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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: **Gateway Regional Medical Center**
Street Address: **2100 Madison Avenue**
City and Zip Code: **Granite City, IL 62040**
County: **Madison** Health Service Area **11** Health Planning Area: **F-01**

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: **Granite City Hospital Company, LLC d/b/a Gateway Regional Medical Center**
Address:**See above**
Name of Registered Agent: **CT Corporation**
Name of Chief Executive Officer: **W. Larry Cash**
CEO Address: **4000 Meridian Blvd., Franklin, TN 37067**
Telephone Number: **615-465-7349**

Type of Ownership of Applicant/Co-Applicant

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

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

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:**Clare Connor Ranalli**
Title:**Partner**
Company Name:**McDermott, Will & Emery**
Address:**227 W. Monroe St., Chicago, IL. 60606**
Telephone Number:**312-984-3365**
E-mail Address:**cranalli@mwe.com**
Fax Number:

Additional Contact

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

Name:**None**
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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: **Gateway Regional Medical Center**
Street Address: **2100 Madison Avenue**
City and Zip Code: **Granite City, IL 62040**
County: **Madison** Health Service Area **11** Health Planning Area: **F-01**

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: **Community Health Systems, Inc.**
Address: **4000 N. Meridian Blvd., Franklin, TN 37067**
Name of Registered Agent: **Rachel Seifert**
Name of Chief Executive Officer: **Wayne T. Smith**
CEO Address: **4000 N. Meridian Blvd., Franklin, TN 37067**
Telephone Number: **615-465-7349**

Type of Ownership of Applicant/Co-Applicant

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

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

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[Person to receive ALL correspondence or inquiries)

Name: **Clare Connor Ranalli**
Title: **Partner**
Company Name: **McDermott, Will & Emery**
Address:**227 W. Monroe St., Chicago, IL. 60606**
Telephone Number:**312-984-3365**
E-mail Address:**cranalli@mwe.com**
Fax Number:

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

Name: **None**
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Post Permit Contact

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

Name: **Mark Edward Cunningham**
Title: **CEO**
Company Name: **Gateway Regional Medical Center**
Address: **2100 Madison Avenue, Granite City, IL 62040**
Telephone Number: **618-798-3000**
E-mail Address: **ed_cunningham@chs.net**
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: **Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center**
Address of Site Owner: **2100 Madison Avenue, Granite City, IL 62040**
Street Address or Legal Description of Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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: Granite City Illinois Hospital Company, LLC d/b/a Gateway Regional Medical Center

Address: 2100 Madison Avenue, Granite City, IL 62040

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

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

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

Organizational Relationships

Provide (for each co-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.

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 following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are 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: GATEWAY REGIONAL MEDICAL CENTER	**CITY: Granite City**				
REPORTING PERIOD DATES:	**From: 01/01/2014**		**to: 12/31/2014**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	166	3,218	14,464		
Obstetrics*	27	280	696		
Pediatrics	5	0	0	-5	0
Intensive Care	12	351	1,289		
Comprehensive Physical Rehabilitation	14	83	1,055		
Acute/Chronic Mental Illness	100	3,018	19,160		
Neonatal Intensive Care	0				
General Long Term Care	19	260	2,578		
Specialized Long Term Care	0				
Long Term Acute Care	0				
Other ((identify)	0				
TOTALS:	343	7,050	39,242		338

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Granite City Illinois Hospital Company, LLC, d/b/a Gateway Regional Medical Center* 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

Mark Edward Cunningham SIGNATURE	_____ SIGNATURE
Mark Edward Cunningham PRINTED NAME	Rachel Seifert PRINTED NAME
CEO PRINTED TITLE	Secretary PRINTED TITLE
Notarization: Subscribed and sworn to before me this 25 day of February	Notarization: Subscribed and sworn to before me this _____ day of _____
Ky L. Scott Signature of Notary	_____ Signature of Notary
Seal OFFICIAL SEAL KY L. SCOTT Notary Public - State of Illinois My Commission Expires 8/10/2018	Seal

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Granite City Illinois Hospital Company, LLC, d/b/a Gateway Regional Medical Center* 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Mark Edward Cunningham PRINTED NAME	Rachel A. Seifert PRINTED NAME
CEO of Gateway Regional Medical Center PRINTED TITLE	Executive Vice President and Secretary PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 9th day of March, 2015
Signature of Notary	Signature of Notary
Seal	Seal

JENIFER J. HOLLINGSWORTH
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
My Comm. Expires May 22, 2017

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 for Permit is filed on the behalf of Community Health Systems, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Martin Schweinhart
PRINTED NAME

Executive Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of March, 2015

Signature of Notary

Seal

MARY ANN EATMAN NOTARY PUBLIC STATE OF TENNESSEE WILLIAMSON COUNTY

My Comm. Expires
September 27, 2015

SIGNATURE

Rachel A. Seifert
PRINTED NAME

EVP, Secretary and General Counsel
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of March, 2015

Signature of Notary

Seal

JENIFER J. HOLLINGSWORTH STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY

My Comm. Expires
May 22, 2017

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - 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 is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service 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. 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 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not 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 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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 -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

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

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

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

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

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-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS

Certificates of Good Standing for
Applicant and Co-Applicant

File Number 6483-188-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

COMMUNITY HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 31, 2006, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS 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* 13TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Authentication #: 1504402528

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

File Number 0058590-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

GRANITE CITY ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 03, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 13TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Authentication #: 1504402516

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

Proof of Ownership

N/A – Discontinuation of Category of Service

Certificate of Good Standing
for Licensee

File Number 0058590-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

GRANITE CITY ILLINOIS HOSPITAL COMPANY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 03, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 13TH *day of* FEBRUARY *A.D.* 2015 .

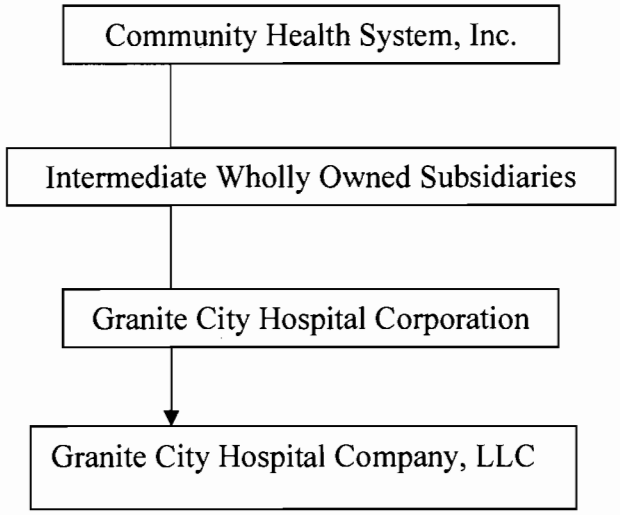
Jesse White

SECRETARY OF STATE

Authentication #: 1504402516

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

Organization Chart



NOTE: Granite City Hospital Corporation is the sole member of Granite City Hospital Company, LLC.

Section 1110.130 Discontinuation of Authorized Pediatric Inpatient Beds

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.

Gateway Regional Medical Center currently provides a pediatric service that includes 5 authorized pediatric beds. The Hospital is proposing to continue to provide pediatric services on an outpatient basis but to discontinue the 5 authorized pediatric beds. During the last 2 years (2012 and 2013), there has been no volume in the pediatric beds. Some patients under 14 were admitted for overnight stays, but in medical surgical beds.

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

None

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

The pediatric beds will be discontinued at the time that this certificate of need is approved by the Health Facilities and Services Review Board.

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

Gateway expects that the space vacated by the 5-bed pediatric inpatient unit will be used for non-clinical functions with no associated modernization cost.

5. Provide the anticipated disposition and location of all medical records pertaining to pediatric inpatient utilization.

All paper medical records related to pediatric patients will be scanned and stored for many years. All paper records will be destroyed after 90 days. The electronic medical records will be maintained according to the Hospital's current medical records policy which will continue to meet all licensure and regulatory requirements.

6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and date 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 60 days following the date of discontinuation.

Not Applicable.

REASONS FOR DISCONTINUATION

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

The basis for the request to discontinue is low volume / no need.

For the last several years, almost all pediatric patients requiring inpatient care from either Gateway or its Medical Staff physician practices have been referred to children's hospitals and especially SSM Cardinal Glennon Children's Medical Center, St. Louis Children's Hospital, and St. John's Mercy Hospital in St. Louis, Missouri. Gateway has transfer agreements with the children's hospitals in St. Louis. This shift of care to specialized children's hospitals is consistent with national experience.

There are 3 existing hospitals in Illinois within 45 minutes travel time, based on Mapquest normal drive times, of Gateway with authorized pediatric beds that have excess capacity to serve pediatric patients. Two of them have an application to discontinue the service pending.

IMPACT ON ACCESS

1. *Document that the discontinuation of Gateway's authorized pediatric beds will not have an adverse effect upon access to care for the residents of the facility's market area.*

The available pediatric beds in the Hospital's market area could support the current annual utilization of zero days at the unit proposed for discontinuation at Gateway.

2. *Document that a written request for an impact statement was received by all existing or approved hearth care facilities (that provide inpatient pediatric services located within 45 minutes travel time of the applicant facility*

Gateway sent letters to the area hospitals with authorized pediatric beds within 45-minute travel time of Gateway requesting a statement of the impact the discontinuation would have on each respective facility. These letters, in addition to the documentation that the letters were sent return receipt requested and the letters received by Gateway in response are included in Appendix A, attached to this application. No Hospitals that have responded to date have indicated a negative impact relating to the proposed pediatric discontinuation. Any letters received from other area pediatric providers after this application is filed will be forwarded to the State Agency upon receipt.

Safety Net

1. The discontinuation of the pediatric inpatient service will not impact other area providers, since Gateway's service has had no volume over the past two (2) years.

2. The applicants have no knowledge regarding cross subsidization of services.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2013**	**2012**	**2011**
Inpatient	548	641	466
Outpatient	1013	1097	752
Total	1561	1738	1218
Charity (cost In dollars)			
Inpatient	2,493,972	2,224,137	1,597,918
Outpatient	806,089	671,406	481,026
Total	3,290,061	2,895,544	2,078,944
MEDICAID			
Medicaid (# of patients)	**2013**	**2012**	**2011**
Inpatient	1633	1999	2104
Outpatient	19,623	20,476	20,587
Total	21,256	22,475	22,601
Medicaid (revenue)			
Inpatient	100,032,066	74,755,465	89,505,111
Outpatient	78,579,366	47,681,091	66,302,814
Total	178,611,432	122,436,556	155,807,925

The above safety net information is true and accurate to the best of my knowledge.

Mark Edward Cunningham
CEO, Gateway Regional Medical Center

Subscribed and sworn to before me this
25 day of February, 2015.

Ky L. Scott
Notary Public

OFFICIAL SEAL
KY L. SCOTT
Notary Public - State of Illinois
My Commission Expires 8/10/2018

Charity Care

CHARITY CARE			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	91,988,762	89,195,659	100,579,862
Amount of Charity Care (charges)	19,484,009	27,137,241	30,854,688
Cost of Charity Care	2,078,944	2,895,544	3,290,061

Appendix A

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Ms. Maryann Reese
St. Elizabeth's Hospital
211 South Third Street
Belleville, IL 62220

Re: Discontinuation of 5 Bed Pediatric Service

Dear Ms. Reese,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

Per the rules of the Health Facilities and Services Review Board, if you do not respond to this request within fifteen days of receipt, it is assumed there is no impact on your facility.

Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO

7011 1570 0001 2158 9473

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here
2/13/15

Se
St or
Ci

Ms. Maryann Reese
St. Elizabeth's Hospital
211 South Third Street
Belleville, IL 62220

PS Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Maryann Reese
St. Elizabeth's Hospital
211 South Third Street
Belleville, IL 62220

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible]
C. Date of Delivery 2/17/15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
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4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 1570 0001 2158 9473

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Mr. Larry McCulley
Touchette Regional Hospital
5900 Bond Avenue
Centreville, IL 62207

Re: Discontinuation of 5 Bed Pediatric Service

Dear Mr. McCulley,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

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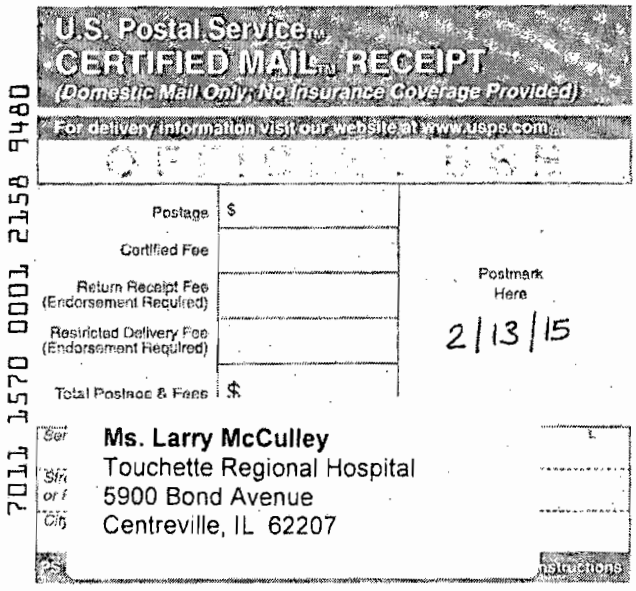
Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO

2100 Madison Avenue • Granite City, IL 62040 • (618) 798-3000



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Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $

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2/13/15

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City

Ms. Larry McCulley
Touchette Regional Hospital
5900 Bond Avenue
Centreville, IL 62207

Instructions

7011 1570 0001 2158 9480

SENDER: COMPLETE THIS SECTION

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Larry McCulley
Touchette Regional Hospital
5900 Bond Avenue
Centreville, IL 62207

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x Sue A. Reynolds ☑ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
Sue A Reynolds

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
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4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 9480

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Mr. David A. Braasch
Alton Memorial Hospital
One Memorial Drive
Alton, IL 62002

Re: Discontinuation of 5 Bed Pediatric Service

Dear Mr. Braasch,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

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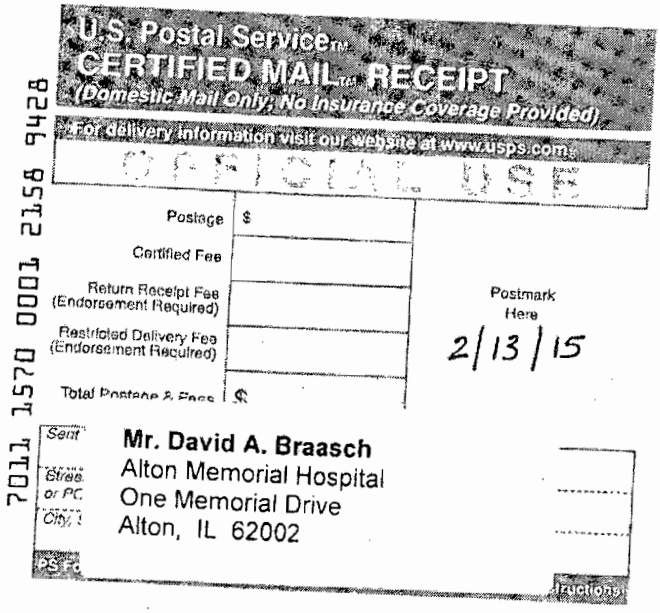
Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO



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Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $

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2/13/15

Sent To
Mr. David A. Braasch
Alton Memorial Hospital
One Memorial Drive
Alton, IL 62002

Street, Apt. No., or PO Box No.
City, State, ZIP+4
PS Form
Instructions

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. David A. Braasch
Alton Memorial Hospital
One Memorial Drive
Alton, IL 62002

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Tom J Keller ☐ Agent ☐ Addressee

B. Received by (Printed Name) Tom J Keller
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 9428

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Mr. Ajay Pathak
OSF Saint Anthony's Health Center
P. O. Box 340
Alton, IL 62002

Re: Discontinuation of 5 Bed Pediatric Service

Dear Mr. Pathak,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

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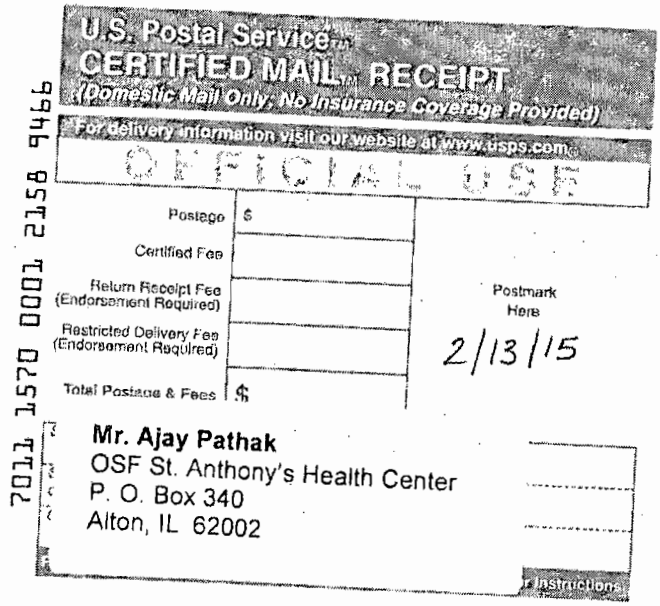
Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO



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7011 1570 0001 2158 9466
Mr. Ajay Pathak
OSF St. Anthony's Health Center
P. O. Box 340
Alton, IL 62002
Instructions

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Ajay Pathak
OSF St. Anthony's Health Center
P. O. Box 340
Alton, IL 62002

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name) D Pace
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 9466

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Recd 2/23/2015

PHONE (618) 635-2200

COMMUNITY MEMORIAL HOSPITAL
400 CALDWELL ST.
STAUNTON ILLINOIS 62088-1499

February 19, 2015

Mr. Edward Cunningham, CEO
Gateway Regional Medical Center
2100 Madison Avenue
Granite City, IL 62040

RE: Discontinuation of 5 Bed
Pediatric Service

Dear Mr. Cunningham,

I would like to thank you for the notice that you sent regarding the discontinuation of the five (5) bed Pediatric Service. I have been asked by our Nursing Administrator and Emergency Department Supervisor to verify that this is not the Kettler Adolescent Psych Unit.

Our facility does not transfer any pediatric patients to Gateway Regional Medical Center, but we do utilize the Kettler Adolescent Unit, and we are hopeful that program will continue. Thank you for responding to this inquiry.

Sincerely,

Sue Campbell

Sue Campbell, CEO
Community Memorial Hospital
400 North Caldwell Street
Staunton, IL 62088
618-635-4241
scampbell@stauntonhospital.org

C: Roberta Brown, Nursing Administrator, CMH

Morris, Vickie L

From: Sue Campbell <scampbell@stauntonhospital.org>
Sent: Monday, February 23, 2015 4:26 PM
To: Morris, Vickie L
Cc: Cunningham, Ed
Subject: RE: Gateway Regional Medical Center Discontinuation of 5 Bed Pediatric Service

Thank you so kindly. We truly appreciate your response, and I want to add that the Psychiatric beds that your facility offers are truly a resource for our rural hospital. Thank you again.

Sue Campbell, CEO
Community Memorial Hospital
Staunton, IL 62088
618-635-4241
scampbell@stauntonhospital.org

From: Morris, Vickie L [mailto:Vickie_Morris@chs.net]
Sent: Monday, February 23, 2015 4:21 PM
To: Sue Campbell
Cc: Cunningham, Ed
Subject: Gateway Regional Medical Center Discontinuation of 5 Bed Pediatric Service

Ms. Campbell,

This is being sent to you on behalf of Ed Cunningham, CEO at Gateway Regional Medical Center.

In response to the clarification request in your letter dated February 19, 2015 and received by our office today, the 5 Bed Pediatric Service is Acute Care, not Psychiatric.

Thanks,

Vickie Morris | *Sr. Administrative Assistant* | **Gateway Regional Medical Center**
2100 Madison Avenue | Granite City, IL 62040 | T: 618.798.3280 | F: 618.798.3724

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Ms. Peggy Sebastian
St. Joseph's Hospital Highland
12866 Troxler Avenue
Highland, IL 62249

Re: Discontinuation of 5 Bed Pediatric Service

Dear Ms. Sebastian,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

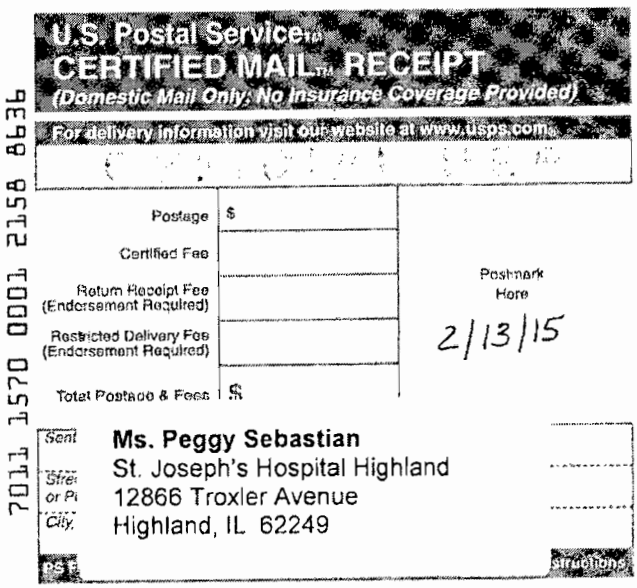
Per the rules of the Health Facilities and Services Review Board, if you do not respond to this request within fifteen days of receipt, it is assumed there is no impact on your facility.

Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO

2100 Madison Avenue • Granite City, IL 62040 • (618) 798-3000



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City, State, ZIP+4

Ms. Peggy Sebastian
St. Joseph's Hospital Highland
12866 Troxler Avenue
Highland, IL 62249

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
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1. Article Addressed to:

Ms. Peggy Sebastian
St. Joseph's Hospital Highland
12866 Troxler Avenue
Highland, IL 62249

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Deb Hartzog ☐ Agent ☐ Addressee

B. Received by (Printed Name) Deb Hartzog C. Date of Delivery 2-17-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 8636

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Mr. Mark Turner
Memorial Hospital
4500 Memorial Drive
Belleville, IL 62226

Re: Discontinuation of 5 Bed Pediatric Service

Dear Mr. Turner,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

For your information, the volume in our pediatric beds has been zero in years 2013 and 2014. We do not see this changing, which is one of the reasons we are planning to discontinue the service. However, please advise us if you believe your facility would have the capacity (or would not have capacity) to serve residents of the planning area requiring this service. Also, if you believe there are restrictions in the planning area preventing area residents from receiving appropriate pediatric services, please advise us.

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Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO

2100 Madison Avenue • Granite City, IL 62040 • (618) 798-3000

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2/13/15

Sent To
Street, Apt. No.; or PO Box No.
City, State, ZIP+4

Mr. Mark Turner
Memorial Hospital
4500 Memorial Drive
Belleville, IL 62226

PS Form 3800, August 2006 — See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Mark Turner
Memorial Hospital
4500 Memorial Drive
Belleville, IL 62226

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Fred Weigand ☐ Agent ☐ Addressee

B. Received by (Printed Name) Fred Weigand — C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 1570 0001 2158 9459

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Mr. Keith Page
Anderson Hospital
6800 State Route 162
Maryville, IL 62062

Re: Discontinuation of 5 Bed Pediatric Service

Dear Mr. Page,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

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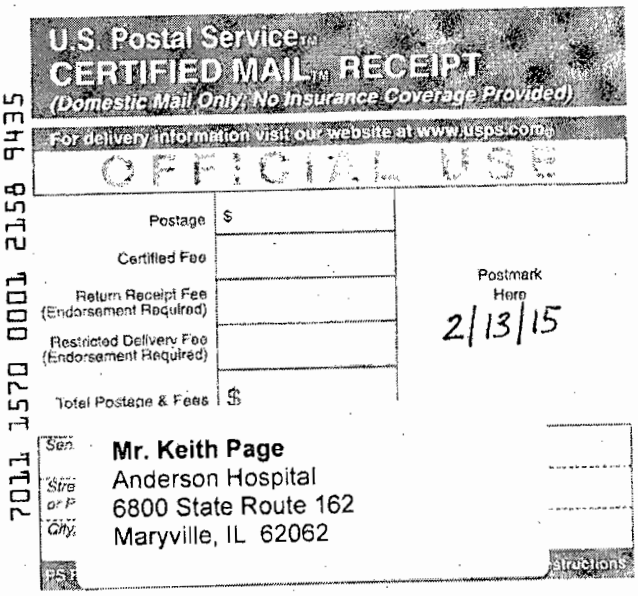
Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO



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City
Mr. Keith Page
Anderson Hospital
6800 State Route 162
Maryville, IL 62062
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structions
7011 1570 0001 2158 9435

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- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Keith Page
Anderson Hospital
6800 State Route 162
Maryville, IL 62062

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Laura Ellis ☐ Agent ☐ Addressee

B. Received by (Printed Name) Laura Ellis
C. Date of Delivery 2-17-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 9435

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

GATEWAY REGIONAL MEDICAL CENTER

VIA CERTIFIED MAIL / RETURN RECEIPT

February 13, 2015

Ms. Sue Campbell
Community Memorial Hospital
400 Caldwell
Staunton, IL 62088

Re: Discontinuation of 5 Bed Pediatric Service

Dear Ms. Campbell,

I am writing to inform you that Gateway Regional Medical Center plans to file a Certificate of Need application with the Health Facilities and Services Review Board, seeking approval to discontinue its five (5) bed category of service. As part of this process, I am writing to ask you to advise us whether you believe this discontinuation will have any impact on your facility, or its pediatric bed category of service.

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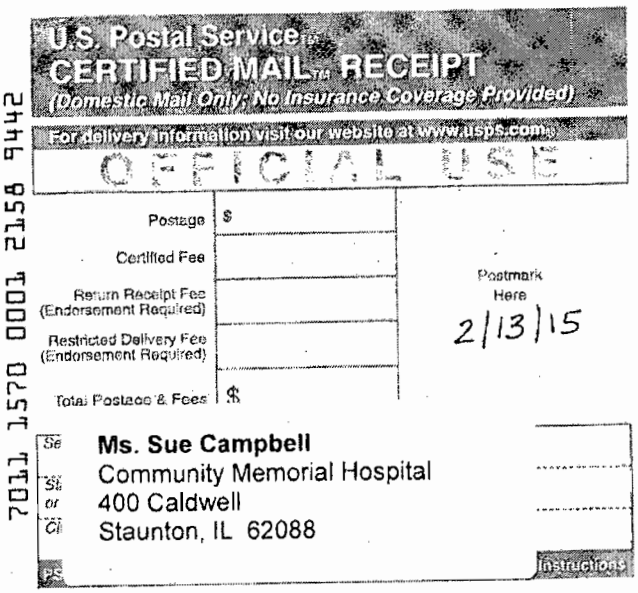
Thank you for your consideration.

Sincerely,

M. Edward Cunningham, CEO

2100 Madison Avenue • Granite City, IL 62040 • (618) 798-3000



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7011 1570 0001 2158 9442
Ms. Sue Campbell
Community Memorial Hospital
400 Caldwell
Staunton, IL 62088
PS Instructions

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Sue Campbell
Community Memorial Hospital
400 Caldwell
Staunton, IL 62088

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 2-17-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1570 0001 2158 9442

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mapquest

Notes

Alton Memorial Hospital
1 Memorial Drive, Alton, IL 62002

Trip to:

Alton Memorial Hospital
1 Memorial Dr
Alton, IL 62002
(618) 463-7311
18.58 miles / 27 minutes
Estimated Fuel Cost: **$2.12**

mapquest

Notes
Anderson Hospital
6800 State Route 162, Maryville, IL 62062

Trip to:
Anderson Hospital
6800 State Route 162
Maryville, IL 62062
(618) 288-5711
11.62 miles / 18 minutes
Estimated Fuel Cost: **$1.27**

mapquest

Notes

Community Memorial Hospital
400 Caldwell Street, Staunton, IL 62088

Trip to:
400 N Caldwell St
Staunton, IL 62088-1423
35.83 miles / 42 minutes
Estimated Fuel Cost: **$3.93**

mapquest

Trip to:

Memorial Hospital
4500 Memorial Dr
Belleville, IL 62226
(618) 233-7750
16.55 miles / 24 minutes
Estimated Fuel Cost: **$1.99**

Notes

Memorial Hospital
4500 Memorial Drive, Belleville, IL 62226

mapquest

Notes

OSF Saint Anthony's Health Center
1 Saint Anthony's Way, Alton, IL 62002

Trip to:

1 St Anthonys Way

Alton, IL 62002-4568

19.55 miles / 28 minutes

Estimated Fuel Cost: **$2.21**

mapquest

Notes

St. Elizabeth's Hospital
211 South Third, Belleville, IL 62220

Trip to:

St. Elizabeth's Hospital
211 S 3rd
Belleville, IL 62220
(618) 234-3750
22.32 miles / 29 minutes
Estimated Fuel Cost: **$2.49**

mapquest

Notes

St. Joseph's Hospital - Highland
12866 Troxler Avenue - Highland, IL 62249

Trip to:

St. Joseph's Hospital - Highland
12866 Troxler Ave
Highland, IL 62249
(618) 651-2600
29.81 miles / 36 minutes
Estimated Fuel Cost: **$3.23**

mapquest

Notes

Touchette Regional Hospital
5900 Bond Avenue, East St. Louis, IL 62207

Trip to:

Touchette Regional Hospital
5900 Bond Ave
East Saint Louis, IL 62207
(314) 241-8958
12.14 miles / 20 minutes
Estimated Fuel Cost: **$1.45**