

E-042-17

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
HEALTH FACILITIES & SERVICES REVIEW BOARD  
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

ORIGINAL

Facility/Project Identification

Facility Name: Midwest Medical Center
Street Address: One Medical Center Drive
City and Zip Code: Galena, IL 61036
County: Jo Daviess                      Health Service Area: I                      Health Planning Area: B-2

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

Exact Legal Name: Midwest Medical Foundation
Street Address: One Medical Center Drive
City and Zip Code: Galena 61036
Name of Registered Agent: Stephen T. Moore
Registered Agent Street Address: 100 Park Avenue
Registered Agent City and Zip Code: Rockford, IL 61101
Name of Chief Executive Officer Tracy Bauer
CEO Street Address: 1 Medical Center Drive
CEO City and Zip Code Galena, IL 61036
CEO Telephone Number: 815-776-7266

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o Partnerships must provide the name of the state in which 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: Tracy Bauer
Title: CEO
Company Name: Midwest Medical Center
Address: One Medical Center Drive
Telephone Number: 815-776-7266
E-mail Address: tbauer@midwestmedicalcenter.org
Fax Number: 815-777-2560

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

Name: Marie Wamsley
Title: CFO

Company Name: Midwest Medical Center
Address: One Medical Center Drive
Telephone Number: 815-776-7277
E-mail Address: MWamsley@midwestmedicalcenter.org
Fax Number: 815-777-2560

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APPLICATION FOR EXEMPTION PERMIT**

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City and Zip Code: Galena, IL 61036		
County: Jo Daviess	Health Service Area: I	Health Planning Area: B-2

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

Exact Legal Name: MMC Health System
Street Address: One Medical Center Drive
City and Zip Code: Galena 61036
Name of Registered Agent: Stephen T. Moore
Registered Agent Street Address: 100 Park Avenue
Registered Agent City and Zip Code: Rockford, IL 61101
Name of Chief Executive Officer Tracy Bauer
CEO Street Address: 1 Medical Center Drive
CEO City and Zip Code Galena, IL 61036
CEO Telephone Number: 815-776-7266

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E-mail Address: MWamsley@midwestmedicalcenter.org
Fax Number: 815-777-2560

### Post Exemption 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: Tracy Bauer
Title: CEO
Company Name: Midwest Medical Center
Address: One Medical Center Drive
Telephone Number: 815-776-7266
E-mail Address: tbauer@midwestmedicalcenter.org
Fax Number: 815-777-2560

### Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Midwest Medical Center
Address of Site Owner: One Medical Center Drive, Galena, IL 61036
Street Address or Legal Description of the Site: One Medical Center Drive, Galena, IL 61036
<b>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.</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

### Operating Identity/Licensee

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

Exact Legal Name: Midwest Medical Center
Address: One Medical Center Drive, Galena, IL 61036
<input checked="" type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"><li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li><li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li></ul>
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

### 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.

<b>APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>
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### **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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

**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 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- Change of Ownership
- Discontinuation of an Existing Health Care Facility or of a category of service
- Establishment or expansion of a neonatal intensive care or beds



## 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.

Midwest Medical Foundation (the "Foundation"), is an Illinois not for profit corporation, exempt under IRC § 501(c)(3). MMC Health System (the "System") is the sole member of the Foundation and of Midwest Medical Center ("MMC"), an Illinois not for profit corporation, exempt under IRC § 501(c)(3), which owns and operates a licensed critical access hospital, two rural health clinics, assisted living facilities and a licensed skilled nursing facility. The System has no assets or liabilities.

The Foundation is seeking funds through the USDA Rural Development Community Facilities Loan Program ("USDA Program") which will be used to finance the costs of construction of an additional road/entrance to the MMC campus (the cost of which is well below the capital expenditure threshold published by the Board), and the refinance of existing bonded indebtedness of the System, Foundation and MMC. In order to satisfy the USDA Program requirements, the Foundation, System and MMC will reorganize.

This application seeks an exemption for a Change in Ownership Among Related Persons by a change in membership of MMC, whereby the Foundation will become the sole member of MMC and the System will dissolve. There are no other changes being proposed that would otherwise require a permit or exemption under the Act.

Pursuant to Section 1110.40 of the Illinois Administrative Code, this project is considered "non-substantive" because it involves only the substitution of membership of MMC, and does not involve the establishment or discontinuation of any category of service, does not impact bed capacity and otherwise does not involve construction or modification classified as substantive or emergency under the Board's rules.

### Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

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)			
<b>TOTAL USES OF FUNDS</b>			
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			
<b>TOTAL SOURCES OF FUNDS</b>			
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purchase Price: \$ _____ Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all <b>non-capitalized</b> 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**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>
Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): Upon approval by HFSRB
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> 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 <input type="checkbox"/> Financial Commitment will occur after permit issuance.
<b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**State Agency Submittals [Section 1130.620(c)]**

Are the following submittals up to date as applicable: <input checked="" type="checkbox"/> Cancer Registry <input checked="" type="checkbox"/> APORS <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted <input checked="" type="checkbox"/> All reports regarding outstanding permits <b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b>
---

**CERTIFICATION**

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

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

This Application is filed on the behalf of Midwest Medical Foundation\* 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.

Tracy L. Bauer  
 SIGNATURE  
Tracy Bauer  
 PRINTED NAME  
CEO  
 PRINTED TITLE

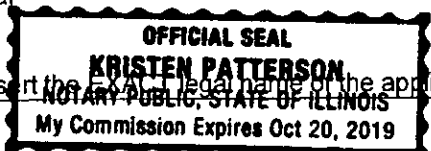
Cheryl Farruggia  
 SIGNATURE  
Cheryl Farruggia  
 PRINTED NAME  
Vice Chair  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 31<sup>st</sup> day of August

Notarization:  
 Subscribed and sworn to before me  
 this 31<sup>st</sup> day of August

Kristen Patterson  
 Signature of Notary

Kristen Patterson  
 Signature of Notary

Seal  
  
 \*Insert the EXACT legal name of the applicant

Seal  


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Tracy L. Bauer  
SIGNATURE  
Tracy Bauer  
PRINTED NAME  
CEO  
PRINTED TITLE

Cheryl Ferruggi  
SIGNATURE  
Cheryl Ferruggi  
PRINTED NAME  
Vice Chair  
PRINTED TITLE

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Signature of Notary

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Seal  
\*Insert the EXACT legal name of the applicant  
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**KRISTEN PATTERSON**  
NOTARY PUBLIC, STATE OF ILLINOIS  
My Commission Expires Oct 20, 2019

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This Application is filed on the behalf of MMC Health System\* 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.

Tracy L. Bauer  
SIGNATURE

Tracy Bauer  
PRINTED NAME

CEO  
PRINTED TITLE

[Signature]  
SIGNATURE

Cheryl Caruggate  
PRINTED NAME

Vice Chair  
PRINTED TITLE

Notarization:  
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this 31<sup>st</sup> day of August

Kristen Patterson  
Signature of Notary

Seal  
  
 \*Insert EXACT legal name of the applicant

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this 31<sup>st</sup> day of August

Kristen Patterson  
Signature of Notary

Seal  


**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.

**Background**

**READ THE REVIEW CRITERION and provide the following required information:**

**BACKGROUND OF APPLICANT**

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

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

**Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership) – N/A, as this application involves only a Change of Ownership**

**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 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** of 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 V. CHANGE OF OWNERSHIP (CHOW)

### 1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.
3. READ the applicable review criteria outlined below and submit the required documentation (key terms) for the criteria:

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	X
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year	X

period following the change of ownership transaction	
1130.520(b)(2) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

### **Application for Change of Ownership Among Related Persons**

*When a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership. [20 ILCS 3960/8.5(a)]*

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

**SECTION VIII.      1120.140 - ECONOMIC FEASIBILITY**

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

**A. Reasonableness of Financing Arrangements – N/A as this application requests a certificate of exemption for a Change in Ownership Among Related Persons and involves no project cost.**

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 of the cash and equivalents must be retained in the balance sheet asset accounts in order 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 - N/A as this application requests a certificate of exemption for a Change in Ownership Among Related Persons and involves no project cost.**

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 Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

\* Include the percentage (%) of space for circulation

**D. Projected Operating Costs - N/A as this application requests a certificate of exemption for a Change in Ownership Among Related Persons and involves no project cost.**

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 - N/A as this application requests a certificate of exemption for a Change in Ownership Among Related Persons and involves no project cost.**

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

**SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)**

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 41.

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

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**ATTACHMENT 1**

***Section 1 – Certificates of Good Standing***

Certificates of good standing for the following entities are attached:

Midwest Medical Foundation: an Illinois not-for-profit corporation.

Midwest Medical Center: an Illinois not-for-profit corporation.

MMC Health System: an Illinois not-for-profit corporation.

File Number

6467-284-3



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

MIDWEST MEDICAL FOUNDATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 25, 2006, 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.



Authentication #: 1723301536 verifiable until 08/21/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set**  
*my hand and cause to be affixed the Great Seal of*  
*the State of Illinois, this 21ST*  
*day of AUGUST A.D. 2017 .*

*Jesse White*

SECRETARY OF STATE

Attachment 1

File Number

6467-283-5



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

MIDWEST MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 25, 2006, 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.



Authentication #: 1723301624 verifiable until 08/21/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 21ST day of AUGUST A.D. 2017 .**

*Jesse White*

SECRETARY OF STATE



File Number

6464-200-6



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

MMC HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 25, 2006, 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.



Authentication #: 1723301688 verifiable until 08/21/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 21ST  
day of AUGUST A.D. 2017 .**

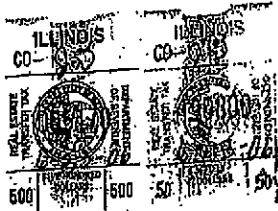
*Jesse White*

SECRETARY OF STATE

**ATTACHMENT 2**

***Section 1 – Site Ownership***

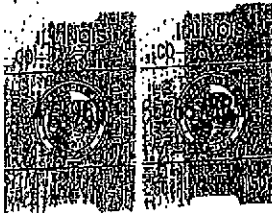
There is no change in site ownership. Attached is a copy of the Warranty Deed conveying ownership of the site to Midwest Medical Center.



PREPARED BY:  
Vincent & Roth P.C.  
Main & Perry Streets  
Galena, IL 61036

MAIL TAX BILL TO:  
Midwest Regional Medical Center  
215 Summit Street  
Galena, IL 61036

MAIL RECORDED DEED TO:  
Midwest Regional Medical Center  
215 Summit Street  
Galena, IL 61036



328766

JO DAVIESS COUNTY RECORDER  
STATE OF ILLINOIS

June 23 06 1:40 P M  
DATE TIME

Jan Dinty

Rental Housing Support Program  
\$10 State Surcharge Paid  
Date: 6-23-06

**WARRANTY DEED**

Statutory (Illinois)

THE GRANTORS, J Eric Einsweiler and Kurt D Einsweiler, as Tenants in Common, and not as Joint Tenants with right of survivorship, both of the City of Galena, County of Jo Daviess and State of Illinois, for and in consideration of Ten Dollars (\$10.00) and other good and valuable considerations, in hand paid, CONVEY AND WARRANT to MIDWEST REGIONAL MEDICAL CENTER, an Illinois not-for-profit corporation, of 215 Summit Street, Galena, IL 61036, all right, title, and interest in the following described real estate situated in the County of JO DAVIESS, State of Illinois, to wit:

Part of the Southeast and Southwest Quarters of Section 2, Township 28 North, Range 1 West of the Fourth Principal Meridian, Jo Daviess County, Illinois, more particularly described as follows: Beginning at a hex bolt found in concrete at the South Quarter Corner of Section 2, Township 28 North, Range 1 West of the Fourth Principal Meridian, Jo Daviess County, Illinois; thence North 87 degrees 30 minutes 49 seconds West along the South line of the Southwest Quarter of said Section 2, a distance of 985.07 feet to an iron rod survey monument set in Norris Lane over the center of an existing North-South drainage ditch; thence North 4 degrees 02 minutes 18 seconds West along said ditch line, a distance of 160.48 feet; thence North 20 degrees 04 minutes 28 seconds East along said ditch, a distance of 249.38 feet; thence North 3 degrees 27 minutes 05 seconds East along said ditch, a distance of 177.13 feet; thence North 17 degrees 34 minutes 11 seconds East along said ditch, a distance of 199.47 feet; thence North 14 degrees 08 minutes 41 seconds West along said ditch, a distance of 111.10 feet; thence North 37 degrees 31 minutes 30 seconds East along said ditch, a distance of 95.72 feet; thence North 20 degrees 45 minutes 17 seconds East along said ditch, a distance of 138.77 feet; thence North 27 degrees 51 minutes 05 seconds East along said ditch, a distance of 158.58 feet; thence North 15 degrees 29 minutes 06 seconds East along said ditch, 96.18 feet to an iron rod survey monument set on the North line of the South Half of said Southwest Quarter of Section 2; thence South 87 degrees 26 minutes 30 seconds East along said North line, a distance of 649.27 feet to an iron rod survey monument found at the Northeast Corner of the Southwest Quarter of Section 2; thence South 87 degrees 30 minutes 08 seconds East along the North line of the South Half of the Southeast Quarter of said Section 2, a distance of 92.64 feet to the centerline of US Highway 20; thence South 15 degrees 54 minutes 48 seconds East along said centerline, a distance of 1395.73 feet to the South line of said Southeast Quarter of Section 2; thence North 86 degrees 55 minutes 47 seconds West, a distance of 465.66 feet to the point of beginning, containing 34.440 acres, more or less, all situated in Jo Daviess County, Illinois.  
Permanent Index Number(s): Split of 43-13-000-056-00  
Property Address: Route 20 West, Galena, IL 61036

Subject, however, to the general taxes for the year of 2005 and thereafter, and all instruments, covenants, restrictions, conditions, applicable zoning laws, ordinances, and regulations of record.

Hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.  
Dated this 23rd Day of June 20 06

*J Eric Einsweiler*  
J Eric Einsweiler

*Kurt D Einsweiler*  
Kurt D Einsweiler

JO DAVIESS COUNTY, ILLINOIS  
Real Estate Transfer Tax  
\$ 215.75  
25¢ per \$500 consideration

Warranty Deed: Page 1 of 2  
FOR USE IN ALL STATES

ATG FORM 4067-R  
© ATG (REV. 04/02)

Exhibit B

Warranty Deed - Continued

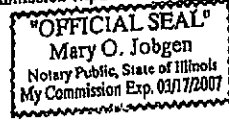
STATE OF ILLINOIS )  
 ) SS.  
COUNTY OF JO DAVIESS )

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, do hereby certify that J Eric Einsweiler and Kurt D Einsweiler, personally known to me to be the same persons whose names are subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that they signed, sealed and delivered the said instrument, as their free and voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.

Given under my hand and notarial seal, this 23rd Day of June 20 06

Mary O. Jobgen  
Notary Public  
My commission expires: \_\_\_\_\_

Exempt under the provisions of paragraph \_\_\_\_\_



Warranty Deed: Page 2 of 2  
FOR USE IN ALL STATES

### ATTACHMENT 3

#### ***Section 1 – Operating Identity/Licensee***

Midwest Medical Center: an Illinois not-for-profit corporation, is the owner and operator of a licensed critical access hospital, two rural health clinics (Midwest Health Clinic and Midwest Health Clinic of Elizabeth), a 24-apartment assisted living center (Galena-Stauss Assisting Living), a 57-bed intermediate care skilled nursing facility (Galena-Stauss Nursing Care Center) and an adult day care center. Midwest Medical Center will remain the owner and operator of such facilities following the transaction. A copy of the Midwest Medical Center Illinois Certificate of Good Standing is attached.

File Number

6467-283-5



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

MIDWEST MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 25, 2006, 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.



Authentication #: 1723301524 verifiable until 08/21/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set**  
*my hand and cause to be affixed the Great Seal of*  
*the State of Illinois, this 21ST*  
*day of AUGUST A.D. 2017 .*

*Jesse White*

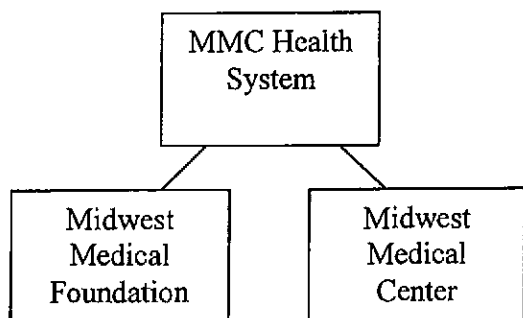
SECRETARY OF STATE

**ATTACHMENT 4**

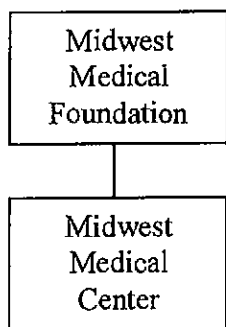
***Section I – Organizational Relationship***

An organizational chart showing the current organizational structure of Midwest Medical Center, along with the post-closing organizational structure, is set forth below.

**Pre-Closing Structure**



**Post-Closing Structure**



Under the proposed Change of Ownership Among Related Persons transaction, MMC Health System will dissolve and Midwest Medical Foundation will become the sole member of Midwest Medical Center.

**ATTACHMENT 5**

By their signature on the certification page for this application, the applicants certify that the hospital and other health care facilities located at One Medical Center Drive, Galena, Illinois are not located in a special flood hazard area and this project complies with the requirements of the Flood Plain Rule under Illinois Executive Order #2006-5.



**ATTACHMENT 6**

The proposed project does not involve or include the demolition of any structures; the construction of any new building; or the modernization of any existing buildings and will not affect historic resources.

## ATTACHMENT 11

### **Section III – Background of the Applicant**

1. **A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

Midwest Medical Center, an Illinois not-for-profit corporation, and an applicant hereto, owns the following health care facilities:

- Midwest Medical Center, a licensed critical access hospital
- Midwest Health Clinic, a rural health clinic
- Midwest Health Clinic of Elizabeth, a rural health clinic
- Galena-Stauss Senior Care Community, consisting of:
  - Galena-Stauss Assisted Living, a 24-apartment assisted living center
  - Galena-Stauss Nursing Care Center, a 57-bed licensed skilled nursing facility
  - An adult day care center

Licensure and certifications of the above-listed facilities are attached.

Neither Midwest Medical Foundation nor MMC Health System own or operate any health care facilities.

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

By their signatures on the Certification pages to this application, each of the applicants attest that no adverse action has been taken against any facility owned and/or operated by them during the three years prior to the filing of this application.

3. **Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

By their signatures to the Certification pages to this application, each of the applicants authorize the HFSRB and DPH to access any documents necessary to verify the information submitted, including, but not limited to: (i) official records of DPH or other State agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of nationally recognized accrediting organizations.

4. **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 is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.**

N/A – no other applications for permit have been submitted by any of the applicants in this calendar year.

HF 111994

**Illinois Department of  
PUBLIC HEALTH**

**LICENSE PERMIT CERTIFICATION REGISTRATION**

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

**Nirav D. Shah, M.D., J.D.**  
Director

ISSUED UNDER THE SUPERVISION OF  
THE ILLINOIS DEPARTMENT OF  
PUBLIC HEALTH

EXPIRATION DATE	CATEGORY	ID NUMBER
12/4/2017		0005488

**Critical Access Hospital**

Effective: 12/05/2016

Midwest Medical Center  
One Medical Center Drive  
Galena, IL 61036

This type of this license has a colored background. Printed by authority of the State of Illinois • P.H.S. 24013220 10M 6/16

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

Exp. Date 12/4/2017  
Lic Number 0005488

Date Printed 10/26/2016

Midwest Medical Center  
One Medical Center Drive  
Galena, IL 61036

FEE RECEIPT NO.

REGISTRATION NUMBER	REGISTRATION PERIOD	FEE PAID
FM0574809	01-31-2019	3751
SCHEDULE	BUSINESS ACTIVITY	DATE ISSUED
2,3,4,5	HOSPITAL/CLINIC	12-28-2018
MIDWEST REGIONAL CENTER PHARMACY ONE MEDICAL CENTER DRIVE GALENA, IL 61036		

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**  
UNITED STATES DEPARTMENT OF JUSTICE  
DRUG ENFORCEMENT ADMINISTRATION  
WASHINGTON, D.C. 20537

Sections 304 and 308 (21 U.S.C. 874 and 878) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

**THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.**

REGISTRATION NUMBER	REGISTRATION PERIOD	FEE PAID
FM0574809	01-31-2019	3751
SCHEDULE	BUSINESS ACTIVITY	DATE ISSUED
2,3,4,5	HOSPITAL/CLINIC	12-28-2018
MIDWEST REGIONAL CENTER PHARMACY ONE MEDICAL CENTER DRIVE GALENA, IL 61036		

**CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE**  
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**THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.**


<https://www.deaiversion.usdoj.gov/webforms/printCertImage.do>

12/28/2015

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS  
CERTIFICATE OF ACCREDITATION**

<b>LABORATORY NAME AND ADDRESS</b> MIDWEST MEDICAL CENTER ONE MEDICAL CENTER DRIVE GALENA, IL 61038	<b>CLIA ID NUMBER</b> 14D0428720
	<b>EFFECTIVE DATE</b> 09/18/2016
<b>LABORATORY DIRECTOR</b> ANDREW VANDERHEYDEN M.D.	<b>EXPIRATION DATE</b> 09/17/2018

Pursuant to Section 253 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown herein (and other approved locations) may accept human specimens for the purpose of performing laboratory examinations or procedures. This certificate shall be valid until the expiration date shown, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



*Karen W. Dyer*  
Karen W. Dyer, Acting Director  
Division of Laboratory Services  
Survey and Certification Group  
Center for Clinical Standards and Quality

808 CertID\_037417

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)	EFFECTIVE DATE	LAB CERTIFICATION (CODE)	EFFECTIVE DATE
BACTERIOLOGY (110)	09/18/2012		
GENERAL IMMUNOLOGY (220)	09/18/2012		
ROUTINE CHEMISTRY (310)	09/18/2012		
URINALYSIS (320)	09/18/2012		
ENDOCRINOLOGY (330)	09/18/2012		
TOXICOLOGY (340)	09/18/2012		
HEMATOLOGY (400)	09/18/2012		
ABO & RH GROUP (510)	09/18/2012		
ANTIBODY TRANSFUSION (520)	09/18/2012		
ANTIBODY NON-TRANSFUSION (530)	09/18/2012		
COMPATIBILITY TESTING (550)	09/18/2012		

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT [WWW.CMS.GOV/CLIA](http://WWW.CMS.GOV/CLIA) OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.  
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.



# American College of Radiology

Mammographic Imaging Services of

Midwest Medical Center

One Medical Ctr Dr  
Galena, Illinois 61036

were surveyed by the  
Committee on Mammography Accreditation of the  
Commission on Quality and Safety

The following unit was approved

**General Electric Co. (GE Medical Systems) SENOGAPHE  
ESSENTIAL 2010**

Accredited from:

**June 12, 2015 through June 12, 2018**

CHAIRMAN, COMMITTEE ON  
MAMMOGRAPHY ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF  
RADIOLOGY

MAP# 07794-03

**AIEMA**



**STATE OF ILLINOIS  
Illinois Emergency Management Agency  
CERTIFIED MAMMOGRAPHY FACILITY**

This certifies that

**Midwest Medical Center  
One Medical Ctr Dr  
Galena, IL 61036-1697**

has complied with the requirements of the Mammography Quality Standards Act of 1992 and is hereby authorized to perform mammography examinations pursuant to 32 Illinois Administrative Code 370 and 42 U.S.C. 263b.

ACCREDITATION BODY: American College of Radiology  
1891 Preston White Drive  
Reston, VA 22091  
703/648-8980

FACILITY ID NUMBER: 113563  
EXPIRATION DATE: 6/12/2018

Patients may report comments or complaints to the Accreditation Body or:

Bruce Rauner, Governor

Joseph Klingler, Assistant Director

Registration & Certification  
Illinois Emergency Management Agency  
1035 Outer Park Drive  
Springfield, Illinois 62704  
217/785-9923  
217/782-6023 (TDD)

CONTRDL NUMBER: 15-03987

*American Association for Accreditation of  
Ambulatory Surgery Facilities, Inc.*

*Presents this certificate to*

*Midwest Health Clinic of Elizabeth*

*for having met the standards set by the American Association for Accreditation of Ambulatory  
Surgery Facilities, Inc. Medicare Program for Rural Health Clinics*

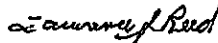
**Rural Health Clinic Accreditation**

AAAASF President  
David O. Watts, MD



Certified from 7/18/2017 to 7/18/2018

Secretary/Treasurer  
Lawrence S. Reed, MD



Certification Number 6228



Midwestern Consortium  
Division of Survey and Certification



CMS Certification Number (CCN): 14-8511

February 18, 2011  
(Via Certified Mail)

Keri Connor  
Practice Manager  
Midwest Health Clinic  
One Medical Center Drive  
Galena, Illinois 61036

Dear Ms. Connor:

The Centers for Medicare & Medicaid Services (CMS) has accepted your request for participation as a provider-based rural health clinic in the Medicare program (Title XVIII of the Social Security Act). Your effective date of participation is December 9, 2010.

Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the CMS Certification Number (CCN) shown above; please provide it when contacting this office, when contacting the Illinois Department of Public Health (IDPH), or any time it is requested.

National Government Services has been authorized to serve as your fiscal intermediary. Any bills previously submitted for Medicare Part B reimbursement for services after the effective date of participation as a rural health clinic should not be resubmitted to your intermediary.

When you make general inquiries to your fiscal intermediary (FI) and/or Medicare Administrative Contractor (MAC), you will be prompted to give either your provider-transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary- and claim-specific information. When prompted for your PTAN, give your CCN. Please note that the processing time of your Medicare approval for billing may take several weeks after your receipt of this notice of approval. For questions related to billing, please contact National Government Services directly.

Your participation as a RHC under the Medicare program will also be accepted as certification as a RHC under the Medicaid program. If you need information about payment for RHC services under the State plan for medical assistance, please contact the Illinois Department of Healthcare and Family Services.

233 North Michigan Avenue  
Suite 600  
Chicago, Illinois 60601-5519

Richard Dolling Federal Building  
601 East 12th Street, Room 235  
Kansas City, Missouri 64106-2802

Page 2  
Keri Connor

The IDPH has advised you of certain deficiencies which were noted during the survey of your rural health clinic. We have reviewed your written plan for correcting the deficiencies and have determined that your plan is acceptable. We expect that you will correct the deficiencies within the time frames specified in your plan of correction. The IDPH will verify correction of the deficiencies.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Regulations at 42 CFR 489.18 require that providers notify CMS when there is a change of ownership. Therefore, you must notify this office promptly if there is a change in your legal status as owner of this facility. You should report to the IDPH any changes in staffing, services, or organization which might affect your certification status.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions about this letter, please contact Stephanie Yarnal at (812) 353-2908.

Sincerely,

/s/  
Mai Lo-Yuen  
Principal Program Representative  
Non-Long Term Care Certification  
& Enforcement Branch

cc: Illinois Department of Public Health  
Illinois Department of Healthcare and Family Services  
National Government Services  
Illinois Foundation for Quality Health Care

State of Illinois  
Department of Public Health

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.

NIRAV D. SHAH, M.D., J.D.      Issued under the authority of  
DIRECTOR      The State of Illinois  
Department of Public Health

EXPIRES	LICENSE
10/29/2017	S100612
Issued: 10/29/2016    Category: A-14	
ASSISTED LIVING LICENSE	
Regular Units    24	Total Units    24

BUSINESS ADDRESS

STATUS: UNRESTRICTED  
LICENSEE BUSINESS ADDRESS

GALENA STAUSS ASSISTED LIVING  
200 ALTENBURG DRIVE  
GALENA      IL 61036

The face of this license has a colored background, printed by Authority of the State of Illinois - 5/16

State of Illinois  
Department of Public Health

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.

NIRAV D. SHAH, M.D., J.D.  
DIRECTOR

Issued under the authority of  
The State of Illinois  
Department of Public Health

EXPIRES	ISSUE
12/05/2018	0049718
LONG TERM CARE LICENSE SKILLED	CATEGORY 57
UNRESTRICTED	57 TOTAL BEDS

BUSINESS ADDRESS  
LICENSES

MIDWEST MEDICAL CENTER

GALENA STAUSS NURSING HOME  
215 SUMMIT STREET  
GALENA IL 61036  
EFFECTIVE DATE: 12/06/16

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## ATTACHMENT 15

### *Section V – Change of Ownership*

1. **1130.250(b)(1)(A), Names of the Parties:** The applicants are: (1) Midwest Medical Foundation, an Illinois not-for-profit corporation; (2) Midwest Medical Center, an Illinois not-for-profit corporation; and (3) MMC Health System, an Illinois not-for-profit corporation.
2. **1130.250(b)(1)(B), Background of the Parties:** Each of the applicants, by their signatures to the Certification pages of this application, attest that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of this application.
3. **1130.250(b)(1)(C), Structure of the Transaction:** This is a Change of Ownership Among Related Persons. Midwest Medical Foundation will become the sole member of Midwest Medical Center; MMC Health System will thereafter dissolve.
4. **1130.250(b)(1)(D), Name of Licensed Entity after Transaction:** There is no change, as Midwest Medical Center will be the licensed entity after the transaction.
5. **1130.250(b)(1)(E), List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons:** MMC Health System is currently the sole member of Midwest Medical Foundation and of Midwest Medical Center, the licensed entity. Following the transaction, Midwest Medical Foundation, an Illinois not-for-profit corporation, will be the sole member of Midwest Medical Center; MMC Health System (which has no assets and no liabilities) will thereafter dissolve.
6. **1130.250(b)(1)(F), Fair market value of assets to be transferred:** The fair market value of the assets to be transferred is \$46,100,000.
7. **1130.250(b)(1)(G), Purchase Price of Other Forms of Consideration to be Provided:** As an internal reorganization among related persons, there is no consideration being provided as part of this transaction other than a commitment by Midwest Medical Foundation to retire the existed indebtedness and obtain a new loan through the USDA Rural Development Community Facilities Loan Program.
8. **1130.250(b)(2), Affirmations:** In accordance with 77 Ill. Admn. Code 1130.520, each of the applicants affirm that any project for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.
9. **1130.250(b)(2), If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction:** Midwest Medical Center, as the only applicant that owns and/or operates one or more health care facilities, including a licensed critical access hospital, affirms that it will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction, and further affirms that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.
10. **1130.250(b)(2), A statement as to the anticipated benefits of the proposed changes in ownership to the community:** The proposed changes in ownership will benefit the community by enabling Midwest Medical Foundation, as the sole member of Midwest Medical Center, to obtain funds through the USDA Rural Development Community Facilities Loan Program. The funds obtained through this program will be used, in part, to finance the costs of construction of

an additional road/entrance to the Midwest Medical Center campus, which will provide safer access by the community to the Midwest Medical Center facilities. The funds obtained through this program will also be used to retire existing bonded indebtedness of MMC Health System, Midwest Medical Foundation and Midwest Medical Center, which will enhance the financial performance and sustainability of Midwest Medical Center and, in turn, will ensure the community has continued access to care provided by the hospital and other health care facilities owned and operated by Midwest Medical Center.

11. **1130.250(b)(2), The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership:** The use of funds for retirement of the existing bonded indebtedness will result in cost savings to Midwest Medical Center of approximately \$700,000 per year.
12. **1130.250(b)(2), A description of the facility's quality improvement program mechanism that will be utilized to assure quality control:** In order to ensure that quality is provided, Midwest Medical Center has an ongoing Quality Improvement (QI) program, the purpose of which is to ensure that the governing body, medical staff and professional service staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. The organizational QI program consists of these focus components: performance improvement, patient safety, quality assessment/improvement and quality control activities. Indicators of key processes and outcomes of care are designed, measured and assessed by all appropriate departments/services and disciplines of Midwest Medical Center.
13. **1130.250(b)(2), A description of the selection process that the acquiring entity will use to select the facility's governing body:** There will be no change in the composition of or the process for selecting the governing body of Midwest Medical Center.
14. **1130.250(b)(2), Statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility:** The applicants have prepared a joint written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240, that will be available for public review on the premises of Midwest Medical Center.
15. **1130.250(b)(2), A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition:** There are no proposed changes to the scope of services or levels of care currently provided at the hospital and related health care facilities owned and operated by Midwest Medical Center that are anticipated to occur within 24 months as a result of the transaction.

**ATTACHMENT 19**

*Section VIII – Economic Feasibility*

**B. Conditions of Debt Financing**

Please see attached notarized statement.





**ATTACHMENT 21**

**Section X – Charity Care Information**

Midwest Medical Center is the only applicant that owns and/or operates one or more health care facilities.

The table below contains the relevant charity care information for the hospital and other health care facilities owned and operated by Midwest Medical Center:

<b>CHARITY CARE</b>			
	<b>2014</b>	<b>2015</b>	<b>2016</b>
<b>Net Patient Revenue</b>	\$17,971,201	\$19,411,684	\$21,319,195
Amount of Charity Care (charges)	\$ 202,480	\$ 145,120	\$ 119,655
Cost of Charity Care	\$ 147,000	\$ 107,000	\$ 85,000

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

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