each hour of this 9-hour period were above

2,000 visits, ranging from 2,070 to 2,278 per hour. These arrival peak hour volumes exceeded non-peak hour arrival volumes by up to 4 to 5 times. Average lengths of stay for the daily 24-hour periods in the ED ranged from just over four hours to almost seven hours. During these peak hours, all treatment stations are fully occupied. Combining the arrival data and length of stay data results in the ED being at or near capacity until volumes reduce between 1:00 AM and 3:00 AM on typical days.

In 2023, there were more than 2,000 patients who left without being seen (LWBS), due to a variety of reasons, especially an inadequate number of treatment stations during the 9-hour peak time period.

Capacity remains a difficult issue to manage, as annual visits continue to grow. Recent year volumes were: 29,188 in 2020, 33,418 in 2021, 35,151 in 2022 and 35,548 in 2023. For the first ten months of 2024, there were 30,756 visits, annualized to 36,907 visits. Overlooking the relatively lower volume in 2020 due to a full year of COVID, annual growth in visits was 1,163 yearly from 2021 through 2024. There is nothing to demonstrate that volumes will plateau, but instead it is anticipated that annual growth of over 1,100 visits will continue.

<u>Treatment facilities don't meet requirements for patients with special needs.</u>

The caring for certain types of patients is not as patient-oriented or effective when provided in standard ED treatment bays. Over recent decades, ED planning has recognized and accommodated safe space for behavioral health patients, sexual abuse victims, trauma cases, and patients who have been treated/stabilized and are awaiting transport to another facility.

Patients with behavioral health needs.
Last year there were 340 patients with behavioral health issues who received care at Anderson Hospital's emergency department. Some of these patients were suicidal, others were disruptive to care delivery in the department. Special rooms are now planned to separate these patients from the standard flow in EDs, and treat them in rooms that must meet special regulatory requirements and ligature safety standards (doors that open outward to prevent blocking, furnishings that cannot be used to inflict injury, avoidance of ceiling track/grids, electric cords, etc.) These patients need a dedicated bathroom with the staff able to keep constant visual connection. These rooms need to accommodate longer lengths of stay for patients that require transfer to an Acute Mental Illness unit, since it can take a day or two to find an available inpatient AMI bed and arrange transport. This condition means there should be a shower in close proximity; at present, staff have to accompany patients to a medical/surgical room for showering. In the past 11 years, 14 hospitals in Illinois have closed their AMI units, of which 11 with 245 beds are in downstate locations. Too often AMI beds are not available locally, but at distances of 100 miles or more, creating a hardship for the patient and family and extended time by ED/hospital staff to arrange a transport. Anderson's current ED has only one room that has been modified for patients with behavioral health issues, but does not meet all requirements for patient safety and ligature risk.

Victims of sexual abuse.
Anderson Hospital is a full treatment facility and is required to accept sexual assault patients from other hospitals in the region. Anderson has transfer agreements with Alton Memorial Hospital, Jerseyville, and Staunton Hospital to care for their sexual assault patients. By law, treatment of patients suffering sexual abuse must meet specific requirements, such as providing for showers and other necessary amenities. At Anderson, there is no shower in the current ED; patients have to be taken to an available inpatient room to shower. A quiet and comfortable room setting is preferred to the noise and intensity of the ED. Over

the past two years, an annual average of 37 sexual assault patients have been treated at Anderson Hospital's ED.

Trauma cases.
Anderson Hospital's ED is rated comprehensive. While the hospital is not a designated trauma center, it does receive and treat certain types of trauma cases. These trauma cases are now treated in a small exam room, with lighting that is less than optimal, where it is difficult to bring carts with meds, supplies, and equipment, and there is limited space for staff. In 2023, there were 159 trauma patients treated at the Anderson Hospital ED with head, spine, violent injury and other significant injuries.

Patients awaiting transfer for tertiary care.
The Anderson Hospital ED treated 1,096 patients last year who required transport to a tertiary care hospital for further needed treatment. These patients have an average length of stay of over 9 hours in the emergency department, more than double the average time for an ED visit. Averaging 3 patients every day, these patients put a stress on ED capacity, especially during the daily peak volume period. Some of these patients have been held for over 90 hours before a transfer can be arranged. There have been increased delays in 2024, unfortunately, due to shortages in some specialties in the area.

Other limitations

In addition to the above patient needs, the existing ED has insufficient space/rooms for the storage of supplies, medical equipment, linens, crash carts, EKG machines, infant warmers, wheelchairs, and numerous other essential clinical and non-clinical necessities. Too often these supplies and equipment are located in areas used for clinical and support functions such as registration, triage, EMS and contamination areas Need for more storage space is a universal issue in hospitals, and certainly is a problem in the emergency department at Anderson Hospital.

4. Cite the sources of information.
- Anderson Hospital medical records
- HFSRB Hospital Profiles
- HFSRB *Inventory of Health Facilities and Services and Need Determinations*, December, 2023; Monthly Updates to the Inventory of Health Facilities and Services.
- (410 ILCS 70/) Sexual Assault Survivors Emergency Treatment Act (SASETA)
- Special Report: Suicide Prevention in Health Care Settings, The Joint Commission Perspectives JC standards for behavioral health

5. Detail how the project will address the previously referenced issues, as well as the population status and well-being.

The modernization project will add capacity for patient care and support space that will address the issues outlined above.

Replacement of the 22 ED bays and a total of 26 treatment rooms, including 12 rooms for specialized treatment, will allow staff to implement the "Pull to Full" processes more effectively, allowing for triage at the designated triage area and at treatment bays and rooms. This will reduce the need for staff to conduct triage in alternate areas not designated for triage. The added space will provide dedicated

locations for physicians and staff to review test results and reports, communicate with each other and specialists, and prepare their treatment plans and documentation. Space for EMS and decontamination functions will be enlarged and properly located near related functional areas.

Added capacity will enable the ED to keep pace with historic growth and better accommodate patient peak arrival and treatment hours. To accommodate these daily peak hours and not have patients leaving due to unavailable treatment stations, 26 treatment stations are planned: 14 standard treatment rooms and 12 special rooms. As previously stated, the special rooms include:

- 2 seclusion treatment rooms for behavioral health patients; the rooms will also accommodate those patients while they are waiting to be transferred to an inpatient AMI unit;
- 1 room for victims of sexual assault;
- 3 larger rooms for treating patients with head, spine, violent injury and other trauma injuries;
- 4 "quick visit rooms" that will also treat pediatric patients;
- 2 isolation rooms

The request for 26 rooms including 12 specialized rooms is based in part on the need to operate effectively during the peak arrival hours, which as stated range from 9:00 AM until 6:00 PM.

None of the 12 special rooms themselves meet the volume threshold of 2,000 visits/room/year. Accordingly, the rooms will function not only for these specialized purposes, but also to accommodate volume surges during the daily peak times.

6. Provide goals with quantifiable and measurable objectives, with specific timeframes that relate to achieving stated goals as appropriate.

- Accommodate approximately 42,700 annual ED visits in 2029, two years after project completion, based on an annual average increase of 1,163 visits annually based on historic volumes.
- Reduce the number of patients who leave without being seen by at least 25% by 2027.
- Complete the project in time to treat the first patient by May, 2027 in the new ED.

ALTERNATIVES

The project proposes the construction of a building addition to house the new emergency department, replacing the outdated ED that has been in service since the hospital opened in 1977 and expanded in 1999. The new ED is located adjacent to and immediately south of the current ED, and has a total gross footprint of about 24,900 sq ft. The project also includes a full basement, including 18,530 sq ft of shell space, and a 1,716 sq ft interior connecting corridor that joins the proposed ED to the existing hospital circulation system. The project addresses several current facility limitations affecting patient flow and operational performance, provides additional treatment room capacity to accommodate patients, especially during regularly experienced peak hours, and accommodates the requirements of patients with special needs, such as patients with behavioral health problems and victims of sexual abuse.

There were several alternatives considered in the planning of the project:

1. Renovation of the existing emergency department at its current location.
2. Construction of a smaller adjacent addition that would accommodate some of the new ED functions, and allow sequential renovation/upgrading of zones within the existing ED.
3. Construction of a completely new emergency department adjacent to and immediately south of the existing ED to replace the existing ED. (SELECTED ALTERNATIVE)
4. Construction of a completely new emergency department but at a different location (on the north side of the hospital.

1. Renovation of the existing emergency department at its current location.

Staff and consultants evaluated how to modernize the existing emergency department in order to accommodate better patient flows and staff operations. The effort included addressing space deficiencies in the triage function, maintaining patient privacy, having sufficient capacity to achieve acceptable patient through-put during the peak hours, and providing work space for physicians, nurses and staff separated from patients and the public. Solutions to some of the current problems resulted in worsening and preventing the resolution of other existing deficiencies. For example, having some of the rooms sized and located to serve specialized functions (isolation for sexual abuse victims and for behavioral health treatment) required spaces that were required for other functions. The conclusion was quickly apparent that fitting a modern emergency department into the presently undersized facility was not achievable.

In addition, the disruption that would occur by renovating an emergency department in active use prevents consideration of this option. Partial area renovation would take out rooms and areas that are needed on a daily basis for the functioning of the ED. Even if it were to be achievable, the staging of renovations would double or triple the time required to replace the facility.

The cost of this option was estimated at $27 million – inclusive of all site work, new construction and modernization costs. The option was rejected as being impractical and in conflict with the continuous operation of an emergency department serving an average of 100 visits per day. Moreover, the alternative yields the same amount or less treatment space, and does not accommodate any opportunity for continued annual growth in visits, as has been experienced in recent years.

2. Construction of a smaller adjacent addition that would accommodate some of the new ED functions, and allow sequential renovation/upgrading of zones within the existing ED.

The planning considered building an addition half as large as the proposed footprint. Once the new addition opened, the remaining space could be changed and renovated so the new construction and renovated existing space would function as a modern ED.

Analysis showed that the cost of such a plan would be about $25,500,000 – inclusive of all site work, new construction and modernization costs, similar to the preferred alternative. Disruption of operations would be significant, since the ED area would be in and adjacent to a construction zone. Moreover, the time required for the new construction would be similar to the preferred alternative for phase 1, and the second phase of renovating the existing space would require ten additional months in two sequences. The total timetable for this project would be 31 months, exceeding the planned new construction associated with the preferred alternative.

This alternative was rejected as costly, disruptive to current operations and extending the project timetable beyond the time required for a totally new ED.

3. Construction of a completely new emergency department adjacent to and immediately south of the existing ED to replace the existing ED. (SELECTED ALTERNATIVE)

This alternative best achieved the objectives of the project – a) resolve current facility limitations affecting patient flow and operational performance, b) provide additional treatment room capacity to accommodate patients, especially during regularly experienced peak hours, and c) accommodate the requirements of patients with special needs, such as patients with behavioral health problems and victims of sexual abuse.

The area outside the current emergency department is in current use as parking, and is immediately convertible to buildable area. There is sufficient space to allow expanded functions and capacity for additional rooms. The area benefits from proximity to the hospital's existing radiology and surgery departments, functions that actively support emergency department operations. Moreover, the location adjacent to the existing ED allows for ambulance and community access to continue using the current route off of Valadabene Dr).

The cost of this option is $27,700,000 – inclusive of all site work, new construction and modernization costs. Alternative 3 is the preferred alternative because it uniquely meets all of the objectives associated with a modern ED.

4. Construction of a completely new emergency department but at a different location (on the north side of the hospital.

This alternative has many of the features of the Preferred Alternative, because as new construction, it can be proactively designed to have the size and layout to accommodate the project objectives. The capital cost of the alternative is comparable to the capital cost of the preferred alternative.

The alternative was rejected because of consequences related to traffic. An ED located on the north creates a new destination in conflict with other functions accessed on the relatively dense-activity north side of the hospital: the main hospital entrance, patients accessing outpatient services, loading docks, and other active uses. An ED on the north side does not achieve the desired separation of traffic that is achieved by having the ED access from Valadabene Dr on the south.

Finally, if the ED were located on the north side of the hospital, it would create access issues for outpatients coming to have diagnostic imaging in radiology. The preferred ED location on the south does not create access problems for radiology.

This alternative was rejected because of the access issues created and because it does not have the desired proximity to radiology and surgery.

Following the consideration of these various alternatives, the hospital selected replacing the ED adjacent to and immediately south of the current location, Alternative 3.

SIZE OF THE PROJECT

The 49,991 sq ft project includes 48,275 dgsf of new construction and 1,716 sq ft of modernization. New construction includes a first-floor emergency department and a lower level (basement) that includes 18,530 sq ft of unassigned shell space. The 1,716 sq ft modernization component is a corridor through existing space to connect the Emergency Department to the existing hospital circulation system. Of the total 49,991 sq ft, 14,728 dgsf is clinical; 35,263 is non-clinical, including the shell space.

The table shows the distribution of space by function.

Department/Service	DGSF	State Standard (dgsf)	Difference	Met Standard?
Clinical Space				
Emergency Department	14,728	900 dgsf/treatment station x 26 stations	-8672 dgsf	Yes
Total Clinical	14,728	= 23,400 dgsf		
Non-clinical space				
Public areas	2,435	NA		NA
Circulation - vertical	1,657	NA		NA
Training	465	NA		NA
Staff offices - administrative	1,032	NA		NA
Staff support	1,203	NA		NA
Circulation - horizontal	2,675	NA		NA
Building systems	5,550	NA		NA
Connecting corridor	1,716	NA		NA
Unassigned (Shell space)	18,530	NA		NA
Total Non-clinical	35,263	NA		NA
Total dgsf	49,991	NA		NA

The proposed project meets the State standard of a maximum of 900 dgsf per treatment station.

A separate CON permit application will be submitted in the future when it is decided what function(s) will be located in the basement shell space.

PROJECT SERVICES UTILIZATION

The request to expand the emergency department at Anderson Hospital is based on several factors: a) address the facility deficiencies and inefficiencies in the emergency department built and opened in 1977; b) enable the ED to better accommodate patient arrivals during the 9 hour daily peak times; c) provide expanded rooms to keep pace with projected growth based on the historic annual average increase of 1,163 patients; and d) provide rooms that meet the specialized needs of patients, such as patients with behavioral health issues or victims of sexual abuse.

The relevant historic growth and projections based on historic utilization are shown below.

The following table shows that ED visits increased from 29,188 in year 2020 to 36,907 in 2024 (extrapolated based on 30,756 for the ten months ending October 31, 2024). This is an increase of 26.4% since the end of 2020. This 26.4% is an annual average increase of 6.6%.

Emergency Department Visits - Historic and Projected

	Historic Utilization	Projected Utilization	Projected visits /treatment room	Standard 2000 visits/rm/yr	Treatment rooms
2020	29,188				22
2021	33,418				22
2022	35,151				22
2023	35,584				22
2024	36,907*				22
2025		38,070	1,730		22
2026		39,233	1,783		22
2027		40,396	1,836		22/26
2028		41,559	1,598		26
2029		42,722	1,643	No	26

The projected treatment volumes are based on growth during the three years from the end of 2021 through 2024. This 3-year growth of 3,489 patients is an annual growth of 1,163 patients, and is the annual increase used to project increasing visit volumes from 2025 through 2029, two years after project completion in 2027. The projected volume of 42,722 visits in 2029 is full utilization of 22 ED treatment rooms. There are 22 treatment stations in the existing Anderson Hospital ED.

The ED visit volume in 2020 was not used as a base year for projections. That is due to the onset of COVID, and patient avoidance of EDs for selected conditions, and a lower than normal ED visit volume. The use of 2020 as a base year would have justified a higher annual growth from 2020 through 2024, but not a realistic annual level of increase that could be sustained through the projection years. As a result, the projected increase of 1,163 is conservative as a basis for projecting utilization.

For the last decade, it has been a constant experience that these existing 22 rooms are not able to accommodate the daily peak arrival times, from 9:00 AM – 6:00 AM. Section 1110.270 in this permit application includes calculations that show that 27 treatment stations would be needed to accommodate patients arriving during these nine peak arrival hours, if the volumes in these hours were

annualized and compared to the 2,000 visits per year per room standard. The project is planned with 26 treatment stations, an increase of four treatment stations above the existing 22. The request for 26 treatment stations is conservative when compared to the calculated need for 27 treatment stations in the peak hour.

The additional four planned rooms above the current 22 will be available to help accommodate arrivals and treatment during the peak hours. In addition, the ED plan has specialized rooms, including 2 seclusion rooms for behavioral health patients, rooms that meet ligature standards to assure protection for these patients. Two isolation rooms (2), and one designed to accommodate victims of sexual abuse (OB/GYN) (1). Three enlarged rooms are designed and equipped to accommodate certain types of patients with trauma conditions (3). None of the current 22 rooms were designed to deliver the special treatment required by these types of patients.

Apart from meeting the specialized needs of patients, all of the special rooms will be used on a regular basis to accommodate general ED visits; these special rooms will all be utilized during the peak hours to accommodate all patients.

While the strict application of the 2,000 visits per year per room and the projected volume of 42,722 visits in 2029 standard justifies 22 rooms, peak hour utilization drives the need for 27 rooms, and supports the proposed ED plan with 26 treatment room.

UNFINISHED OR SHELL SPACE

1. The planned 49,991 sq ft building includes a ground level floor for the emergency department, above a full basement. The basement includes 18,530 sq ft of unfinished or shell space.

2. At this time, it is not known what the use(s) of the unfinished / shelled space will be. That will be determined based on hospital operations and future space needs following the opening of the emergency room. Potential uses include additional space for generic storage, expanded IT functions, and offices for physicians and other providers. It is not anticipated that the shell space will be required to accommodate future support functions for the emergency department.

3. Anderson Hospital's facility was built in 1977. In the 47 years since it opened, there has been only one addition, in 1999. In response to the changing dynamics of health care during these past five decades, the hospital has done a good job of adapting and modifying its space over time. While there has been expansion at the hospital's campus in Edwardsville in the past 15 years, growth at the hospital in Maryville has been limited within the existing structure.

This second building addition since opening in 1977 is an opportunity to build in some additional space to enable flexibility and capacity for future needs at the hospital.

4. There is no known timetable for reaching a decision on the future uses of the unfinished / shell space.

Consistent with decisions on the future uses of the space, Anderson Hospital will submit a permit application for Certificate of Need approval of the utilization plans for the unfinished / shell space.

December 16, 2024

Mr. John P. Kniery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: Unfinished / Shell Space

Dear Mr. Kniery

I affirm that Anderson Hospital will submit a permit application for the development and use of shell space in the proposed project. The amount of shell space in the plan is 18,530 sq ft, located in the basement of the addition accommodating the emergency department on the first floor. This commitment to file the permit application is independent of the capital expenditure thresholds that will be in effect at the time and the categories of service involved.

Because the future possible uses of the unfinished space are uncertain, there is not a specific date that I can commit for submittal of the permit application.

If you have any questions, please contact Lisa Spencer, President, Anderson Hospital at 618-391-6404, or Weber, CON Consultant, at 847-791-0830.

Sincerely,

Michael W Marshall

Michael Marshall
President
Anderson Healthcare
6800 State Rte 162
Maryville, IL 62062

NOTARY

Ranada Ridenhour
County of Madison
State of IL
12/16/2024

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

Attachment 17

1110.270 Clinical Service Areas other than Categories of Service – Emergency Services and/or Trauma

Background and Summary

The project is the modernization and expansion of the emergency department at Anderson Hospital. The current emergency department is located in part of the hospital that was built in 1977.
The current 22 treatment bays served 35,584 patients in 2023, a slight increase from 35,181 in 2022. The 22 stations are not able to accommodate daily peaks in service. 55% of patient volume is seen between the 9 hours from 9:00 AM to 6:00 PM (38% of the daily hours). Capacity issues resulted in over 2,000 LWBS patients (Left Without Being Seen) last year. Calculations below show that it would require 27 bays/rooms to accommodate this patient volume during the peak 9 hours.

The project addresses these issues by constructing a new emergency department replacing the existing 22 bays and adding specialized rooms for behavioral health patients (2), sexual assault patients (1), trauma patients in specially equipped rooms (3), isolation rooms (2) and rooms for quick visits that also accommodate pediatric patients (4). These 12 rooms will also serve the function of accommodating patients during daily peak hours. There is also a room with three recliners for patients waiting to be transferred to other hospitals for services.

(c)(1) Service Modernization – Deteriorated equipment or facilities

The current ED has several facility deficiencies and operational inefficiencies. For example, there is no dedicated procedure room, nor multiple rooms to accommodate behavioral health patients, sexual assault patients, resuscitation bays for patients meeting certain trauma codes, and rooms to accommodate patients that are awaiting transfer to other hospitals for tertiary care services. The patient registration area is undersized. There is limited workspace separated from patients and families for physicians, and for EMS. There is insufficient space for equipment and supply storage. The arrangement of space within the department is not an efficient layout compared to modern EDs.

(c)(2) Service Modernization – Necessary Expansion

The following table shows historic patient volumes for the past 5 years.

Anderson Hospital – Emergency visits
Source: HFSRB Profiles, based on Anderson Hospital AHQs

Emergency Department	2020	2021	2022	2023	2024
Number of ER Stations	22	22	22	22	22
Persons treated	29,188	33,418	35,151	35,584	36,907*

* Extrapolated from 30,756 visits for the first 10 months of 2024.

Year 2020 was a low volume year, due to the impact of COVID, and as a result is not an appropriate base year. Projecting growth from that year would over-estimate future volume projections. Using 33,418 visits in 2021 as the base, annual historic growth has been 1,163 visits through 2024. A continued yearly growth of 1,163 visits results in a projection of 42,722 visits in 2029, two years after project completion.

At 2,000 visits per room per year, the volume of 42,722 visits results in a need for 21.4 treatment rooms (22 rooms). As documented elsewhere in this permit application, two additional rooms above the 22 are associated with accommodating patients who leave without being seen due to lack of a treatment station during the peak hours.

An additional method for documenting the need for treatment stations analyzes the need associated with the 9 daily hours that constitute the peak for emergency services. The data for this analysis is shown on the table below. The 9 peak hours (hours with more than 2,000 arrivals annually) are highlighted with shaded background.

Anderson Hosp ED: Arrival Hours, 2023

Arrival Hour	Number of visits	ALOS (hours: minutes)
0	773	5:54
1	564	7:29
2	561	4:19
3	444	4:29
4	499	4:01
5	535	5:37
6	702	5:02
7	1,025	4:56
8	1,637	5:31
9	2,093	4:26
10	2,331	5:11
11	2,278	4:38
12	2,187	5:47
13	2,139	4:41
14	2,091	5:25
15	2,070	4:46
16	2,133	4:04
17	2,060	5:09
18	1,985	4:38
19	1,979	4:39
20	1,834	4:17
21	1,500	5:07
22	1,220	6:31
23	942	5:49
Total for year 2023	35582	

The calculations using the peak volume data to determine need for treatment stations are as follows:

1) During 2023, 19,382 visits (of the 35,582 total) occurred during the peak hours from 9:00 AM to 6:00 PM

2) If the 2,014 patients who left without being seen during these peak hours had stayed a full duration of treatment (average 4 hours 23 min) instead of their average of 2 hours and 34 minutes, that would be the equivalent of an additional 835 patient visits:

4 hrs 23 minutes – 2 hrs 34 minutes = 1 hour 49 minutes (109 minutes)
109 minutes x 2,014 visits = 219,526 extra minutes of service
219,526 / 263 minutes for the average ER visit = 835 equivalent visits

3) 19,382 visits plus 835 visits = 20,217 annual visits during the peak 9-hour period

4) 20,217 visits in the 9-hour period is the equivalent of 53,912 annual visits

20,217 visits / 9 hours = x visits / 24 hours
x = 53,912 annualized (for purpose only of deriving the number of stations needed for the 9-hour peak)

5) 53,912 visits / 2000 visits per year per room = 27.0 rooms

This methodology concludes that 27 treatment bays or rooms are needed to accommodate the daily 9-hour peak arrival times between 9:00 AM and 6:00 PM. The methodology is conservative. The average hourly arrival for the 9-hour peak period is 2,154 visits. By using a 9-hour time period for the entire year, the methodology calculates a lower need than if need for treatment stations were based solely on the peak hours of 10:00 AM (2,331 annual visits) and 11:00 AM (2,278 annual visits). Using just these two hours would over-estimate the number of treatment stations needed.

(c)(3) Service Modernization – Utilization

As shown in the table in section (c)(2), emergency visits totaled 35,181 in 2022 and 35,584 in 2023. These volumes are an average of 35,382 for the two years. Application of the State standard of 2,000 visits per year per room results in a computed need for 17.7, or 18 treatment stations.

The request for 26 rooms is based on the need to operate effectively during the peak hours, which as stated range from 9:00 AM until 6:00 PM. To accommodate these daily peak hours and not have patients leaving due to unavailable treatment stations, 27 treatment stations are required. The project is planned with 26 treatment rooms.

None of the 12 special rooms themselves meet the requirement of 2,000 visits/room/year. In 2023, the demand for these rooms was as follows:

340 Behavioral health patient visits
37 Sexual Assault patients - average for the past two years
1,096 Patients waiting for transfer to tertiary care. Note: these patients have a length of stay of over 9 hours in the emergency department, more than double the average time for an ED visit. Averaging 3 patients every day, these patients put a stress on ED capacity, especially during the peak volume period.
159 Trauma - head, spine, violent injury and other significant injuries (1 room)

Because none of these specialized rooms meet the volume threshold, the rooms will function not only for these specialized purposes, but also to accommodate volume surges during the daily peak times.

In addition, 4,522 of the 35,584 emergency room visits last year were pediatric patients. The planning of the emergency department will address the special needs of pediatric patients and their families, but will not have dedicated pediatric facilities within the department.

1120.120 AVAILABILITY OF FUNDS

Audited Financial Statements follow in this section as evidence of the financial capability of Anderson Healthcare.

The project will be funded by a combination of cash and securities and borrowing. A letter addressing financing arrangements and a letter of commitment by a lending institution are included in this section following the Audited Financial Statements.

Attachment 34

ANDERSON HEALTHCARE

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2023 AND 2022

CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

Attachment 34

ANDERSON HEALTHCARE
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CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Trustees
Anderson Healthcare
Maryville, Illinois

Report on the Consolidated Financial Statements

Opinion

We have audited the accompanying consolidated financial statements of Anderson Healthcare (the "Organization"), which comprise the consolidated balance sheet as of December 31, 2023, and the related consolidated statements of operations, changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Organization as of December 31, 2023, and the results of their operations, changes in net assets and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

We did not audit the financial statements of Anderson Rehabilitation Institute, LLC, a majority-owned subsidiary, which statements reflect total assets of approximately $26,900,000, as of December 31, 2023, and total revenues of approximately $15,045,000 for the year then ended. Those statements were audited by other auditors, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Anderson Rehabilitation Institute, LLC is based solely on the report of the other auditors.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the *Auditors' Responsibilities for the Audit of the Consolidated Financial Statements* section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Adjustments to Prior Period Financial Statements

The consolidated financial statements of the Organization as of December 31, 2022 were audited by other auditors whose report dated August 16, 2023, expressed an unmodified opinion on those consolidated statements. As more fully described in Note 19, the Organization has restated its consolidated financial statements during the current year to consolidate a majority owned subsidiary, in accordance with accounting principles generally accepted in the United States of America. The other auditors reported on the Organization's consolidated financial statements before the restatement.

As part of our audit of the 2023 consolidated financial statements, we also audited adjustments described in Note 19, that were applied to restate the 2022 consolidated financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review, or apply any procedures to the 2022 consolidated financial statements of the Organization other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2022 consolidated financial statements as a whole.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 8, 2024 on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control over financial reporting and compliance.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating supplementary schedules on pages 35 through 40 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
May 8, 2024

ANDERSON HEALTHCARE
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2023 AND 2022

ASSETS	2023	As Restated 2022
CURRENT ASSETS		
Cash and Cash Equivalents	$ 13,403,335	$ 7,623,929
Short-Term Investments	4,153,796	6,278,517
Patient Accounts Receivable	29,296,731	26,672,496
Current Portion of Assets Limited as to Use	5,209,305	8,343,277
Other Receivables	534,181	419,177
Inventories	3,925,597	3,896,630
Prepaid Expenses	2,799,063	2,154,134
Total Current Assets	59,322,008	55,388,160
ASSETS LIMITED AS TO USE		
Self-Insurance Trust	14,757,050	10,927,794
Restricted by Bond Agreement for Debt Service Reserve	612,886	574,093
Total	15,369,936	11,501,887
Less: Current Portion	(5,209,305)	(8,343,277)
Total Assets Limited as to Use, Net	10,160,631	3,158,610
OTHER ASSETS		
Long-Term Investments	100,845,038	108,953,727
Property and Equipment, Net	136,553,634	142,587,430
Financing Right of Use Assets	1,751,494	2,209,913
Operating Right of Use Assets	18,075,556	20,158,876
Investment in Joint Venture	605,324	535,508
Intangible Assets	5,690,000	5,690,000
Excess Malpractice Insurance Receivable	2,783,199	2,975,364
Total Other Assets	266,304,245	283,110,818
Total Assets	$ 335,786,884	$ 341,657,588

See accompanying Notes to Consolidated Financial Statements.

ANDERSON HEALTHCARE
CONSOLIDATED BALANCE SHEETS (CONTINUED)
DECEMBER 31, 2023 AND 2022

LIABILITIES AND NET ASSETS	2023	As Restated 2022
CURRENT LIABILITIES		
Current Maturities of Long-Term Debt	$ 6,387,827	$ 6,001,427
Current Portion of Long-Term Finance Lease Obligations	388,010	433,263
Current Portion of Long-Term Operating Lease Obligations	1,551,480	1,909,611
Line of Credit	-	914,773
Accounts Payable	10,958,580	12,328,317
Accrued Expenses	16,862,084	14,986,137
Current Portion of Estimated Self-Insurance Costs	4,781,198	4,126,214
Medicare Advance Payments	-	5,380,457
Estimated Third-Party Payor Settlements Payable	10,533,630	11,039,864
Total Current Liabilities	51,462,809	57,120,063
LONG-TERM LIABILITIES		
Long-Term Debt, Less Current Maturities	36,477,255	43,482,340
Financing Long-Term Lease Obligations, Less Current Maturities	1,534,685	1,798,101
Operating Long-Term Lease Obligations, Less Current Portion	16,892,554	18,421,181
Estimated Self-Insurance Costs, Less Current Portion	14,994,857	15,657,786
Total Long-Term Liabilities	69,899,351	79,359,408
Total Liabilities	121,362,160	136,479,471
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Anderson Healthcare	211,228,703	202,552,936
Noncontrolling Interest	3,196,021	2,625,181
Total Net Assets Without Donor Restrictions	214,424,724	205,178,117
Total Liabilities and Net Assets	$ 335,786,884	$ 341,657,588

See accompanying Notes to Consolidated Financial Statements.

ANDERSON HEALTHCARE
CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	As Restated 2022
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT		
Patient Service Revenue	$ 250,286,696	$ 228,320,809
Other Revenue	9,891,888	8,591,980
Total Unrestricted Revenues, Gains, and Other Support	260,178,584	236,912,789
EXPENSES		
Salaries and Wages	114,500,025	105,164,490
Employee Benefits	18,530,166	16,395,037
Purchased Services and Professional Fees	37,558,524	43,501,373
Supplies and Other	83,186,694	75,737,055
Depreciation and Amortization	11,056,948	11,035,331
Interest	1,410,458	1,651,891
Total Expenses	266,242,815	253,485,177
OPERATING LOSS	(6,064,231)	(16,572,388)
OTHER INCOME (LOSS)		
Investment Income	16,027,288	(18,509,440)
Unrestricted Contributions	568,753	410,212
Loss on Sale of Assets	(633,369)	(60,697)
Total Other Income (Loss)	15,962,672	(18,159,925)
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES	9,898,441	(34,732,313)
(Income) Deficit Attributable to Noncontrolling Interest	(715,500)	218,853
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES ATTRIBUTABLE TO ANDERSON HEALTHCARE	$ 9,182,941	$ (34,513,460)

See accompanying Notes to Consolidated Financial Statements.

ANDERSON HEALTHCARE
CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	As Restated 2022
NET ASSETS WITHOUT DONOR RESTRICTIONS		
CHANGE IN NET ASSETS		
Excess (Deficit) of Revenues Over Expenses Attributable to Anderson Healthcare	$ 9,182,941	$ (34,513,460)
Income (Deficit) Attributable to Noncontrolling Interest	715,500	(218,853)
Distribution Attributable to Noncontrolling Interest	(651,834)	-
Contributions from Noncontrolling Interest	-	125,000
Change in Net Assets Without Donor Restrictions	9,246,607	(34,607,313)
Net Assets - Beginning of Year, as Previously Stated	-	232,749,244
Impact of Restatement	-	7,036,186
NetT Assets - Beginning of Year, as Restated	205,178,117	239,785,430
NET ASSETS - END OF YEAR	$ 214,424,724	$ 205,178,117

See accompanying Notes to Consolidated Financial Statements.

ANDERSON HEALTHCARE
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	As Restated 2022
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase (Decrease) in Net Assets	$ 9,246,607	$ (34,607,313)
Adjustments to Reconcile Increase (Decrease) in Net Assets to Net Cash Provided (Used) by Operating Activities:		
Depreciation and Amortization	11,056,948	11,354,021
Unrealized (Gains) Losses on Investments	(7,959,524)	21,710,012
(Income) Loss from Joint Venture Investments	(69,816)	315,233
Loss on Sale of Assets	633,369	63,698
(Contributions) Distributions (from) to Non-Controlling Interest	651,834	(125,000)
(Increase) Decrease in Assets:		
Patient Receivables	(2,624,235)	5,909,040
Other Receivables, Inventories and Prepaid Expenses	(788,900)	1,334,879
Increase (Decrease) in Liabilities:		
Accounts Payable and Accrued Expenses	886,992	2,931,696
Medicare Advance Payments	(5,380,457)	(10,910,996)
Estimated Third-Party Payor Settlements	(506,234)	1,565,252
Net Cash Provided (Used) by Operating Activities	5,146,584	(459,478)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Property and Equipment	(5,721,534)	(12,470,507)
Proceeds from Sale of Property and Equipment	680,298	730,000
Purchase of Noncontrolling Interest	(100,000)	(50,000)
Purchase of Investments	(12,554,604)	(11,638,476)
Proceeds From Disposition of Investments	27,529,115	20,892,319
Net Cash Provided (Used) by Investing Activities	9,833,275	(2,536,664)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds From Borrowings on Long-Term Debt	-	1,100,000
Principal Payments on Finance Lease Obligations	(465,535)	(359,393)
Principal Payments on Bonds and Notes Payable	(6,618,685)	(5,979,340)
Proceeds (Net of Repayments) of Line of Credit	(914,773)	414,773
Contributions (Distributions) from (to) Non-Controlling Interest	(551,834)	125,000
Net Cash Used by Financing Activities	(8,550,827)	(4,698,960)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	6,429,032	(7,695,102)
Cash and Cash Equivalents - Beginning of Year	8,469,270	16,164,372
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 14,898,302	$ 8,469,270

See accompanying Notes to Consolidated Financial Statements.

ANDERSON HEALTHCARE
CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)
YEARS ENDED DECEMBER 31, 2023 AND 2022

	2023	As Restated 2022
RECONCILIATION OF CASH AND CASH EQUIVALENTS		
Cash and Cash Equivalents	$ 13,403,335	$ 7,623,929
Restricted Cash Included in Assets Limited as to Use	1,494,967	845,341
Total Cash and Cash Equivalents	$ 14,898,302	$ 8,469,270
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Operating Lease Obligations Incurred for ROU Assets	$ -	$ 3,586,100
Finance Lease Obligations Incurred for ROU Assets	$ 142,663	$ 1,948,930
Cash Payments for Interest	$ 1,403,734	$ 1,645,346

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Anderson Healthcare (the "Organization") is an Illinois nonprofit corporation and parent company that primarily earns revenues by providing inpatient, outpatient, emergency care, physician and urgent care services to patients in Maryville, Illinois, and surrounding areas.

The Organization is the sole member of the following entities:

- Anderson Hospital (the Hospital), which provides inpatient, outpatient, and emergency care services in Maryville, Illinois, and surrounding areas.
- Anderson Medical Group, LLC (AMG), which is an Illinois limited liability corporation that contracts with various providers to provide primary and specialty care as well as urgent care services in the Organization's service area and provide the related billing for these services.
- Anderson Hospital Foundation (the Anderson Foundation), an Illinois nonprofit corporation. The Anderson Foundation offers such donor opportunities as endowments, planned giving, charitable gift annuities, grants, memorials, bequests, naming rights, annual campaigns, and future capital campaigns.
- Anderson Real Estate, LLC (Anderson Real Estate), an Illinois limited liability corporation that was established for real estate transactions and holdings.
- Maryville Imaging, LLC (Maryville Imaging), an Illinois limited liability corporation, which operates freestanding outpatient diagnostic imaging centers with locations in Maryville, Illinois and Edwardsville, Illinois.
- Community Hospital of Staunton (Staunton Hospital), an Illinois nonprofit corporation that primarily earns revenues by providing inpatient, outpatient and emergency care services to patients in Staunton, Illinois and the immediate surrounding area.
- Staunton Hospital is the sole member of Friends of Community Hospital dba: Friends of Community Hospital of Staunton (the Staunton Foundation), which conducts fundraising activities and manages activity related to contributions.

The Organization is the controlling member of the following entities:

- Anderson Surgery Center, LLC (Anderson Surgery Center), an Illinois limited liability company in which the Organization controls approximately 90% and 83%, respectively, of the membership units as of December 31, 2023 and 2022.
- Anderson Rehabilitation Institute, LLC (Anderson Rehabilitation Institute), an Illinois limited liability company in which the Organization controls approximately 60% of the membership units.

Consolidation

The consolidated financial statements include the accounts of the Hospital, AMG, Maryville Imaging, Anderson Real Estate, Anderson Surgery Center, Anderson Rehabilitation Institute Anderson Foundation, Staunton Hospital and the Staunton Foundation (collectively, the Organization). All significant inter-company accounts and transactions have been eliminated in consolidation.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use.

Investments and Investment Income

Investments in debt and equity securities with readily determinable fair values are measured at fair value on the consolidated balance sheets. Investment income or loss (including realized and unrealized gains and losses on investments, interest and dividends) is included in excess of revenues over expenses unless the income or loss is restricted by donor or law.

Assets Limited as to Use

Assets limited as to use include restricted assets held under self-insurance trust arrangement and amounts reserved for bond agreements. Amounts available to meet current obligations are included in current assets.

Intangible Assets

Intangible assets with indefinite lives are not amortized but reviewed for impairment annually or more frequently if certain indicators arise. There has been no impairment recorded during years ended December 31, 2023 and 2022.

Patient Accounts Receivable and Allowance for Credit Losses

Patient accounts receivable consist of amounts due for the provision of health care services which are recorded in the accompanying consolidated balance sheets at amortized cost at the net amount expected to be collected. In evaluating the collectability of patient accounts receivable, Management regularly reviews data and develops a loss rate to determine expected credit losses based on several factors including whether a patient has third party payor coverage or is uninsured, the aging of receivables, historical collection and loss experience, current contract prices or claims paid data, and trends for each of its major payors sources of revenue. These estimates are adjusted for recoveries and any anticipated changes in trends, including significant changes in payor mix, economic conditions or trends in federal and state governmental health care coverage.

Inventories

Inventories are stated at the lower of cost, determined using the first-in, first-out method, or net realizable value.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment acquisitions over $5,000 are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligation is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements.

Gifts of long-lived assets such as land, buildings or equipment are reported as additions to unrestricted net assets, and are excluded from excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when donated or when acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets

The Organization reviews long-lived assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of carrying amount or the fair value less costs to sell.

Leases

The Organization determines if an arrangement is a lease at inception. Operating and Financing leases are included in Right of Use Assets (ROU) and Long-Term Lease Obligations on the consolidated balance sheet, respectively.

ROU assets represent the Organization's right to use an underlying asset for the lease term and lease liabilities represent the Organization's obligation to make lease payments arising from the lease. ROU assets and liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when it is reasonably certain that the Organization will exercise that option. Lease expense for operating lease payments is recognized on a straight-line basis over the lease term. The Organization has elected to recognize payments for short-term leases with a lease term of 12 months or less as expense as incurred and these leases are not included as lease liabilities or right of use assets on the consolidated balance sheet.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Leases (Continued)

The individual lease contracts do not provide information about the discount rate implicit in the lease. Therefore, the Organization has elected to use an estimation of its incremental borrowing rate determined using a period comparable with that of the lease term for computing the present value of lease liabilities. The Organization has elected not to separate non-lease components from lease components and instead accounts for each separate lease component and the non-lease component as a single lease component.

Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Patient service revenue is reported at the estimated net realizable amount from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Charity Care

The Organization provides care without charge to patients meeting certain criteria under its charity care policy. Because the Organization does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as patient service revenue.

Excess (Deficit) of Revenues Over Expenses

The consolidated statements of operations include excess (deficit) of revenues over expenses. Changes in net assets without donor restrictions which are excluded from excess (deficit) of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets) and related party transactions.

Contributions

Contributions received are recorded as an increase in net assets without donor restrictions or net assets with donor restrictions, depending on the existence or nature of any donor restrictions. Accordingly, net assets of the Organization and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions – Those resources over which the board of directors have discretionary control. Designated amounts represent those revenues that the board have set aside for a particular purpose.

Net Assets With Donor Restrictions – Those resources subject to donor-imposed restrictions that will be satisfied by actions of the Organization or through passage of time.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Contributions (Continued)

The gifts are reported as restricted if they are received with donor stipulations that limit the use of the donated assets. When donor restrictions are satisfied, net assets are released and reported as an increase in net assets without donor restrictions. Donor-restricted contributions whose restrictions are met in the same reporting period as received are recorded as unrestricted contributions.

Income Taxes

The Organization has been recognized as exempt from income taxes under Section 501 of the Internal Revenue Code and a similar provision of state law. However, the Organization is subject to federal income tax on any unrelated business taxable income and taxable income of AMG. The Organization applies the income tax standard for uncertain tax positions. This standard clarifies the accounting for uncertainty in income taxes recognized in an organization's financial statements in accordance with the income tax standard. This standard prescribes recognition and measurement of tax positions taken or expected to be taken on a tax return that are not certain to be realized.

Fair Value Measurement

Fair value measurement applies to reported balances that are required or permitted to be measured at fair value under an existing accounting standard. The Organization emphasizes that fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability and establishes a fair value hierarchy.

The fair value hierarchy consists of three levels of inputs that may be used to measure fair value as follows:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the Organization has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Value Measurement (Continued)

The Organization also adopted the policy of valuing certain financial instruments at fair value. This accounting policy allows entities the irrevocable option to elect fair value for the initial and subsequent measurement for certain financial assets and liabilities on an instrument-by-instrument basis. The Organization has not elected to measure any existing financial instruments at fair value, however, may elect to measure newly acquired financial instruments at fair value in the future.

Available for Sale securities are recorded at fair value on a recurring basis. Fair value measurement is based upon quoted prices, if available. If quoted prices are not available, fair values are measured using independent pricing models or other model-based valuation techniques such as the present value of future cash flows, adjusted for the security's credit rating, prepayment assumptions, and other factors such as credit loss assumptions. Securities valued using Level 1 inputs include those traded on an active exchange, such as the New York Stock Exchange, as well as U.S. Treasury and other U.S. government and agency mortgage-backed securities that are traded by dealers or brokers in active over-the-counter markets. Securities valued using Level 2 inputs include private collateralized mortgage obligations, municipal bonds, and corporate debt securities. The Organization does not have any securities that are valued using Level 3 inputs.

New Accounting Pronouncements – ASU 2016-13

The Organization has adopted ASU 2016-13, *Financial Instruments – Credit Losses* (Topic 326): *Measurement of Credit Losses on Financial Instruments*, as amended, which modifies the measurement of expected credit losses. The Organization adopted this new guidance utilizing the modified retrospective transition method. The adoption of this Standard did not have a material impact on the Organization's consolidated financial statements.

New Accounting Pronouncements – ASU 2020-04

In March 2020, the Financial Accounting Standards Board (FASB) issued ASU No. 2020-04, *Reference Rate Reform*, (Topic 848). This new standard allows an entity to elect optional expedients and exceptions for applying accounting principles generally accepted in the United States of America (U.S. GAAP) to contracts, hedging relationships, and other transactions affected by reference rate reform upon the transition from the use of the London Interbank Offer Rate (LIBOR) to alternative reference rates. This standard provides this temporary election through December 31, 2022 (sunset date).

In December 2022, the Financial Accounting Standards Board (FASB) issued ASU No. 2022-06 to defer the sunset date of *Reference Rare Reform* (Topic 848). This new standard allows an entity to elect not to apply certain modification accounting requirements to contracts affected by reference rate reform as entities transition from LIBOR to alternative reference rates. The standard provides this temporary election through December 31, 2024, and cannot be applied to contract modifications that occur after December 31, 2024.

The Organization adopted the requirements of this guidance effective January 1, 2023 and has elected to apply the provisions of these standards to the beginning of the period of adoption.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

New Accounting Pronouncements – ASU 2020-04 (Continued)

The Organization's Line of Credit have LIBOR as a reference rate and changes the reference rate from LIBOR to the Secured Overnight Financing Rate (SOFRS).

The Organization elected the practical expedient to account for the refunding as if the modification was not substantial (continuation of the current contract) and not as an extinguishment.

These standards did not have an impact on the balance sheets, statement of operations and changes in net deficit nor the statement of cash flows.

Reclassifications

Certain reclassifications have been made to the 2022 consolidated financial statements to conform to the 2023 presentation. The reclassifications had no effect on the changes in net assets.

Subsequent Events

In preparing these financial statements, the Organization has evaluated events and transactions for potential recognition or disclosure through May 8, 2024, the date the consolidated financial statements were available to be issued.

NOTE 2 PATIENT SERVICE REVENUE

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected or actual charges. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services or patients receiving services in outpatient clinics or in their homes (home care).

NOTE 2 PATIENT SERVICE REVENUE (CONTINUED)

The Organization measures the performance obligation from admission into the Organization to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided, and the Organization does not believe it is required to provide additional goods or services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Organization uses a portfolio approach to account for categories of patient contracts as a collective group, rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue. Based on the historical collection trends and other analysis, The Organization believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and/or implicit price concessions provided to uninsured patients. Estimated contractual adjustments and discounts are based on contractual agreements, its discount policy (or policies), and historical experience. Estimated implicit price concessions are based on its historical collection experience with this class of patients. The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare

The Hospital is paid at prospectively determined rates per discharge for inpatient acute care services and substantially all outpatient services rendered to Medicare program beneficiaries. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. The Hospital is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare administrative contractor. The Hospital's Medicare cost reports have been audited by the Medicare administrative contractor through December 31, 2019.

NOTE 2 PATIENT SERVICE REVENUE (CONTINUED)

Staunton Hospital is designated as a critical access hospital. This designation provides for inpatient and outpatient services to be reimbursed on a cost-based methodology. Staunton Hospital is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by Staunton Hospital and audits thereof by the Medicare administrative contractor. Staunton Hospital's Medicare cost reports have been audited by the Medicare administrative contractor through December 31, 2020.

Medicaid

Inpatient and substantially all outpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates. The state of Illinois has legislation that provides for a hospital assessment program intended to qualify for federal matching funds under the Illinois Medicaid program.

Under the assessment plan the Hospital received approximately $16.9M and $14.5M in payments and paid assessments of approximately $9.9M and $7.9M for the years ended December 31, 2023 and 2022, respectively. The programs are subject to future modification through legislative action, specifically related to Medicaid reform initiatives.

Other

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Uninsured

For uninsured patients that do not qualify for charity care, the Organization recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, an increased portion of the Organization's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for bad debts related to uninsured patients in the period the services are provided.

There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims, or penalties would have upon the Organization. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

NOTE 2 PATIENT SERVICE REVENUE (CONTINUED)

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved.

Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions.

The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Adjustments arising from a change in the transaction price were not significant for the years ended December 31, 2023 and 2022.

The Organization provides care to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balance (for example, copays, and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount the Organization expects to collect based on its collection history with those patients.

Patients who meet the Organization's criteria for charity care are provided care without charge. Such amounts determined to qualify as charity care are not reported as revenue. The Organization has determined the nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of patient's service/episode of care
- Geography of the service location
- Method of reimbursement (fee for service or capitation)
- The Organization's line of business that provided the service (for example, inpatient, outpatient, clinic, etc.)

NOTE 2 PATIENT SERVICE REVENUE (CONTINUED)

For the years ended December 31, 2023 and 2022, all of the patient service revenue recognized by the Organization was from goods and services that transfer to the customer over time.

The opening and closing contract balances were as follows:

	Patient Accounts Receivable
Balance as of January 1, 2022	$ 31,519,454
Balance as of December 31, 2022	26,672,496
Balance as of December 31, 2023	$ 29,296,731

NOTE 3 LIQUIDITY

As of December 31, 2023 and 2022, the Organization had working capital (deficit) of approximately $7,860,000 and ($1,732,000), respectively. Average days (based on normal expenditures) cash on hand at December 31, 2023 and 2022, is 169 and 185, respectively.

Financial assets available for general expenditure within one year of the consolidated balance sheet date, consist of the following:

	2023	2022
Cash and Cash Equivalents	$ 13,403,335	$ 7,623,929
Short-Term Investments	4,153,796	6,278,517
Patient Accounts Receivable, Net	29,296,731	26,672,496
Other Receivables	534,181	419,177
Total	$ 47,388,043	$ 40,994,119

NOTE 4 INVESTMENTS AND INVESTMENT INCOME

Assets Limited as to Use

The composition of assets limited as to use at December 31 is shown in the following table:

	2023	2022
Held by Trustee Under Self-Insurance Trust		
Cash Equivalents	$ 882,081	$ 271,248
Fixed Income Securities:		
Corporate Bonds	3,303,389	2,570,842
U.S. Government Agencies	2,953,112	92,400
U.S. Treasury Notes	93,588	2,565,621
Fixed Income Mutual Funds	253,460	704,520
Equity:		
Mutual Funds		
Small Cap	418,811	319,099
Mid Cap	360,295	2,924,603
Large Cap	4,289,330	338,287
International	2,140,314	1,093,547
Interest Receivable	62,670	47,627
	14,757,050	10,927,794
Restricted by Bond Agreement for Debt Service Reserve		
Cash Equivalents	612,886	574,093
Less: Current Portion of Assets Limited as to Use	(5,209,305)	(8,343,277)
Total Assets Limited as to Use, Less Current	$ 10,160,631	$ 3,158,610

Investments

The composition of investments as to use at December 31 is shown in the following table:

	2023	2022
Cash Equivalents	$ 3,855,008	$ 6,009,439
Fixed Income Securities:		
Corporate Bonds	17,278,415	15,827,644
U.S. Treasury Notes	13,104,067	20,191,287
U.S. Government Agencies	1,167,148	749,222
Fixed Income Mutual Funds	4,852,577	5,384,860
Equity Securities:		
Common Stock	2,853,119	2,413,341
Mutual Funds		
Small Cap	5,376,690	4,715,859
Mid Cap	5,287,120	8,124,586
Large Cap	27,127,155	33,622,234
International	20,673,664	14,881,907
Other	3,125,082	3,042,786
Interest Receivable	298,789	269,079
Total Investments	104,998,834	115,232,244
Less: Short-Term Investments	(4,153,796)	(6,278,517)
Total Investments, Less Short-Term	$ 100,845,038	$ 108,953,727

NOTE 4 INVESTMENTS AND INVESTMENT INCOME (CONTINUED)

Investment Income

Investment returns and losses on assets limited as to use, cash and cash equivalents, and other investments are comprised of the following for the years ended December 31:

	2023	2022
Investment Income:		
Interest and Dividend Income	$ 3,319,573	$ 3,048,271
Realized Gains on Investments	4,748,191	1,573,997
Change in Unrealized Position on Investments	7,959,524	(23,131,708)
Total Investment Return (Loss)	$ 16,027,288	$ (18,509,440)

Unrealized Losses

Certain investments in debt securities are reported in the consolidated financial statements at an amount less than their historical cost. The following table shows the Organization's debt investments, gross unrealized losses, and fair value, aggregated by investment category and that individual securities have been in a continuous unrealized loss position at December 31:

	2023		2022	
	Fair Value	Unrealized Loss	Fair Value	Unrealized Loss
US Treasury and Agencies	$ 13,651,740	$ 1,279,658	$ 22,756,907	$ 1,442,831
Corporate Bonds	21,346,248	2,090,425	18,270,383	2,226,886
Total	$ 34,997,988	$ 3,370,083	$ 41,027,290	$ 3,669,717

Based on evaluation of available evidence including credit rating information and information obtained from regulatory filings, management believes the declines in fair value for these securities are temporary. Should the impairment of any of these securities become other than temporary, the cost basis of the investment will be reduced, and the resulting loss recognized in the period the other-than-temporary impairment is identified.

Risk and Uncertainties

The Organization provides for investments in a variety of investment funds. In general, investments are exposed to various risks, such as interest rate, credit, and overall market volatility risk. Due to the level of risk associated with certain investments, it is reasonably possible that changes in the values of the investments will occur in the near term and that such changes could materially affect the investment balances and the amounts reported in the consolidated balance sheets.

NOTE 5 FAIR VALUE MEASUREMENTS

The Organization uses fair value measurements to record fair value adjustments to certain assets and liabilities and to determine fair value disclosures. For additional information on how the Organization measures fair value, refer to Note 1 – Summary of Significant Accounting Policies.

The following tables present the fair value hierarchy for the balances of the assets of the Organization measured at fair value on a recurring basis as of December 31:

	2023			
	Level 1	Level 2	Level 3	Total
Fixed Income Securities:				
Corporate Bonds	$ -	$ 20,581,804	$ -	$ 20,581,804
U.S. Treasury Notes	-	13,197,655	-	13,197,655
U.S. Government Agencies	-	4,120,260	-	4,120,260
Fixed Income Mutual Funds	-	5,106,037	-	5,106,037
Equity Securities:				
Common Stock	2,853,119	-	-	2,853,119
Mutual Funds				
Small Cap	5,795,501	-	-	5,795,501
Mid Cap	5,647,415	-	-	5,647,415
Large Cap	31,416,485	-	-	31,416,485
International	22,813,978	-	-	22,813,978
Other	3,125,082	-	-	3,125,082
Total	$ 71,651,580	$ 43,005,756	$ -	$ 114,657,336

	2022			
	Level 1	Level 2	Level 3	Total
Fixed Income Securities:				
Corporate Bonds	$ -	$ 18,398,486	$ -	$ 18,398,486
U.S. Treasury Notes	-	22,756,908	-	22,756,908
U.S. Government Agencies	-	841,622	-	841,622
Fixed Income Mutual Funds	-	6,089,380	-	6,089,380
Equity Securities:				
Common Stock	2,413,341	-	-	2,413,341
Mutual Funds				
Small Cap	5,034,958	-	-	5,034,958
Mid Cap	11,049,189	-	-	11,049,189
Large Cap	33,960,521	-	-	33,960,521
International	15,975,454	-	-	15,975,454
Other	3,042,786	-	-	3,042,786
Total	$ 71,476,249	$ 48,086,396	$ -	$ 119,562,645

The estimated fair values of financial instruments have been derived, in part, by management's assumptions, the estimated amount and timing of future cash flows, and estimated discount rates. Different assumptions could significantly affect these estimated fair values. Accordingly, the net realizable value could be materially different from the estimates presented below. In addition, the estimates are only indicative of the value of individual financial instruments and should not be considered an indication of the fair value of the Organization.

NOTE 6 PROPERTY AND EQUIPMENT

A summary of property and equipment at December 31 is as follows:

	2023	2022
Land and Land Improvements	$ 9,470,428	$ 11,832,236
Buildings and Improvements	174,586,772	172,520,376
Fixed and Movable Equipment	68,047,960	65,909,039
Construction in Progress	779,976	1,973,008
Total	252,885,136	252,234,659
Less: Accumulated Depreciation	(116,331,502)	(109,647,229)
Net Property and Equipment	$ 136,553,634	$ 142,587,430

NOTE 7 JOINT VENTURE INVESTMENT

The Organization previously entered into a partnership with Mercy Health East Communities (Mercy) (collectively the Members) to form Maryville Cancer Center, LLC (the Cancer Center). Control of this joint venture is shared evenly between its two members. The investment in the Cancer Center is recorded under the equity method of accounting. The Organization would be entitled to 50% of the Cancer Center equity upon dissolution of the Cancer Center and has recorded an investment of $605,324 and $535,508 as of December 31, 2023 and 2022, respectively, within the accompanying consolidated balance sheets.

A summary of certain estimated financial data for the Organization's joint venture investment under the equity method of accounting as of and for the years ended December 31 is as follows:

	2023	2022
Total Assets	$ 2,749,284	$ 1,976,691
Total Liabilities	$ 1,538,636	$ 785,677
Net Assets	$ 1,210,648	$ 1,191,014
Operating Revenue	$ 14,852,868	$ 11,892,677
Operating Expense	14,905,748	12,523,143
Deficit of Revenue Over Expenses	$ (52,880)	$ (630,466)

NOTE 8 LINE OF CREDIT

On October 11, 2021, Anderson Rehabilitation Institute entered into a variable rate revolving line of credit agreement with an affiliate of the noncontrolling partner of the company, with available credit of $1,500,000, which had an original maturity date of October 21, 2022. During 2022, the parties agreed to extend the maturity date to October 21, 2023. The line of credit bears interest payable monthly at an annual variable rate equal to the one-month LIBOR rate plus 3.00%. The line of credit matured and was repaid in October 2023. The line of credit had an outstanding balance of $0 and $914,773 at December 31, 2023 and 2022, respectively.

NOTE 9 LONG-TERM DEBT

A summary of long-term debt at December 31 is as follows:

Description	2023	2022
Series 2016 Revenue Bonds	$ 18,760,950	$ 21,746,585
Series 2019 Revenue Bonds	8,736,813	10,220,111
USDA Promissory Note	7,145,103	7,273,693
Anderson Real Estate, Notes Payable	5,228,744	6,778,402
Anderson Surgery Center, Notes Payable	3,410,888	3,943,513
Total Long-Term Debt	43,282,498	49,962,304
Less: Unamortized Debt Issuance Costs	(417,416)	(478,537)
Less: Current Maturities of Long-Term Debt	(6,387,827)	(6,001,427)
Long-Term Debt, Net of Current Maturities	$ 36,477,255	$ 43,482,340

Series 2016 Revenue Bonds

The Series 2016 Revenue Bonds consist of four series of bonds in the aggregate principal amount of $21,746,586 designated as Revenue Bond, Series 2016 A, Revenue Bond, Series 2016 B, Revenue Bond, Series 2016 C and Revenue Bond, Series 2016 D. The Bonds bear interest at various rates of 2.38% to 3.12% and are payable in monthly installments. The bonds mature at various dates from 2027 to 2036.

The 2016 Revenue Bonds are secured by the unrestricted receivables, unrestricted gross revenues, and any other property securing other long-term debt for which the Hospital is obligated. The indenture agreement also requires the Hospital to comply with certain restrictive covenants including minimum insurance coverage, maintaining a historical debt service coverage ratio of at least 1.20 to 1.00, maintaining a debt to capitalization ratio of not greater than 66%, and restrictions on the incurrence of additional debt. Management is not aware of any non-compliance with these requirements as of December 31, 2023.

The Organization incurred financing costs in connection with the issuance of the Series 2016 Bonds in the amount of $582,656. Issuance costs are included net of accumulated amortization of $289,742 and $251,606 on the consolidated balance sheets at December 31, 2023 and 2022, respectively. Amortization for the years ended December 31, 2023 and 2022 was $38,136 and $38,137, respectively. The deferred costs are being amortized over the life of the related bonds using the effective interest method.

NOTE 9 LONG-TERM DEBT (CONTINUED)

Series 2019 Revenue Bonds

Series 2019 Revenue Bonds consist of Southwestern Illinois Development Authority Health Facilities Revenue Bonds in the original amount of $15,229,849, dated May 30, 2019, which bear interest at 2.59% commencing July 1, 2019, payable in monthly installments through June 1, 2029.

The 2019 Revenue Bonds are secured by certain property and equipment. The bond agreement also requires the Hospital to comply with certain restrictive covenants including maintaining a historical debt-service coverage ratio of at least 1.10 to 1.00. Management is not aware of any non-compliance with these requirements as of December 31, 2023.

The Organization incurred financing costs in connection with the issuance of the Series 2019 Bonds in the amount of $229,849. Issuance costs are included net of accumulated amortization of $105,347 and $82,362 on the consolidated balance sheets at December 31, 2023 and 2022, respectively. Amortization for the years ended December 31, 2023 and 2022 was $22,985 and $22,985, respectively. The deferred costs are being amortized over the life of the related bonds using the effective interest method.

USDA Promissory Note

USDA promissory note dated July 10, 2014, in the amount of $8,000,000; monthly installments of $31,760 including interest at 3.5% through July 2054; the note is secured by the net revenues of Staunton Hospital and a USDA reserve account which is funded $3,179 monthly with a maximum funding of $381,120, of which $317,943 and $$278,900 has been funded at December 31, 2023 and 2022, respectively.

Anderson Real Estate, Notes Payable

Anderson Real Estate has several notes payable to a bank which are secured by the associated real estate. The notes bear interest at rates from 2.75% to 2.99% and are due at various dates from December 27, 2027 to March 6, 2028, payable in monthly amounts totaling approximately $110,000.

Future Maturities

Scheduled principal repayments on long-term debt are as follows:

Year Ending December 31,	Revenue Bonds Payable	Notes Payable	Total Long-Term Debt
2024	$ 4,582,940	$ 1,804,887	$ 6,387,827
2025	4,707,362	1,862,490	6,569,852
2026	4,833,874	1,921,143	6,755,017
2027	3,435,498	1,981,691	5,417,189
2028	3,427,513	1,054,288	4,481,801
Thereafter	6,510,576	7,160,236	13,670,812
Total	$ 27,497,763	$ 15,784,735	$ 43,282,498

NOTE 10 LONG-TERM LEASE OBLIGATIONS

The Organization leases real property, equipment as well as certain office facilities for various terms under long-term, non-cancelable lease agreements. The leases expire at various dates through 2031 and provide for various renewal options. In the normal course of business, it is expected that these leases will be renewed or replaced by similar leases. Various equipment and office leases provide for increases in future minimum annual rental payments based on defined increases in the Consumer Price Index, subject to certain minimum increases.

The following table provides quantitative information concerning the Organization's leases for the years ended December 31:

Lease Cost:	2023	2022
Finance Lease Cost:		
Amortization of Right-of-Use Assets	$ 472,622	$ 363,533
Interest on Lease Liabilities	65,420	38,359
Operating Lease Cost	3,297,328	3,975,259
Total	$ 3,835,370	$ 4,377,151
Other Information:		
Cash Paid for Amounts Included in the Measurement of Lease Liabilities		
Operating Cash Flows from Financing Leases	$ 65,420	$ 38,359
Operating Cash Flows from Operating Leases	3,297,328	3,975,259
Financing Cash Flows from Financing Leases	465,535	359,393
Right-of-Use Assets Obtained in Exchange for New Financing Lease Liabilities	142,663	1,948,930
Right-of-Use Assets Obtained in Exchange for New Operating Lease Liabilities	-	3,586,100
Weighted-Average Years Remaining Lease Term:		
Financing Leases	5.09	5.86
Operating Leases	11.61	12.56
Weighted-Average Discount Rate:		
Financing Leases	3.11%	3.17%
Operating Leases	6.22%	6.22%

NOTE 10 LONG-TERM LEASE OBLIGATIONS (CONTINUED)

A maturity analysis of annual undiscounted cash flows for lease liabilities as of December 31, 2023, is as follows:

Year Ending December 31,	Financing Leases	Operating Leases
2024	$ 469,104	$ 2,630,398
2025	411,523	2,529,976
2026	358,689	2,526,711
2027	340,729	1,885,940
2028	323,283	1,813,056
Thereafter	181,314	14,880,671
Total Future Undiscounted Lease Payments	2,084,642	26,266,752
Less: Interest	(161,947)	(7,822,718)
Total	$ 1,922,695	$ 18,444,034

NOTE 11 SELF-FUNDED HEALTH INSURANCE

Substantially all of the Organization's employees are eligible to participate in the Organization's health insurance plan. The Organization is self-insured for health claims of participating employees and dependents up to limits provided for in an agreement with its insurance Plan Administrator. The Organization has purchased insurance that limits its exposure for individual claims and that limits its aggregate exposure to $10,000,000. A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. At December 31, 2023 and 2022, the Organization has estimated an accrual of approximately $913,300 and $917,500, respectively, for incurred but unreported claims included in accrued expenses on the accompanying consolidated balance sheets. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Organization's estimate will change by a material amount in the near term.

NOTE 12 RISK MANAGEMENT AND PROFESSIONAL LIABILITY CLAIMS

The Organization is self-insured for the first $6,000,000 per occurrence with no aggregate limit of medical malpractice risks per claim year. The Organization purchases commercial insurance coverage above the self-insurance limits which covers an additional $15,000,000 of aggregate claims per year. The Hospital's reserves for professional liability claims were approximately $19,769,000 and $19,784,000 at December 31, 2023 and 2022, respectively. The current portion of the reserves were approximately $4,781,000 and $4,126,000 at December 31, 2023 and 2022, respectively. The Hospital's professional liability risks, in excess of certain per claim and aggregate deductible amounts, are insured through unrelated commercial insurance carriers. The total amounts receivable under these insurance contracts are approximately $2,501,000 and $2,577,000 and are included in Excess Malpractice Insurance Receivable at December 31, 2023 and 2022, respectively.

NOTE 12 RISK MANAGEMENT AND PROFESSIONAL LIABILITY CLAIMS (CONTINUED)

Prior to 2020, AMG purchased medical malpractice insurance with a claim limit of $1,000,000 per occurrence and $3,000,000 in aggregate per physician and a total aggregate of $20,000,000 of medical malpractice claims per year. AMG reports the liability for claims outstanding for this timeframe and a corresponding receivable. The amounts outstanding for these insured claims are $11,400 and $19,500 and are included in reserves for professional liability and Excess Malpractice Insurance Receivable at December 31, 2023 and 2022, respectively.

Beginning in 2020, AMG came into Anderson Hospital's self-insured professional liability program on a first dollar basis at limits of $1,000,000 per occurrence and $3,000,000 in aggregate per physician with no aggregate limit. There is no insurance purchased above AMG's retention limits. AMG reserves for professional liability claims under this program were approximately $2,224,508 and $2,029,085 at December 31, 2023 and 2022, respectively.

The Organization's provision for losses related to professional liability risks are presented net of expected insurance recoveries in the consolidated statements of operations and was approximately $1,509,000 and $2,924,000 for the years ended December 31, 2023 and 2022, respectively. Professional liability reserve estimates represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserve for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The time period required to resolve these claims can vary depending upon whether the claim is settled or litigated. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in professional liability reserve estimates, we believe the reserves for losses and loss expenses are adequate based on information currently known. It is reasonably possible that this estimate could change materially in the near term.

Staunton Hospital has joined together with other providers of health care services to form the Illinois Provider Trust and the Illinois Compensation Trust, two risk pools currently operating as common risk management and insurance programs for their members. Staunton Hospital pays annual premiums to the pools for its general liability torts, medical malpractice and employee injuries insurance coverage. The pools' governing agreements specify that the pools will be self-sustaining through member premiums and will reinsure through commercial carriers for claims in excess of specified stop-loss amounts.

NOTE 12 RISK MANAGEMENT AND PROFESSIONAL LIABILITY CLAIMS (CONTINUED)

Staunton Hospital purchases medical malpractice insurance as described above on a claims made, fixed premium basis. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate cost of the incidents. Based upon Staunton's experience, an accrual has been made for Staunton Hospital's estimated medical malpractice costs, including costs associated with litigating or settling claims, under its malpractice insurance policy, amounting to approximately $7,000 and $57,000 as of December 31, 2023 and 2022, respectively, and are included within accrued expenses in the consolidated balance sheet. It is reasonably possible that this estimate could change materially in the near term.

NOTE 13 DEFINED CONTRIBUTION PENSION PLANS

401(k) and 403(b) Plans

The Organization has a defined contribution 401(k) and 403(b) pension plan covering substantially all employees. The board of trustees annually determines the amount, if any, of the Organization's contributions to the Organization Plan. Pension expense was approximately $1,691,000 and $1,779,000 for the years ended December 31, 2023 and 2022, respectively.

NOTE 14 CHARITY CARE

The Organization provides care without charge, or at amounts less than its established rates, to patients meeting certain criteria under its charity care policy. Because the Organization does not pursue collections of amounts determined to qualify as charity care, these amounts are not reported as patient care service revenue. The Organization's direct and indirect costs for services furnished under its charity care policy aggregated approximately $1,187,000 and $1,456,000 for the years ended December 31, 2023 and 2022, respectively. The costs of charity care provided is determined by computing a ratio of allowable costs to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients.

NOTE 15 SIGNIFICANT CONCENTRATIONS AND CREDIT RISK

Patient Receivables

The Organization grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31 is as follows:

	2023	2022
Medicare	34.0 %	33.0 %
Medicaid	13.0	13.0
Other Third-Party Payors and Patients	53.0	54.0
Total	100.0 %	100.0 %

FDIC Coverage

The Organization maintains cash balances at several financial institutions. Federal Deposit Insurance Corporation (FDIC) insurance coverage is $250,000 for all accounts at a financial instruction. At times, cash balances may have been in excess of insured limits.

NOTE 16 FUNCTIONAL EXPENSES

The Organization provides health care services to residents within its geographic location. Expenses related to providing these services by functional class for the years ended December 31 are as follows:

	2023				
	Services	Support	Real Estate	Foundation	Total
Salaries and Wages	$ 98,763,133	$ 15,648,219	$ -	$ 88,673	$ 114,500,025
Employee Benefits	13,686,052	4,822,818	-	21,296	18,530,166
Purchased Services and Professional Fees	26,861,869	10,259,155	407,236	30,264	37,558,524
Supplies and Other	49,839,490	31,263,721	1,905,770	177,713	83,186,694
Depreciation and Amortization	7,530,966	2,704,357	819,301	2,324	11,056,948
Interest	63,438	1,149,341	197,679	-	1,410,458
Total	$ 196,744,948	$ 65,847,611	$ 3,329,986	$ 320,270	$ 266,242,815

	2022				
	Services	Support	Real Estate	Foundation	Total
Salaries and Wages	$ 90,619,066	$ 14,357,858	$ -	$ 187,566	$ 105,164,490
Employee Benefits	12,088,539	4,259,872	-	46,626	16,395,037
Purchased Services and Professional Fees	31,187,260	11,906,244	368,119	39,750	43,501,373
Supplies and Other	45,530,476	28,567,163	1,333,100	306,316	75,737,055
Depreciation and Amortization	7,570,487	2,718,549	738,687	7,608	11,035,331
Interest	88,561	1,363,265	200,065	-	1,651,891
Total	$ 187,084,389	$ 63,172,951	$ 2,639,971	$ 587,866	$ 253,485,177

NOTE 17 COMMITMENTS AND CONTINGENCIES

Risk Management

The Organization is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions, injuries to employees; and natural disasters. These risks are covered by commercial insurance purchased from independent third parties. This coverage has not changed significantly from the previous year. Settled claims from these risks have not exceeded commercial insurance coverage for the past five years.

Health Care Legislation and Regulation

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violation of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Organization is in substantial compliance with fraud and abuse as well as other applicable government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations is subject to government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Litigation

The Organization is involved in various legal actions in the normal course of business. The actions are in various stages of processing, and some may ultimately be brought to trial. In the opinion of management, adequate provision has been made for amounts expected to be paid under the policy's deductible limits for unasserted claims not covered by the policy and any other uninsured liability.

NOTE 18 MEDICARE ACCELERATED AND ADVANCE PAYMENT PROGRAM

As a result of the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) expanded the current Accelerated and Advance Payment Program to a broader group of Medicare Part A and B providers. Providers who submit a request to the appropriate Medicare Administrative Contractor (MAC) and meet the required qualifications can receive up to six months of Medicare payments in advance of the services being performed.

The Organization received accelerated payments in April 2020 in the amount of approximately $18,710,000. During the years ended December 31, 2023 and 2022, Medicare has applied approximately $5,381,000 and $10,911,000, respectively, of accelerated Medicare payment requests against filed claims. The remaining balance was $-0- and $5,380,457, as of December 31, 2023 and 2022, respectively.

NOTE 19 RESTATEMENT TO PRIOR PERIOD FINANCIAL STATEMENTS

During the year ended December 31, 2023 the Organization revised the consolidated financial statements for the year ended December 31, 2022 to correct an error in reporting the consolidation of Anderson Rehab Institute. The predecessor auditors reported on the December 31, 2022 consolidated financial statements prior to the revision to the estimated reporting change. This revision was applied to the consolidated financial statements for the year ended December 31, 2022, as reflected in the December 31, 2022 consolidated statements as follows:

	As Previously Reported	Retroactive Adjustments	As Restated
Consolidated Balance Sheet:			
Current Assets	$ 38,191,569	$ 2,574,797	$ 40,766,366
Other Assets	144,794,382	24,177,432	168,971,814
Total Assets	$ 182,985,951	$ 26,752,229	$ 209,738,180
Current Liabilities	26,795,968	3,342,870	30,138,838
Long-Term Liabilities	2,551,300	15,869,881	18,421,181
Total Liabilities	$ 29,347,268	$ 19,212,751	$ 48,560,019
Net Assets Without Donor Restrictions			
Anderson Healthcare	198,073,249	4,479,687	202,552,936
Noncontrolling Interest	(434,610)	3,059,791	2,625,181
Total Net Assets Without Donor Restrictions	$ 197,638,639	$ 7,539,478	$ 205,178,117
Consolidated Statements of Operations:			
Total Unrestricted Revenues, Gains, and Other Support	$ 226,099,596	$ 10,813,193	$ 236,912,789
Total Expenses	242,937,414	10,547,763	253,485,177
Operating Loss	(16,837,818)	265,430	(16,572,388)
Total Other Income (Loss)	(18,397,787)	237,862	(18,159,925)
Deficit of Revenue Over Expenses	(35,235,605)	503,292	(34,732,313)
(Income) Deficit Attributable to Noncontrolling Interest	420,170	(201,317)	218,853
Deficit of Revenue Over Expenses Attributable to Anderson	$ (34,815,435)	$ 301,975	$ (34,513,460)

Attachment 34

ANDERSON HEALTHCARE
CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

ASSETS	Anderson Hospital	Anderson Medical Group, LLC	Maryville Imaging, LLC	Anderson Real Estate, LLC	Anderson Surgery Center, LLC
CURRENT ASSETS					
Cash and Cash Equivalents	$ 4,330,790	$ 915,941	$ 538,435	$ 248,565	$ 1,166,113
Short-Term Investments	3,180,459	-	-	-	-
Patient Accounts Receivable	21,590,018	2,426,644	507,126	-	185,005
Due From Related Parties	3,504,154	-	-	-	-
Current Portion of Assets Limited as to Use	5,209,305	-	-	-	-
Other Receivables	1,113,375	243	-	306,378	-
Inventories	3,582,989	-	6,948	-	-
Prepaid Expenses	2,258,438	14,559	94,395	144,791	38,228
Total Current Assets	44,769,528	3,357,387	1,146,904	699,734	1,389,346
ASSETS LIMITED AS TO USE					
Self-Insurance Trust	14,461,403	295,647	-	-	-
Restricted by Bond Agreement for Debt Service Reserve	294,943	-	-	-	-
Total	14,756,346	295,647	-	-	-
Less: Current Portion	(5,209,305)	-	-	-	-
Total Assets Limited as to Use, Net	9,547,041	295,647	-	-	-
OTHER ASSETS					
Long-Term Investments	81,804,542	-	-	-	-
Property and Equipment, Net	78,472,102	1,351,301	623,375	32,689,345	1,468,851
Financing Right of Use Assets	4,420	-	1,550,305	-	34,298
Operating Right of Use Assets	1,731,613	(8,902)	685,342	115,208	28,829
Investment in Joint Venture	32,806,768	-	-	-	-
Investment in Subsidiary	-	-	-	-	-
Intangible Assets	-	-	-	-	-
Excess Malpractice Insurance Receivable	2,501,000	282,199	-	-	-
Total Other Assets	197,320,445	1,624,598	2,859,022	32,804,553	1,531,978
Total Assets	$ 251,637,014	$ 5,277,632	$ 4,005,926	$ 33,504,287	$ 2,921,324

ANDERSON HEALTHCARE
CONSOLIDATING BALANCE SHEET (CONTINUED)
DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

Anderson Hospital Foundation	Anderson Healthcare	Community Hospital of Staunton	Friends of Community Hospital of Staunton	Anderson Rehabilitation Institute, LLC	Eliminations	Consolidated
$ 173,013	$ 133,147	$ 4,248,219	$ 140,907	$ 1,508,205	$ -	$ 13,403,335
271,440	-	646,410	55,487	-	-	4,153,796
-	-	2,676,800	-	1,911,138	-	29,296,731
-	-	-	-	-	(3,504,154)	-
-	-	-	-	-	-	5,209,305
-	-	14,364	-	17,572	(917,751)	534,181
-	-	286,741	-	48,919	-	3,925,597
-	-	140,955	-	107,697	-	2,799,063
444,453	133,147	8,013,489	196,394	3,593,531	(4,421,905)	59,322,008
-	-	-	-	-	-	14,757,050
-	-	317,943	-	-	-	612,886
-	-	317,943	-	-	-	15,369,936
-	-	-	-	-	-	(5,209,305)
-	-	317,943	-	-	-	10,160,631
7,903,223	-	10,792,220	345,053	-	-	100,845,038
-	-	19,861,501	-	2,087,159	-	136,553,634
-	-	162,471	-	-	-	1,751,494
-	-	-	-	15,523,466	-	18,075,556
-	-	-	-	-	(32,201,444)	605,324
-	247,714,236	-	-	-	(247,714,236)	-
-	-	-	-	5,690,000	-	5,690,000
-	-	-	-	-	-	2,783,199
7,903,223	247,714,236	30,816,192	345,053	23,300,625	(279,915,680)	266,304,245
$ 8,347,676	$ 247,847,383	$ 39,147,624	$ 541,447	$ 26,894,156	$ (284,337,585)	$ 335,786,884

ANDERSON HEALTHCARE
CONSOLIDATING BALANCE SHEET (CONTINUED)
DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

LIABILITIES AND NET ASSETS	Anderson Hospital	Anderson Medical Group, LLC	Maryville Imaging, LLC	Anderson Real Estate, LLC	Anderson Surgery Center, LLC
CURRENT LIABILITIES					
Current Maturities of Long-Term Debt	$ 4,582,940	$ -	$ -	$ 1,061,526	$ 610,197
Current Portion of Long-Term Finance Lease Obligations	4,561	-	263,203	-	41,635
Current Portion of Long-Term Operating Lease Obligations	563,391	-	197,875	124,834	-
Accounts Payable	8,266,265	695,377	131,721	100,487	64,720
Accrued Expenses	9,213,228	4,619,743	161,266	-	102,279
Current Portion of Estimated Self-Insurance Costs	4,781,198	-	-	-	-
Medicare Advance Payments	-	-	-	-	-
Due From Related Parties	-	2,365,864	77,940	612,239	272,378
Estimated Third-Party Payor Settlements Payable	9,924,181	-	-	-	-
Total Current Liabilities	37,335,764	7,680,984	832,005	1,899,086	1,091,209
LONG-TERM LIABILITIES					
Long-Term Debt, Less Current Maturities	22,497,407	-	-	4,167,218	2,800,691
Financing Long-Term Lease Obligations, Less Current Portion	211	-	1,321,917	-	127,039
Operating Long-Term Lease Obligations, Less Current Portion	1,175,783	(1)	487,467	(1)	24,806
Estimated Self-Insurance Costs, Less Current Portion	14,987,802	-	-	-	-
Total Long-Term Liabilities	38,661,203	(1)	1,809,384	4,167,217	2,952,536
Total Liabilities	75,996,967	7,680,983	2,641,389	6,066,303	4,043,745
NET ASSETS					
Net Assets Without Donor Restrictions:					
Anderson Healthcare	175,640,047	(2,403,351)	1,364,537	27,437,984	(1,014,669)
Noncontrolling Interest	-	-	-	-	(107,752)
Total Net Assets	175,640,047	(2,403,351)	1,364,537	27,437,984	(1,122,421)
Total Liabilities and Net Assets	$ 251,637,014	$ 5,277,632	$ 4,005,926	$ 33,504,287	$ 2,921,324

Attachment 34

ANDERSON HEALTHCARE
CONSOLIDATING BALANCE SHEET (CONTINUED)
DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

Anderson Hospital Foundation	Anderson Healthcare	Community Hospital of Staunton	Friends of Community Hospital of Staunton	Anderson Rehabilitation Institute, LLC	Eliminations	Consolidated
$ -	$ -	$ 133,164	$ -	$ -	$ -	$ 6,387,827
-	-	78,611	-	-	-	388,010
-	-	-	-	665,380	-	1,551,480
22,011	2,371	633,250	-	1,960,129	(917,751)	10,958,580
-	1,173,709	787,145	-	804,714	-	16,862,084
-	-	-	-	-	-	4,781,198
-	-	-	-	-	-	-
44,055	45,135	86,543	-	-	(3,504,154)	-
-	-	609,449	-	-	-	10,533,630
66,066	1,221,215	2,328,162	-	3,430,223	(4,421,905)	51,462,809
-	-	7,011,939	-	-	-	36,477,255
-	-	85,518	-	-	-	1,534,685
-	-	-	-	15,204,500	-	16,892,554
-	-	7,055	-	-	-	14,994,857
-	-	7,104,512	-	15,204,500	-	69,899,351
66,066	1,221,215	9,432,674	-	18,634,723	(4,421,905)	121,362,160
8,281,610	246,626,168	29,714,950	541,447	4,955,660	(279,915,680)	211,228,703
-	-	-	-	3,303,773	-	3,196,021
8,281,610	246,626,168	29,714,950	541,447	8,259,433	(279,915,680)	214,424,724
$ 8,347,676	$ 247,847,383	$ 39,147,624	$ 541,447	$ 26,894,156	$ (284,337,585)	$ 335,786,884

Attachment 34

ANDERSON HEALTHCARE
CONSOLIDATING STATEMENT OF OPERATIONS
YEAR ENDED DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

	Anderson Hospital	Anderson Medical Group, LLC	Maryville Imaging, LLC	Anderson Real Estate, LLC
UNRESTRICTED REVENUES, GAINS, AND OTHER SUPPORT				
Patient Service Revenue	$ 182,086,894	$ 26,268,842	$ 4,774,275	$ -
Other Revenue	4,751,951	1,475,109	41,526	3,495,538
Total Unrestricted Revenues, Gains, and Other Support	186,838,845	27,743,951	4,815,801	3,495,538
EXPENSES				
Salaries and Wages	68,343,155	28,234,074	1,555,213	-
Employee Benefits	13,728,520	2,733,050	219,422	-
Purchased Services and Professional Fees	20,117,178	9,922,997	1,158,178	407,236
Supplies and Other	63,718,380	4,310,983	1,994,090	1,905,770
Depreciation and Amortization	7,744,990	346,207	45,714	819,301
Interest	845,630	-	-	197,679
Total Expenses	174,497,853	45,547,311	4,972,617	3,329,986
OPERATING GAIN (LOSS)	12,340,992	(17,803,360)	(156,816)	165,552
OTHER INCOME AND EXPENSE				
Investment Income	13,444,562	51,268	330	-
Earnings on Joint Venture Investment	1,283,725	-	-	-
Earnings in Subsidiary	-	-	-	-
Unrestricted Contributions	-	-	-	-
Gain (Loss) on Sale of Assets	(35,608)	-	-	(597,761)
Total Other Income and Expense	14,692,679	51,268	330	(597,761)
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES	27,033,671	(17,752,092)	(156,486)	(432,209)
Transfers Between Affiliates	(18,137,357)	15,854,701	270,501	(131,807)
(Income) Deficit Attributable to Noncontrolling Interest	-	-	-	-
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	$ 8,896,314	$ (1,897,391)	$ 114,015	$ (564,016)

Attachment 34

ANDERSON HEALTHCARE
CONSOLIDATING STATEMENT OF OPERATIONS (CONTINUED)
YEAR ENDED DECEMBER 31, 2023
(SEE INDEPENDENT AUDITORS' REPORT)

Anderson Surgery Center, LLC	Anderson Hospital Foundation	Anderson Healthcare	Community Hospital of Staunton	Friends of Community Hospital of Staunton	Anderson Rehabilitation Institute, LLC	Eliminations	Consolidated
$ 1,275,699	$ -	$ -	$ 20,908,899	$ -	$ 14,972,087	$ -	$ 250,286,696
1,125	-	-	282,279	-	72,360	(228,000)	9,891,888
1,276,824	-	-	21,191,178	-	15,044,447	(228,000)	260,178,584
692,233	88,673	2,080,454	7,125,901	-	6,380,322	-	114,500,025
136,036	21,296	331,635	1,360,207	-	-	-	18,530,166
399,995	30,264	-	4,162,137	-	1,588,539	(228,000)	37,558,524
992,745	174,942	9,189	5,436,671	2,771	4,641,153	-	83,186,694
402,165	2,324	-	1,395,741	-	300,506	-	11,056,948
115,272	-	-	257,490	-	(5,613)	-	1,410,458
2,738,446	317,499	2,421,278	19,738,147	2,771	12,904,907	(228,000)	266,242,815
(1,461,622)	(317,499)	(2,421,278)	1,453,031	(2,771)	2,139,540	-	(6,064,231)
-	1,087,911	-	1,394,252	48,965	-	-	16,027,288
-	-	-	-	-	-	(1,283,725)	-
-	-	12,012,944	-	-	-	(12,012,944)	-
-	545,526	-	-	23,227	-	-	568,753
-	-	-	-	-	-	-	(633,369)
-	1,633,437	12,012,944	1,394,252	72,192	-	(13,296,669)	15,962,672
(1,461,622)	1,315,938	9,591,666	2,847,283	69,421	2,139,540	(13,296,669)	9,898,441
1,418,962	(150,000)	2,300,000	-	-	-	(1,425,000)	-
140,316	-	-	-	-	(855,816)	-	(715,500)
$ 97,656	$ 1,165,938	$ 11,891,666	$ 2,847,283	$ 69,421	$ 1,283,724	$ (14,721,669)	$ 9,182,941

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Trustees
Anderson Healthcare
Maryville, Illinois

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Anderson Healthcare, which comprise the consolidated balance sheet as of December 31, 2023, and the related consolidated statements of operations, changes in net assets, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated May 8, 2024.

Report Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Anderson Healthcare's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Anderson Healthcare's internal control. Accordingly, we do not express an opinion on the effectiveness of Anderson Healthcare's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that have not been identified. We identified certain deficiencies in internal control, described in the accompanying schedule of findings and questioned costs as items 2023-001 and 2023-002 that we consider to be a material weaknesses.

Board of Trustees
Anderson Healthcare

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether Anderson Healthcare's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Anderson Healthcare's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on Anderson Healthcare's response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. Anderson Healthcare's response was not subjected to the other auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
May 8, 2024

CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM, REPORT ON INTERNAL CONTROL OVER COMPLIANCE, AND REPORT ON THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS REQUIRED BY THE UNIFORM GUIDANCE

Board of Trustees
Anderson Healthcare
Maryville, Illinois

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited Anderson Healthcare (the Organization) compliance with the types of compliance requirements identified as subject to audit in the Office of Management and Budget *(OMB) Compliance Supplement* that could have a direct and material effect on each of the Organization's major federal programs for the year ended December 31, 2023. The Organization's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings, responses and questioned costs.

In our opinion, the Organization complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2023.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditors' Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of the Organization's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the Organization's federal programs.

Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the Organization's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the Organization's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- exercise professional judgment and maintain professional skepticism throughout the audit.
- identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the Organization's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- obtain an understanding of the Organization's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A material weakness in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Board of Trustees
Anderson Healthcare

Our consideration of internal control over compliance was for the limited purpose described in the Auditors' Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
May 8, 2024

ANDERSON HEALTHCARE
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
YEAR ENDED DECEMBER 31, 2023

Federal Grantor/Pass Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Federal Expenditures	Passed Through to Subrecipients
U.S. DEPARTMENT OF AGRICULTURE:				
Community Facilities Loans and Grants	10.766	N/A	$ 7,273,693	$ -
Total Expenditures of Federal Awards			$ 7,273,693	$ -

See accompanying Notes to Schedule of Expenditures of Federal Awards.

Attachment 34

ANDERSON HEALTHCARE
NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
YEAR ENDED DECEMBER 31, 2023

NOTE 1 BASIS OF PRESENTATION

The accompanying schedule of expenditures of federal awards (Schedule)includes the federal grant activity of Anderson Healthcare's (the Organization) and is presented on the accrual basis of accounting. The information in this Schedule is presented in accordance with the applicable requirements of *Title 2 U.S. Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the Organization, it is not intended to and does not present the financial position, changes in net assets, or cash flows of the Organization.

NOTE 2 SIGNIFICANT ACCOUNTING POLICIES

No funds were identified as having been provided to subrecipients by the Organization and accordingly, no funds identified in the Schedule are attributable to subrecipient entities. There were no federal awards expended for noncash assistance or insurance. The Organization has elected to use the 10% de minimis indirect cost rate allowable under the Uniform Guidance.

NOTE 3 RECONCILIATION OF SEFA AND FINANCIAL STATEMENTS

The amount in the accompanying Schedule represents the beginning loan balances during the year under audit. The outstanding loan balance at December 31, 2023 was $7,145,103.

ANDERSON HEALTHCARE
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED DECEMBER 31, 2023

Section I – Summary of Auditors' Results

Financial Statements

1. Type of auditors' report issued:	Unmodified		
2. Internal control over financial reporting:			
• Material weakness(es) identified?	X	yes	_____ no
• Significant deficiency(ies) identified that are not considered to be material weakness(es)?	_____	yes	X no
3. Noncompliance material to financial statements noted?	_____	yes	X no

Federal Awards

1. Internal control over major federal programs:			
• Material weakness(es) identified?	_____	yes	X no
• Significant deficiency(ies) identified that are not considered to be material weakness(es)?	_____	yes	X no
2. Type of auditors' report issued on compliance for major federal programs:	Unmodified		
3. Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	_____	yes	X no

Identification of Major Federal Programs

Assistance Listing Number	Name of Federal Program or Cluster
10.766	Community Facilities Loans and Grants

Dollar threshold used to distinguish between Type A and Type B programs: $ 750,000

Auditee qualified as low-risk auditee? _____ yes X no

ANDERSON HEALTHCARE
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED DECEMBER 31, 2023

Section II – Financial Statement Findings

2023-001 PROPOSED AUDIT ADJUSTMENTS

Condition: Management is responsible for establishing and maintaining internal controls, including monitoring, and the fair presentation in the consolidated balance, and the related consolidated statements of operations, changes in net assets, and cash flows, including the notes to financial statements, in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP).

Criteria or specific requirement: Internal controls are in place to provide reasonable assurance that financial statements are prepared in accordance with U.S. GAAP.

Context: It is the responsibility of management to adjust the financial statements in order to ensure accuracy and completeness of all financial records.

Effect: During our audit and with the assistance of management certain misstatements were identified which resulted in adjusting journal entries to the 2023 consolidated financial statements. The overall impact of the proposed adjustments resulted in an increase in change in net assets of approximately $375,000.

In addition, certain adjustments were identified to the 2022 consolidated financial statements to retroactively correct reporting of consolidated subsidiaries. The overall impact of the prior period adjustment on the consolidated balance sheet was an increase in approximately $26.5M of assets, $19M in liabilities, $7.5M in net assets. The overall impact of the prior period adjustment on the consolidated statement of operations was an increase in approximately $11M in revenue, $10.5M in expenses and $500,000 improvement to deficit of revenues over expenses.

Recommendation: We recommend reviewing the policy and procedures in place related to reconciling financial statement activity.

Views of responsible officials and planned corrective actions: Management agrees with the finding and recommendations and is in the process of implementing policies and procedures regarding reconciliation of balance sheet accounts with appropriate review procedures. Patrick Garvey, CFO will be responsible to ensure policy and procedures are reviewed and implemented in the reconciliation of statement of net asset activity.

Section II – Financial Statement Findings (Continued)

2023-002 SEGREGATION OF DUTIES

Condition; During the performance of the audit, we gained an understanding of internal control processes. As such, we identified that there are segregation of duties concerns within the disbursements and payroll process.

Criteria or specific requirement: In any system of internal accounting control, one primary goal is adequate segregation of duties. Because of the way certain duties are assigned and carried out within the various accounting cycles, an adequate segregation of duties and responsibilities is not always present.

Context: It is the responsibility of management to implement effective internal control processes or mitigating controls to ensure accuracy of all financial records and safeguarding of assets.

Effect: The potential exists that a misstatement or misappropriation of assets could occur and not be prevented or detected by the Organization's internal controls.

Cause: In certain circumstances duties are not completely segregated and management has not implemented mitigating controls to reduce the risk.

Recommendation: While a complete segregation of duties is not always feasible given the limited resources available in an organization of this size we recommend implementing segregation of duties where feasible or mitigating review and approval processes to limit those instances where complete segregation is not possible.

Views of responsible officials and planned corrective actions: Management will review the internal controls and determine a best course of action to properly segregate responsibilities to the extent feasible. Patrick Garvey, CFO will be responsible to ensure policy and procedures are reviewed and implemented to properly segregate duties or mitigate risk through other controls.

Section III – Findings and Questioned Costs – Major Federal Programs

There were no findings in the current year that were required to be reported in accordance with 2 CFR 200.516(a).

Anderson Healthcare

December 16, 2024

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: Financing Arrangements
Conditions of Debt Financing

Dear Chairwoman Savage:

Anderson Hospital plans to fund the emergency department project with a combination of cash and securities and borrowing. The borrowing will be in the range of $25 - $27 million of debt to be issued. Based on conversations with our banks, the interest rate is anticipated to be about $4.8% at the time we borrow the funds this summer. We anticipate that such an arrangement will allow us to access funds at the lowest net cost available in the markets.

Use of borrowing will allow Anderson to retain other existing funds in our balance sheet accounts to maintain our current financial positions.

If you have any questions, please contact me at 618-391-6421.

Sincerely,

Patrick Garvey
Chief Financial Officer
Anderson Healthcare
6800 State Rte 162
Maryville, IL 62062

NOTARY

Ranada Ridenhour
State of IL
County of Madison

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

Attachment 34

BANK OF AMERICA

December 13, 2024

Mike Siurek
Senior Vice President
Banc of America Public Capital Corp
Phone: 872-222-3212
Michael.siurek@baml.com

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

Re: Anderson Hospital Emergency Department project

To whom it may concern:
Banc of America Public Capital Corp ("BAPCC"), on behalf of Banc of America Leasing & Capital, LLC ("BALCAP") is pleased to continue our financing relationship and provide this letter for Anderson Hospital (the "Borrower"). Total project/financing of $25,000,000 for the Anderson Hospital Emergency Department project. The financing would be via a ten (10) year loan utilizing an existing Master Financing Agreement and/or via our Public Finance group on an extended term.

This letter includes only a brief description of the principal terms of the proposed transaction, are intended for discussion purposes only, and are subject to satisfactory completion of BALCAP's credit, legal and investment approval process.

Very truly yours,
BANC OF AMERICA PUBLIC CAPITAL CORP

Michael Siurek

Michael Siurek

Attachment 34

1120.130 Financial Viability

Financial viability ratios have been calculated for Anderson Hospital.

As documented on the next three pages, Anderson Hospital is in compliance with all of the financial viability ratios except for the Current Ratio. Anderson Hospital does not meet the CON standard for hospitals and hospital systems for the Current Ratio for any of the four most recent historic years or for the projected first full year at target utilization, 2023.

The only reason for this ratio being below 2.0 is that Anderson Hospital takes an aggressive approach to moving operating cash to long-term investments. All of Anderson Hospital's long-term investments are unrestricted and can be converted to cash within 7 – 10 days. As a result, the Current Ratio can be increased to exceed the CON standard within that brief time period.

As is apparent by review of the audited financial statements, Anderson Hospital's long-term investments are of sufficient size to meet the hospital's debt obligations and to insure that the applicant will not default. Consequently, there is no reason to provide a variance to the financial viability ratios, as described in 77 Ill. Adm. Code 1120.130(c) or to secure a financial viability waiver, as described in 77 Ill. Adm. Code 1120.130(a).

Anderson Hospital
Financial Ratios based on Anderson Healthcare Audited Financial Statements

1.	Current Ratio	=	Current Assets / Current Liabilities		
	FY 2020		$ 61,610,990 / $ 48,909,923	=	1.26
	FY 2021		$ 70,824,405 / $ 55,179,854	=	1.28
	FY 2022		$ 55,388,160 / $ 57,120,053	=	0.97
	FY 2023		$ 59,322,008 / $ 51,462,809	=	1.15
	FY 2027		$ 75,000,000 / $ 60,000,000	=	1.25
2.	Net Margin %	=	Net Income x100 / Net Operating Revenue		
	FY 2020		$ 4,786,506 / $ 197,338,471	=	2.43%
	FY 2021		$ 32,517,118 / $ 234,300,400	=	13.88%
	FY 2022		$ (34,513,460) / $ 236,912,789	=	-14.57%
	FY 2023		$ 9,182,941 / $ 260,178,584	=	3.53%
	FY 2027		$ 17,500,000 / $ 292,500,000	=	5.98%
3.	LTD to Total Capitalization	=	Long Term Debt / Long Term Debt + Net Assets		
	FY 2020	$ 49,480,997 / $49,480,997 + $200,748,671	$ 49,480,997 / $ 250,229,668	=	19.77%
	FY 2021	$ 46,371,480 / $46,371,480 + $232,789,244	$ 46,371,480 / $ 279,120,724	=	16.61%
	FY 2022	$ 43,482,340 / $43,482,340 + 205,178,117	$ 43,482,340 / $ 248,660,457	=	17.49%
	FY 2023	$ 36,477,255 / $36,477,255 + $214,424,724	$ 36,477,255 / $ 250,901,979	=	14.54%
	FY 2027	$37,000,000 / $37,000,000 + $248,000,000	$ 37,000,000 / $ 285,000,000	=	12.98%

Attachment 36

Anderson Hospital
Financial Ratios based on Anderson Healthcare Audited Financial Statements

4.	Projected Debt Service Coverage Ratio	=	Net Income + Depr + Interest + Amort / Principle + Interest for MADS Year		
	FY 2020	$4,786,506+$10,101,295+$1,827,889 / $5,533,496 + $899,988	$ 16,715,690 / $ 6,433,484	=	2.60
	FY 2021	$32,517,118+$10,125,304+$1,731,367 / $5,600,528 + $909,864	$ 44,373,789 / $ 6,510,392	=	6.82
	FY 2022	($34,513,460)+$11,035,331+$1,651,891 / $6,385,896 + $997,589	$ (21,826,238) / $ 7,383,485	=	(2.96)
	FY 2023	$9,182,941+$11,056,948+$1,410,458 / $6,385,896 + $997,589	$ 21,650,347 / $ 7,383,485	=	2.93
	FY 2027	$17,500,000+$12,500,000+$2,100,000 / $5,765,912 + $2,100,000	$ 32,100,000 / $ 7,865,912	=	4.08
5.	Days Cash on Hand	=	Cash + Investments + Board Designated / Operating Expense/365		
	FY 2020	$13,455,309+$5,037,385+$115,845,239 / $207,582,893/365	$ 134,337,933 / $ 568,720	=	236.21
	FY 2021	$15,235,506+$5,988,190+$137,594,856 / $218,480,778/365	$ 158,818,552 / $ 598,577	=	265.33
	FY 2022	$7,623,929+$6,278,517+$108,953,727 / $253,485,177/365	$ 122,856,183 / $ 694,480	=	176.90
	FY 2023	$13,403,335+$4,153,796+$100,845,038 / $266,242,815/365	$ 118,402,169 / $ 729,432	=	162.32
	FY 2027	$10,000,000+$6,000,000+$125,000,000 / $280,000,000/365	$ 141,000,000 / $ 767,123	=	183.80
6.	Cushion Ratio	=	Cash + Investments + Board Designated / Principle + Interest for MADS Year		
	FY 2020	$13,455,309+$5,037,385+$115,845,239 / $5,533,496 + $899,988	$ 134,337,933 / $ 6,433,484	=	20.88
	FY 2021	$15,235,506+$5,988,190+$137,594,856 / $5,600,528 + $909,864	$ 158,818,552 / $ 6,510,392	=	24.39
	FY 2022	$7,623,929+$6,278,517+$108,953,727 / $6,385,896 + $997,589	$ 122,856,183 / $ 7,383,485	=	16.64
	FY 2023	$13,403,335+$4,153,796+$100,845,038 / $6,385,896 + $997,589	$ 118,402,169 / $ 7,383,485	=	16.04
	FY 2027	$10,000,000+$6,000,000+$125,000,000 / $5,765,912 + $2,100,000	$ 141,000,000 / $ 7,865,912	=	17.93

Attachment 36

1120.140 ECONOMIC FEASIBILITY

A. Reasonableness of Financing Arrangements and
B. Conditions of Debt Financing

See the following letters by Patrick Garvey, Chief Financial Officer, Anderson Healthcare and Michael Siurek, Senior Vice President, Banc of America Public Capital Corp

C. Reasonableness of Project and Related Costs

See the following table of capital construction and modernization costs for the clinical and non-clinical components of the project. Also included in this section is a copy of the table *Project Costs and Sources of Funds*, and accompanying narrative explanations of the line items of cost.

D. Projected Operating Cost

Table follows in this section.

E. Total Effect of the Project on Capital Costs

Table follows in this section.

Attachment 37

Anderson Healthcare

December 16, 2024

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street - 2nd Floor
Springfield, IL 62761

Re: Financing Arrangements
Conditions of Debt Financing

Dear Chairwoman Savage:

Anderson Hospital plans to fund the emergency department project with a combination of cash and securities and borrowing. The borrowing will be in the range of $25 - $27 million of debt to be issued. Based on conversations with our banks, the interest rate is anticipated to be about $4.8% at the time we borrow the funds this summer. We anticipate that such an arrangement will allow us to access funds at the lowest net cost available in the markets.

Use of borrowing will allow Anderson to retain other existing funds in our balance sheet accounts to maintain our current financial positions.

If you have any questions, please contact me at 618-391-6421.

Sincerely,

Patrick Garvey
Chief Financial Officer
Anderson Healthcare
6800 State Rte 162
Maryville, IL 62062

NOTARY

Ranada Ridenhour
State of IL
County of Madison

OFFICIAL SEAL
RANADA RIDENHOUR
Notary Public, State of Illinois
Commission No. 976988
My Commission Expires
August 21, 2027

BANK OF AMERICA

Mike Siurek
Senior Vice President
Banc of America Public Capital Corp
Phone: 872-222-3212
Michael.siurek@baml.com

December 13, 2024

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

Re: Anderson Hospital Emergency Department project

To whom it may concern:
Banc of America Public Capital Corp ("BAPCC"), on behalf of Banc of America Leasing & Capital, LLC ("BALCAP") is pleased to continue our financing relationship and provide this letter for Anderson Hospital (the "Borrower"). Total project/financing of $25,000,000 for the Anderson Hospital Emergency Department project. The financing would be via a ten (10) year loan utilizing an existing Master Financing Agreement and/or via our Public Finance group on an extended term.

This letter includes only a brief description of the principal terms of the proposed transaction, are intended for discussion purposes only, and are subject to satisfactory completion of BALCAP's credit, legal and investment approval process.

Very truly yours,
BANC OF AMERICA PUBLIC CAPITAL CORP

Michael Siurek

Michael Siurek

C. Reasonableness of Project and Related Costs

COST AND SQUARE FOOT BY DEPARTMENT

Department	A	B	C	D	E	F	G	H		Vacated
	Cost / Sq ft		DGFS		DGSF		Const $	Mod $	Total Cost	
	New	Mod	New	Circ %	Mod	Circ %	(A x C)	(B x E)	(G + H)	
CLINICAL										
Emergency Department	$497.28		14,728	26%			$7,323,931			11,043
Clinical subtotal	$497.28		14,728	26%			$7,323,931			11,043
NON-CLINICAL										
Public areas	$528.35		2,435	31%			$1,286,533			
Circulation - vertical	$777.31		1,657	100%			$1,288,009			
Training	$488.11		465	18%			$226,971			
Staff offices - administrative	$487.30		1,032	20%			$502,890			
Staff support	$528.53		1,203	20%			$ 635,818			
Circulation - horizontal	$440.50		2,675	100%			$ 1,178,326			
Building systems	$432.40		5,550	17%			$ 2,399,817			
Connecting corridor		$499.43			1,716	100%		$ 857,024		
Unassigned - shell space	$517.15		18,530	0%			$ 9,582,885			
Non-clinical subtotal	$509.77		33,547	19%	1,716	100%	$17,101,249			
TOTAL	$505.96	$499.43	48,275		1,716		$24,425,181	$857,024	$25,282,205	11,043

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	$ 13,749	$ 0	$ 13,749
Site Preparation	$ 313,264	$ 731,466	$ 1,044,730
Off Site Work			
New Construction Contracts	$ 7,323,931	$ 17,101,250	$ 24,425,181
Modernization Contracts		$ 857,024	$ 857,024
Contingencies	$ 88,000	$ 312,000	$ 400,000
Architectural/Engineering Fees	$ 403,915	$ 943,134	$ 1,347,049
Consulting and Other Fees	$ 41,000	$ 123,506	$ 164,506
Movable or Other Equipment (not in construction contracts)	$ 1,962,189	$ 1,290,396	$ 3,252,585
Bond Issuance Expense (project related)	$ 100,000	$ 215,000	$ 315,000
Net Interest Expense During Construction (project related)	$ 508,377	$ 1,186,213	$ 1,694,590
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
a) IT	$ 310,500	$ 116,200	$ 426,700
b) artwork	$ 4,250	$ 21,358	$ 25,608
c) signage	$ 52,000	$ 31,595	$ 83,595
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$ 11,121,175	$ 22,929,141	$ 34,050,316
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 3,621,175	$ 5,429,141	$ 9,050,316
Pledges			
Gifts and Bequests			
Bond Issues (project related)	$ 7,500,000	$ 17,500,000	$ 25,000,000
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$ 11,121,175	$ 22,929,141	$ 34,050,316

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

Project Costs and Source of Funds

Narrative Description of Line Items.

Line 2 – Site Survey and Soil Investigation $13,749

- Subsurface Soils Investigation
- Foundation System Recommendations
- Site Topographic Survey
- Pavement and Percolation recommendations
- Site Seismic classification analysis.

Of the total amount, $13,749.00 is clinical cost.

Line 3 – Site Preparation $1,044,730

- General Site Work
  - Earth Moving
  - Import and Export of Material
  - Shoring
  - Paving
  - Concrete Curb and Gutter
  - Site Utilities
  - Stormwater management (Quality and Quantity Treatment)
- Utility Company Service work
  - Relocation of existing, temporary and permanent services for Power, Gas, Fire Water, Telecom, Cable

Of the total amount, $313,264 is clinical cost. Together with Site Survey and Soil Investigation this is 4.23% of the clinical New Construction ($7,323,931), Modernization ($0) plus Contingencies ($88,000).

Line 4 – Off Site Work $0

- Costs are included in Site Preparation above. Work includes installation of new IDOT campus entrance, minimal tie-in work offsite.

Line 5 – New Construction Contracts $24,425,181

- Project Background
  - Market Analysis
  - Feasibility Studies
  - Legal Investigation
  - Zoning Investigation
- Preconstruction Services
  - Budgeting
  - Schedule
  - Construction Phasing
  - Site Logistics
- Programing
  - Gather information for occupant space requirements.
  - Review and Analysis of space standards

    - Prepare Space Occupancy Program for Design
        - Department and Room Occupancy
        - Space systems and services requirements
        - Space level FFE concepts
- All construction contracts, cost to complete the new addition project. Construction of a new single story building addition with a basement and designed for future vertical expansion. Cost includes structure, building envelope, interior finishes and building MEP services.
- Includes contractor's markup, overhead, and profit.
- Costs are escalated to the mid-point of construction.

Of the total amount, $7,323,931 is clinical cost. At 14,728 clinical sq ft, the cost is $497.28 per clinical square foot.

Line 6 – Modernization Contracts $857,024

- All construction contracts, cost to complete the modernization scope of the project. Scope includes tie ins of select services and utilities within the existing hospital and creation of the new horizontal connector through the hospital.
- Includes contractor's markup, overhead, and profit.
- Costs are escalated to the mid-point of construction.

Of the total amount, $0 is clinical cost. The modernization cost of the connecting corridor is $499.43 per sq ft. It is a non-clinical component of the project.

Line 7 – Contingencies $400,000

- Allowance for unforeseen New Construction and Modernization Costs

Of this amount, $88,000 is allocated as a clinical cost. $88,000 is 1.2% of the clinical construction cost of $7,323,931. None of the modernization cost associated with the corridor connector component of this project is clinical. All clinical contingency is associated with new construction.

Line 8 – Architectural/ Engineering Fees $1,347,049

- Concept Design, Schematic Design, Design Development, Construction Documents services along with full engineering, Bidding and Negotiation, and construction administration.

Of the total amount, $403,915 is clinical cost. This amount is 5.52% of the total of clinical construction plus contingencies.

Line 9 - Consulting and Other Fees $164,506

- Charges for the services of various types of consulting and professional experts including:
    - Legal Fees
    - Signage/ Wayfinding Consultant
    - FF&E Consultant Fees
    - CON Consultant
    - CON Application Fee

Of the total amount, $41,000 is assigned as a clinical cost.

Line 10 - Movable Capital Equipment $3,252,585

- All furniture, furnishings, fixtures and equipment for the proposed project for clinical and support spaces.
- The Architect will be retained to provide specific expertise during equipment planning and specification, and to assist and ensure effective use of available funding. Equipment planning will be closely coordinated with architectural design.
- Freight and installation costs are also included in the estimate.

Of the total amount, $1,962,189 is clinical equipment:

Arjo lifts	$ 45,000
Cardiac Monitor Central stations	$ 1,332,396
Defibrillators	$ 113,695
Dopplers	$ 1,000
EKGs	$ 75,272
IV Poles	$ 9,200
Pyxis Auxillary	$ 12,700
Safety psych bed	$ 2,700
Safety chairs (psych rooms)	$ 2,063
Stretchers	$ 214,663
Surgical lights	$ 153,500
Other clinical equipment	

Line 11 – Bond Issuance Expense $315,000

This expense includes borrower's counsel, bond counsel, issuer's counsel, lender's counsel and the placement agency fee. It is anticipated that bonds will be issued through the Illinois Finance Authority.

Line 12 – Net Interest Expense During Construction (project related) $1,684,590

Borrowing of $25,000,000 will be used to fund part of the construction, scheduled from July 2025 through May, 2027, as well as other project costs. The cost of borrowing is offset by interest earned on the balance of principal throughout the construction period.

Line 14 – Other Costs to be Capitalized $535,903

- Information Technology
  - Premise Cabling, Computers, Switches and equipment for Telephone and Data systems.
  - Building Safety and Security Systems including Access Control, CCTV, Intrusion Detection.
- Artwork
- Signage
  - Interior wayfinding
  - Exterior Building and Site Signage.

Of the total amount, $366,750 is allocated as clinical cost.

D. Project Operating Costs

Estimated Project Start Up Operating Cost
(first year) $ __7,726,805_____

Project Direct Operating Expenses – 2 years after project completion (Year 2029)

	ED Expansion Project
Total Operating Costs	$8,890,503
Equivalent Patient Days	9,127
Direct Cost per Equivalent Patient Day	$208.10

E. Total Effect of the Project on Capital Costs

Projected Capital Costs – two years after project completion (2029)

	Project, FY 2029	Total hospital, FY 2029
Equivalent Patient Days (all Anderson Hospital)	--	81,616.78
Total Project Capital Cost	$33,966,721	--
Useful Life	18.4	--
Total Annual Depreciation	$2,254,070	$9,634,422
Depreciation Cost per Equivalent Patient Day	$247	$118

CHARITY CARE - Anderson Healthcare			
	2021	2022	2023
Net Patient Revenue	$ 215,281,648	$ 228,320,809	$ 250,286,696
Amount of Charity Care (charges)	$ 5,929,168	$ 5,276,468	$ 4,355,834
Cost of Charity Care	$ 1,380,500	$ 1,263,418	$ 929,952

CHARITY CARE - Anderson Hospital			
	2021	2022	2023
Net Patient Revenue	$ 170,082,979	$ 167,230,177	$ 182,086,894
Amount of Charity Care (charges)	$ 5,582,890	$ 4,828,329	$ 4,069,528
Cost of Charity Care	$ 1,238,526	$ 1,079,681	$ 812,567

Attachment 38

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: ANDERSON HOSPITAL (Name) 6800 STATE RTE 162 (Address)
   MARYVILLE (City) IL (State) 62062 (ZIP Code) 618 288 5711 (Telephone Number)
2. Project Location: ANDERSON HOSPITAL (Address) 6800 STATE RTE 162 MARYVILLE, IL (City) (State)
   MADISON (County) COLLINSVILLE (Township) 3N 8WS2 (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: 17043600 95B Effective Date: 4/15/1982

Name of Official: Marc Hahlt Title: Stormwater Coordinator

Business/Agency: Madison County Address: 157 N. Main St.

Edwardsville (City) IL (State) 62025 (ZIP Code) 618-296-4665 (Telephone Number)

Signature: Marc Hahlt Date: 12/10/2024

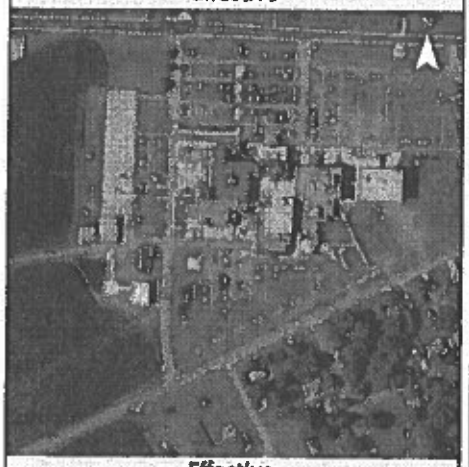
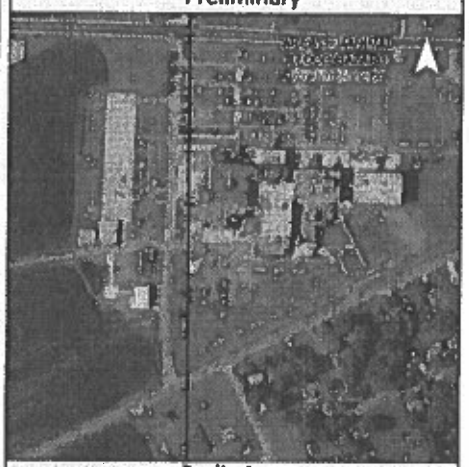
NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

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

Comparison of Flood Hazard

FEMA

Effective & Preliminary Flood Hazards

Effective	Preliminary
	

Effective	
POI Longitude/Latitude	38.7363, -89.9467
Effective FIRM Panel	17043600958
Effective Date	4/15/1982

There is no modernized effective data to determine the flood hazard for the selected location; please refer to the static legacy FIRM which can be accessed by selecting the following link:

http://msc.fema.gov/portal/viewProduct?productID=17043600958

Preliminary	
POI Longitude/Latitude	38.7363, -89.9467
Preliminary FIRM Panel	17119C0352D
Preliminary Issue Date	8/10/2022
Flood Zone	X
Estimated Static BFE*	Not Available
Estimated Flood Depth	Not Available
Vertical Datum	Not Available

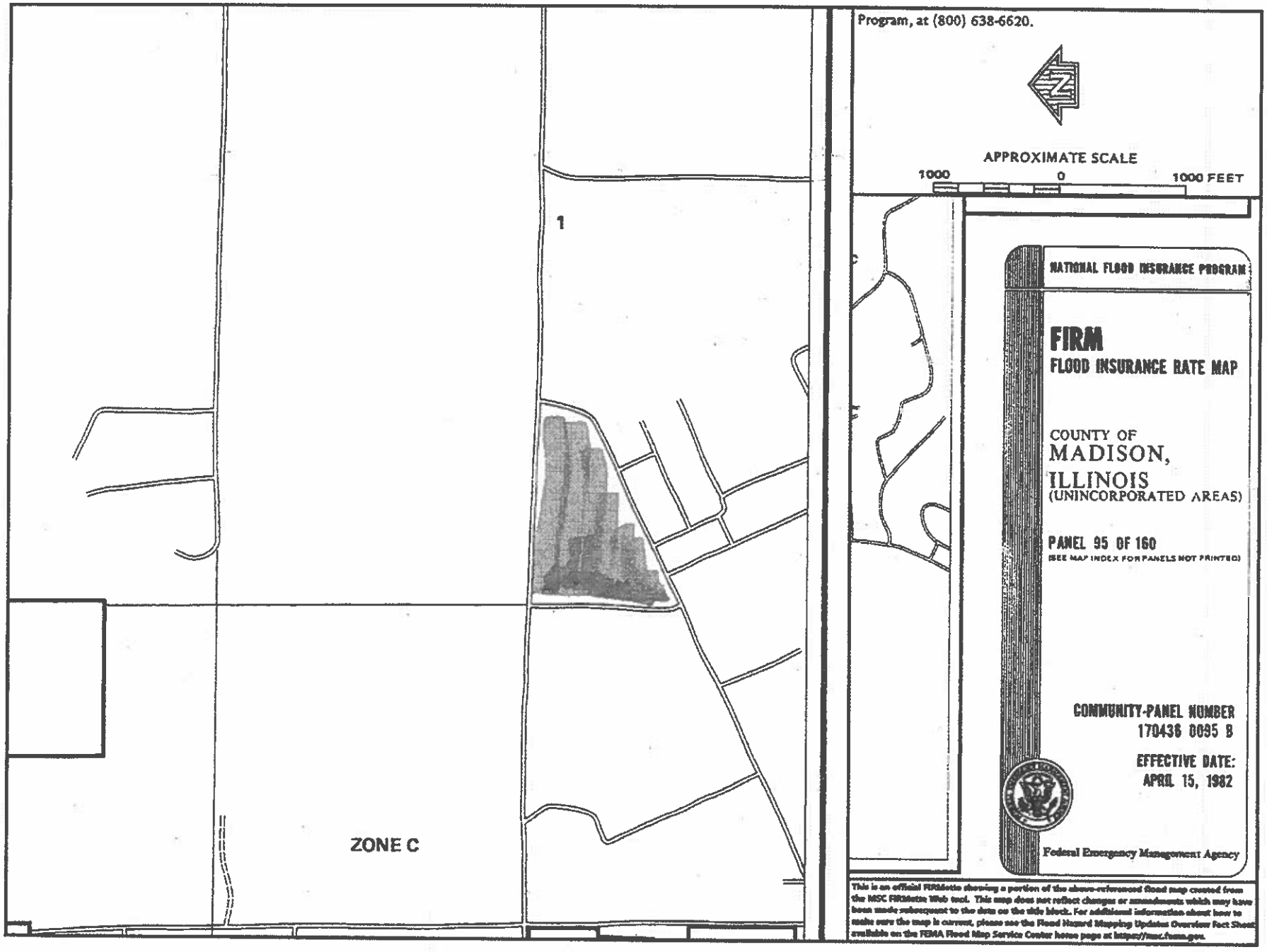
* A Base Flood Elevation is the expected elevation of flood water during the 1% annual chance storm event. Structures below the estimated water surface elevation may experience flooding during a base flood event.

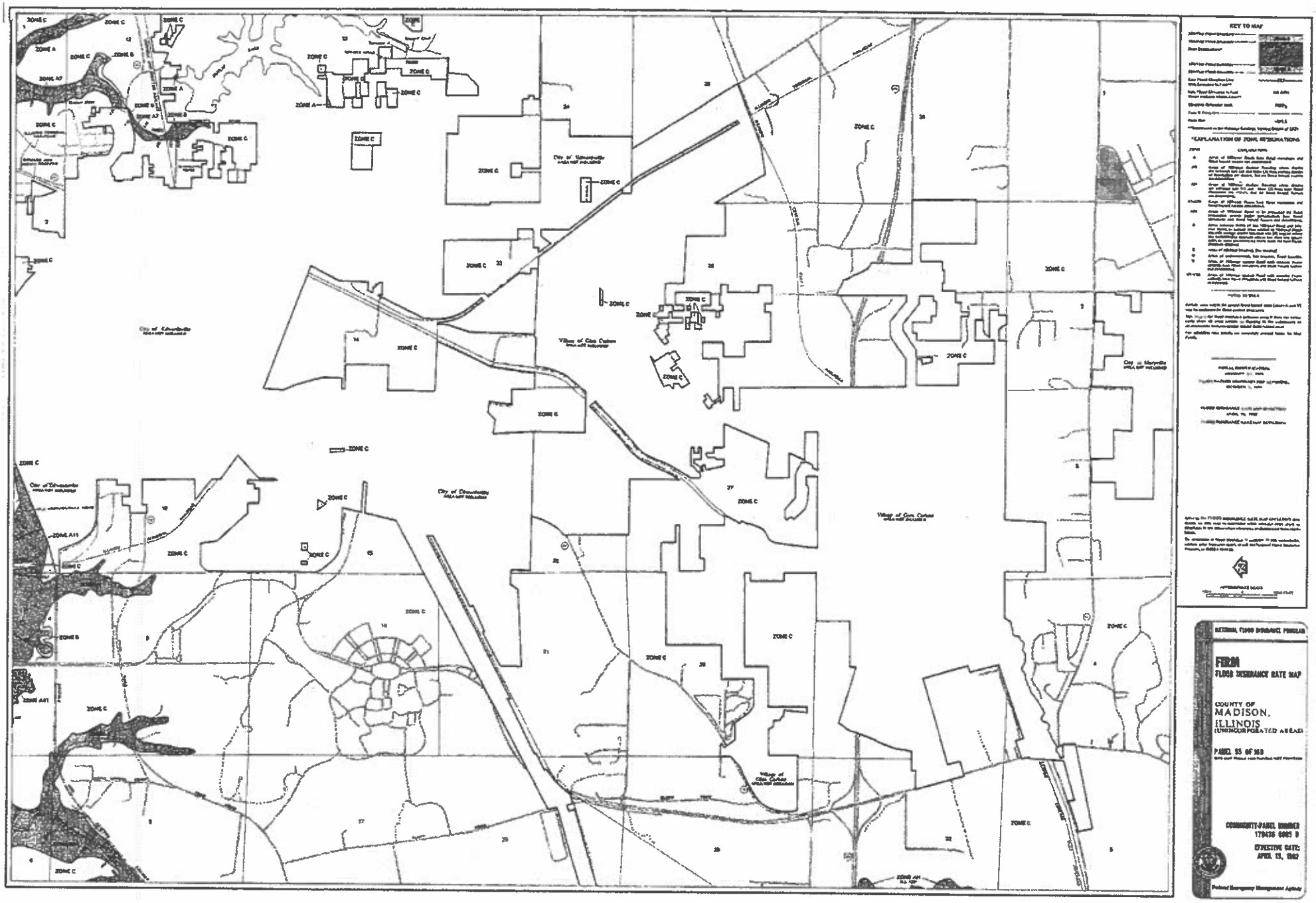
Hazard Level	Flood Hazard Zone
High Flood Hazard	AE, A, AH, AO, VE and V Zones. Properties in these flood zones have a 1% chance of flooding each year. This represents a 26% chance of flooding over the life of a 30-year mortgage.
Moderate Flood Hazard	Shaded Zone X. Properties in the moderate flood risk areas also have a chance of flooding from storm events that have a less than 1% chance of occuring each year. Moderate flood risk indicates an area that may be provided flood risk reduction due to a flood control system or an area that is prone to flooding during a 0.2% annual chance storm event. These areas may have been indicated as areas of shallow flooding by your community. Unshaded Zone X. Properties on higher ground and away from local flooding sources have a reduced flood risk when compared to the Moderate and High Flood Risk categories. Structures in these areas may be affected by larger storm events, in excess of the 0.2% annual chance storm event.
Low Flood Hazard	Insurance Note: High Risk Areas are called 'Special Flood Hazard Areas' and flood insurance is mandatory for federally backed mortgage holders. Properties in Moderate and Low Flood Risk areas may purchase flood insurance at a lower-cost rate, known as Preferred Risk Policies. See your local insurance agent or visit https://www.fema.gov/national-flood-insurance-program for more information.

Disclaimer: This report is for informational purposes only and is not authorized for official use. The positional accuracy may be compromised in some areas. Please contact your local floodplain administrator for more information or go to msc.fema.gov to view an official copy of the Flood Insurance Rate Maps.

Service Layer Credits: USGS, USDA

12/10/2024 4:05 PM


Program, at (800) 638-6620.
APPROXIMATE SCALE
1000
0
1000 FEET
1
ZONE C
NATIONAL FLOOD INSURANCE PROGRAM
FIRM
FLOOD INSURANCE RATE MAP
COUNTY OF
MADISON,
ILLINOIS
(UNINCORPORATED AREAS)
PANEL 95 OF 160
(SEE MAP INDEX FOR PANELS NOT PRINTED)
COMMUNITY-PANEL NUMBER
170436 0095 B
EFFECTIVE DATE:
APRIL 15, 1982
Federal Emergency Management Agency
This is an official FIRMette showing a portion of the above-referenced flood map created from the MSC FIRMette Web tool. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For additional information about how to make sure the map is current, please see the Flood Hazard Mapping Updates Overview Fact Sheet available on the FEMA Flood Map Service Center home page at https://msc.fema.gov.


KEY TO MAP
EXPLANATION OF ZONE DESIGNATIONS
NATIONAL FLOOD INSURANCE PROGRAM
FIRM
FLOOD INSURANCE RATE MAP
COUNTY OF
MADISON,
ILLINOIS
(UNINCORPORATED AREAS)
PANEL 55 OF 350
COMMUNITY-PANEL NUMBER
170436 0055 B
EFFECTIVE DATE:
APRIL 15, 1982
Federal Emergency Management Agency