ORIGINAL

09-068

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
NOV 20 2009
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	**Pinckneyville Community Hospital**				
Street Address:	**101 North Walnut Street**				
City and Zip Code:	**Pinckneyville 62274**				
County:	**Perry**	Health Service Area	**5**	Health Planning Area:	**F-07**

Applicant Identification

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

Exact Legal Name:	**Pinckneyville Community Hospital District (Primary Applicant, Legal entity)**
Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Name of Registered Agent:	
Name of Chief Executive Officer:	**Thomas J. Hudgins**
CEO Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Telephone Number:	**(618) 357-5901**

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Type of Ownership

☐	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.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name:	**Thomas J. Hudgins, FACHE**
Title:	**Administrator / CEO**
Company Name:	**Pinckneyville Community Hospital**
Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Telephone Number:	**(618) 357-5901**
E-mail Address:	**thudgins@pvillehosp.org**
Fax Number:	**(618) 357-6470**

Additional Contact

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

Name:	**Edwin W. Parkhurst, Jr.**
Title:	**Managing Principal**
Company Name:	**PRISM Healthcare Consulting**
Address:	**799 Roosevelt Road, Building 4, Suite 317, Glen Ellyn, Illinois 60137**
Telephone Number:	**(630) 790-5089**
E-mail Address:	**Eparkhurst@consultprism.com**
Fax Number:	**(630) 790-2696**

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	**101 North Walnut Street**				
City and Zip Code:	**Pinckneyville 62274**				
County:	**Perry**	Health Service Area	**5**	Health Planning Area:	**F-07**

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

Exact Legal Name:	**Pinckneyville Community Hospital (License Holder)**
Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Name of Registered Agent:	
Name of Chief Executive Officer:	**Thomas J. Hudgins**
CEO Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Telephone Number:	**(618) 357-5901**

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Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name:	**Thomas J. Hudgins, FACHE**
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Telephone Number:	**(618) 357-5901**
E-mail Address:	**thudgins@pvillehosp.org**
Fax Number:	**(618) 357-6470**

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	**Pinckneyville Community Hospital District**
Address of Site Owner:	**101 North Walnut Street, Pinckneyville, Illinois 62274**
Street Address or Legal Description of Site:	**101 North Walnut Street, Pinckneyville, IL 62274**

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:	**Pinckneyville Community Hospital**
Address:	**101 North Walnut Street, Pinckneyville, Illinois 62274**

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Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person 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-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.idph.state.il.us/about/hfpb.htm)**.

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[Provide this information for each applicable site]

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Street Address or Legal Description of Site:	**101 North Walnut Street, Pinckneyville, IL 62274**

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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-5, 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:	Part 1120 Applicability or Classification: [Check one only.]
☒ Substantive	☐ Part 1120 Not Applicable
☐ Non-substantive	☐ Category A Project
	☒ Category B Project
	☐ DHS or DVA Project

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care	X			X	25
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery (1 Procedure Room and Prep/Recovery)	X			X	2 + 7 = 9
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging	X			X	6
• Therapeutic Radiology					
• Laboratory	X			X	NA
• Pharmacy	X			X	NA
• Occupational Therapy (Inpatient)	X			X	1
• Physical Therapy (Inpatient)	X			X	
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

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

3. Narrative Description

Provide in the space below, 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.

Pinckneyville Community Hospital District (legal entity) d.b.a. Pinckneyville Community Hospital (license holder) proposes to discontinue an existing healthcare facility with a single medical / surgical bed category of service and establish a new healthcare facility with a single medical / surgical bed category of service on a new site, within the City of Pinckneyville, approximately 1.8 miles to the east of the Hospital's existing campus. If establishment is not granted by the State Agency, discontinuation will not occur.

The current site is located at 101 North Walnut Street. The new site is at the northeast corner of White Walnut Road and State Route 154, whose legal address is 5383 State Route 154.

The Hospital is a 25-bed Critical Access Hospital (CAH) designated as necessary provider of health services by IDPH. It became a CAH in November 2000. The Hospital's market area is designated both a physician shortage area and as a health professional shortage area.

This is a substantive project in that it will both discontinue and establish a medical / surgical category of service (development of a replacement hospital) and the total capital expenditures are in excess of the capital expenditure minimum.

Once the replacement facility is complete and occupied, the existing Hospital campus will be vacated and sold or donated for non-hospital purposes. It is expected the existing Hospital facilities will be demolished while the rural health clinic building will be transferred to new owners and used as general office space.

RECEIVED
DEC 3 0 2008
HEALTH FACILITIES
PLANNING BOARD

December 19, 2008

Mr. Jeffrey S. Mark
Executive Secretary
Illinois Health Facilities Planning Board
535 W. Jefferson Street
Springfield, IL 62761

Re: Letter of Intent (LOI) to Discontinue the Medical-Surgical Category of Service at Pinckneyville Community Hospital, 101 North Walnut Street, Pinckneyville, Illinois and develop a new Medical-Surgical Category of Service (Replacement Hospital) on a new site in Pinckneyville

Dear Mr. Mark,

In accordance with Section 1130.620 of the Illinois Health Facilities Planning Boards rules, please accept this as our Letter of Intent (LOI) to replace our existing hospital on a new site. As a Critical Access Hospital (CAH), we will discontinue our current 25 bed medical-surgical category of service and replace the service in a new replacement facility on a new site. Pursuant to the rules, we provide the following information:

1. Applicants
    a. The primary applicant will be Pinckneyville Community Hospital District, the legal entity.
    b. The co-applicant will be Pinckneyville Community Hospital, the license holder.
2. Proposed Project Site(s)
    a. The medical-surgical category of service will be discontinued at the Hospital's existing site, 101 North Walnut Street, Pinckneyville, Illinois, along with all supporting services. This facility will be closed.
    b. The replacement hospital project will be located at the NE corner of IL 154 and White Walnut Road (County Highway 1), Pinckneyville, Illinois. The subject property is described in the attached Special Flood Plan Hazard Area Determination. A permanent street address has been requested but not yet issued due to determinations yet to be made by IDOT. The expected address for the new site, when issued, will be between 5309 and 5407 State Route 154, Pinckneyville, Illinois.

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

3. Project Description

   The proposed project will discontinue the organization's current 25 bed medical-surgical category of service and replace the service and related hospital services as required by license on a new site. The estimated building gross square footage is 110,000 bgsf and the estimated maximum project cost is $ 53,422,000. This new hospital campus will also include replacing the organization's existing rural health program located on the existing hospital site at the new hospital site.

   The application is expected to be submitted in the second quarter, 2009.

4. Discontinuance Rationale

   The current medical-surgical category of service on the existing hospital site will be discontinued when the replacement hospital opens in mid 2011 on its new site in Pinckneyville. Discontinuation and replacement is necessary due to the physical condition of the existing Hospital. It is less expensive to replace the hospital than retro-fit the existing facility to contemporary codes and standards. The existing hospital will be closed and all services relocated to a new site.

We look forward to working with you and your staff on this project. If you have any questions about this Letter of Intent or other related issues to this project, please contact Tom Hudgins at 618-357-5901.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital District
Pinckneyville Community Hospital

C.W. Roe, DDS
Chairman of the Board
Pinckneyville Community Hospital District
Pinckneyville Community Hospital

Attachment: Special Flood Plan Hazard Area Determination (site description)

Perry County 9-1-1

PERRY COUNTY EMERGENCY TELEPHONE SYSTEM BOARD
304 E. Poplar St. DuQuoin, IL 62832
Phone: (618) 542-8905 Fax: (618) 542-8519

May 26, 2009

Mr. Tom Hudgens, CEO
Pinckneyville Community Hospital
101 N Walnut St
Pinckneyville, Illinois 62274

RE: Address for proposed new hospital site

To Whom It May Concern:

The Perry County E9-1-1 Office has issued the following new street address for the proposed new Pinckneyville Community Hospital being built on the north side of State Rte 154.

Pinckneyville Community Hospital (proposed site)
5383 State Rte 154
Pinckneyville, Illinois 62274

This address is based upon the information and/or markings provided by the person(s) requesting this address. If the information or location as marked changes you must contact the Perry County 9-1-1 office for an address correction. Consult the local Post Office for instructions for mail delivery and for verification of City and Zip Code before using this address as your mailing address.

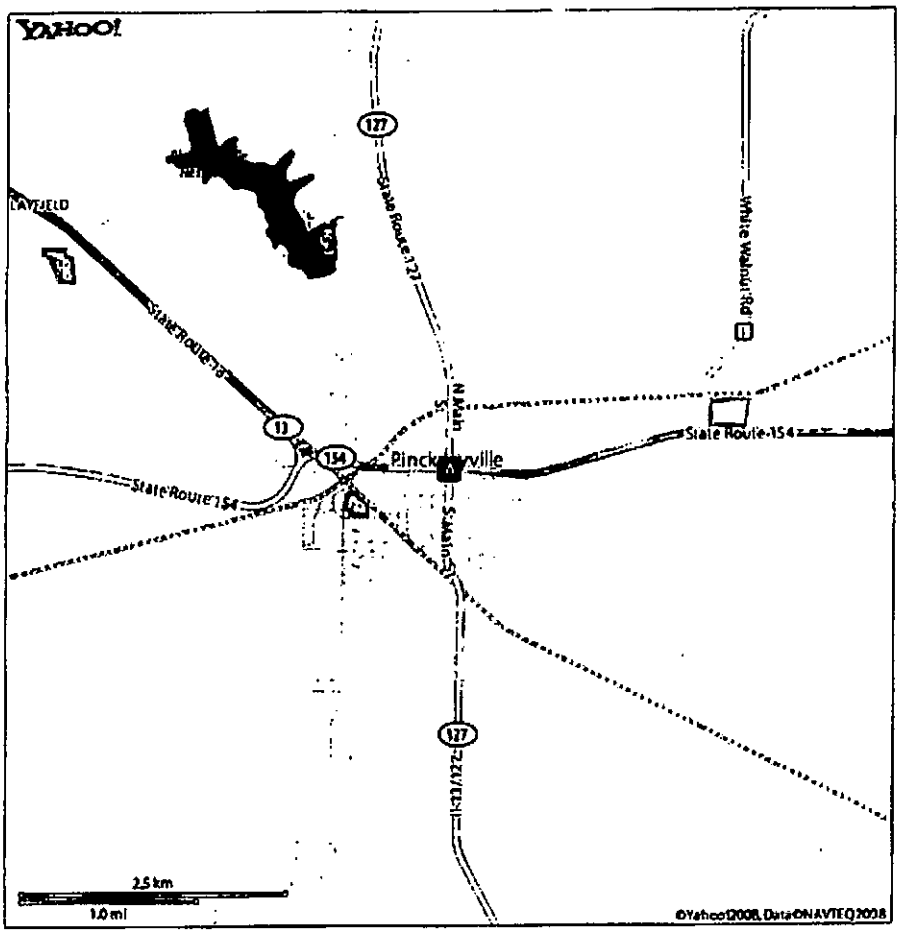
James R. DeMent, ENP
Perry County E9-1-1

cc: Pinckneyville Postmaster
Perry County Office of Planning & Development
Perry County Assessor's Office

-WS/S-WS 6/23/2008

Map of 38.080095,-89.381749

YAHOO! LOCAL



When using any driving directions or map, it's a good idea to do a reality check and make sure the road still exists, watch out for construction, and follow all traffic safety precautions. This is only to be used as an aid in planning.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	$59,470	$35,530	$95,000
Site Survey and Soil Investigation	17766	29,321	47,087
Site Preparation	703158	420,097	1,123,255
Off Site Work	49924	29826	79750
New Construction Contracts	19,510,189	11,658,928	31,169,117
Modernization Contracts	0	0	0
Contingencies	1,054,717	630,134	1,684,851
Architectural/Engineering Fees	1,244,300	743,400	1,987,700
Consulting and Other Fees	214,153	234,792	448,945
Movable or Other Equipment (not in construction contracts)	2,056,467	1,228,624	3,285,091
Bond Issuance Expense (project related)	1,243,660	743,018	1,986,678
Net Interest Expense During Construction (project related)	1,150,692	687,474	1,838,166
Fair Market Value of Leased Space or Equipment	0	0	0
Debt Service Reserve Fund	501,326	299,515	800,841
Other Costs To Be Capitalized	1,201,529	876,395	2,077,924
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	$29,007,351	$17,617,054	$46,624,405
SOURCE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Cash and Securities	3,545,881	2,153,524	5,699,405
Pledges	0	0	0
Gifts and Bequests	0	0	0
Bond Issues (project related)	25,461,470	15,463,530	40,925,000
Mortgages	0	0	0
Leases (fair market value)	0	0	0
Governmental Appropriations	0	0	0
Grants	0	0	0
Other Funds and Sources	0	0	0
TOTAL SOURCES OF FUNDS	$29,007,351	$17,617,054	$46,624,405

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

Related Project Costs

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

Land acquisition is related to project ☒ Yes ☐ No
Purchase Price: $ 345,271 **Acquired in 2006**
Fair Market Value: $ 345,271

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

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

Estimated start-up costs and operating deficit cost is $ Start up costs $250,000
Operating deficit first full operational year $1,948,526 (2012).

* See financial feasibility analysis Attachment 75

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): June 30, 2012

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON contingencies.
☒ Project obligation will occur after permit issuance.

State Agency Submittals

Are the following submittals up to date as applicable:

☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Cost / Space Requirements							
Department	Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
		Existing	Proposed	New Construction	Remodeled	As Is	Vacated Space
Clinical							
Medical / Surgical	$ 6,375,060	5,990	13,671	13,671			5,990
Emergency	$ 1,713,136	550	3,674	3,674			550
Diagnostic Imaging	$ 2,843,436	2,840	6,098	6,098			2,840
Surgery	$ 1,704,103	1,800	3,654	3,654			1,800
Same Day Surgery / Prep/Recovery / PACU	$ 1,402,389	0	3,007	3,007			0
Central Sterile Processing	$ 434,268	310	931	931			310
Laboratory	$ 1,013,098	1,640	2,173	2,173			1,640
Pharmacy	$ 629,916	800	1,351	1,351			800
Oncology Infusion Area	$ 1,251,009	1,170	2,683	2,683			1,170
Specialty Clinics (Physician Offices)	$ 1,392,046	2,100	2,985	2,985			2,100
Rural Health Clinic (Physician Offices)	$ 4,778,875	7,340	10,248	10,248			7,340
Outpatient Rehabilitation	$ 3,818,813	7,828	8,189	8,189			7,828
Sleep Lab	$ 202,853	0	435	435			0
Cardio-Pulmonary (EKG)	$ 311,717	0	668	668			0
Pre-Admission Services (Draw Station)	$ 233,280	0	500	500			0
Inpatient Rehabilitation	$ 563,865	0	1,209	1,209			0
General Surgeon Suite (Physician Offices)	$ 339,487	0	728	728			0
Total Clinical	**$ 29,007,351**	**32,368**	**62,204**	**62,204**	**0**	**0**	**32,368**
Non-Clinical							
Registration	$ 534,576	0	1,284	1,284			0
Lobby / Public Space	$ 2,316,147	860	5,564	5,564			860
Ambulance Vestibule	$ 235,741	0	566	566			0
Business Office	$ 324,296	0	779	779			0
Health Information Management	$ 592,142	0	1,422	1,422			0
Administration	$ 2,015,380	7,450	4,841	4,841			7,450
Information Technology	$ 177,135	0	426	426			0
Dietary	$ 2,039,692	4,460	4,900	4,900			4,460
General Store / Materials Management	$ 818,171	800	1,965	1,965			800
Housekeeping / Linen	$ 788,364	560	1,894	1,894			560
Maintenance	$ 348,941	600	838	838			600
Circulation / Building Gross	$ 5,313,758	24,872	12,764	12,764			24,872
Mechanical / Electrical	$ 863,818	3,750	2,075	2,075			3,750
Canopies	$ 1,248,893	0	3,000	3,000			0
Storage	$ -	2,520	0	0			2,520
Vacant Space	$ -	17,298	0	0			17,298
Total Non-Clinical	**$ 17,617,054**	**63,170**	**42,318**	**42,318**	**0**	**0**	**63,170**
Total Project	**$ 46,624,405**	**95,538**	**104,522**	**104,522**	**0**	**0**	**95,538**

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

Note: The existing facility will be vacated and converted to non-hospital use.

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**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Pinckneyville Community Hospital		**CITY: Pinckneyville**			
REPORTING PERIOD DATES:	**From: January 1, 2008**		**to: December 31, 2008**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days** [a]	**Bed Changes**	**Proposed Beds**
Medical/Surgical [b]	36	544	1,919	11	25
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care [c]	0	23	9,063		
Specialized Long Term Care					
Long Term Acute Care					
Other (Swing beds)		147	1,775		
TOTALS:	36	714	12,757	11	25

a. Does not include the following observation utilization in authorized beds.

Observation Days	
Category of Bed	Days
Medical/Surgical	234

b. Based on 2008 IDPH Bed Inventory
c. Project #08-019 discontinued the General Long Term Care Category of Service.
* Note: CON authorized beds were misstated as 36 on 12/31/08; the 4/24/09 authorized beds were 28; a CAH is limited to 25 beds. The Hospital has been a CAH since November 2000. A letter seeking a declaratory ruling has been submitted.

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 Pinckneyville Community Hospital District * 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

Thomas J. Hudgins, FACHE
PRINTED NAME

Administrator / CEO
PRINTED TITLE
Pinckneyville Community Hospital District
Pinckneyville Community Hospital

Notarization:
Subscribed and sworn to before me
this 13th day of November 2009

Signature of Notary

Seal

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

SIGNATURE

John Shotton
PRINTED NAME

Chairman of the Board
PRINTED TITLE
Pinckneyville Community Hospital District
Pinckneyville Community Hospital

Notarization:
Subscribed and sworn to before me
this 13th day of November, 2009

Signature of Notary

Seal

OFFICIAL SEAL
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NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

*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);
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*Insert EXACT legal name of the applicant

Applicable Permit Sections

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 are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service 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-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

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, certification and accreditation identification numbers, 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 the information has been 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-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as 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.

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

NOTE: The description of the "Purpose of the Project" should not exceed one page in length. Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTERNATIVES

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options 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

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, 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.

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

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

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

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

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

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

PROJECT SERVICES UTILIZATION:

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

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;

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

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

4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data are available; and

b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

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

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

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

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

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

1. This Section is applicable to all projects proposing establishment, expansion or modernization of **ALL categories of service that are subject to CON review**, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960], WITH THE EXCEPTION OF:
   - General Long Term Care;
   - Subacute Care Hospital Model;
   - Postsurgical Recovery Care Center Alternative Health Care Model;
   - Children's Community-Based Health Care Center Alternative Health Care Model; and
   - Community-Based Residential Rehabilitation Center Alternative Health Care Model.

   If the project involves any of the above-referenced categories of service, refer to " SECTION VIII.- Service Specific Review Criteria" for applicable review criteria, and submit all necessary documentation for each service involved..

2. READ THE APPLICABLE REVIEW CRITERIA FOR EACH OF THE CATEGORIES OF SERVICE INVOLVED. **[Refer to SECTION VIII regarding the applicable criteria for EACH action proposed, for EACH category of service involved.]**

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:** Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

Planning Area F-07

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFSRB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
Medical Surgical	25	118 Excess *	60%

* Adjusted to reflect CON authorized beds per revised State Bed Inventory, April 17, 2009

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

1. If establishing or expanding beds/stations/key rooms, document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

2. If expanding an existing category of service, provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, document that at least 50% of the projected patient volume will be from residents of the

area.

3. If expanding an existing category of service, submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

APPEND DOCUMENTATION AS ATTACHMENT -19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Service Demand - Establishment of Category of Service

Document "Historical Referrals" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Referrals
   If the applicant is an existing facility, document the number of referrals for the last two years for each category of service, as formatted below:

EXAMPLE:

Year	CY or FY	Category of Service	Patient Origin by Zip Code	Name & Specialty of Referring Physician	Name & Location of Recipient Hospital
2008	CY	Medical/Surgical	62761 [Patient Initials]	Dr. Hyde	Wellness Hospital

2. Projected Referrals
   An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in Criterion 1110.530(b)(3)

3. Project Service Demand - Based on Rapid Population Growth

   If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the Criterion titled "Project Service Demand - Based on Rapid Population Growth".

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Service Demand - Expansion of an Existing Category of Service

Document "Historical Service Demand" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Service Demand

Category of Service	Board Occupancy/Utilization Standards	Year One Indicate CY or FY	Year Two Indicate CY or FY
	[Indicate standards for the planning area.]		

a. As formatted above, document that the average annual occupancy/utilization rate has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years;

b. If patients have been referred to other facilities in order to receive the subject services, provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years

2. Projected Referrals
An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in subsection(b)(4) of the criteria for the subject service(s).

3. Projected Service Demand – Based on Rapid Population Growth

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the criterion titled "Projected Service Demand-Based on Rapid Population Growth" of the criteria for the subject service(s).

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

E. Service Accessibility - Service Restrictions

1. The applicant shall document that at least one of the factors listed in subsection (b)(5) of the criteria for subject service(s) exists in the planning area.

2. Provide documentation, as applicable, listed in subsection (b)(5) of the criteria for the subject service(s), concerning existing restrictions to service access:

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Unnecessary Duplication/Maldistribution

1. Document that the project will not result in an unnecessary duplication, and provide the following information:

a. A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;

b. The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and

c. The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2. Document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as presented in subsection (c)(1) and (2) of the criteria for the subject service(s)..

3. Document that, within 24 months after project completion, the proposed project:

   A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

   B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

APPEND DOCUMENTATION AS ATTACHMENT-23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Category of Service Modernization

1. Document that the inpatient beds areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, citing factors, as listed in subsection (d)(1) of the criteria for the subject service(s), but not limited to the reasons cited in the rule.

2. Provide the following documentation of the need for modernization:

   A. the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports;
   B. the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports;

3. Include other documentation, as applicable to the factors cited above:

   A. Copies of maintenance reports;
   B. Copies of citations for life safety code violations; and
   C. Other pertinent reports and data.

4. Provide the annual occupancy/utilization for each category of service to be modernized, for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT-24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

H. Staffing Availability

1. For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met.

2. Provide the following documentation:

   a. The name and qualification of the person currently filling the position, if applicable; and
   b. Letters of interest from potential employees; and
   c. Applications filed for each position; and
   d. Signed contracts with the required staff; or
   e. A narrative explanation of how the proposed staffing will be achieved.

APPEND DOCUMENTATION AS ATTACHMENT-25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE

APPLICATION FORM.

I. Performance Requirements

READ the subsection titled "Performance Requirements" for the subject service(s).

K. Assurances

Submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy/utilization standards specified in 77 Ill. Adm Code 1100 for each category of service involved in the proposal.

APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☒ Medical/Surgical	25	25	25	0	0
☐ Obstetric					
☐ Pediatric					
☐ Intensive Care					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.530(c)(1) -	Unnecessary Duplication of Services	X		
1110.530(c)(2) -	Maldistribution			
1110.530(c)(3) -	Impact of Project on Other Area Providers	X		
1110.530(d)(1) -	Deteriorated Facilities			X
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms	# to Establish	# to Expand	# to Modernize
☒ Central Sterile Supply Department	NA	NA	NA		
☒ Diagnostic Imaging (Radiation and Nuclear)	6	6	6		
☒ Emergency Services	4	5	5		
☒ Laboratory	NA	NA	NA		
☒ Pharmacy	NA	NA	NA		
☒ Physical & Occupational Therapy (Inpatient)	1	1	1		
☒ Surgery and Recovery	2 + 6 = 8	2+ 7 = 9	2+ 7 = 9		

3. READ the applicable review criteria outlined below and SUBMIT all required information:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) –	Need Determination – Establishment
Service Modernization	(c)(1) –	Deteriorated Facilities
		and/or
	(c)(2) –	Necessary Expansion
		PLUS
	(c)(3)(A) –	Utilization – Major Medical Equipment
		Or
	(c)(3)(B) –	Utilization – Service or Facility

APPEND DOCUMENTATION AS INDICATED BELOW, IN NUMERIC SEQUENCIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM:

APPLICABLE REVIEW CRITERIA	Attachment Number
Need Determination - Establishment	62
Service Demand	63
Referrals from Inpatient Base	64
Physician Referrals	65
Historical Referrals to Other Providers	66
Population Incidence	67
Impact of Project on Other Area Providers	68
Utilization	69
Deteriorated Facilities	70
Necessary Expansion	71
Utilization -Major Medical Equipment	72
Utilization - Service or Facility	73

SECTION IX. Financial Feasibility

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

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No ☒.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2007	FY 2008	FY 2009	FY 2013
Current Ratio	3.45	4.60	4.33	2.43
Net Margin Percentage	4.75%	- 0.29%	0.27%	0.14%
Percent Debt to Total Capitalization	11.28%	8.94%	8.07%	78.63%
Projected Debt Service Coverage	4.40	3.14	5.23	1.16
Days Cash on Hand	140.82	161.86	155.65	79.27
Cushion Ratio	16.93	26.99	45.05	1.27

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

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN) (continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

$ 5,699,405 Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

40,925,000 Debt Financing (indicate type(s) Bond Issue associated with HUD mortgage guarantee)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations
Provide a copy of the appropriation act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_____ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

$46,624,405 TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☐ No ☒ If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. Economic Feasibility

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

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ☒ No ☐ If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes ☐ No ☒. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☒ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. 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. Criterion 1120.310(b), Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

B. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify on the following:

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)
(continued)

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☒ No ... If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310(f), Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes I No ☒. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT -76, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SAFETY NET IMPACT STATEMENT that describes all of the following:

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

APPEND DOCUMENTATION AS ATTACHMENT-77, 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

ATTACHMENT NO.		PAGES
1	Applicant Identification	40
2	Site Ownership	41
3	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	42 – 46
4	Flood Plain Requirements	47 – 48
5	Historic Preservation Act Requirements	49
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7	Project and Sources of Funds Itemization	51 – 52
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10	Background of the Applicant	104 – 107
11	Purpose of the Project	108 – 109
12	Alternatives to the Project	110 – 116
13	Size of the Project	117 – 126
14	Project Service Utilization	127 – 133
15	Unfinished or Shell Space	NA
16	Assurances for Unfinished/Shell Space	NA
17	Master Design Project	NA
18	Mergers, Consolidations and Acquisitions	NA
	Categories of Service:	
19	Planning Area Need	134 – 142
20	Service Demand – Establishment of Category of Service	143 – 174
21	Service Demand – Expansion of Existing Category of Service	NA
22	Service Accessibility – Service Restrictions	175 – 199
23	Unnecessary Duplication/Maldistribution	200 – 208
24	Category of Service Modernization	209 – 211
25	Staffing Availability	212 – 227
26	Assurances	228 – 230
	Service Specific:	
27	Comprehensive Physical Rehabilitation	NA
28	Neonatal Intensive Care	NA
29	Open Heart Surgery	NA
30	Cardiac Catheterization	NA
31	In-Center Hemodialysis	NA
32	Non-Hospital Based Ambulatory Surgery	NA
	General Long Term Care:	NA
33	Planning Area Need	NA
34	Service to Planning Area Residents	NA
35	Service Demand-Establishment of Category of Service	NA
36	Service Demand-Expansion of Existing Category of Service	NA
37	Service Accessibility	NA
38	Description of Continuum of Care	NA
39	Components	NA
40	Documentation	NA
41	Description of Defined Population to be Served	NA

INDEX OF ATTACHMENTS

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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

Exact Legal Name: **Pinckneyville Community Hospital District (Primary Applicant, Legal Entity)**
Address: **101 North Walnut Street, Pinckneyville, Illinois 62274**
Name of Registered Agent:
Name of Chief Executive Officer: **Thomas J. Hudgins**
CEO Address: **101 North Walnut Street, Pinckneyville, Illinois 62274**
Telephone Number: **(618) 357-5901 X 203**

Exact Legal Name: **Pinckneyville Community Hospital (License Holder)**
Address: **101 North Walnut Street, Pinckneyville, Illinois 62274**
Name of Registered Agent:
Name of Chief Executive Officer: **Thomas J. Hudgins**
CEO Address: **101 North Walnut Street, Pinckneyville, Illinois 62274**
Telephone Number: **(618) 357-5901 X 203**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Site Ownership

Exact Legal Name of Site Owner: **Pinckneyville Community Hospital District**
Address of Site Owner: **101 N. Walnut Street, Pinckneyville, Illinois 62274**
Street Address or Legal Description of Site: **101 N. Walnut Street, Pinckneyville, Illinois 62274**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Operating Identity/Licensee

Organizational Relationships

Certificate of Good Standing

As a public hospital organized under 70ILCS910/, a Certificate of Good Standing, as issued by the Secretary of State, is not required.

See Attachment-3 for Certificate of Incorporation and Hospital License.

DUPLICATE

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

Whereas, there has been filed, in the Office of the Secretary of State, on the 15th day of March A. D. 19 51, under and in accordance with the provisions of " AN ACT providing for the creation and operation of Hospital Districts"

approved July 15 19 49, in force July 15 19 49, a copy of the Order of Judson E. Harriss, County Judge of Perry County, Illinois, finding the results of the election in a certain proceeding for the organization of the Pinckneyville Community Hospital District, and

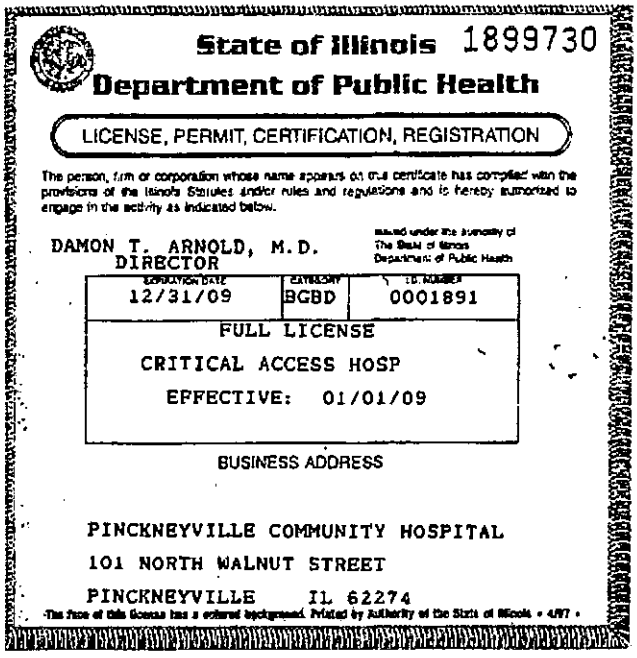
Whereas, said Order was entered and is dated the 18th day of December A. D. 19 50, and is certified to be a true and correct copy by the County Clerk of Perry County, Illinois, and

Whereas, it is found by said Order that those voting in favor of the establishment of the Pinckneyville Community Hospital District were 1,078, and those voting in the negative and against such proposition were 787, and that the affirmative of said proposition received a majority of 291, and said Order determines the said Pinckneyville Community Hospital District to be established.

Now, Therefore, I, EDWARD J. BARRETT, Secretary of State of the State of Illinois, by virtue of the power and authority vested in me by law, do hereby issue this Certificate of Incorporation to said Pinckneyville Community Hospital District.

In Testimony Whereof, I hereto set my hand and the Great Seal of the State of Illinois. Done at the Capitol in the City of Springfield this the fifteenth day of March, A. D. nineteen hundred and fifty-one, and of the Independence of the United States the one hundred and seventy-fifth.

SECRETARY OF STATE



State of Illinois 1899730

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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0001891

FULL LICENSE

CRITICAL ACCESS HOSP

EFFECTIVE: 01/01/09

BUSINESS ADDRESS

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET
PINCKNEYVILLE IL 62274

This face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1899730

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PINCKNEYVILLE COMMUNITY HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0001891

FULL LICENSE

CRITICAL ACCESS HOSP

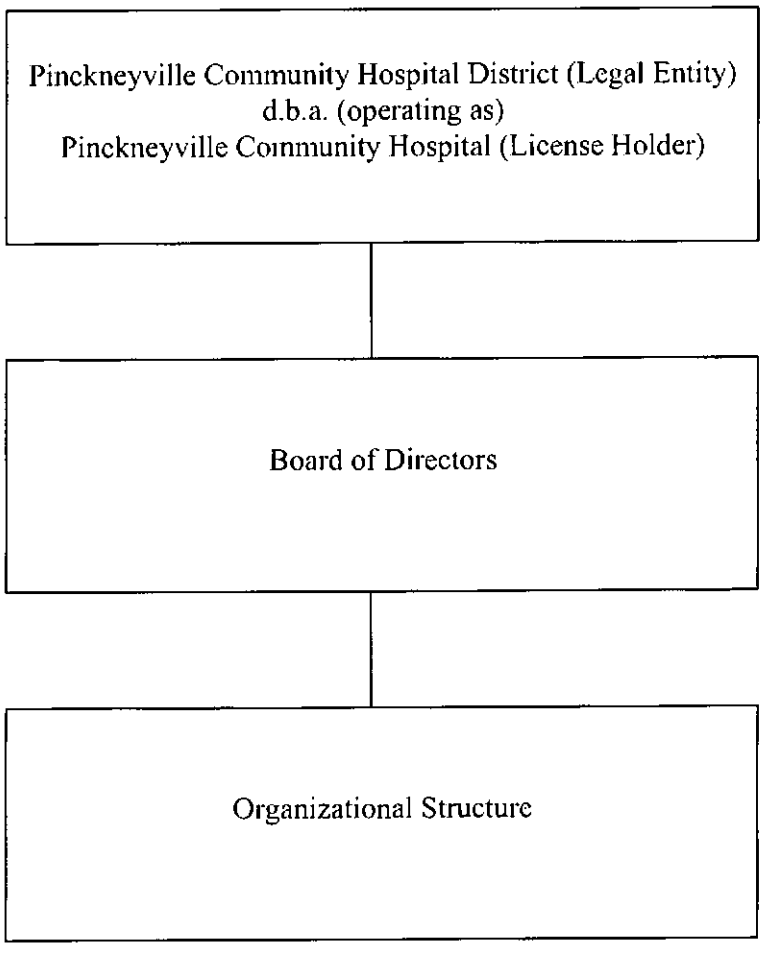
EFFECTIVE: 01/01/09

11/01/08

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET

PINCKNEYVILLE IL 62274

FEE RECEIPT NO.


Pinckneyville Community Hospital District (Legal Entity)
d.b.a. (operating as)
Pinckneyville Community Hospital (License Holder)
Board of Directors
Organizational Structure

Pinckneyville Community Hospital – Organizational Structure Effective 01-07-09

Board of Directors – John Shotton, Chairman

Administrator/CEO - Thomas J. Hudgins, FACHE

Medical Staff President – Robert Davidson, MD

Billing Compliance – Debbie

Medical Staff Coordinator - Norma

Chief Financial Officer	*RHC Business Office Mgr	Human Resources Adm. Asst.	Chief Nurse Exec	Engineering	*RHC Med Dir	Rehabilitation Services	Risk Manager	Food Service	Information Systems	Environmental Services
Kara Carson	**Lisa Heisner**	**Phyllis Keller**	**Eva Hopp**	**Charles Herring**	**Dr. J. Gregg Fozard**	**Dan Northcutt**	**Carla Bruns**	**Martha Kellerman**	**Bill Doerflein**	**Kevin Daugherty**
Accounts Payable	RHC Business Office	Administrative Services	CAH Nursing	Bio-Med	RHC Physicians	Fitness/Wellness	Risk Management	Food Service	Information Systems Technology	Housekeeping
Accounts Receivable	Accounts Receivable	Human Resources	Cardiopulmonary	Building & Grounds	Physician Assistants	Inpatient Therapies	QA/CQI	Cafeteria		Laundry
Audits	Cashiering	ICT Safety Liaison	Case Mngt.	Construction	*Patient Care	Marketing II	IPT Liaison	Meals on Wheels		Linen
CAH Business Office	RHC Communication	Man-Tra-Con	Central Service	Communication Systems		Outpatient Therapies				
Corp. Compliance	Reception	Marketing II	Education RLC/LPN/CNA	Engineering		SCU Therapies				
HIPPA			Imaging	Maintenance		Sports Medicine				
Materials Mngt			Infection Control			Work Hardening				
Payroll			Inservice							
			Laboratory							
			Medical Records							
			Outpatient Services							
			Pharmacy							
			Specialty Clinic							
			Surgery/Anes							
			Social Services							

*Pt. Care issues addressed in conjunction with Risk Mgr./Med Dir RHC & CNE. II-Collaboration

Exec. Council: Thomas Hudgins, Eva Hopp, Kara Carson, Phyllis Keller, & *others as relates to dept./service.*

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Flood Plain Requirements

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois State Water Survey

Main Office • 2204 Griffith Drive • Champaign, IL 61820-7495 • Tel (217) 333-2210 • Fax (217) 333-6540
Peoria Office • P.O. Box 697 • Peoria, IL 61652-0697 • Tel (309) 671-3196 • Fax (309) 671-3106

SWS

Special Flood Hazard Area Determination
pursuant to Governor's Executive Order 5 (2006)
(supersedes Governor's Executive Order 4 (1979))

Requester: Edwin W. Parkhurst, Jr., Managing Principal, PRISM Healthcare Consulting
Address: 799 Roosevelt Rd (Bldg 4, Ste 317)
City, state, zip: Glen Ellyn, IL 60137 Telephone: (630) 790-1265

Site description of determination:
Site address: NE corner IL 154 & White Walnut Rd. (Co Hwy 1)
City, state, zip: Pinckneyville, IL
County: Perry Sec¼: W 1/2 of SW 1/4 Section: 17 T. 5 S. R. 2 W. PM: 3rd
Subject area: Property within the area bounded by the Missouri (Union) Pacific Railroad on the north, White Walnut Rd. on the west, State Route 154 on the south, and the east line of the W 1/2 SW 1/4 Sec. 17, T. 5 S., R. 2 W., 3rd P.M., Perry County IL on the east.

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.
Floodway mapped: N/A Floodway on property: No
Source used: FEMA Flood Hazard Boundary Map - Perry County Unincorporated Areas (FHBM, attached); mapquest.com
Community name: City of Pinckneyville, IL* Community number: 170540*
Panel/map number: 170538 0005 B Effective Date: August 1, 1980
Flood zone: C Base flood elevation: N/A ft NGVD 1929

**Area annexed by City, but shown on effective FEMA flood hazard map for Perry County, IL, Unincorporated Areas.*

N/A a. The community does not currently participate in the National Flood Insurance Program (NFIP). NFIP flood insurance is not available; certain State and Federal assistance may not be available.
N/A b. Panel not printed: no Special Flood Hazard Area on the panel (panel designated all Zone C or unshaded X).
N/A c. No map panels printed: no Special Flood Hazard Areas within the community (NSFHA).

The primary structure on the property:
N/A d. Is located in a Special Flood Hazard Area. Any activity on the property must meet State, Federal, and local floodplain development regulations. Federal law requires that a flood insurance policy be obtained as a condition of a federally-backed mortgage or loan that is secured by the building.
N/A e. Is located in shaded Zone X or B (500-yr floodplain). Conditions may apply for local permits or Federal funding.
X f. Is not located in a Special Flood Hazard Area or 500-year floodplain area shown on the effective FEMA map.
N/A g. A determination of the building's exact location cannot be made on the current FEMA flood hazard map.
N/A h. Exact structure location is not available or was not provided for this determination.

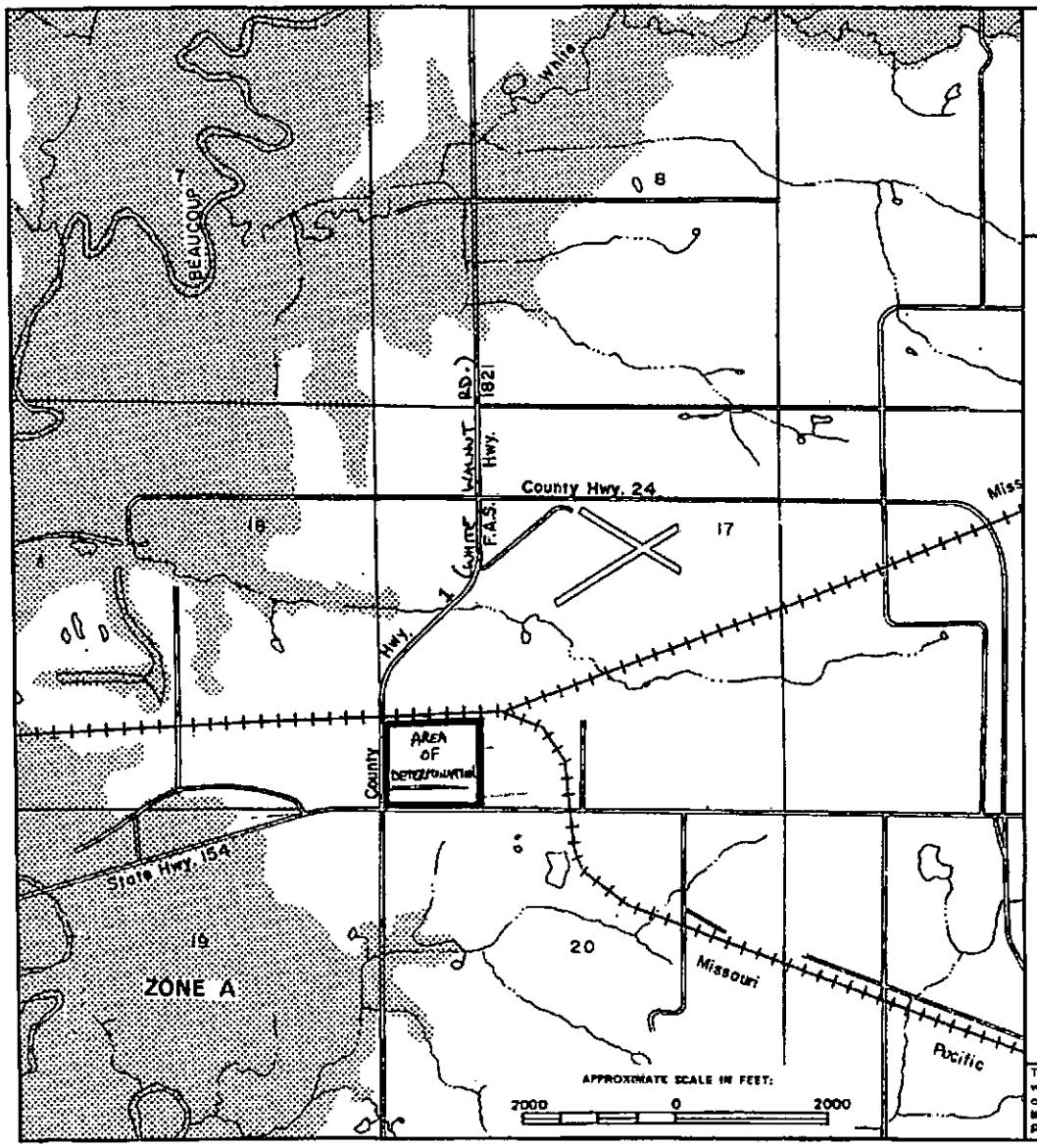
Note: This determination is based on the current Federal Emergency Management Agency (FEMA) flood hazard map for the community. This letter does not imply that the referenced property will or will not be free from flooding or damage. A property or structure not in a Special Flood Hazard Area may be damaged by a flood greater than that predicted on the FEMA map or by local drainage problems not mapped. This letter does not create liability on the part of the Illinois State Water Survey, or employee thereof for any damage that results from reliance on this determination. This letter does not exempt the project from local stormwater management regulations.

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 5 (2006), or State floodplain regulations, may be directed to Paul Osman (217/782-3862) at the IDNR Office of Water Resources.

William Saylor Title: ISWS Surface Water & Floodplain Information Date: 6/23/2008
William Saylor, CFM IL-02-00167, Illinois State Water Survey

Printed on recycled paper

Form rev. 1/10/2008



SPECIAL FLOOD HAZARD AREA — ZONE A

FLOOD HAZARD BOUNDARY MAP

PERRY COUNTY
ILLINOIS
UNINC. AREAS

PAGE 6 OF 8
(SEE MAP INDEX FOR PAGES NOT PRINTED)

MAP REVISED:
AUGUST 1, 1980

COMMUNITY—PANEL NUMBER
170538 0005 B

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
FEDERAL INSURANCE ADMINISTRATION

-WS/ISWS 6/23/2008

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Historic Resources Preservation Act Requirements

Illinois Historic
Preservation Agency

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Perry County
Pinckneyville
New Construction, Critical Access Hospital - Pinckneyville Community Hospital
Existing - IL Rt. 154, East of Pinckneyville; Proposed - NE Corner IL Rt. 154 and White Walnut Road
IHPA Log #003012908

March 19, 2008

Edwin Parkhurst, Jr.
Prism Consulting Services Inc.
Healthcare Consulting Division
Building 4, Suite 317
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr. Parkhurst:

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

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

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

If you have any further questions, please contact Patrick Gleason, Cultural Resources Manager, 1 Old State Capitol Plaza, Springfield, IL 62701, 217/785-3977.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

A teletypewriter for the speech/hearing impaired is available at 217-524-7128. It is not a voice or fax line.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care	X			X	25
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery (1 Procedure Room and Prep/Recovery)	X			X	2 + 7 = 9
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging	X			X	6
• Therapeutic Radiology					
• Laboratory	X			X	NA
• Pharmacy	X			X	NA
• Occupational Therapy (Inpatient)	X			X	1
• Physical Therapy (Inpatient)	X			X	
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	$59,470	$35,530	$95,000
Site Survey and Soil Investigation	17766	29,321	47,087
Site Preparation	703158	420,097	1,123,255
Off Site Work	49924	29826	79750
New Construction Contracts	19,510,189	11,658,928	31,169,117
Modernization Contracts	0	0	0
Contingencies	1,054,717	630,134	1,684,851
Architectural/Engineering Fees	1,244,300	743,400	1,987,700
Consulting and Other Fees	214,153	234,792	448,945
Movable or Other Equipment (not in construction contracts)	2,056,467	1,228,624	3,285,091
Bond Issuance Expense (project related)	1,243,660	743,018	1,986,678
Net Interest Expense During Construction (project related)	1,150,692	687,474	1,838,166
Fair Market Value of Leased Space or Equipment	0	0	0
Debt Service Reserve Fund	501,326	299,515	800,841
Other Costs To Be Capitalized	1,201,529	876,395	2,077,924
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	$29,007,351	$17,617,054	$46,624,405
SOURCE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Cash and Securities	3,545,881	2,153,524	5,699,405
Pledges	0	0	0
Gifts and Bequests	0	0	0
Bond Issues (project related)	25,461,470	15,463,530	40,925,000
Mortgages	0	0	0
Leases (fair market value)	0	0	0
Governmental Appropriations	0	0	0
Grants	0	0	0
Other Funds and Sources	0	0	0
TOTAL SOURCES OF FUNDS	$29,007,351	$17,617,054	$46,624,405

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

Project Cost Summary – Select Line Items

	Clinical	Total Project
New Construction	$ 19,510,189	$ 31,169,117
Modernization	$ -	$ -
Subtotal	$ 19,510,189	$ 31,169,117
Contingency	$ 1,951,018	$ 3,116,912
Subtotal	$ 21,461,207	$ 34,286,029
Equipment	$ 1,630,096	$ 4,320,423
Total	$ 23,091,303	$ 38,606,452

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Cost / Space Requirements

Department	Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
		Existing	Proposed	New Construction	Remodeled	As Is	Vacated Space
Clinical							
Medical / Surgical	$ 6,375,060	5,990	13,671	13,671			5,990
Emergency	$ 1,713,136	550	3,674	3,674			550
Diagnostic Imaging	$ 2,843,436	2,840	6,098	6,098			2,840
Surgery	$ 1,704,103	1,800	3,654	3,654			1,800
Same Day Surgery / Prep/Recovery / PACU	$ 1,402,389	0	3,007	3,007			0
Central Sterile Processing	$ 434,268	310	931	931			310
Laboratory	$ 1,013,098	1,640	2,173	2,173			1,640
Pharmacy	$ 629,916	800	1,351	1,351			800
Oncology Infusion Area	$ 1,251,009	1,170	2,683	2,683			1,170
Specialty Clinics (Physician Offices)	$ 1,392,046	2,100	2,985	2,985			2,100
Rural Health Clinic (Physician Offices)	$ 4,778,875	7,340	10,248	10,248			7,340
Outpatient Rehabilitation	$ 3,818,813	7,828	8,189	8,189			7,828
Sleep Lab	$ 202,853	0	435	435			0
Cardio-Pulmonary (EKG)	$ 311,717	0	668	668			0
Pre-Admission Services (Draw Station)	$ 233,280	0	500	500			0
Inpatient Rehabilitation	$ 563,865	0	1,209	1,209			0
General Surgeon Suite (Physician Offices)	$ 339,487	0	728	728			0
Total Clinical	**$ 29,007,351**	**32,368**	**62,204**	**62,204**	**0**	**0**	**32,368**
Non-Clinical							
Registration	$ 534,576	0	1,284	1,284			0
Lobby / Public Space	$ 2,316,147	860	5,564	5,564			860
Ambulance Vestibule	$ 235,741	0	566	566			0
Business Office	$ 324,296	0	779	779			0
Health Information Management	$ 592,142	0	1,422	1,422			0
Administration	$ 2,015,380	7,450	4,841	4,841			7,450
Information Technology	$ 177,135	0	426	426			0
Dietary	$ 2,039,692	4,460	4,900	4,900			4,460
General Store / Materials Management	$ 818,171	800	1,965	1,965			800
Housekeeping / Linen	$ 788,364	560	1,894	1,894			560
Maintenance	$ 348,941	600	838	838			600
Circulation / Building Gross	$ 5,313,758	24,872	12,764	12,764			24,872
Mechanical / Electrical	$ 863,818	3,750	2,075	2,075			3,750
Canopies	$ 1,248,893	0	3,000	3,000			0
Storage	$ -	2,520	0	0			2,520
Vacant Space	$ -	17,298	0	0			17,298
Total Non-Clinical	**$ 17,617,054**	**63,170**	**42,318**	**42,318**	**0**	**0**	**63,170**
Total Project	**$ 46,624,405**	**95,538**	**104,522**	**104,522**	**0**	**0**	**95,538**

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

Note: The existing facility will be vacated and converted to non-hospital use.

SECTION II. DISCONTINUATION

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 are to be discontinued.

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

3. Provide the anticipated date of discontinuation for each identified service 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 HFPB 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.

SECTION II. DISCONTINUATION

SECTION II. GENERAL INFORMATION REQUIREMENTS

The following responds, in kind, to the review criterion. The Hospital proposes to discontinue the categories of service and clinical services at its existing location and replace them at a new site while vacating the existing. The intent is to develop a replacement critical access hospital (CAH).

1. As a CAH, the Hospital has 25 medical / surgical beds. These beds will be discontinued and established on a new site. (Note: the IDPH Hospital Profile for calendar year 2008 indicates Pinckneyville Community Hospital has 28 CON authorized medical / surgical beds. This is in error and in an October 7, 2009 letter to Ms. Avery, the Hospital requested a correction in the official record reducing the number to 25.)

2. Other clinical type services to be discontinued and relocated to the new site are those typical to an acute care hospital including (see Attachments 8 and 62):

    a. Emergency Department

    b. Imaging

    c. Surgery

    d. Laboratory

    e. Pharmacy

    f. PT / OT (inpatient / outpatient)

    g. Diagnostic / Treatment Services (inpatient / outpatient)

    h. Rural Health and special clinics (physician offices)

3. Discontinuation of the existing facility and its services will occur simultaneously with establishing / opening the new hospital facilities. This is expected to occur by October 1, 2011. Calendar year 2012 will be the first full operational year. Project completion is scheduled for June 30, 2012 to allow time to dispose of the existing site.

4. The existing site will be vacated and transferred to a yet to selected new owner. The Hospital anticipates demolishing the current Hospital buildings prior to new ownership transfer. As much equipment as possible will be relocated to the new hospital campus and any remaining equipment will be disposed of.

5. All medical records will be transferred to the new site owner once the existing facilities are discontinued and the new facilities established. Records will be maintained based on the then current policies consistent with applicable rules and regulations.

6. Not considered applicable in that even though an entire facility will be discontinued (existing hospital) a new site will be established. There will be no break in ongoing operations. Hence, all required documentation by the various agencies will be submitted. There are no anticipated compliance issues. If the proposed new facility is not approved / developed, the existing facility will not be discontinued.

Pinckneyville
Community
Hospital

leading the way to a healthier tomorrow

November 13, 2009

Ms. Courtney Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holders) propose to develop a replacement hospital on a new site. By Planning Agency rules, this requires both a "discontinuation" as well as an "establishment" of the proposed facilities and service categories.

In accordance with the Permit Application Form, Section II, Criterion 1110.130, Discontinuation, all questionnaires and data required by HFSRB or IDPH will be provided through the discontinuation date, and required information will be submitted no later than 60 days following the discontinuation date, in the event discontinuation does occur. However, we have every intent to remain an ongoing operation in the replacement facility as an essential community hospital provider (CAH).

Sincerely,

Thomas J. Hudgins, FACHE
Administrator
Pinckneyville Community Hospital
Pinckneyville Community Hospital District

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

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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:

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.

SECTION II. REASONS FOR DISCONTINUATION

Gresham Smith and Partners developed a full site and facility assessment / analysis in 2003. This evaluation concluded that major renovation was required to meet current and anticipated hospital codes including seismic bracing, HVAC requirements, medical gases, and electrical infrastructure as noted in the attached detail. In addition, it was concluded by the Hospital / District Board that the required renovations, if at all possible, would severely constrain ongoing operations.

Renovation costs were judged to be comparable with replacement facility costs due to their inherent complexity, extent, and required time duration / phasing.

Thus, the Board pursued a replacement facility strategy as the most effective and efficient alternative.

Detailed Infrastructure Analysis

GENERAL

Three facilities of the Pinckneyville Community Hospital were reviewed. The facilities evaluated are; The Hospital, the Medical Annex Building and the SIR Facility.

HOSPITAL

The Pinckneyville Community Hospital is a multi-story concrete frame structure constructed in two (2) major phases. The original hospital construction occurred in 1964 with the second phase of construction in 1976. The first phase of construction is comprised of a four (4) level patient care facility with single story attached power plant. The second phase of construction is two (2) levels with patient rooms on the upper level and ancillary services on the lower level.

MEDICAL ANNEX BUILDING

The PCH Medical Annex Building is single story wood frame structure with partial basement constructed in 1998. This building is business occupancy and capable of supporting the office and outpatient services that currently housed in it.

The wood frame structure is well suited for business occupancy by a single tenant. Use of the building for institutional use or multi-tenant functions will require evaluation of the fire separations of the floors and walls, as well as overall construction type.

SIR FACILITY

The SIR (Southern Illinois Rehabilitation) program is housed in a two story un-reinforced masonry structure in the square in Pinckneyville. The building is actually three structures tied together; all structures are of indeterminate age. The second floor of the SIR facility is not currently occupied and is utilized for storage.

The un-reinforced masonry structure is not constructed to current standards for seismic bracing or reinforcement. Options for renovation of this structure should include an evaluation of the structural system.

Detailed Infrastructure Analysis

MECHANICAL

COOLING

HOSPITAL

Hospital cooling is provided by several systems. The original hospital construction is cooled by a packaged water cooled reciprocating chiller installed in 1994. The chiller is in good condition and could provide 10 to 15 years of additional service. The chiller is located in the same space as the hospital boilers, elevator equipment and main electrical service gear. There is no refrigerant monitoring system or exhaust system. Relocation of the chiller to separate it from the other systems in the powerhouse is anticipated to be required if the facility undergoes major renovation. The installation of a refrigerant monitoring system and controls is recommended regardless of renovation.

The chiller is tied to a cooling tower located on the roof of the power house less than 25 feet from the operable patient windows of the patient floors. The location of cooling towers away from the operable windows of the facility is strongly recommended to reduce the possibility of the introduction of airborne contaminants from the cooling tower basin and discharge.

The hospital addition is cooled by room cooling units in the patient rooms and two air cooled condensing units on the roof tied to a central station air handling unit located on the lower level. The packaged room cooling units, installed in 1976, require increasing service and replacement as they have exceeded their anticipated useful life of 15 years. The direct expansion condensing units are in fair condition and also exceeded their anticipated useful life of 20 years. Replacement of the cooling equipment in the hospital addition is expected to continue to increase until all of the equipment has been replaced sometime in the next 3 to 5 years.

MEDICAL ANNEX BUILDING

The medical annex building is cooled by five split system residential condensing units tied to residential furnaces. The equipment was installed in 1998 and is in good condition. The equipment could provide adequate service for 7 to 12 years if proper maintenance is continued. There is no cooling zone dedicated for the basement of the building. The basement temperature is not controlled and causes hot and cold spots with continued occupant comfort problems. This cannot be remedied without the addition of dedicated equipment for the area.

SIR FACILITY

The SIR facility is cooled by four split system residential condensing units tied to residential furnaces. The equipment was installed in 1994 and is in good condition. The installation of unit on the second floor does not appear to be complete and facility staff could not report on the operation of the unit. The equipment could provide adequate service for 5 to 7 years if proper maintenance is continued.

Detailed Infrastructure Analysis

HEATING

HOSPITAL

Heating for the hospital is provided by natural gas fired scotch-marine steam boilers located in the ground floor power house of the original construction. The three boilers are of different ages and condition.

The oldest boiler was installed in 1964 and has a capacity of 70 Boiler Horsepower. This boiler burner was replaced in 1994. The boiler is in fair condition and has exceeded its anticipated useful life of 25 years. With continued maintenance the boiler could provide an additional 3 to 5 years of service.

The second boiler was installed in 1976 and has a capacity of 70 boiler horsepower. The boiler burner is original. The unit is in fair to poor condition and has exceeded its anticipated useful life of 25 years. Replacement or major overhaul of this boiler is recommended in the next 2 years.

The third boiler was installed in 1994 and has a capacity of 30 boiler horsepower. This boiler is in good condition and could provide 15 to 20 years of continued service. This unit is used to provide steam during the summer when steam demand is low.

None of the boilers are capable of utilizing another source of fuel for back-up heating as required by current code. The installation of dual fuel capability is recommended to ensure that the hospital can provide services in the event of a loss of utility service.

The boiler room lacks the high and low combustion air intakes as required by current code. The installation of additional combustion air intake capability is recommended to ensure proper operation of the boilers.

The boilers are located adjacent to the chiller and the elevator machinery without code required separations or clearances. The relocation of the elevator machines and the installation a separation for the boilers from the electrical and mechanical equipment is recommended. (The relocation of the elevator machinery is anticipated to be required if the elevators are upgraded to meet current code.)

MEDICAL ANNEX BUILDING

The medical annex building is heated by five residential furnaces. The furnaces are natural gas fired high efficiency condensing type in good condition. The furnaces were installed in 1998 and have an anticipated useful life of 18 years. With continued maintenance the equipment could provide 12 to 15 years of additional service.

Detailed Infrastructure Analysis

SIR FACILITY

The SIR facility is heated by four residential furnaces. The furnaces are natural gas fired high efficiency condensing type in good condition. The furnaces were installed in 1994 and have an anticipated useful life of 18 years. With continued maintenance the equipment could provide 8 to 12 years of additional service.

AIR DISTRIBUTION

HOSPITAL

Air distribution for the hospital, with the exception of the exterior rooms, is provided by two (2) central station air handling units. One unit is located in the original hospital on the third floor the other unit is located on the lower level of the 1976 addition.

The unit located in the third floor is in poor condition. The unit is a100% outdoor air unit with preheat coil, cooling coil and final filters. The fan has a vibration that cannot be repaired and causes excessive vibration to be transmitted to the areas adjacent to the air handling unit. This unit was installed in 1964 and has exceeded its anticipated useful life of 25 years, is obsolete and replacement parts can no longer be obtained. This unit should be planned for replacement a soon as possible.

The unit located in the lower level was installed in 1976. This unit does not have high efficiency filtration after the cooling coil as required by current codes. The supply ductwork from the unit has internal duct liner; this is not allowed by current standards. The unit outdoor air intake is not 10 feet above grade or 3 feet above the roof as required by current code. The unit uses the corridors as return for the system; this is not allowed under current standards. The unit is in good condition considering its age of 27 years. If the facility is not renovated the unit could provide 3 to 5 years of continued service. Renovation within the 1976 construction will require replacement of the air handling unit to bring the air system into compliance with current standards.

The exterior rooms in the original hospital have room fan-coil units for room air distribution. There is no ventilation air introduced into the rooms from a central system with high efficiency filtration. The fan coil units are two pipe so that only heating or cooling can be provided for the entire facility this is a major source of comfort problems in the spring and fall where both heating and cooling are required simultaneously. These rooms are not used for inpatient beds at this time. These fan-coil units have exceeded their anticipated useful life of 20 years and will require replacement if the areas are renovated.

The exterior rooms in the 1976 addition have incremental packaged air-conditioners installed to provide air distribution in the patient rooms. There is no ventilation air introduced into the rooms from a central system with high efficiency filtration, the hospital has a project under way to

install a ventilation system for the patient rooms to provide the required ventilation air. The incremental units are in fair condition as noted in the cooling section of this report.

The dryer exhaust ducts do not conform to current standards for termination of ducts the discharge of one dryer is directly over a lower level exit from the building. The other dryer exhaust discharges onto the low roof of the 1976 addition. Neither of the exhausts have a trap for lint collection. The renovation or addition to the facility will require the relocation of the dryer exhaust and protection of all rated walls and roofs.

MEDICAL ANNEX BUILDING

The air distribution for the medical annex building is provided by five residential furnaces. The furnaces are in good condition. The furnaces were installed in 1998 and have an anticipated useful life of 18 years. With continued maintenance the equipment could provide 12 to 15 years of additional service. The furnaces have only 1" throw-away filters and are not suited for any non-office use.

SIR FACILITY

The air distribution for the SIR Facility is provided by four residential furnaces. The furnaces are in good condition. The furnaces were installed in 1994 and have an anticipated useful life of 18 years. With continued maintenance the equipment could provide 8 to 12 years of additional service. The furnaces have only 1" throw-away filters and are not suited for any non-office use.

PLUMBING/FIRE PROTECTION

WASTE AND VENT

HOSPITAL

The hospital sewer is tied to the municipal system. The hospital has a grease interceptor for the kitchen.

The waste and vent piping in the original hospital is in fair to poor condition. Hospital staff indicated the required repairs to the piping systems are increasing in frequency and severity. The waste and vent piping system in the original hospital should be planned for replacement in 2 years if the facility is to remain in use.

.The waste and vent system in the 1976 addition is in good to fair condition. He piping system has experienced increased maintenance requirements. This system should be planned for replacement if the addition is renovated.

Detailed Infrastructure Analysis

MEDICAL ANNEX BUILDING

The medical annex building waste and vent piping is all PVC plastic. The waste piping ties in to the municipal sewer system. The use of PVC is limits the building to business functions. The piping is good condition and should provide many years of service in an office /clinic setting.

SIR FACILITY

The SIR facility has limited waste and vent piping. The piping discharges into the municipal sewer system. The SIR facility lacks capacity for any significant additional loads.

DOMESTIC WATER

HOSPITAL

Domestic water enters the hospital from the municipal water system in two locations, one at the original building and the other in the 1976 addition. The two water services cannot be tied together to provide back-up capability. Neither of the waster services have dual backflow prevention as required by current standards. If a major renovation in the facility is performed upgrade to dual backflow preventers on each service may be required.

The domestic water piping in the building is a mixture of copper and galvanized steel piping. The galvanized piping in the original construction is anticipated to require repair or replacement in the next 1 to 5 years.

The hospital has a water softener for the domestic hot water and boiler make up.

The domestic hot water for the facility is generated in a steam to water heater in the lower level mechanical room of the 1976 addition. The water heater was installed in 1976 and is in fair condition. The water heater stores hot water at 120 degrees. Current guidelines do not recommend the storage of water below 140 degrees for control of water borne microbes. If the facility is renovated the replacement of the exiting water system with a higher temperature generation and storage system and mixing valves for lower temperature delivery of water to fixtures is recommended.

The mixing valves in the hospital are not anti-scald as required by current standards. If the hospital is renovated anti-scald mixing valves will be required.

Detailed Infrastructure Analysis

MEDICAL ANNEX BUILDING

The Medical annex building is served from the municipal water system. The water service has limited capacity for additional loads.
Domestic hot water is generated in two (2) electric water heaters located in basement level mechanical rooms. The water heaters do not have circulating system for temperature maintenance.

SIR FACILITY

The SIR Facility is served from the municipal water system. The water service has limited capacity for additional loads.

Domestic hot water is generated in an electric water heater located in the lower level mechanical rooms. The water heaters do not have circulating system for temperature maintenance.

MEDICAL GASSES

HOSPITAL

The hospital has central piped medical gas systems for Oxygen and Vacuum. There is not central system for Nitrous oxide, medical air or nitrogen. There is no system for exhaust of portable anesthesia in the operating rooms. The medical oxygen piping was installed before the current standards for construction and purity were established. Renovation in the systems should anticipate the complete replacement of the oxygen piping.

Current standards require medical air in critical care and surgical locations and some form of anesthesia exhaust or evacuation. Renovation or addition will require the installation of a medical air system complete with alarms to comply with current codes.

The existing oxygen storage tanks are located outside. The reserve manifold is not protected from the weather as required by current standards. The oxygen system does not have the master alarms or the dual alarm installation required by current standards.

The existing vacuum pumps were installed in 1964 and are not capable of generating the 13" of vacuum at the outlets required under the current NFPA standard. The vacuum plant is not alarmed. Current regulations require dual alarms for system pressures in vacuum systems. Renovation or expansion will require the replacement of the vacuum pumps with new pumps capable of drawing a minimum of 19" vacuum.

The patient rooms have one vacuum and one oxygen outlet per patient room; current regulations require one outlet per bed for these systems. The installation of additional outlets and the replacement of the medical gas piping to support the added outlets will be required with renovation or addition.

MEDICAL ANNEX BUILDING
The Medical Annex Building has no medical gas systems.

SIR FACILITY
The SIR Facility has no medical gas systems.

FIRE PROTECTION

HOSPITAL
The hospital is not protected throughout with an automatic sprinkler system. Current standards for accreditation require the complete coverage of the facility with a sprinkler system. The installation of a sprinkler system is recommended if the Hospital is to continue to occupy the building.

The original construction of the hospital does not have stand pipes with hose connections inside the stairs. The standpipes are connected to the fire service without a fore pump. The standpipes installed in the 1964 construction do not have roof outlets as required by current codes. The installation of the fire hose cabinets in the wall of the stairs in the 1964 construction compromises the fire rating of the stair shaft.

Current code requires that standpipes have Hose connections in the stairs, roof outlets, and be capable of providing 100 PSI at the roof outlet. If the facility is renovated the installation of conforming standpipes and a fire pump to provide the required pressure should be included.

The sprinklers installed in the 1976 addition are not quick response. Current standards require that all light hazard installations (like hospitals) have quick response sprinkler heads. Renovation or addition may require complete replacement of the sprinkler heads in the facility to quick response type.

MEDICAL ANNEX BUILDING
The medical annex building is protected with an automatic sprinkler system. The building attic is protected with a dry pipe sprinkler system.

SIR FACILITY
The SIR Facility does not have an automatic sprinkler system. Renovation or revision the use of the building may require the installation of a sprinkler system.

Detailed Infrastructure Analysis

ELECTRICAL

NORMAL POWER

HOSPITAL

The hospital has three electrical services and two electrical service voltages. The two main hospital electrical services are 120/208 Volt, 3 phase 1600 amp. An additional service at 277/480 Volt 3 phase is provided to serve the radiology equipment.

To disconnect power to the hospital many disconnect switches must be thrown. The electrical service to the 1976 addition and water chiller requires 8 throws. The code allows for a maximum of 6 throws for any service. Renovation in the facility will require revision of the electrical service to reduce the number of disconnects.

The electrical service lacks capacity to meet the needs of a modern facility. If the hospital is renovated the replacement of the existing electrical services with a larger capacity service should be anticipated.

MEDICAL ANNEX BUILDING

The medical annex building has a 120/208 volt single phase service. The service is adequate for the current use.

SIR FACILITY

The SIR Facility has a 120/208 volt single phase service. The service is adequate for the current use.

EMERGENCY POWER

HOSPITAL

The hospital emergency power is provided by a diesel emergency generator. The generator has a self contained fuel tank. The Generator has a capacity of 125KVA, 100KW at 120/208 Volt 3 Phase. Generator logs indicate that the generator is 45 to 50 % loaded, the facility staff indicates that the generator becomes fully loaded if an elevator is placed in use when emergency power is being generated. Based upon this information the generator is adequately sized for the present configuration of the facility, but is not capable of serving additional electrical demands.

The emergency power distribution system consists of a single transfer switch feeding all emergency panels. There is only one distribution branch for emergency power. Current code requires that emergency power be distributed in three separate branches, Life-Safety, Critical and Equipment. Renovation in the facility will require the creation of the independent emergency power branches.

The existing patient care areas do not have sufficient emergency power outlets to conform to current requirements. The installation of additional electrical devices will be required if the areas are renovated. The additions of these loads will require upgrade to the emergency power distribution system and increase in the emergency generator capacity. Most likely a complete replacement of the emergency power system will be required.

MEDICAL ANNEX BUILDING
The medical annex building has no emergency power system. Emergency lighting is provided by battery powered wall mounted light fixtures.

The elevator has no emergency battery power so that in the event of a loss of power the elevator doors would not automatically open. he installation of a battery controller and power to open the doors in the event of a utility power outage should be planned.

SIR FACILITY
The SIR Facility has no emergency power system. Emergency lighting is provided by battery powered wall mounted light fixtures.

TELECOMMUNICATIONS
HOSPITAL
The hospital telephone system has no space for additional capacity. The system cannot accommodate the addition of any new telephones or devices. The Hospital system serves the Medical Annex and SIR facility. The Replacement of the system should be explored to assure that continued service can be provided.

MEDICAL ANNEX BUILDING
The Medical Annex Building telecommunications are fed through the Hospital.

SIR FACILITY
The SIR Facility telecommunications are fed through the Hospital.

NURSE CALL
HOSPITAL
The Nurse Call systems in the Hospital were installed when the areas they serve were constructed. The systems do not provide the two-way communication required by current standards. The Nurse Call systems are outdated and will require replacement if the patient care areas are renovated to assure reliable service.

Detailed Infrastructure Analysis

MEDICAL ANNEX BUILDING
The medical Annex Building does not have a nurse call system

SIR FACILITY
The SIR Facility does not have a nurse call system.

LIGHTNING PROTECTION

HOSPITAL
There are no lightning protection systems on any of the buildings. Staff indicates that the hospital has received lightning strikes in the past with ensuing damage to electronic components and systems. The installation of a Lightning protection system is not required by code but is recommended due to the location, height and critical nature of the Hospital.

MEDICAL ANNEX BILDING
A lightning protection system for the Medical Annex would not be recommended due to the building height and non-critical nature of the facility.

SIR FACILITY

A lightning protection system for the SIR facility would not be recommended due to the building height and non-critical nature of the facility

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:

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.

SECTION II. IMPACT ON ACCESS

The following responds to the applicable criterion on a point by point basis.

1. Discontinuation will not impact on any area providers because the replacement hospital will provide the same services as currently provided, assuming State Agency approval. The discontinuation will not occur if the establishment of a replacement hospital is not approved.

2. Attachment 9, Exhibit 1, maps and delineates by organization the 7 hospitals within 45-minutes drive time from the existing hospital site, as well as the 5 hospitals which are within 45-minutes of the proposed new replacement hospital site. Impact letters were sent to the 7 hospitals as noted in Attachment 9, Exhibit 2.

3. Attachment 9, Exhibit 3 provides the responses received from 5 of the 7 requested hospitals.

PCH 45 Minute Drive Time from the Exisiting and Proposed Sites

Pushpins

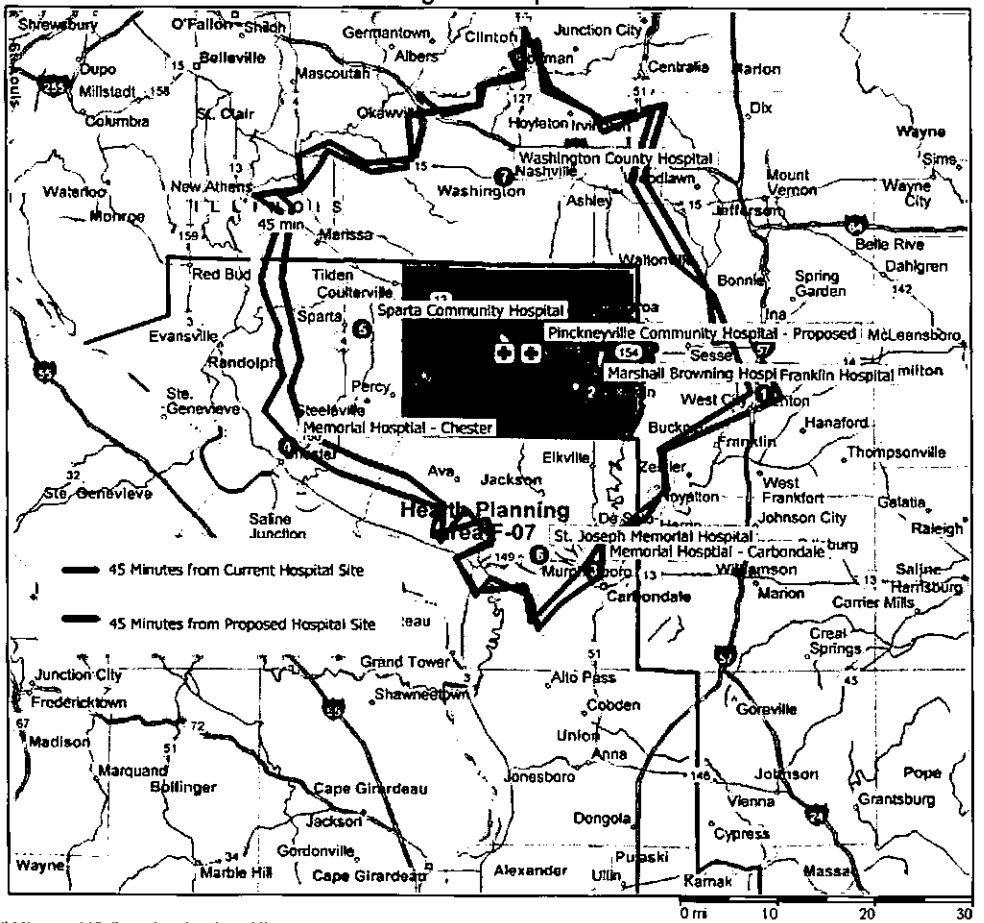
- Pinckneyville Community Hospital - Existing
- Pinckneyville Community Hospital - Proposed
- 1 Franklin Hospital
- 2 Marshall Browning Hospital
- 3 Memorial Hospital - Carbondale
- 4 Memorial Hospital - Chester
- 5 Sparta Community Hospital
- 6 St. Joseph Memorial Hospital
- 7 Washington County Hospital

Service Area by County

- Perry County

Medical-Surgical Health Planning Areas

- Health Planning Area F-07



Hospital Facilites within 45 Minutes of the Current Pinckneyville Community Hospital Site

Facility	CAH	Administrator	Address	Municipality	Zip Code	MapQuest Miles	MapQuest Minutes
Pinckneyville Community Hospital - Current	Yes	Thomas J. Hudgins	101 N. Walnut St.	Pinckneyville	62274	--	--
Pinckneyville Community Hospital - Proposed	Yes	Thomas J. Hudgins	White Walnut Rd & State Route 154	Pinckneyville	62274	1.75	3
Marshall Browning Hospital	Yes	William J. Huff	900 N. Washington St	Du Quoin	62832	12.03	21
Sparta Community Hospital	Yes	Joann Emge	Sparta Community Hospital	Sparta	62286	18.35	24
Washington County Hospital	Yes	Nancy Newby	705 South Grand Ave	Nashville	62263	18.74	28
St. Joseph Memorial Hospital	Yes	Thomas Firestone, MD	2 South Hospital Drive	Murphysboro	62966	23.13	32
Memorial Hospital - Carbondale*	No	Thomas Firestone, MD	405 W Jackson St	Carbondale	62901	31.76	42
Franklin Hospital	Yes	Hervey Davis	201 Bailey Ln	Benton	62812	32.68	45
Memorial Hospital - Chester*	Yes	Karen Wolf	1900 State St	Chester	62233	32.76	45

Hospital Facilites within 45 Minutes of the Proposed Pinckneyville Community Hospital Site

Facility	CAH	Administrator	Address	Municipality	Zip Code	MapQuest Miles	MapQuest Minutes
Pinckneyville Community Hospital - Proposed	Yes	Thomas J. Hudgins	White Walnut Rd & State Route 154	Pinckneyville	62274	--	--
Pinckneyville Community Hospital - Current	Yes	Thomas J. Hudgins	101 N. Walnut St.	Pinckneyville	62274	1.75	3
Marshall Browning Hospital	Yes	William J. Huff	900 N. Washington St	Du Quoin	62832	10.29	16
Sparta Community Hospital	Yes	Joann Emge	818 E Broadway St	Sparta	62286	20.00	28
Washington County Hospital	Yes	Nancy Newby	705 South Grand Ave	Nashville	62263	22.82	31
St. Joseph Memorial Hospital	Yes	Thomas Firestone, MD	2 South Hospital Drive	Murphysboro	62966	24.68	35
Franklin Hospital	Yes	Hervey Davis	201 Bailey Ln	Benton	62812	30.93	40

* Travel time is more than 45 minutes from the proposed new site.

Source: MapQuest.com as of March 19, 2009

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

April 22, 2009

William J. Huff, Administrator/CEO
Marshall Browning Hospital
900 North Washington Street
DuQuoin, Illinois 62832

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Bill:

~~Pinckneyville Community Hospital District (Legal entity)~~ and Pinckneyville Community Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

We require a written response from you as to your perspective on whether or not discontinuation will have an adverse impact on access to care for residents of our market area. In addition, we require a statement indicating your available capacity and the extent to which our workload could be absorbed by your facility without conditions, limitations, restrictions, or discrimination if Pinckneyville Community Hospital were to discontinue its operations.

Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

By way of summary, your letter should address the following points;

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
3. How might the proposed replacement hospital impact on your facility when it opens in July 2011 (expected date)?

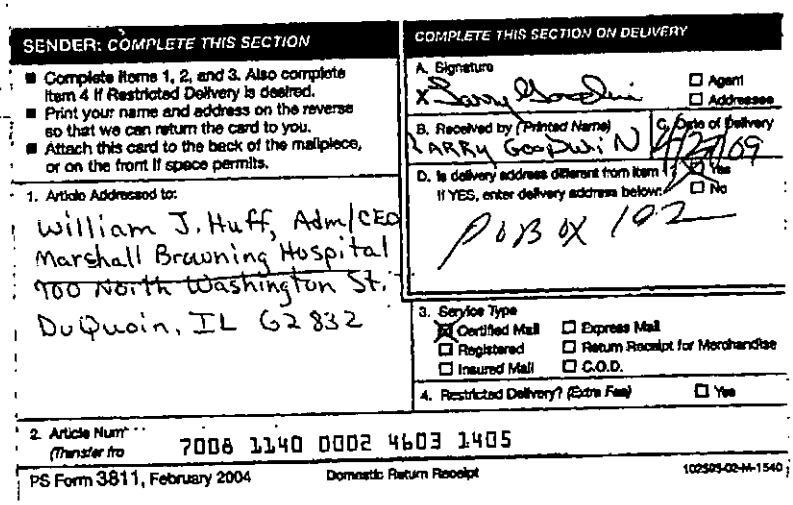
~~Over the past two years Pinckneyville Community Hospital had 1110 patients admitted to~~ the Hospital's Medical Surgical beds which led to 3856 patient days, including observation days. Pinckneyville is also certified for Medicare Swing Beds, there were an additional 295 patients that generated an additional 3024 patient days from this service. Pinckneyville Community Hospital discontinued its Long Term Care Category of Service in September of 2008.

Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

William J. Huff, Adm/CEO
Marshall Browning Hospital
900 North Washington St.
DuQuoin, IL 62832

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) LARRY GOODWIN C. Date of Delivery 4/29/09

D. Is delivery address different from item 1? ☒ Yes ☐ No
If YES, enter delivery address below:
P O B OX 102

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 fro) 7008 1140 0002 4603 1405

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

April 22, 2009

Joann Emge
Sparta Community Hospital
818 East Broadway
Sparta, Illinois 62286

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Joann:

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

We require a written response from you as to your perspective on whether or not discontinuation will have an adverse impact on access to care for residents of our market area. In addition, we require a statement indicating your available capacity and the extent to which our workload could be absorbed by your facility without conditions, limitations, restrictions, or discrimination if Pinckneyville Community Hospital were to discontinue its operations.

Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

By way of summary, your letter should address the following points;

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
3. How might the proposed replacement hospital impact on your facility when it opens in July 2011 (expected date)?

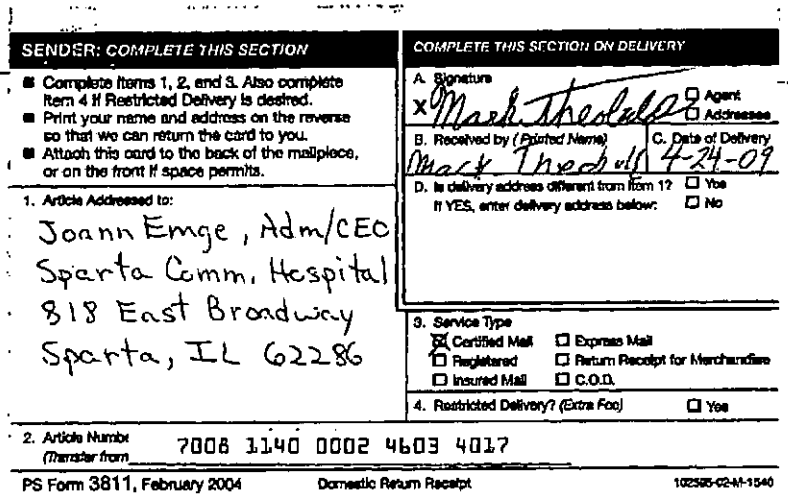
Over the past two years Pinckneyville Community Hospital had 1110 patients admitted to the Hospital's Medical Surgical beds which led to 3856 patient days, including observation days. Pinckneyville is also certified for Medicare Swing Beds, there were an additional 295 patients that generated an additional 3024 patient days from this service. Pinckneyville Community Hospital discontinued its Long Term Care Category of Service in September of 2008.

Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

Joann Emge, Adm/CEO
Sparta Comm. Hospital
818 East Broadway
Sparta, IL 62286

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x Mark Theobald ☐ Agent ☐ Addressee

B. Received by (Printed Name) Mark Theobald
C. Date of Delivery 4-24-09

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) 7008 1140 0002 4603 4017

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

April 22, 2009

Nancy Newby, Administrator/CEO
Washington County Hospital
705 South Grand Avenue
Nashville, IL 62263

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Nancy,

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

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Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

By way of summary, your letter should address the following points;

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
3. How might the proposed replacement hospital impact on your facility when it opens in July 2011 (expected date)?

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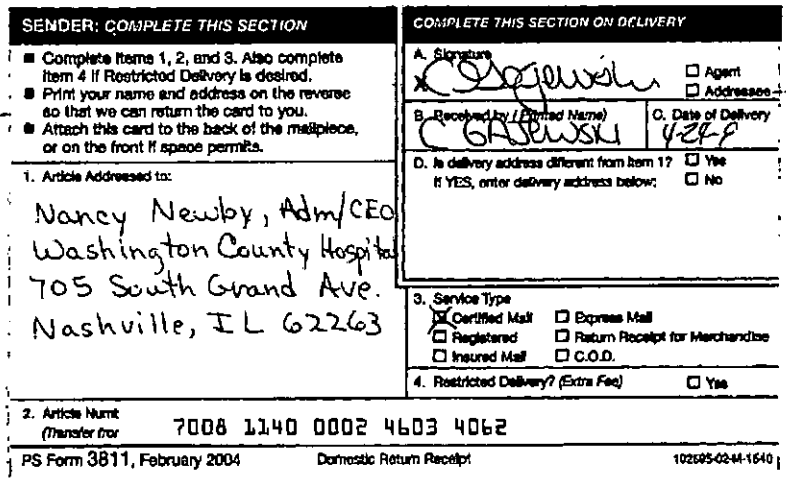
Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

Nancy Newby, Adm/CEO
Washington County Hospital
705 South Grand Ave.
Nashville, IL 62263

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 4-29-9

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) 7008 1140 0002 4603 4062

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

April 22, 2009

Scott Seaborn, Administrator/CEO
St. Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro, Illinois 62966

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Scott:

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

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Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

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2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
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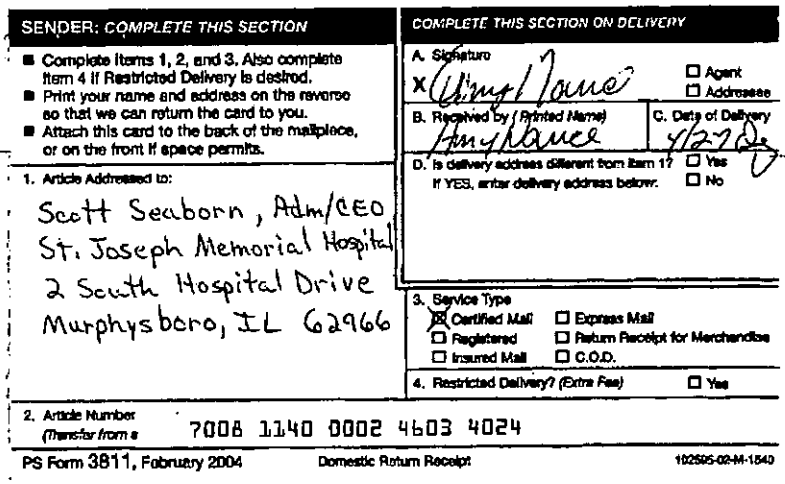
Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



SENDER: COMPLETE THIS SECTION

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1. Article Addressed to:

Scott Seaborn, Adm/CEO
St. Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro, IL 62966

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 4/27

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 s 7008 1140 0002 4603 4024

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

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

April 22, 2009

Bart Milstead, Administrator/CEO
Memorial Hospital of Carbondale
405 West Jackson Street
Carbondale, Illinois 62901

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Bart:

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

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Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

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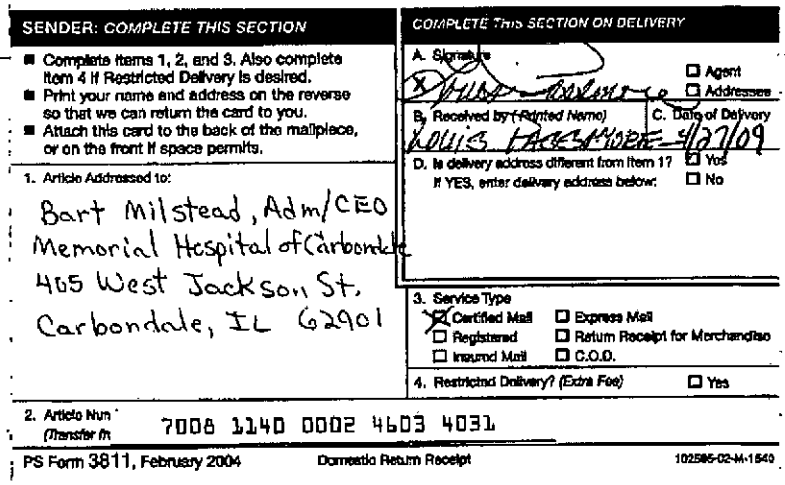
Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

Bart Milstead, Adm/CEO
Memorial Hospital of Carbondale
405 West Jackson St.
Carbondale, IL 62901

COMPLETE This SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) LOUIS HAGEMOEE C. Date of Delivery 4/27/09

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) 7008 1140 0002 4603 4031

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

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

April 22, 2009

Hervey Davis, Administrator/CEO
Franklin Hospital
201 Bailey Lane
Benton, Illinois 62812

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Hervey:

~~Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community~~ Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

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101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

By way of summary, your letter should address the following points;

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
3. How might the proposed replacement hospital impact on your facility when it opens in July 2011 (expected date)?

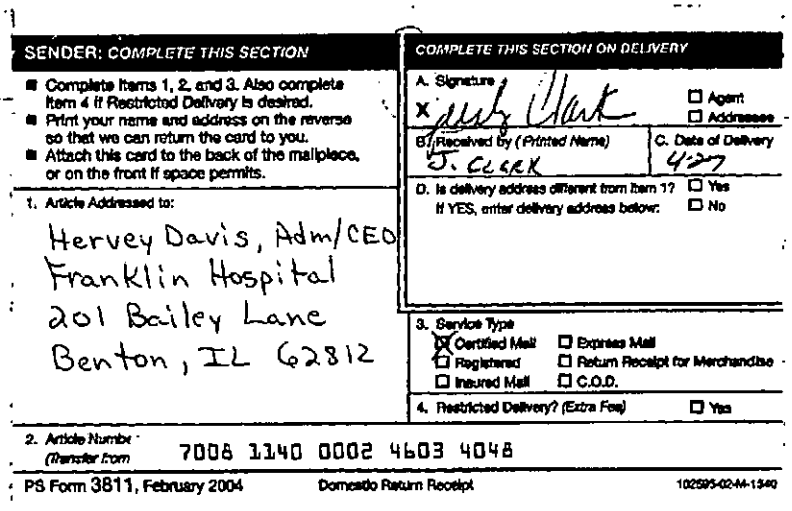
Over the past two years Pinckneyville Community Hospital had 1110 patients admitted to the Hospital's Medical Surgical beds which led to 3856 patient days, including observation days. Pinckneyville is also certified for Medicare Swing Beds, there were an additional 295 patients that generated an additional 3024 patient days from this service. Pinckneyville Community Hospital discontinued its Long Term Care Category of Service in September of 2008.

Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondcoce. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

Hervey Davis, Adm/CEO
Franklin Hospital
201 Bailey Lane
Benton, IL 62812

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) J. CLERK

C. Date of Delivery 4-27

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) 7008 1140 0002 4603 4048

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

April 22, 2009

Steve Hayes, Administrator/CEO
Memorial Hospital of Chester
1900 State Street
Chester, Illinois 62233

Re: Impact Statement Request Letter
Pinckneyville Community Hospital Replacement and Subsequent Discontinuation

Dear Steve:

~~Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community~~ Hospital (License holder) propose to develop a replacement Critical Access Hospital (CAH) on a new site and subsequently abandon its current site and facilities as a healthcare location.

Based on State Agency rules, Pinckneyville is required to both "establish" (Section 1110.530a)3)) the new facility and related categories of service in that it is moving to a new site, and "discontinue" (Section 1110.130) the existing facility and its respective categories of service. "Modernization" criteria do not apply in this instance. As such, we must notify you that discontinuation could potentially occur and have you document "impact on access" per 77 Illinois Administrative Code 1110, Subchapter a, Section 1110.130, Discontinuation, as well as seek your perspective on whether or not, or to what extent, our replacement hospital will impact on your facility (Section 1110.530c)3), "Establishment of Category of Service" when it opens. Please respond to this request as noted herein.

We require a written response from you as to your perspective on whether or not discontinuation will have an adverse impact on access to care for residents of our market area. In addition, we require a statement indicating your available capacity and the extent to which our workload could be absorbed by your facility without conditions, limitations, restrictions, or discrimination if Pinckneyville Community Hospital were to discontinue its operations.

Your written response is required within 15 days of receipt of this letter or the Planning Agency will assume discontinuation will not have an adverse impact on your facility. In addition,

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

please include in your response your perspective on how our proposed replacement facility is expected to impact your hospital's utilization when it opens. We are not expanding our services; this is solely a replacement hospital which is currently expected to open in July 2011. "Establishment", or opening, of the new replacement hospital will occur seamlessly with "discontinuation" of our existing campus.

By way of summary, your letter should address the following points;

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination (rules language)?
3. How might the proposed replacement hospital impact on your facility when it opens in July 2011 (expected date)?

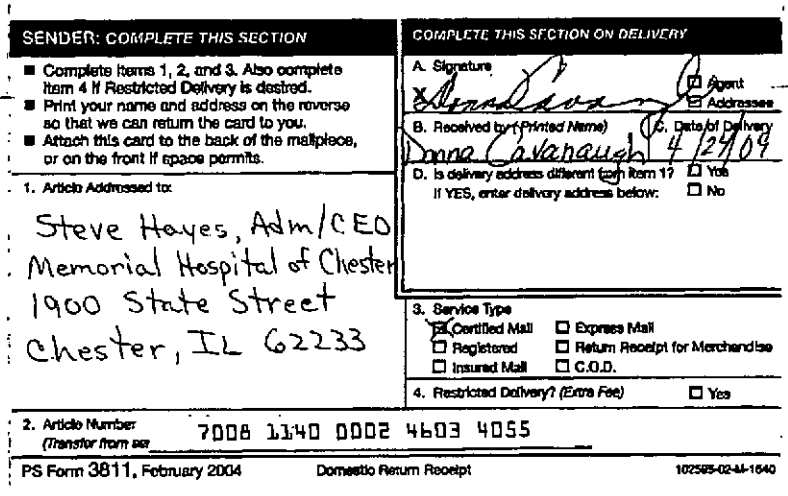
~~Over the past two years Pinckneyville Community Hospital had 1110 patients admitted to~~ the Hospital's Medical Surgical beds which led to 3856 patient days, including observation days. Pinckneyville is also certified for Medicare Swing Beds, there were an additional 295 patients that generated an additional 3024 patient days from this service. Pinckneyville Community Hospital discontinued its Long Term Care Category of Service in September of 2008.

Please send your response to Thomas J. Hudgins, Administrator / CEO, Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, Illinois, 62274, within 15 day of receipt of this correspondence. You may also want to send a copy to Mr. Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761.

If you have any questions regarding our plans for the new hospital or the process of transitioning and discontinuing our current facility please do not hesitate call me at 618-357-5901 or email me at thudgins@pvillehosp.org.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District



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:

Steve Hayes, Adm/CEO
Memorial Hospital of Chester
1900 State Street
Chester, IL 62233

COMPLETE THIS SECTION ON DELIVERY

A. Signature: Agent ☒ Addressee

B. Received by (Printed Name): Donna Cavanaugh C. Date of Delivery: 4/29/09

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): 7008 1140 0002 4603 4055

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

618-542-2146
FAX (618) 542-4756

MARSHALL BROWNING HOSPITAL

900 NORTH WASHINGTON, P. O. BOX 192
DU QUOIN, ILLINOIS 62832

May 1, 2009

Mr. Thomas J. Hudgins, Administrator
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, Illinois 62274

Dear Tom:

In response to your letter dated April 22, 2009, my comments to your questions regarding discontinuation of operations at Pinckneyville Community Hospital and proposed replacement hospital impact on our facility are as follows:

1. Will there be any adverse impact on your facility if Pinckneyville Community Hospital discontinued its operations?
   Answer: I do not see any adverse impact upon Marshall Browning Hospital if your facility discontinued its operations.

2. If Pinckneyville Community Hospital discontinued its operations, to what extent would, or could, your hospital accommodate its work load without conditions, limitations, restrictions, or discrimination?
   Answer: Based upon the statistics that you provided in your letter for the past two years experience at Pinckneyville Community Hospital, I feel that Marshall Browning Hospital could handle the additional patient load as a result of discontinuation. As you are aware and being realistic, since there are three additional hospitals within a 20 mile radius of Pinckneyville Community Hospital, I am sure that we would not receive 100% of your patients if your facility discontinued operations. I feel that even if we did receive 100% of the patients we would be able to handle the additional increase in patient load. As a private not-for-profit community hospital, we treat all patients without conditions, limitations, restrictions, or discrimination.

3. How might the proposed replacement hospital impact on your facility when it opens in July 2011?
   Answer: I feel that the proposed replacement hospital would not have any adverse impact on our facility when it opens in July 2011 with the exception that this would continue the duplication of services in Perry County and increase the cost of healthcare services to the residents of our service area.

If any additional information is needed from Marshall Browning Hospital do not hesitate to contact me.

Sincerely,

William J. Huff
Chief Executive Officer

Cc: Jeffrey Mark, Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

SCH

April 27, 2009

Thomas Hudgins
Pinckneyville Community Hospital
101 N Walnut Street
Pinckneyville, IL 62274

Dear Mr. Hudgins:

This letter is written in response to "impact on access" when Pinckneyville Community Hospital District discontinues services and relocates to a new location. Based on available services, Sparta Community Hospital District is willing and able to accept any patients that may need medical services. If discontinuation were to occur, all patients would be accepted from your market area with little impact on our hospital's workload. We also are Medicare certified for Swing Bed patients so could assume any of these patients who need skilled care. I foresee little impact on our facility if the proposed replacement facility is approved.

Sparta Community Hospital District wishes Pinckneyville Community Hospital District's the best in future endeavors.

Sincerely,

Joann Emge,
Chief Executive Officer

JLE/djp

cc: Mr. Jeffrey Mark

"Quality Health Care Close to Home"
Sparta Community Hospital District
818 E. Broadway • Sparta, Illinois 62286 • 618.443.2177 • 618.443.2938 fax • www.spartahospital.com

Placeholder
Washington County Hospital Response Letter
(Not received as of 11/19/09)

SOUTHERN ILLINOIS HEALTHCARE

May 6, 2009

VIA FEDERAL EXPRESS

Mr. Thomas Hudgins
Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, IL 62274

Dear Mr. Hudgins:

On behalf of Southern Illinois Healthcare, comprised of Herrin Hospital, Memorial Hospital of Carbondale and St. Joseph Memorial Hospital, I am writing in acknowledgement of your notification of intent to establish a replacement Critical Access Hospital facility and discontinue your current facility.

Pinckneyville Community Hospital is a valuable partner in caring for the healthcare needs of residents of southern Illinois. Discontinuation of this facility would create an adverse impact on access to care for residents of the region. In the event that the gap left by discontinuation of Pinckneyville Community Hospital was not filled by a replacement facility, this additional workload could not be readily absorbed by Southern Illinois Healthcare facilities.

Achieving a replacement Critical Access Hospital in Pinckneyville is a prudent and essential step in providing financially expedient care for the area. It is anticipated that the proposed replacement hospital will have no adverse impact on Southern Illinois Healthcare facilities.

We look forward to a continued collaborative relationship with Pinckneyville Community Hospital.

Sincerely,

Rex P. Budde
President and Chief Executive Officer

cc: Becky Ashton
Bart Millstead
Phil Schaefer
Scott Seaborn

Executive Administration
1239 East Main Street | PO Box 3988
Carbondale, IL 62902-3988
TEL 618-457-5200
FAX 618-529-0568
www.sih.net

FRANKLIN Hospital

201 Bailey Lane • Benton, IL 62812 • 618-439-3161 • franklinhospital.net

April 29, 2009

Thomas J. Hudgins, FACHE
Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, Illinois 62274

Dear Mr. Hudgins:

In response to your letter dated April 22nd, 2009, it is the opinion of Franklin Hospital Administration that there would be no adverse impact on our facility here in Benton if Pinckneyville Community Hospital discontinued operations. Further, our hospital could accommodate the workload of your hospital if your operation were to cease.

Having said that, it is unlikely that a patient from Perry County would use our services given the distance between Benton and Pinckneyville. The impact of your proposed replacement hospital would be negligible on our operation.

Sincerely,

HERVEY DAVIS
Chief Executive Officer

HD:jm

MEMORIAL HOSPITAL
1900 STATE STREET • CHESTER, ILLINOIS 62233
(618) 826-4581

May 4, 2009

Thomas J. Hudgins, CEO
Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, Illinois 62274

Dear Tom:

I am responding to your letter received in my office on April 27, 2009, requesting a letter in response to your plans to develop a replacement hospital and eventually terminate services at your existing facility.

We do not anticipate any significant adverse impact on our hospital operations as a result of your plans to discontinue services at your existing facility. As a licensed 25 bed critical access facility, we currently continue to treat patients in need of general acute care services regardless of ethnic background, religion, or willingness to pay, etc. Further, we would expect that your new facility will have minimal or no impact on our operations once opened.

Please contact me if you have any further questions or require further information.

Sincerely,

Steven A. Hayes
Administrator

SAH:vlr

Placeholder
St. Joseph Memorial Hospital, Murphysboro, Illinois Response Letter
(Not received as of 11/19/09)

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

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, certification and accreditation identification numbers, 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 HFPB 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 HFPB.**

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 the information has been 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.

SECTION III. - APPLICANT BACKGROUND

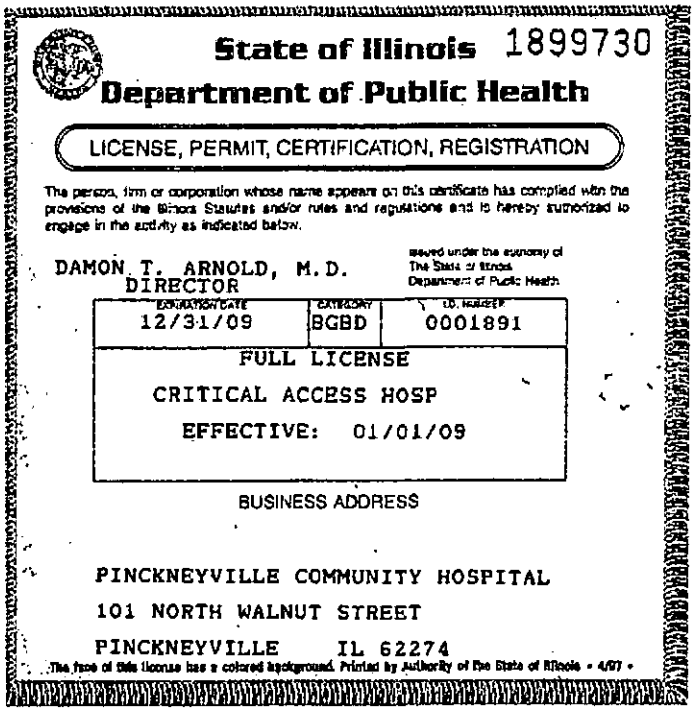
This responds to the applicable criterion point-by-point.

1. Pinckneyville Community Hospital District (legal entity) owns and operates Pinckneyville Community Hospital, a fully licenses Critical Access Hospital located at 101 North Walnut Street, Pinckneyville, Illinois. (See Attachment 10, Exhibit 1)

2. and 3. Attachment 10, Exhibit 2 responds to the adverse action criterion and permitted access to the Hospital's records.

4. Not applicable.

Note: The Hospital is a fully licensed CAH. It has not sought Joint Commission Accreditation since 1995. It relies on IDPH for any required compliance documentation for CMS and related agencies.



State of Illinois 1899730

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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0001891

FULL LICENSE

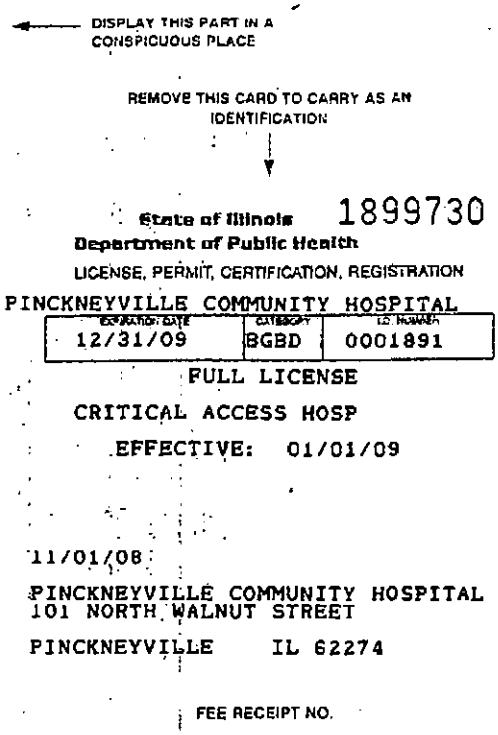
CRITICAL ACCESS HOSP

EFFECTIVE: 01/01/09

BUSINESS ADDRESS

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET
PINCKNEYVILLE IL 62274

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/07 •



DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1899730

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PINCKNEYVILLE COMMUNITY HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0001891

FULL LICENSE

CRITICAL ACCESS HOSP

EFFECTIVE: 01/01/09

11/01/08

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET

PINCKNEYVILLE IL 62274

FEE RECEIPT NO.

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

November 13, 2009

Ms. Courtney Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

In accordance with Criterion 1110.230.a. Background of Applicant, I am submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Neither Pinckneyville Community Hospital nor Pinckneyville Community Hospital District have any adverse action taken during the last three (3) year period prior to filing of this application; and

2. Pinckneyville Community Hospital and Pinckneyville Community Hospital District authorize the Health Facilities and Services Review Board and Illinois Department of Public Health access to any information necessary to verify documents or information submitted in response to the requirements of Criterion 1110.230.a, or to obtain documentation or information which the State Board or Agency finds pertinent to the application.

If further information or documentation relative to this application is needed, please do not hesitate to contact me.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District

Subscribed and sworn to before me
this 13th day of November 2009

Notary Public

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/2012

N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

November 13, 2009

Ms. Courtney Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

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1. Neither Pinckneyville Community Hospital nor Pinckneyville Community Hospital District have any adverse action taken during the last three (3) year period prior to filing of this application; and

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If further information or documentation relative to this application is needed, please do not hesitate to contact me.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District

Subscribed and sworn to before me
this 13th day of November 2009

Notary Public

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/10

1 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

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, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as 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.

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

One Page Only

SECTION III. - PROJECT PURPOSE

Pinckneyville Community Hospital was designated a 25-bed CAH in November 2000 and is considered a necessary provider of health services by IDPH. Its market area is essentially Perry County, Illinois. In 2008, 56.2% of the Hospitals inpatients were from Pinckneyville with another 30.0% from the remainder of Perry County, for a total of 86.2% (COMPdata). (See also Attachment 23, Exhibit 1.)

The Hospitals existing physical plant has a myriad of physical and medical issues as documented by Gresham Smith (see Attachment 9, Exhibit 1). These issues were judged to be too extensive or complicated to be corrected effectively and efficiently by a modernization project; hence, discontinuing the existing facility and establishing a new replacement facility was deemed the best alternative by the Board after applicable analysis.

Various information sources and relevant analysis as provided herein were prepared by qualified consultants, financial advisors, architects / engineers, and construction cost consultants using national, local, as well as state databases, codes, and regulations provided documentation for the project.

By replacing the current facility on a new site, the Hospital will continue to serve its existing market in a new facility which meets the current codes and contemporary design criterion. The population's health status and well-being will be preserved because hospital and related healthcare services will remain in Pinckneyville.

Our overarching goal is to develop and open a replacement hospital within two years of construction start. This contemporary hospital will provide our rural community with a facility that is accessible providing a full range of quality healthcare services in an environment fostering privacy and a positive working environment. Goals will be measured, in part, by applicable quality and satisfaction surveys noting before and after impressions.

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information

ALTERNATIVES

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options 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

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, 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.

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

SECTION III. - ALTERNATIVES

Background

Pinckneyville Community Hospital District operating as or d.b.a. Pinckneyville Community Hospital is a 25 bed Critical Access Hospital Licensed by the State of Illinois. The hospital maintains membership in the American Hospital Association, the Illinois Hospital Association and the Illinois Critical Access Hospital Network. The hospital has a rural network affiliation agreement with SSM Healthcare in St. Louis, Missouri.

Pinckneyville Community Hospital currently provides the following services: medical/surgical care, swing bed program, ambulatory surgery, emergency care, monitored cardiac care, laboratory services, nuclear medicine, electrocardiograms, holter monitoring, echocardiograms, electroencephalograms, radiology, sonograms, C.T. scanning, mammography, blood banking, enterostomal therapy, wound care, pathology, physical therapy, occupational therapy, speech therapy, social services and mobile MRI services. Transfers to other facilities for care not offered at Pinckneyville Community Hospital are handled via ambulance and helicopter. The hospital hosts a number of specialty clinics on a regularly scheduled basis, these include cardiology, podiatry, neurology, pulmonology, rheumatology, oncology, urology, allergy, wound care and OB/GYN.

In addition to the hospital based services, the hospital also operates a Rural Health Clinic which currently houses three physicians, two physician assistants, and rental space for a general surgeon. The Southern Illinois Rehabilitation facility houses the hospital's physical therapy, occupational therapy, speech therapy, work hardening and comprehensive wellness/fitness programs.

The proposed replacement hospital project will relocate all hospital sponsored services to the new site. All exiting facilities will be discontinued and vacated for Hospital purposes. Final disposition of the existing facilities and site is pending.

Hospital History

Hiller Hospital

Dr. Frank Hiller operated a hospital in his home, a two story wood frame house located on Mulberry Street in Pinckneyville. He later moved the hospital to a brownstone building at the corner of Laurel and North Walnut Street. In the early 1920's, Dr. Hiller constructed a hospital facility at 103 North Walnut Street.

The existing Hiller hospital was purchased by the Pinckneyville Community Hospital District from Pinckneyville Community Hospital Inc. In 1952 and an addition to this facility followed on adjacent land.

Hospital District Establishment

On the eighteenth day of December 1950, the residents of a portion of Perry County voted by a margin of 1078 to 787 to approve the creation of the Pinckneyville Community Hospital District. On Monday, January 22, 1951, the initial meeting of the Board was held at the Courthouse with the time and place being designated by the Judge of the County Court of Perry County.

Pinckneyville Community Hospital, which is operated by the Pinckneyville Community Hospital District, is a municipal corporation and the appointed Board is charged with the operation of the District.

Pinckneyville Community Hospital

By the early 1960's, the original Hiller Hospital building (as expanded) was no longer meeting the needs of the community and property south of the existing hospital which was located at 101 N Walnut was acquired on August 3rd, 1962. An application was subsequently made to the Federal Government for assistance under the Hill-Burton program as well as other federal sources. A new 55 bed hospital, Pinckneyville Community Hospital, was opened in December 1965 on the purchased grounds adjacent to the south side of Hiller Hospital and the existing Hiller Hospital was demolished.

In 1977, a nursing home unit with 44 beds was added to the hospital facility. Revenue bonds issued through the Farmer's Home Administration in the amount of $1.8 million were used to defray most of the $2.25 million in construction and equipment costs. This program afforded individuals needing nursing home care and an opportunity to stay in their home community. Most recently this LCT category of service was discontinued due to financial considerations.

In 1981, the locations of the hospital beds and the nursing home beds were switched within the facility itself.

In 1989, the hospital opened a Home Health agency. This was complimented in 1993 with the opening of a Hospice program. The hospital opened a Home Medical Equipment service in 1995. These services have since been divested.

In 1995, the hospital renovated a building adjacent to the hospital on the town square which became the location of the rehabilitation and fitness services of the hospital.

In 1996, the hospital opened a Rural Health Clinic to strengthen its recruiting position and develop a hub for the future of primary care in Pinckneyville. The clinic is located on the Hospital campus.

Current hospital facilities were developed in 1965 and 1977, and are well over 30 years old, as primarily inpatient facilities. The Rural Health Clinic was developed and opened in 1996. As a critical access hospital, the greatest majority of services are delivered on an outpatient basis. Unfortunately, our facilities were primarily designed to serve an inpatient market and are not readily adaptable to providing contemporary ambulatory care.

Current spaces are limited with respect to access, privacy, and modern care delivery protocols.

Existing facilities have a myriad of problems as noted in Attachment 9. These include structural / seismic deficiencies, inefficient design, electrical and plumbing deficiencies, HVAC inadequacies, lack of private rooms, patient rooms without showers and toilets, and an antiquated mechanical / medical gas piping infrastructure. The current campus does not allow for necessary and future modernization / expansion let alone any consideration for a replacement hospital.

Given these considerations meaning from both internal and external analysis, the Hospital considered several options.

1. Discontinue hospital operations.
2. Do nothing … eventually close due to code violations.
3. Modernize the existing facility.
4. Phased replacement on-site.
5. Pursue merger / JV
6. Replacement (establish a new hospital) on a new site.

The following matrix evaluates each alternative based on access, quality, financial, and cost considerations.

Alternatives Evaluation Matrix							
Alternative / Criteria	1) Discontinue Operations	2) Do Nothing	3) Modernize Existing	4) Phased On-site Replacement	5) Merger / JV	6) Replace on New Site	Preferred Alternative
Patient Access	Local access eliminated.	Same as current until closure forced due to code violations – Does not improve access.	Master Plan analysis concluded this was nearly impossible – if possible, access constrained during any renovations.	Current site is land-locked; adjacent sites not available … access is constrained today and over time.	No local hospital provider is available … Pinckneyville is an essential community provider, the existing hospital provides access.	Access improved through adequate parking and single-level facility with multiple entrances.	Replacement hospital on new site improves access.
Quality	Quality suffers due to lack of hospital facilities.	To the degree existing facilities are not modern, quality may suffer.	Quality could be enhanced if modernization was possible.	On-site replacement is not feasible thus quality suffers.	Unknown, there is no local merger / JV partner.	Quality improves with new facilities and a healing environment embracing privacy and contemporary healthcare surroundings.	Quality improves in replacement facilities.

Alternatives Evaluation Matrix							
Alternative / Criteria	1) Discontinue Operations	2) Do Nothing	3) Modernize Existing	4) Phased On-site Replacement	5) Merger / JV	6) Replace on New Site	Preferred Alternative
Financial Benefits / ROI	None – negative ROI	None – negative ROI, deteriorating facilities, upgrades only, if possible	None – Investment in existing plant only "repairs" current deficiencies	None – Onsite replacement is not feasible	Unknown	Highest … new facilities provide for contemporary operations and market growth	Financial benefits, short and long term, highest with replacement facility.
Project Cost	$1.0 Million to close and demolish existing facility (estimate)	Unknown … depends on corrective actions that need to be taken to stay in operation.	Approximately $51.0 Million project cost, assuming a 4-year phased project with a 20% premium over new construction due to complex construction … if modernization could be achieved.	Not possible due to site constraints.	Unknown	$46.6 Million project cost based on current estimates.	Replacement hospital on a new campus is considered the least costly and most effective alternative.

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

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

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

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

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

SECTION IV. – PROJECT SIZE

Introduction

Critical Access Hospitals are unique in that the majority of their respective services are outpatient by their very nature. In addition, they are subject to wide swings in utilization due, in part, to their smaller size. Hence, the applicable State Agency space guidelines, both current and proposed, may not be directly applicable.

The proposed replacement hospital provides 104,522 gsf or 9.4% more area than currently exists (95,538 gsf). Even more significant is the area dedicated to clinical functions. Currently 32,368 gsf or approximately 33.9% of the total Hospital area is assigned to clinical functions. In the replacement facility, 62,204 is proposed for clinical functions or almost double the existing. This allocation is approximately 59.5% of the total proposed area.

New hospitals should meet, at minimum, the "Guideline for Design and Construction of Health Care Facilities, AIA, 2006 Edition to comply with Joint Commission and Medicare participation guidelines, in addition to IDPH criteria. The replacement hospital is conservatively designed to meet these and the proposed State Agency standards. Hence, there will be some expected variance from current Agency standards.

The following address each clinical area by department (See Attachment 8 for space allocations).

Medical Surgical

13,671 gsf are proposed or 547 gsf per bed. This amount is 146 gsf over the current standard but within the proposed new standards approved by the Board but not yet codified. All private rooms with toilet and showers are proposed to support a contemporary care model.

Emergency Services

3,674 gsf are proposed or 735 gsf per key room. This space allocation is within the current and proposed Agency standard. However, based on 2008 department utilization, two key rooms can be justified. Five rooms are proposed in order to meet peak utilization requirements and local disaster preparedness. It is not uncommon to have four patients requiring emergency services at any given time.

Diagnostic Imaging (Including Nuclear Medicine)

6,098 gsf are proposed to support six (6) room including DEXA, Mammography, Radiographic, Fluoroscopic, CT, and Nuclear Medicine. Each room (6 each) has its own unique imaging capabilities. Current standards suggest 1,386 gsf / procedure room and 1,135 for Nuclear Medicine. In this case, 8,065 gsf is allowable. Under the new criteria, 7,800 gsf is permissible. Thus, the space allocated meets current and proposed State Agency criteria. However, current radiographic and fluoroscopic utilization may be considered as not meeting utilization criteria. Two rooms are proposed, one radiographic and one fluoroscopic to ensure availability of these highly utilized modalities. If one unit is down for repairs, another is therefore available for patient care.

Surgery, Same Day Surgery, Prep / Recovery, PACU

6,661 gsf are proposed for this integrated program which also supports endoscopy. Two operating / procedure and 7 total prep / recovery and PACU beds are proposed. 5,596 gsf is allowable under the current guidelines and 7,820 under the proposed new standards assuming 2 OR / procedure rooms and 4 prep / recovery beds / room. Hence the space allocation is below proposed standards and above the current. Two OR / procedure rooms are proposed to provide both a "sterile" and "clean" environment for surgical vs. procedural cases and also back-up for surgical capabilities, if one room is being utilized or shut down for maintenance purposes.

Central Sterile Supply / Processing

931 gsf is allocated for this necessary support function; by State standards, 450 gsf is allowable (25 beds x 18 gsf / bed). AIA minimum guidelines required physically separated decontamination area and clean workroom as well as equipment supply / storage. In addition, cart distribution and staff support is required. Based on current State standards, it would be impossible to comply with minimum requirements. There is no Central Sterile Supply standard in the proposed new guidelines.

Laboratory

2,173 gsf is allocated to this department. 10.59 FTE's are proposed. Based on the State Agency guideline of 225 gsf / FTE 2,383 gsf are allowable. The allocated space is 210 gsf below the standard.

Pharmacy

1,351 gsf are proposed for this department. 300 gsf is allowable based on the current standard of 12 gsf / bed. Again, according to the AIA guidelines, space for receiving, break-down, inventory, drug storage, IV prep, compounding, dispensing, and records must be provided. Compliance with Federal Standard 729 is also required. The current State standard does not allow sufficient area to comply with necessary requirements and the new State standards do not have guidelines for pharmacy.

Oncology Infusion

2,683 gsf are proposed for this clinical service; 9 infusion stations are proposed, or 298 gsf / station. The State has no standard for infusion areas.

Rural Health Clinic, Physician Specialty Clinic and General Surgeon (Physician Offices)

13,961 gsf are proposed for this combined hospital-based physician office area. There are no State standards for physician offices.

Outpatient Rehabilitation

8,189 gsf are proposed for this department. There are no State Agency standards for this clinical service.

Sleep Laboratory

435 gsf are proposed for this department. There are no State Agency standards for this clinical function.

Cardio-Pulmonary Diagnostics

668 gsf are proposed for this department. There are no State Agency standards for this clinical function.

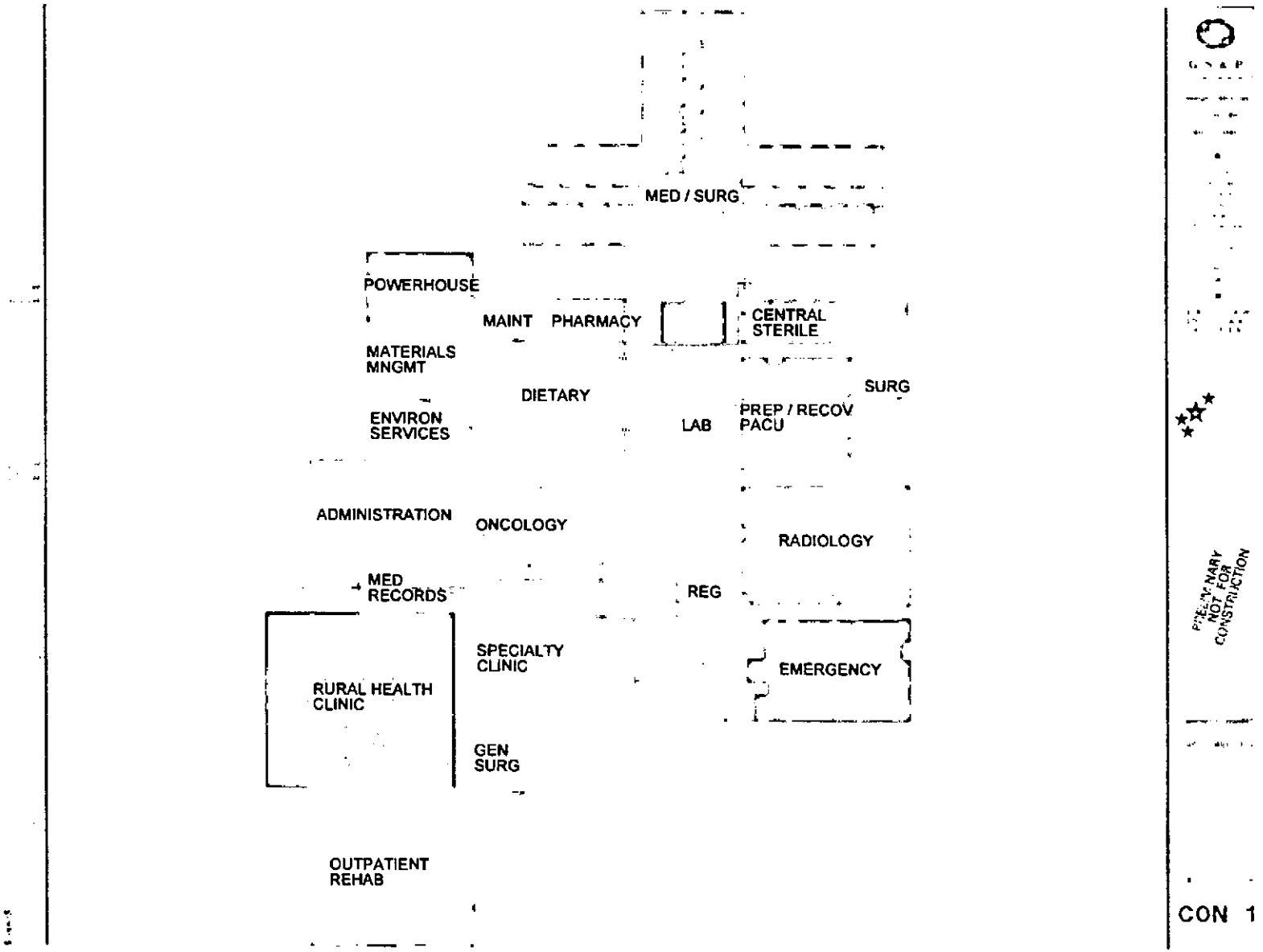
Pre-Admission Services

500 gsf are proposed for this department. There are no State Agency standards for this clinical support function.

Inpatient Rehabilitation (PT / OT)

1,209 gsf is allocated to this department. Current State Agency standards allow 27.3 total gsf / bed or 682 gsf for this clinical function. There is no proposed future standard for this area. Additional space (527 gsf) is justified by the fact our elderly patient population utilizes this critical ancillary support area proportionately greater than a younger population thereby necessitating additional space to provide the clinical service.

Plans for the replacement hospital follow this page.


MED / SURG
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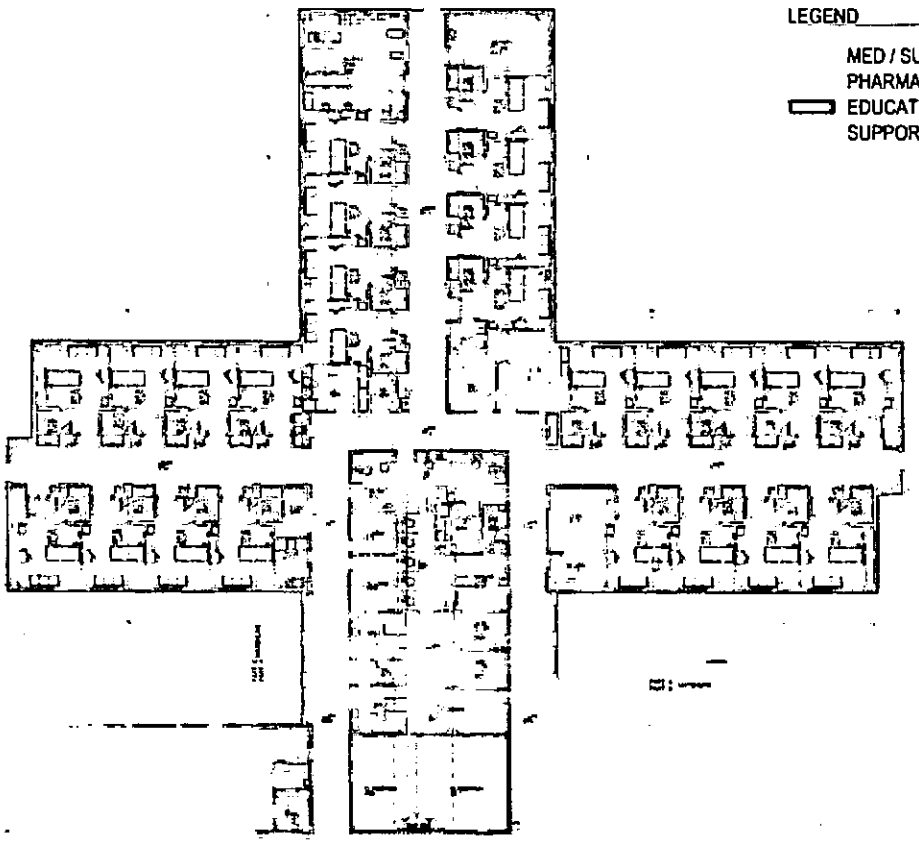
MAINT
PHARMACY
CENTRAL STERILE
MATERIALS MNGMT
DIETARY
SURG
ENVIRON SERVICES
LAB
PREP / RECOV PACU
ADMINISTRATION
ONCOLOGY
RADIOLOGY
MED RECORDS
REG
SPECIALTY CLINIC
EMERGENCY
RURAL HEALTH CLINIC
GEN SURG
OUTPATIENT REHAB
PRELIMINARY NOT FOR CONSTRUCTION
CON 1

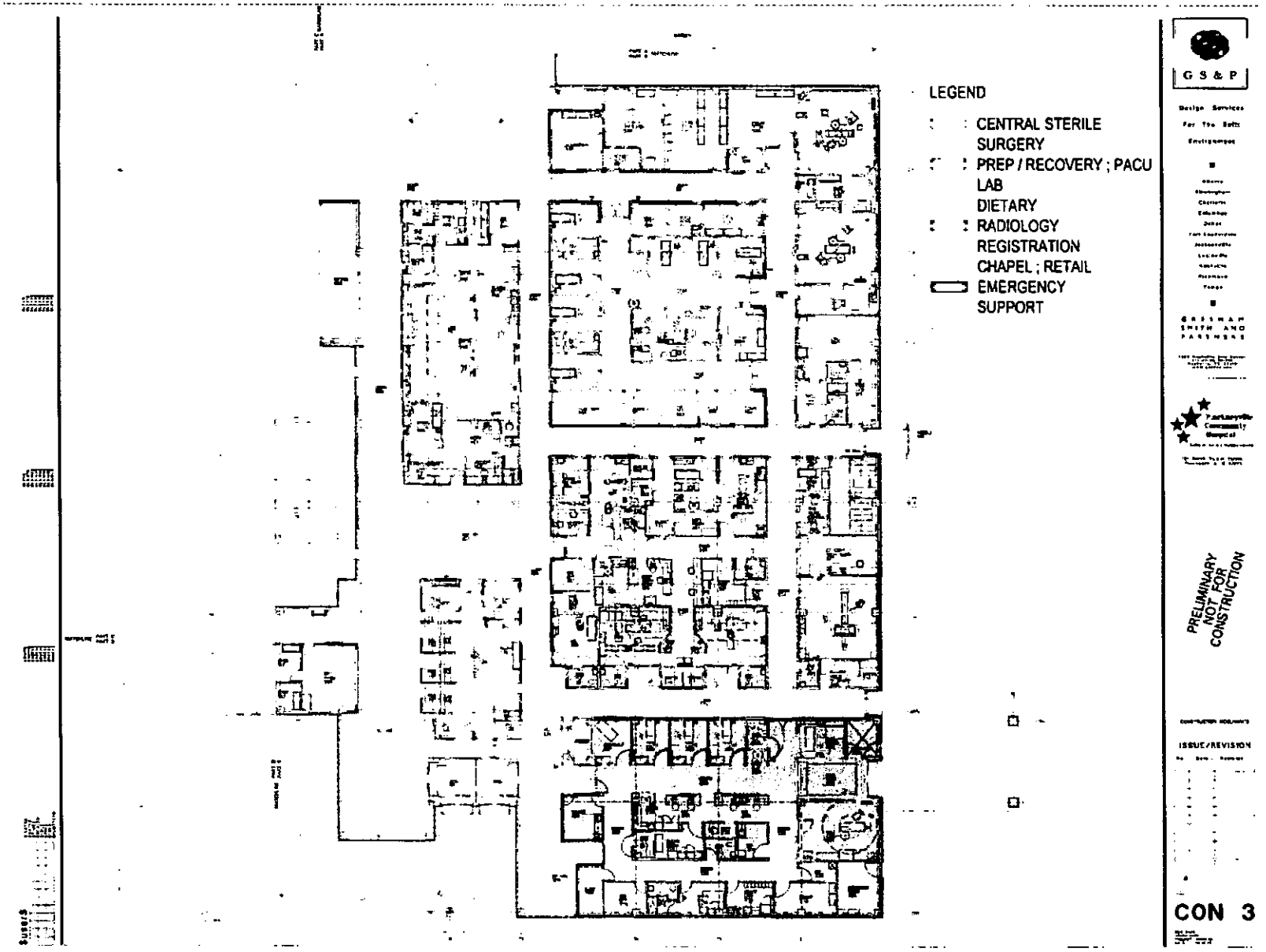


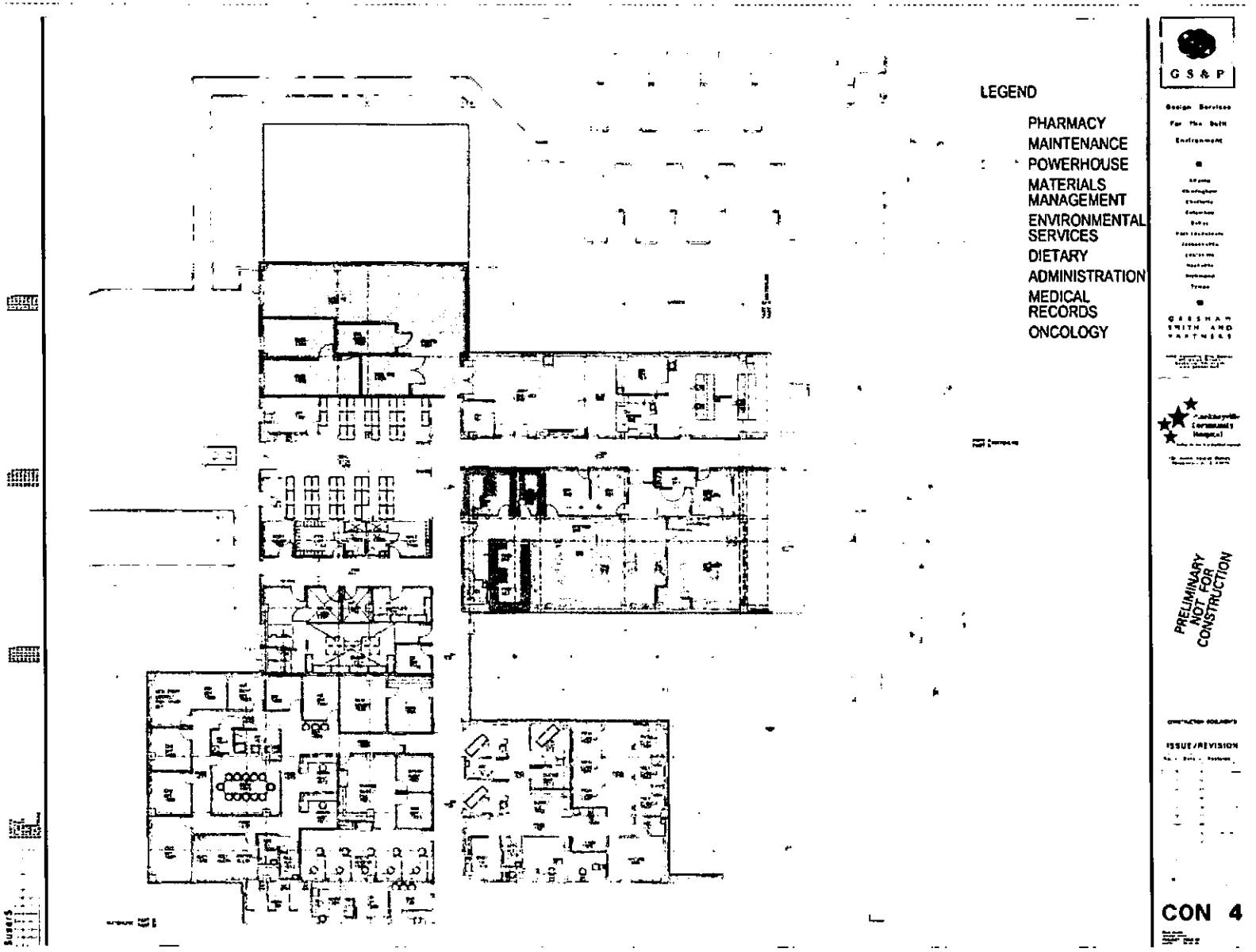
G S & P

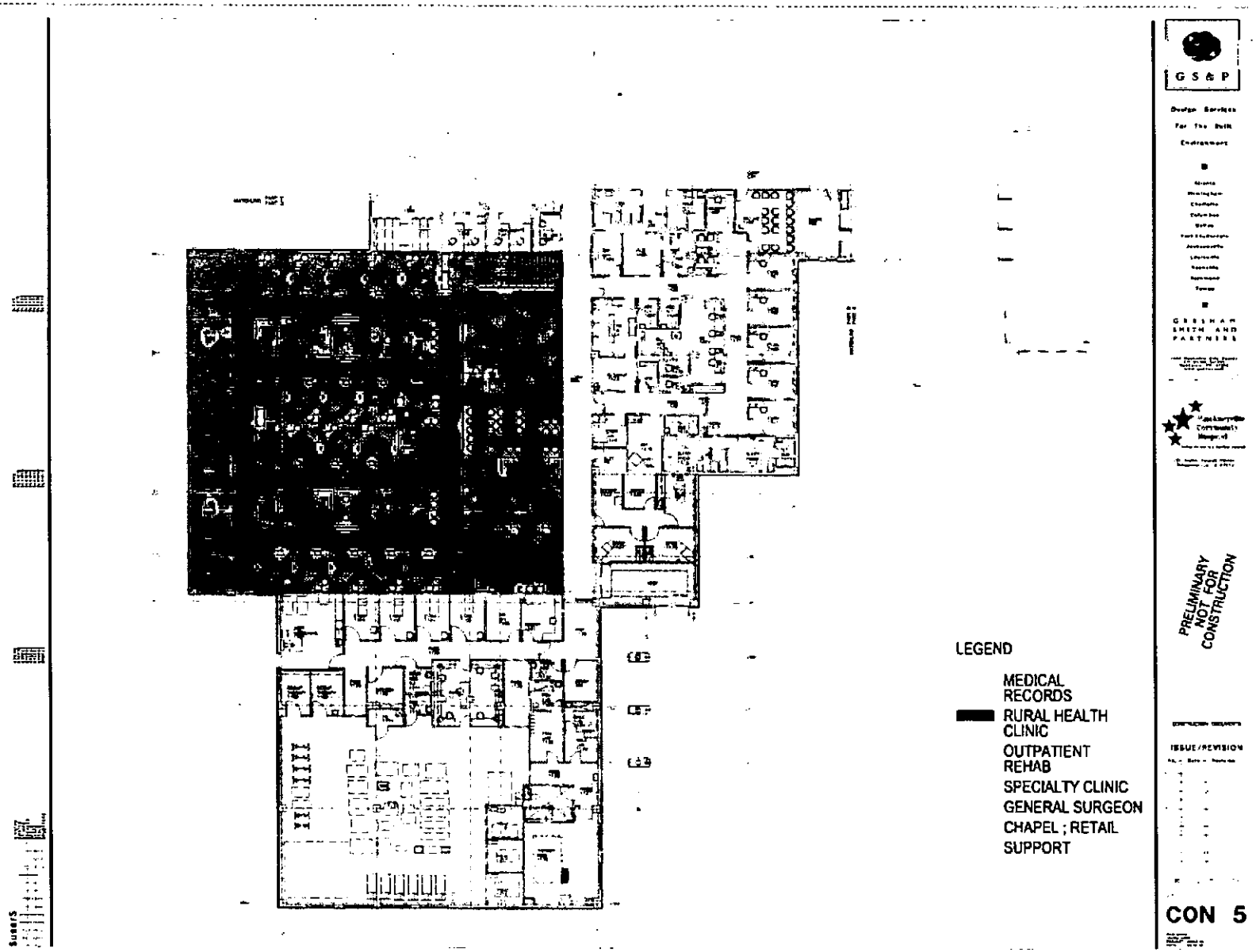
PRELIMINARY NOT FOR CONSTRUCTION

ISSUE/REVISION

CON 2


LEGEND
CENTRAL STERILE
SURGERY
PREP / RECOVERY ; PACU
LAB
DIETARY
RADIOLOGY
REGISTRATION
CHAPEL ; RETAIL
EMERGENCY
SUPPORT
G S & P
PRELIMINARY
NOT FOR
CONSTRUCTION
ISSUE/REVISION
CON 3


LEGEND
PHARMACY
MAINTENANCE
POWERHOUSE
MATERIALS MANAGEMENT
ENVIRONMENTAL SERVICES
DIETARY
ADMINISTRATION
MEDICAL RECORDS
ONCOLOGY
G S & P
PRELIMINARY NOT FOR CONSTRUCTION
ISSUE/REVISION
CON 4


LEGEND
MEDICAL RECORDS
RURAL HEALTH CLINIC
OUTPATIENT REHAB
SPECIALTY CLINIC
GENERAL SURGEON
CHAPEL ; RETAIL
SUPPORT
GS&P
PRELIMINARY NOT FOR CONSTRUCTION
CON 5

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

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFPB has not established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

SECTION IV - PROJECT SERVICES UTILIZATION

The attached Exhibit 1 profiles 10 years of historical utilization. Exhibits 2 and 3 project necessary beds and Attachment 14, Exhibit 3 and Attachment 14, Exhibit 5 estimate ancillary service utilization in 2015 and 2020 respectively. The first full calendar year of Hospital operation is expected to be 2012.

This criterion requests information on those project portions for which the State Agency has not established standards and then requests documentation for utilization that meets or exceeds Appendix B standards. The criterion requests conflicting information. Hence, the projections are included for comparison purposes.

Pinckneyville Community Hospital Historical Utilization (Calendar Year)

Service	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Medical/Surgical										
Admissions	577	648	647	728	837	754	834	791	657	544
Patient Days*	2,315	2,306	2,173	2,447	3,093	2,979	3,169	2,891	2,454	2,153
Swing Beds [1]										
Admissions - new service 02/06/01	0	0	228	320	323	308	301	268	216	147
Patient Days*	0	0	3,428	5,193	4,794	4,593	3,806	3,282	2,430	1,775
Subtotal										
Admissions	577	648	875	1,048	1,160	1,062	1,135	1,059	873	691
Patient Days*	2,315	2,306	5,601	7,640	7,887	7,572	6,975	6,173	4,884	3,928
Emergency Visits	3,365	3,313	3,573	3,526	3,615	3,299	3,745	3,688	3,649	3,494
Hospital Admissions for ED	370	469	478	446	478	449	502	515	458	411
Laboratory Tests (AHQ totals)	40,159	59,830	29,868	45,870	52,977	58,110	68,172	67,799	68,974	64,638
Lab I/P & O/P excluding double count of ref lab tests	38,272	58,119	27,618	42,971	49,574	53,739	61,979	62,652	63,830	64,638
Surgery**										
Inpatient Case	85	78	78	84	74	64	69	69	29	34
Inpatient Hours	345	133	146	255	121	136	99	123	69	78
Outpatient Cases	305	362	449	435	425	389	421	421	437	382
Outpatient Hours	702	406	511	1,039	443	347	368	393	533	410
Total Cases	390	440	527	519	499	453	490	490	466	416
Total Hours	1,047	539	657	1,294	564	483	467	516	602	488
Diagnostic Exams										
Computerized Tomography	512	682	817	1,111	1,093	1,577	2,006	1,869	1,948	1,680
Fluoroscopy/Radiography	5,682	5,452	5,432	5,401	6,592	5,190	6,088	5,910	5,467	5,346
Mammography****	708	826	769	803	748	787	784	774	839	747
MRI	258	330	352	362	415	404	453	461	433	448
Nuclear Medicine	***	***	***	***	***	1,268	1,080	1,206	1,128	756
PET*****	0	0	0	0	0	0	0	12	16	28
Ultrasound	1,028	884	1,063	1,450	1,496	1,650	1,671	1,935	1,685	1,677

* Includes Observation Days

** Includes Gastroenterology

*** Nuclear Medicine statistics where included on the same line of the AHQ as Fluoroscopy/Radiology for reporting years 1999 - 2003.

**** Excludes Mammography CAD testing which is a separate charge for almost every mammogram but not a separate procedure for the patient. It involves running the mammogram film through the CAD to identify areas of concern.

***** Pinckneyville Hospital does not bill the patient claims for PET scans. The mobile unit pays a pad rental fee and they bill the patient claims. We just assist in coordinating scheduling.

[1] Swing bed services include Medicare Certified days from the Long-term Care Unit that were previously reported along with non-certified long-term care admits and patient days.

Source: Illinois Department of Public Health Hospital Profiles, 2001-2007; 2008 Annual Hospital Questionnaire

Pinckneyville Community Hospital High Level Medical/Surgical Bed Projection

Perry County	2015	2020	Change	Percent Change
Population Estimates				
15-44	9,500	9,587	87	0.92%
45-64	6,351	6,293	-58	-0.91%
65+	4,141	4,805	664	16.03%
Total Adult (Excludes 0-14)	19,992	20,685	693	3.47%
Derived Use Rate/1,000 Population (Based on 5-Year Average 2004-2008)				
15-44	58.46	58.46	0.00	0.00%
45-64	97.98	97.98	0.00	0.00%
65+	383.66	383.66	0.00	0.00%
Expected Total Medical Surgical Admissions				
15-44	556	561	5	0.90%
45-64	623	617	-6	-0.96%
65+	1,589	1,844	255	16.05%
Total (Exculding Peds and OB)	2,768	3,022	254	9.18%
PCH Average Market Share - Perry County	22.18%	22.18%	0.00%	--
PCH Expected Medical Surgical Admissions - Perry County Only	614	670	56	9.12%

Source: Illinois Department of Economic Opportunity; COMPdata

Pinckneyville Community Hospital High Level Medical/Surgical Bed Projection

	Actual		Projected		2007 - 2015		2015 - 2020	
	CY 2007	CY 2008	2015	2020	Change	Percent Change	Change	Percent Change
PCH Expected Total Medical Surgical Admissions								
Perry County	567	468	614	670	47	8.29%	56	9.12%
Oakdale (62268)	10	13	12	13	2	20.00%	1	8.33%
Subtotal PSA and SSA (88%)	577	481	626	683	49	8.49%	57	9.11%
Other Illinois/Out of State (12%)	80	62	86	93	6	7.50%	7	8.14%
Total Med/Surg Admissions (100%)	657	543	712	776	55	8.37%	64	8.99%
Total Expected Admissions								
Adult Medical/Surgical (74%)	657	543	712	776	55	8.37%	64	8.99%
Swing Beds (26%)	216	237	250	273	34	15.74%	23	9.20%
Total Admissions (100%)	873	780	962	1,049	89	10.19%	87	9.04%
Expected Patient Days								
Med/Surg @ 3.79 ALOS*	2,454	1,619	2,698	2,941	244	9.94%	243	9.01%
Swing Patients @ 12.76 ALOS	2,430	1,775	3,190	3,483	760	31.28%	293	9.18%
Total Days	4,884	3,394	5,888	6,424	1,004	20.56%	536	9.10%
Average Daily Census	13.38	9.30	16.13	17.60	2.75	20.56%	1.47	9.10%
Beds @ 60% Occupancy	23	16	27	29	4	17.39%	2	7.41%
Beds @ 70% Occupancy	20	14	23	25	3	15.00%	2	8.70%

*Includes Observation Days
Source: 2004-2007 Hospital Data

Pinckneyville Community Hospital High Level Ancillary Services
2015 Projected Utilization

Ancillary Service	Expected Range: Low (10-Year Historical Low)	Expected Range: Probable (10-Year Historical Average)	Expected Range: High (10-Year Historical Peak)	Actual: FY 2007	Actual: FY 2008
Emergency Department	3,133	3,517	4,564	3,653	3,622
Surgery Cases	413	477	577	462	453
Laboratory Tests	40,484	56,554	79,260	62,667	62,897
Radiology	4,457	5,675	9,569	5,919	4,917
Magnetic Resonance Imaging	320	420	484	464	387
Computerized Tomography	748	1,766	2,072	1,934	1,642
Nuclear Medicine	705	1,032	1,111	1,217	882
Ultrasound	1,004	1,709	1,851	1,970	1,467
Mammography	684	1,452	1,680	1,346	1,332
Physical Therapy/Work Hardening	4,870	8,017	9,270	8,082	7,365
Occupational Therapy	2,350	4,699	5,425	5,349	4,307
Speech Therapy	242	570	975	632	773
Oncology	1,559	3,111	3,831	2,661	3,041
Pharmacy	45,703	67,953	84,607	64,813	67,138
Respiratory Therapy	4,286	7,939	8,679	8,415	6,260
EEG's	14	21	36	15	15
EKG's	1,267	1,922	2,449	2,020	1,943
Cardio-Pulmonary Rehabilitation	50	491	2,008	78	40
Sleep Studies	28	85	100	51	81

Source: Hospital Data; Hospital Profiles

Pinckneyville Community Hospital High Level Ancillary Services
2020 Projected Utilization

Ancillary Service	Low (10-Year Historical Low)	Expected Range: Probable (10-Year Historical Average)	Expected Range: High (10-Year Historical Peak)	Actual FY 2007	Actual FY 2008
Emergency Department	3,414	3,833	4,974	3,653	3,622
Surgery Cases	450	520	629	462	453
Laboratory Tests	44,123	61,638	86,384	62,667	62,897
Radiology	4,858	6,185	10,429	5,919	4,917
Magnetic Resonance Imaging	349	458	528	464	387
Computerized Tomography	815	1,924	2,258	1,934	1,642
Nuclear Medicine	768	1,125	1,211	1,217	882
Ultrasound	1,094	1,862	2,018	1,970	1,467
Mammography	745	1,583	1,831	1,346	1,332
Physical Therapy/Work Hardening	5,308	8,738	10,104	8,082	7,365
Occupational Therapy	2,561	5,122	5,913	5,349	4,307
Speech Therapy	264	621	1,063	632	773
Oncology	1,699	3,391	4,175	2,661	3,041
Pharmacy	49,811	74,061	92,212	64,813	67,138
Respiratory Therapy	4,672	8,652	9,459	8,415	6,260
EEG's	16	23	39	15	15
EKG's	1,381	2,095	2,669	2,020	1,943
Cardio-Pulmonary Rehabilitation	54	535	2,188	78	40
Sleep Studies	31	93	109	51	81

Source: Hospital Data; Hospital Profiles

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Bed Need Calculation:

1. **Complete the requested information for each category of service involved:**
Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

Planning Area **F-07**

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFPB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
Medical Surgical	**25**	**118 Excess ***	**60%**

* Adjusted to reflect CON authorized beds per revised State Bed Inventory, April 17, 2009

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

1. If establishing or expanding beds/stations/key rooms, document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

2. If expanding an existing category of service, provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, document that at least 50% of the projected patient volume will be from residents of the area

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

A. Planning Area Need - Formula Bed Need Calculation

1. See attached Exhibit 1, Attachment 19. The current medical / surgical and pediatric beds in the IDPH inventory was adjusted to reflect the CON authorized beds published by the Planning Board in April 2009. The inventory indicates 362 available beds. The adjusted complement is 288 or a 74 bed variance. Thus the calculated excess medical / surgical / pediatric beds in Planning Area F-07 become 118 and not 192.

   In addition, the global bed occupancy target used to derive bed need is 90%. There are 8 hospitals in PA F-07, 6 of which are critical access hospitals (CAH). These CAH hospitals account for over 50% of the available beds and have an "occupancy target" of 60%. If a weighted occupancy target was utilized, rather than the global target, the "excess beds" would be further reduced or possibly eliminated using a hospital specific methodology.

2. The project proposes to replace 25 medical surgical beds in a private room configuration. Attachment 14 provides market based bed need projections as well as ancillary service projections. Attachment 75, Financial Forecasts (McGladrey and Pullen) Note 5 provides an analysis of demand in support of the market needs for a hospital.

3. According to an adjusted bed inventory analysis, there are an excess of 118 medical / surgical / pediatric beds in PA F-07. Further refinement would lower this excess and potentially eliminate any excess if an individual hospital methodology were utilized.

4. In calendar year 2008, the Hospital had 3,928 inpatient days of care according to Hospital Profile Data (IDPH). This includes medical / surgical, swing, and observation bed days. The resulting average daily census (ADC) is therefore 11, requiring 19 beds at 60% occupancy. This "average" calculation does not consider peak daily occupancy days which ranged from 13 to 18 in the first 6 months of 2009 ADC thereby requiring 23 to 27 beds; see Exhibit 2.

   The project replaces a CAH "necessary provider of health services" as designated by IDPH; see Attachment 19, Exhibit 3.

B. Planning Area Need – Service to Planning Area Residents

1. The Hospital proposes to develop a replacement CAH facility. As such, this requires a discontinuation and establishment by Agency criterion. There is no expansion of service, only a relocation of the current medical / surgical category of service in order to maintain necessary provider services within the community.

   The replacement hospital will serve the same service area. It proposes to relocate 1.8 miles to the east within the Pinckneyville city limits. See Attachment 19, Exhibit 4 for CMS concurrence with the relocation.

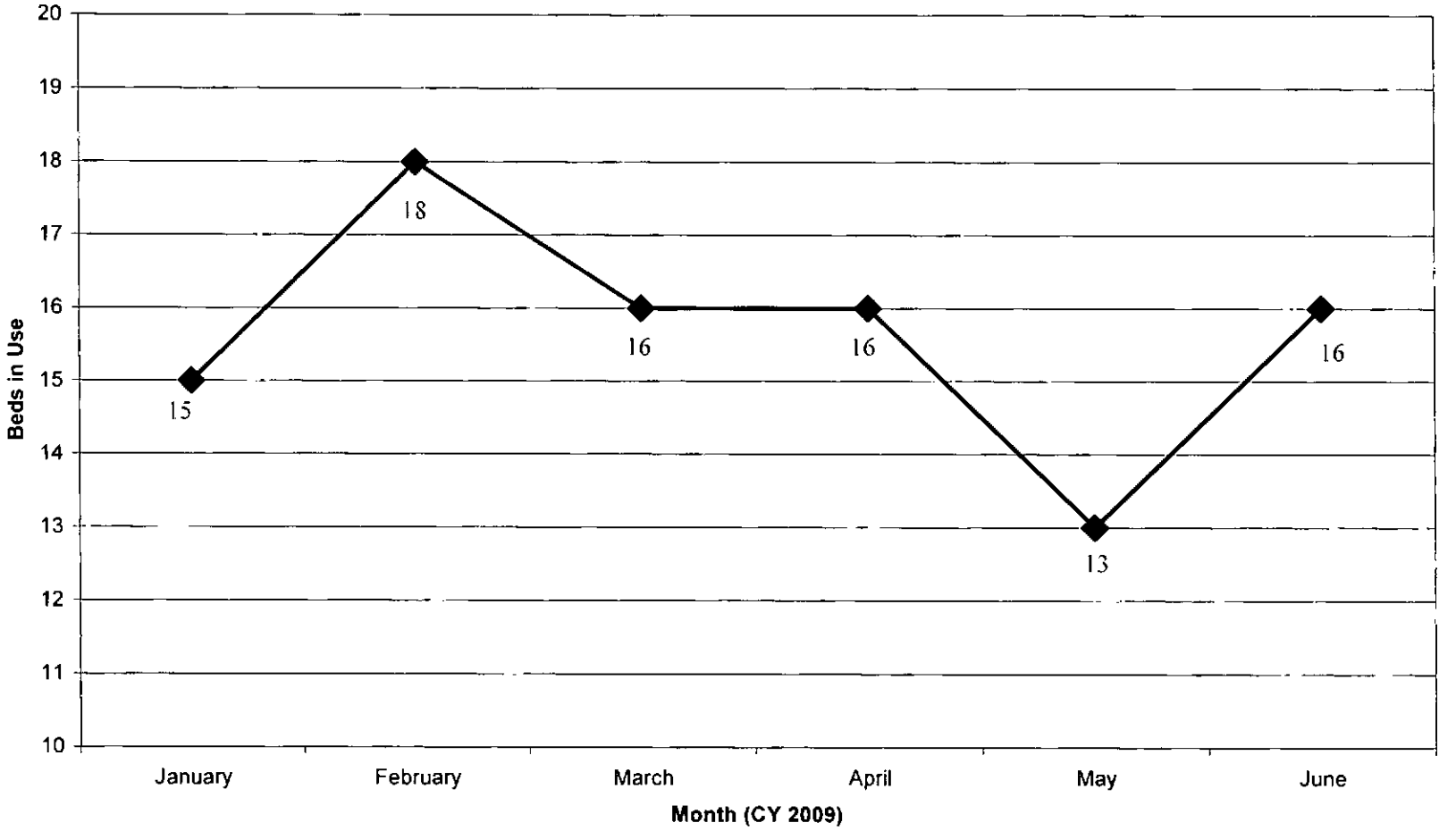
2. The medical / surgical category of service is not expanding, but relocating. Hence, this criteria is not considered applicable.

Planning Area F-07

Category of Service	No. of Beds/Stations/ Key Rooms Proposed	HFPB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
Medical Surgical	25	118 Excess *	60%

* Adjusted to reflect CON authorized beds per revised State Bed Inventory, April 17, 2009

PCH Peak Medical Surgical Bed Census January through June 2009
(Includes Observation and Swing Bed Patients)



Source: Hospital Records

Illinois Department of
Public Health

George H. Ryan, Governor · John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street · Springfield, Illinois 62761-0001

July 18, 2000

Mr. Jerry Bolandis, CEO
Pinckneyville Community Hospital District
101 N. Walnut Street
Pinckneyville, IL 62274

Dear Mr. Bolandis:

A review has been completed of your application to be designated as a necessary provider of health services, authorized by the Medicare Rural Hospital Flexibility Program. This application is the first step in the process of becoming certified as a critical access hospital. The information you submitted documents the importance of the services Pinckneyville Community Hospital District provides to the residents of its primary service area, Perry County. The information identifies that Perry County meets several of the requirements in the ILLINOIS STATE RURAL HEALTH PLAN to be designated as a necessary provider and is supported by the following statements.

- Perry County has a larger proportion of residents 65 years of age and over (17.1%) than the state's proportion (12.5%) of residents for that same age group.
- Perry County is designated as a state Physician Shortage Area.
- A population group within Perry County is designated as a Health Professional Shortage Area.
- Perry County has a higher proportion of residents with incomes at or below 200 percent of the federal poverty level than the state's proportion.

I am notifying you of the designation of your facility as a necessary provider of health services. The Division of Health Care Facilities and Programs will be notified of this action. I am pleased you are pursuing this new opportunity for rural hospitals to maintain an array of services necessary for the well-being of area residents and be reimbursed at a reasonable cost level. Should you have any questions about your application, please contact Mary Ring, Chief of the Center for Rural Health at 217.782.1624.

Sincerely,

John R. Lumpkin, M.D.
Director of Public Health

JRL:ps

Midwestern Consortium
Division of Survey and Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CMS Certification Number (CCN): 14-1307

March 23, 2009

Thomas J. Hudgins, FACHE
Chief Executive Officer
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, Illinois 62274

Dear Mr. Hudgins:

We have received your January 22, 2009 letter of attestation and the supporting documentation received on February 23, 2009 and March 20, 2009 regarding your plan to relocate your Critical Access Hospital (CAH) in 2011. Your letter of attestation addresses all of the necessary requirements prior to the planned relocation.

We have reviewed the January 9, 2009 letter from the Illinois Office of Rural Health. This letter is assuring that the proposed location for the replacement hospital will continue to meet the same criteria that was originally used by the State for its designation of your facility as a necessary provider.

Based on our preliminary evaluation of the documentation you submitted and the letter from the Illinois Office of Rural Health, the Regional Office of the Centers for Medicare & Medicaid Services (CMS-RO) has determined that you have met the requirements to begin the process to relocate your facility. Final determination will not occur until you have completed your relocation. The CAH must continue to meet any appropriate State requirements including licensure.

Once the relocation is complete, you must attest that the CAH remains essentially the same provider serving the same community in its new location and whether the information provided with your earlier attestation remains the same. At that time, you must address any changes in your previous attestation letter and you must provide documentation to demonstrate that the CAH is essentially the same provider and that the CAH meets all the requirements at 42 CFR §485.610(d) at its new location.

Additionally, you must provide another letter from the Illinois Office of Rural Health dated after the relocation is complete, advising CMS as to whether or not your relocated CAH continues to meet the original criteria for its designation as a necessary provider.

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

Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

The documentation from the provider and the letter from the Illinois Office of Rural Health will be reviewed to determine if the CAH is functioning as the same provider to the same community in the new location.

If you have any additional questions or need further assistance, you may contact Mai Le-Yuen, either by phone at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

Heather Lang
Principal Program Representative
Non-Long Term Care Certification & Enforcement Branch

Cc: Illinois Department of Public Health
National Government Services

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

C. Service Demand - Establishment of Category of Service

Document "Historical Referrals" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Referrals
   If the applicant is an existing facility, document the number of referrals for the last two years for each category of service, as formatted below: **(See Attachment 20, Exhibit 1)**

EXAMPLE:

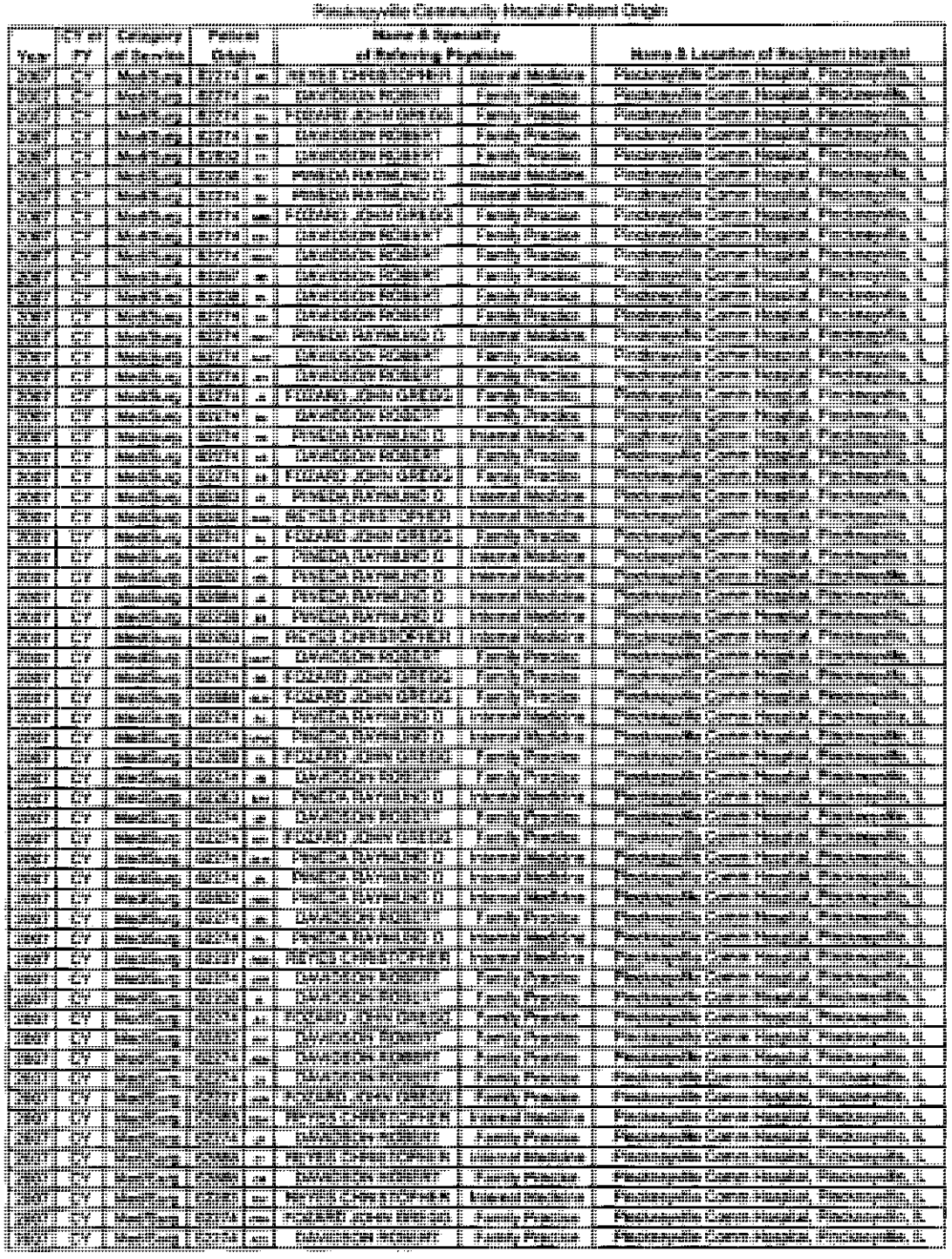
Year	CY or FY	Category of Service	Patient Origin by Zip Code	Name & Specialty of Referring Physician	Name & Location of Recipient Hospital
2008	CY	Medical/Surgical	62761 [Patient Initials]	Dr. Hyde	Wellness Hospital

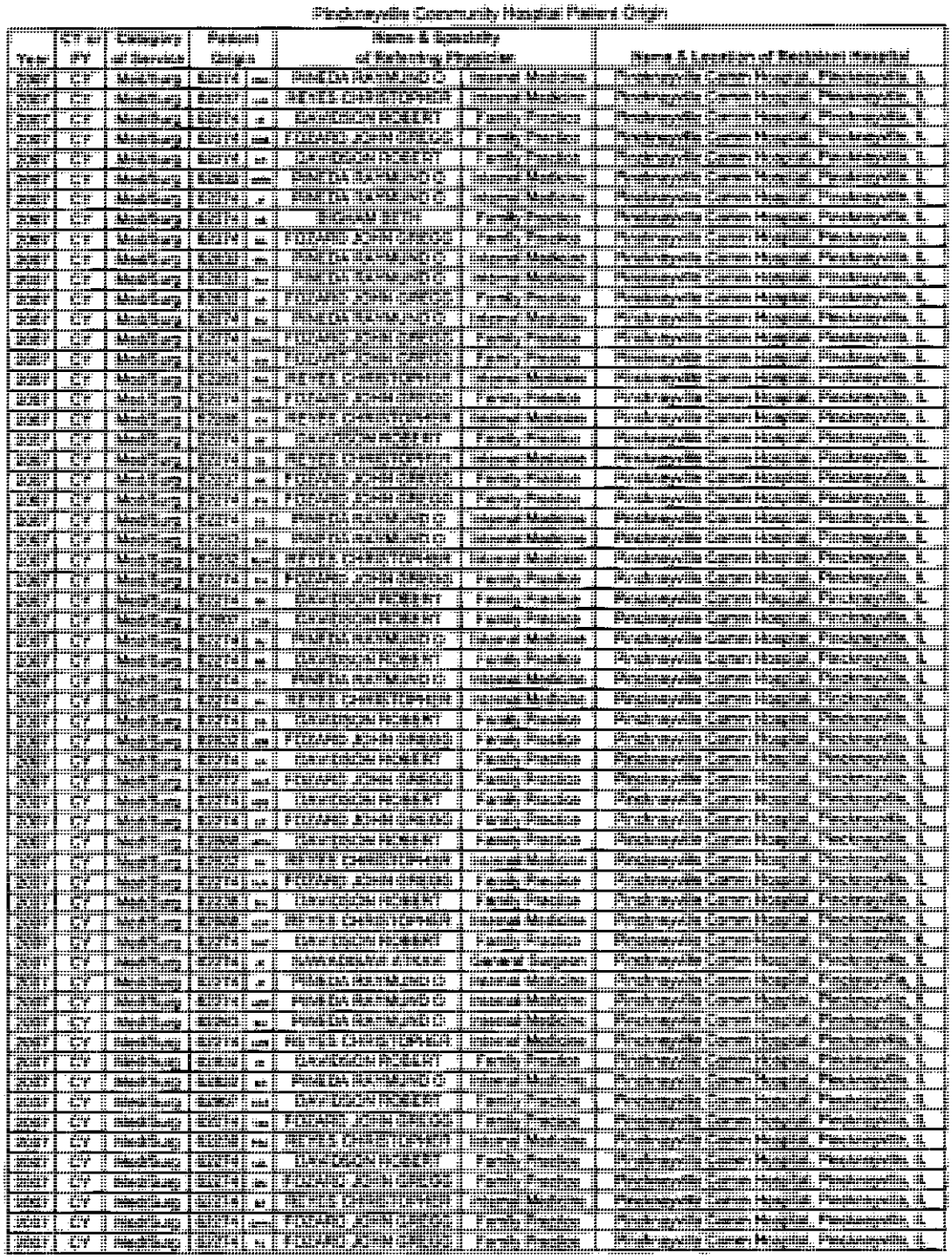
2. Projected Referrals
   An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in Criterion 1110.530(b)(3)

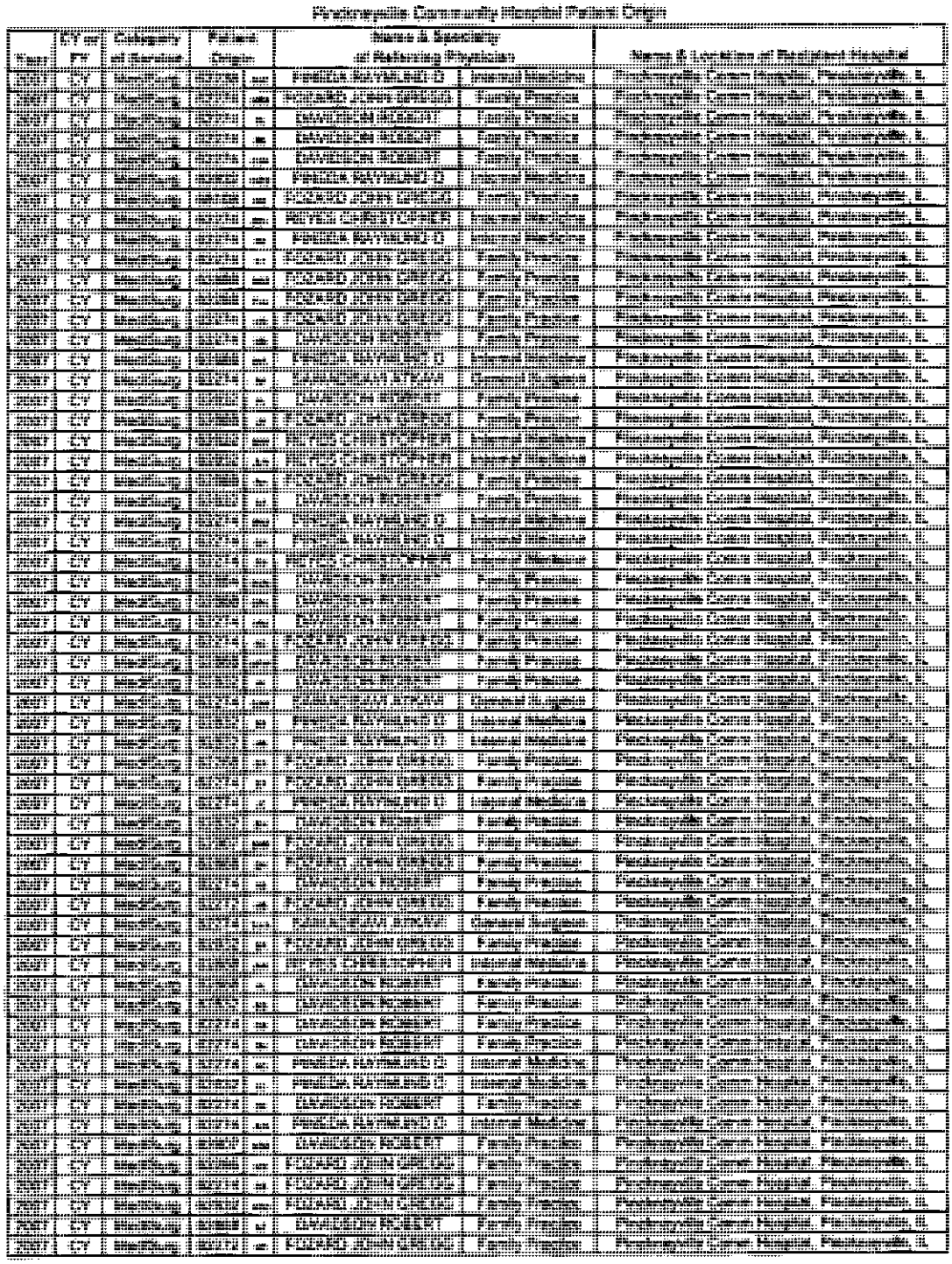
The Hospital's medical staff is primarily employed and provides services through its' Rural Health Clinic. By Agency rules, the replacement technically establishes a "new" category of medical / surgical services, but in reality it is a relocation of an existing facility. Hence, it is not considered a "new hospital" by the applicant, only a new facility. The referral sources will remain the same. Attachments 20, Exhibits 2 through 5 provide physician referral letters supporting the replacement hospital.

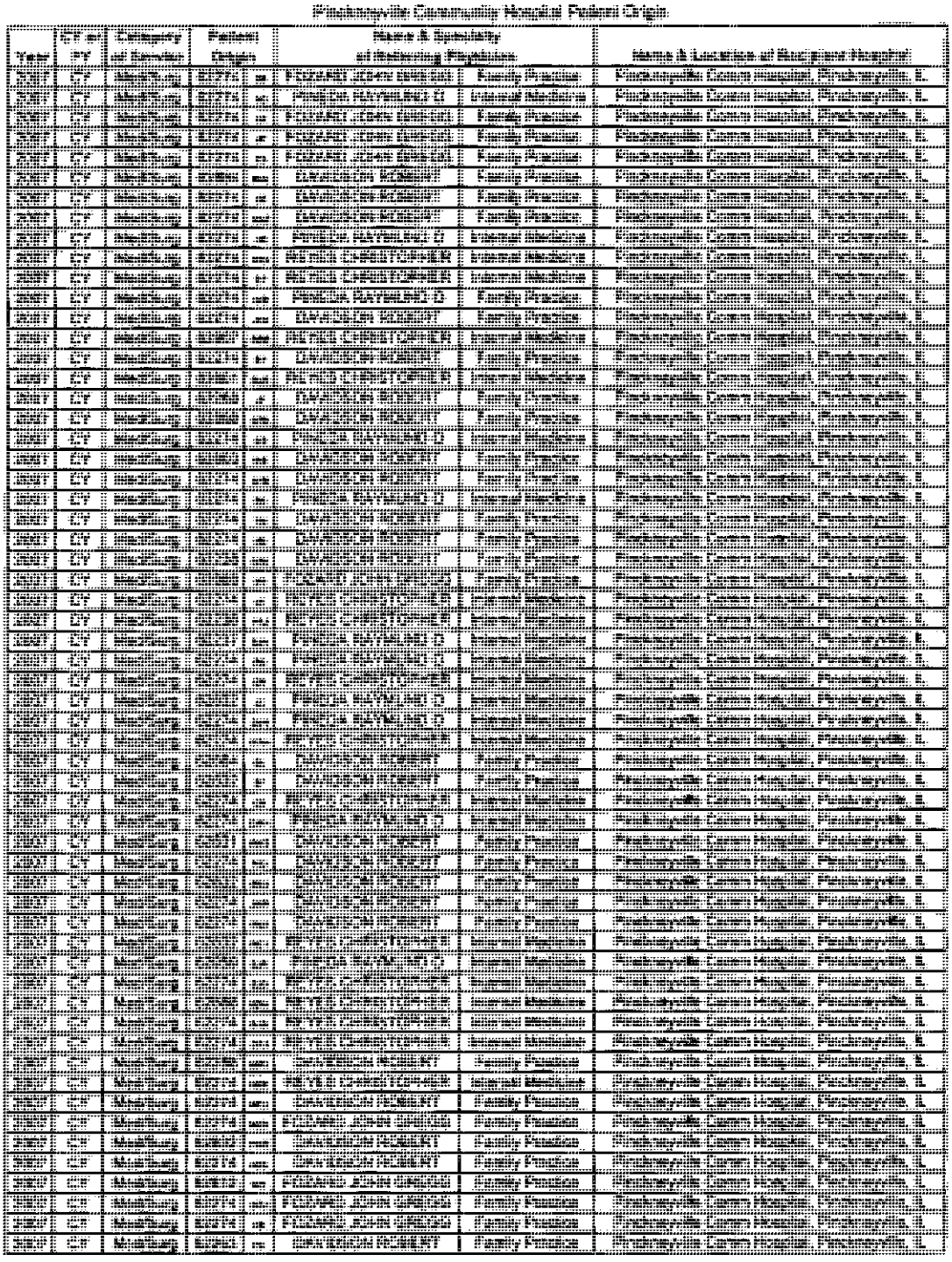
3. Project Service Demand - Based on Rapid Population Growth – **Not Applicable**

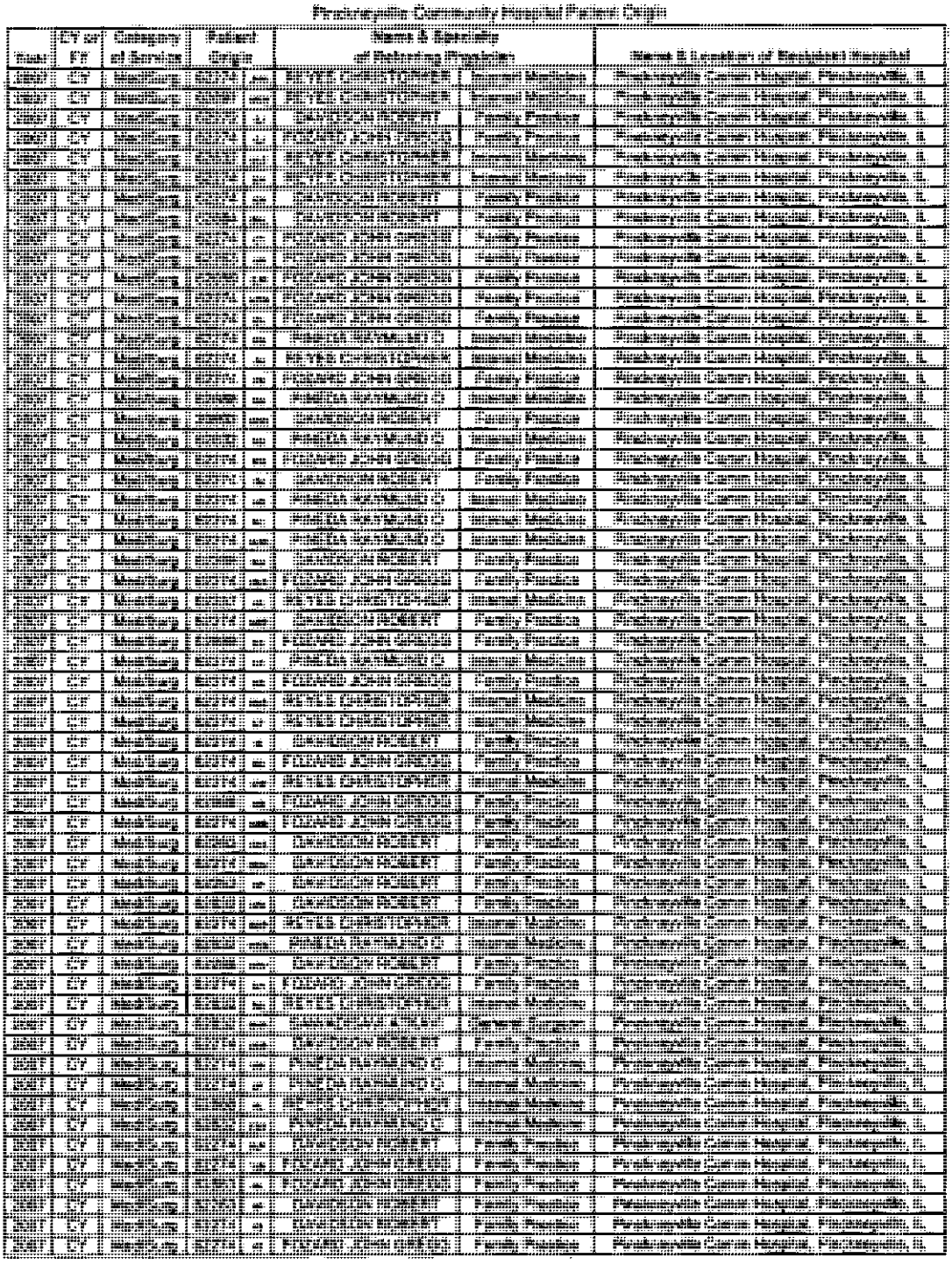
   If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in Criterion 1110.530(b)(3)(C).











Pinckneyville Community Hospital Patient Origin

Year	CY or FY	Category of Service	Patient Origin		Name & Specialty of Referring Physician		Name & Location of Recipient Hospital
[illegible]	CY	Med/Surg	[illegible]	[illegible]	REYES CHRISTOPHER	Internal Medicine	Pinckneyville Comm Hospital, Pinckneyville, IL
[illegible]	CY	Med/Surg	[illegible]	[illegible]	REYES CHRISTOPHER	Internal Medicine	Pinckneyville Comm Hospital, Pinckneyville, IL
[illegible]	CY	Med/Surg	[illegible]	[illegible]	PINEDA RAYMUND O	Internal Medicine	Pinckneyville Comm Hospital, Pinckneyville, IL
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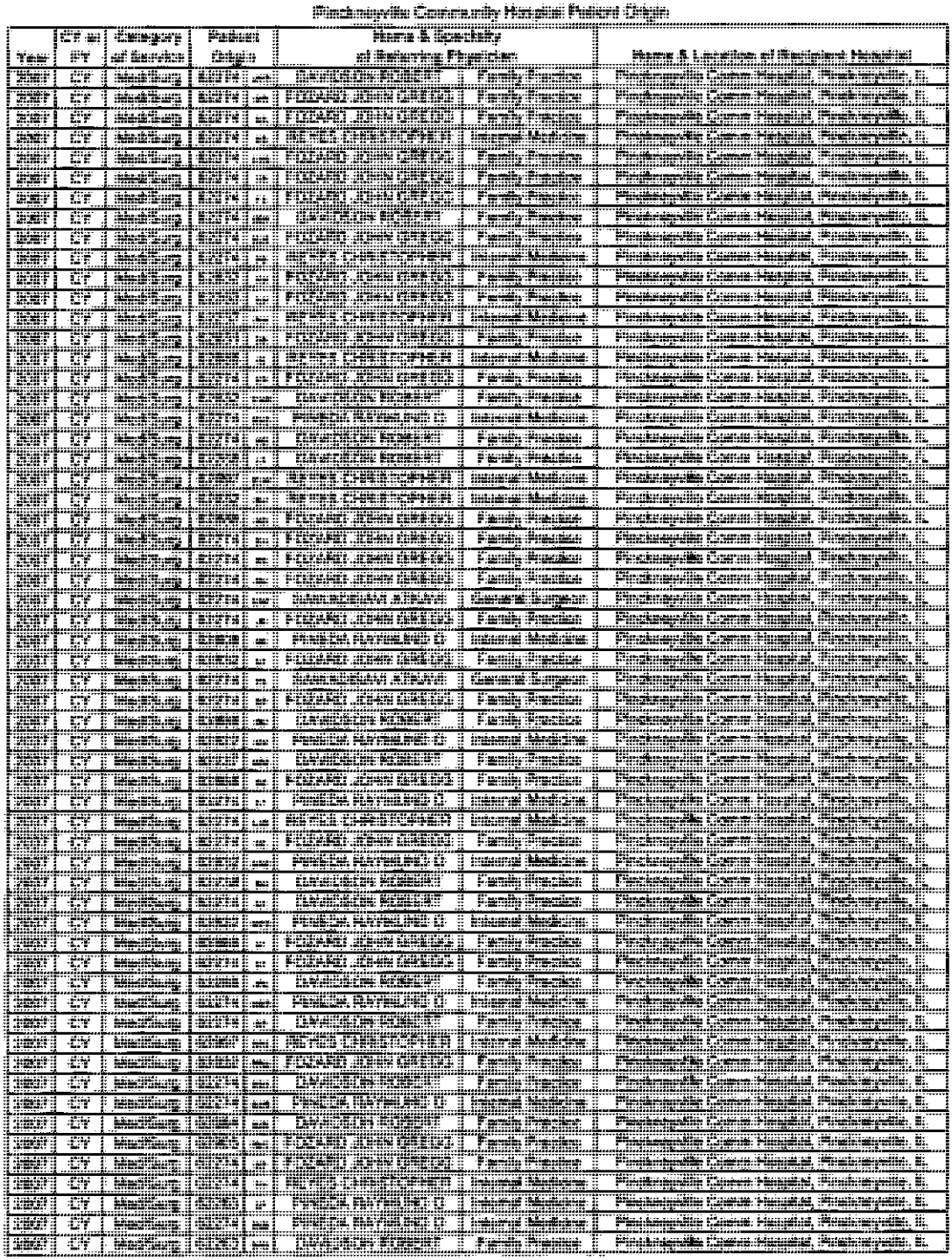

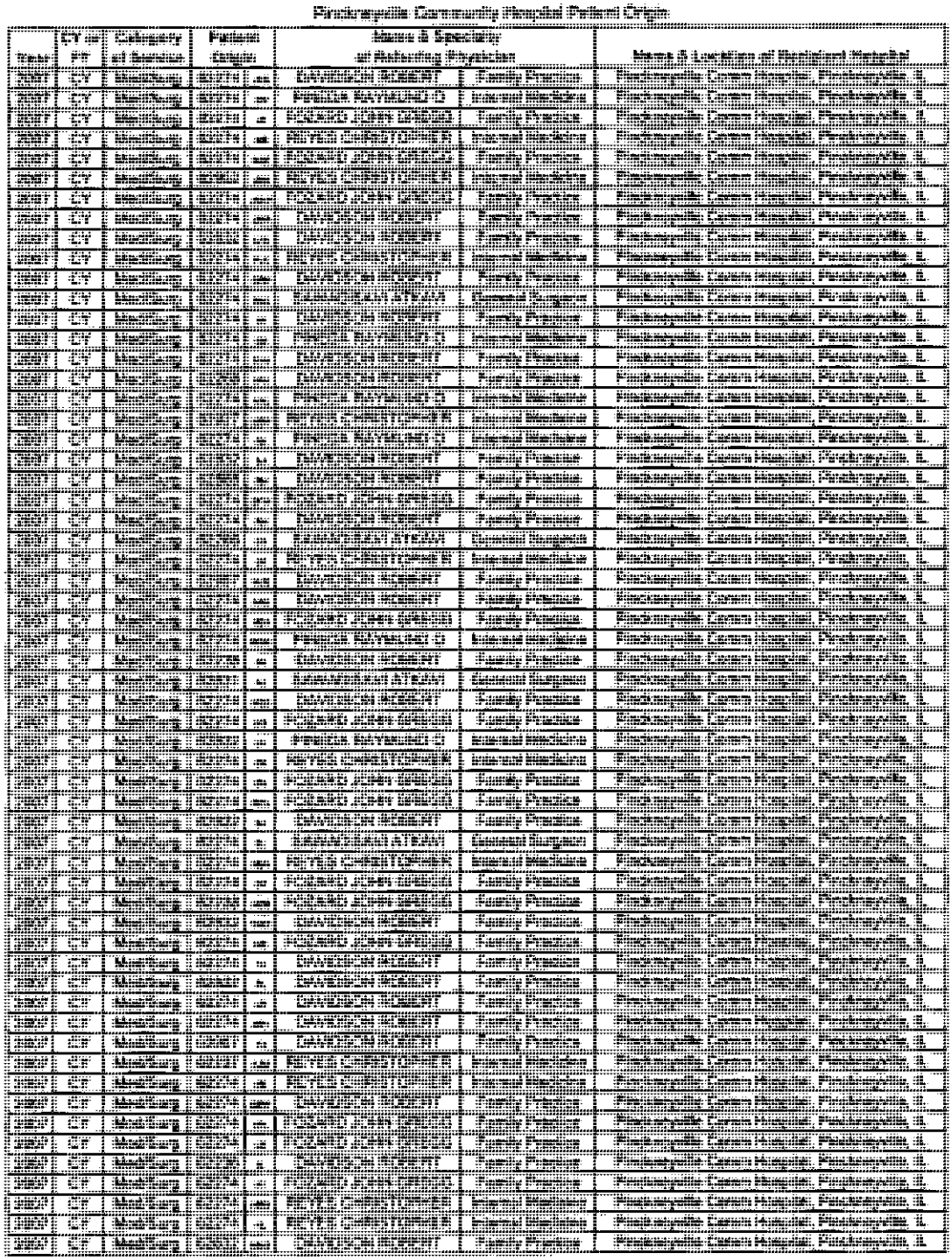

Pinebrookville Community Hospital Patient Origin

Index	CY or FY	Category of Service	Patient Origin		Name & Specialty of Referring Physician		Name & Location of Recruitment Hospital			
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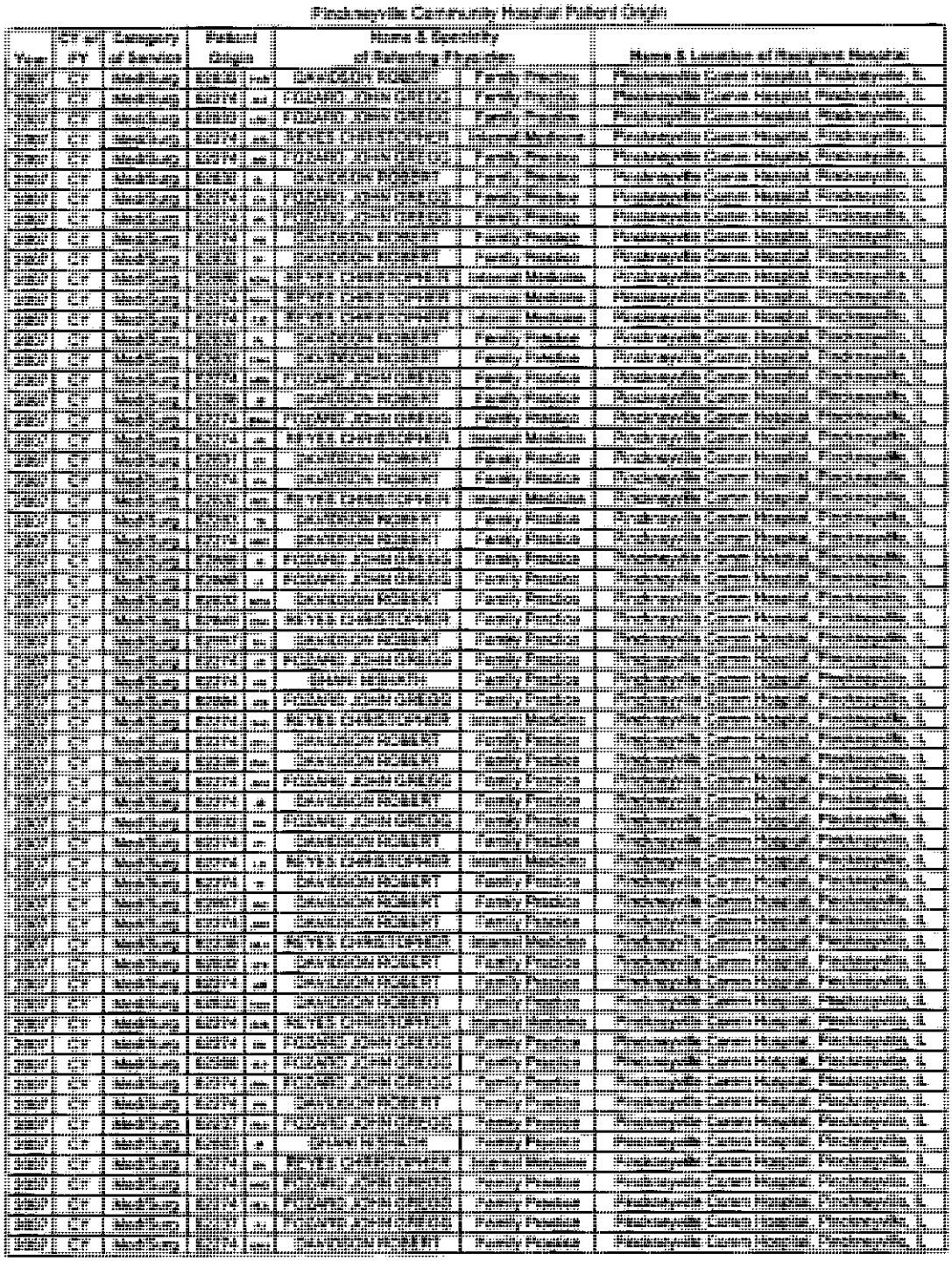
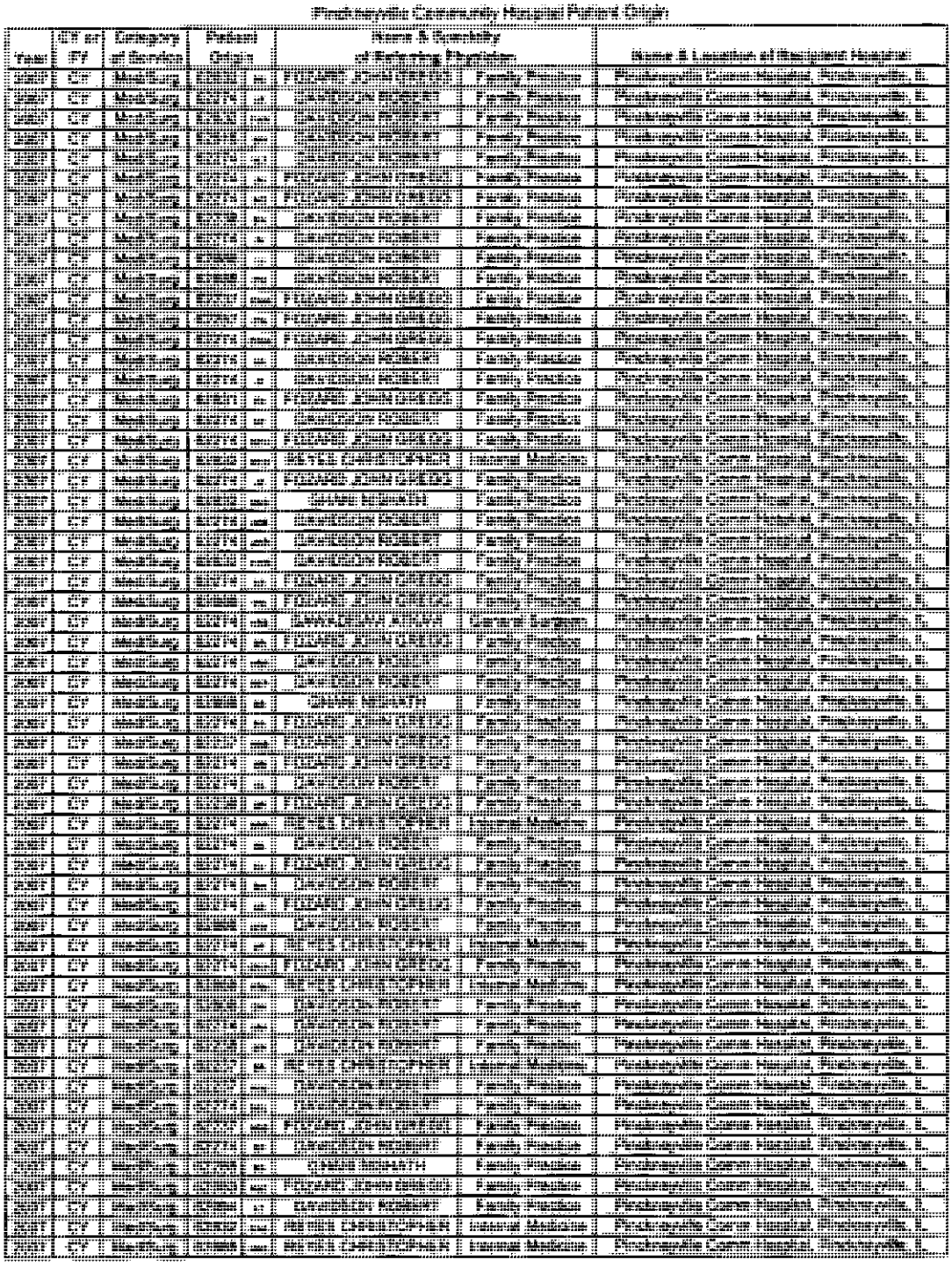
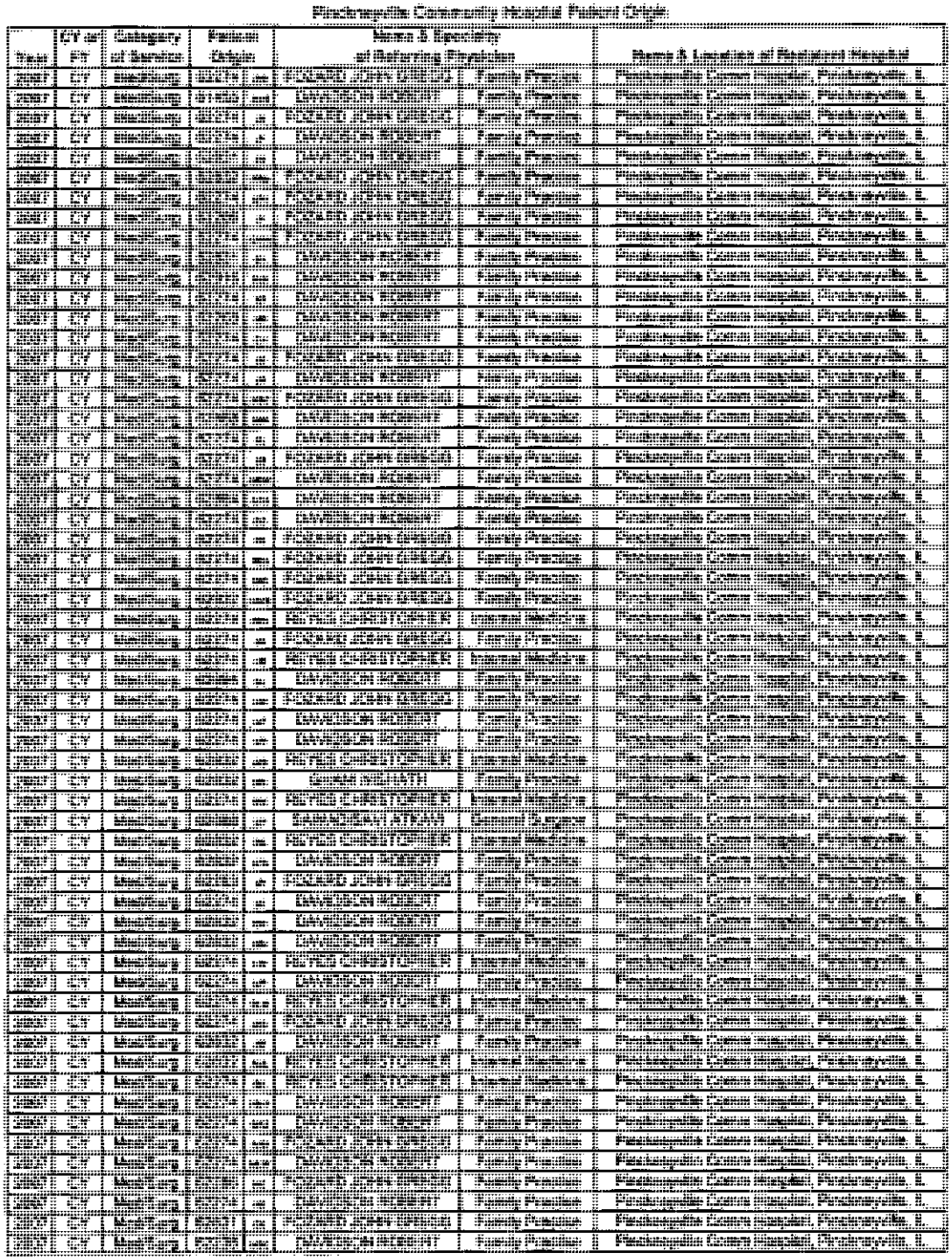
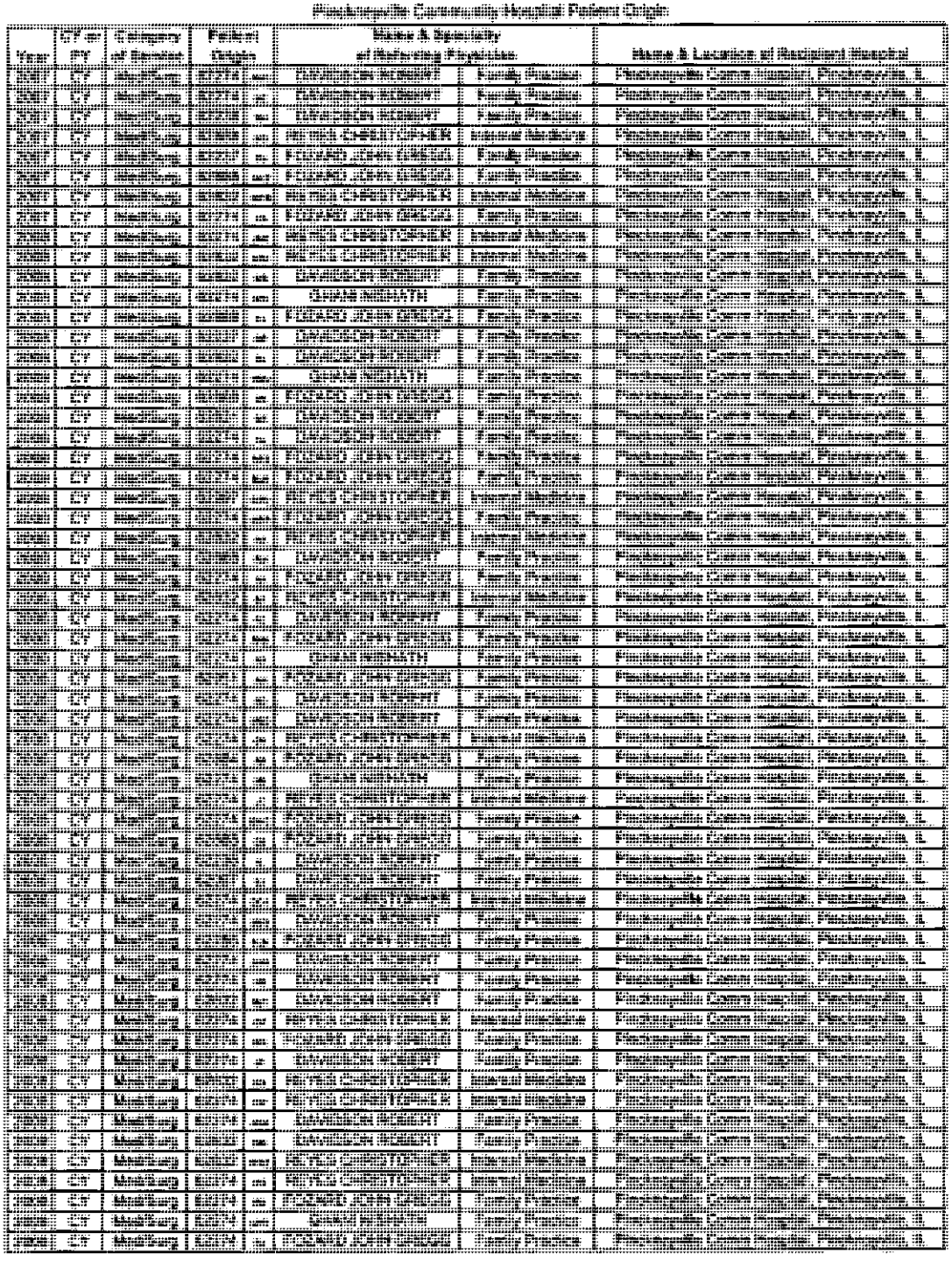
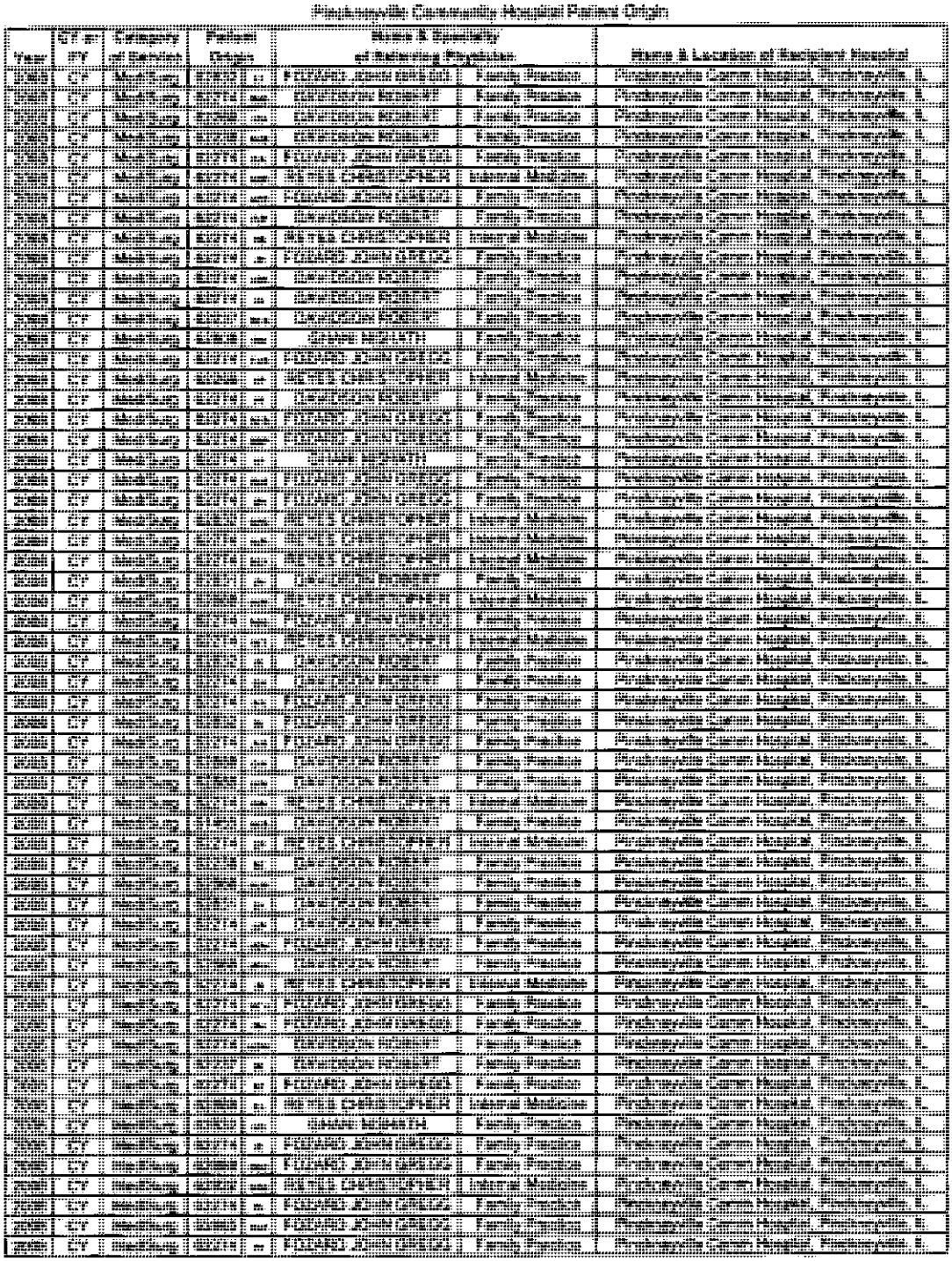
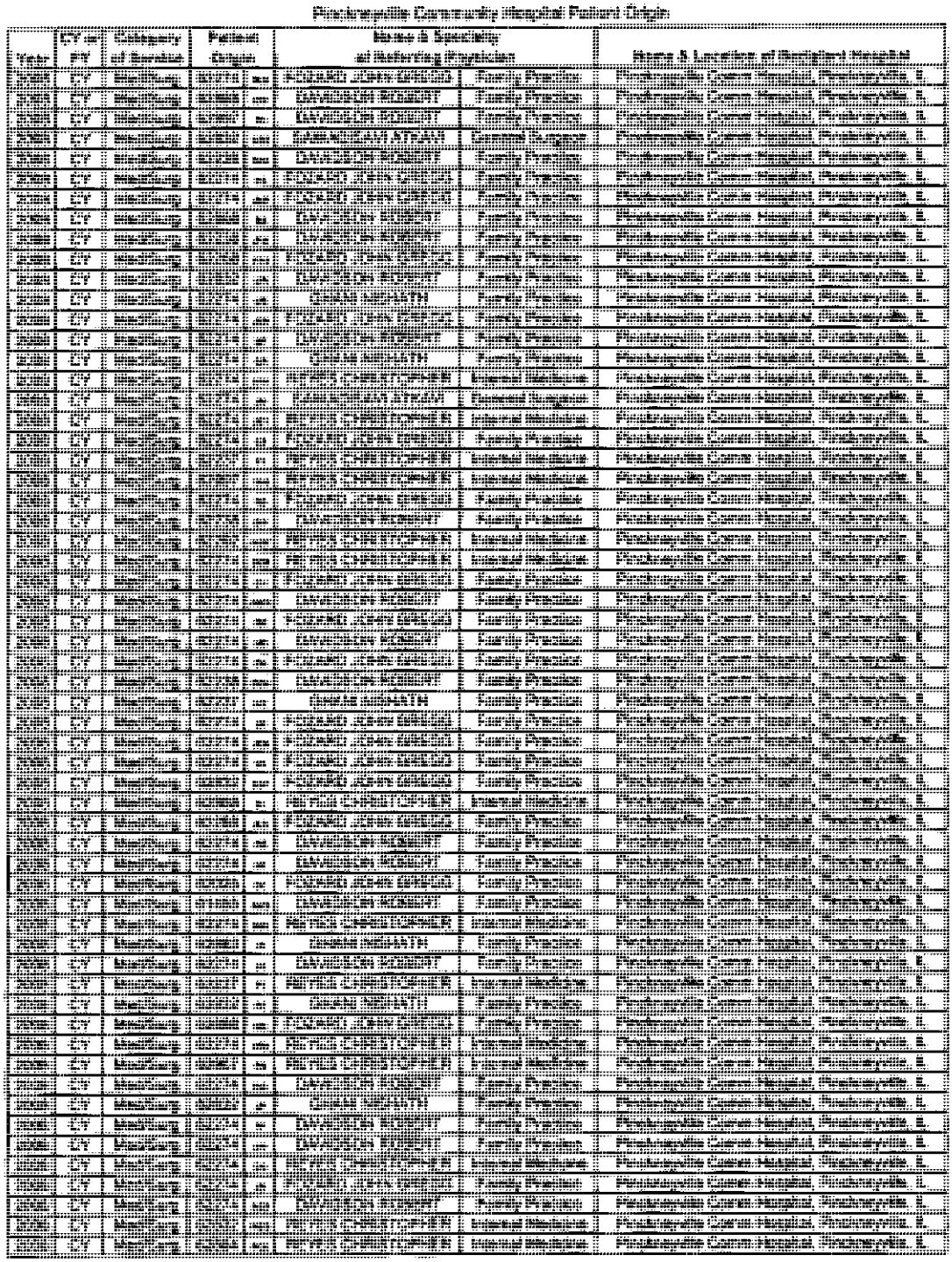


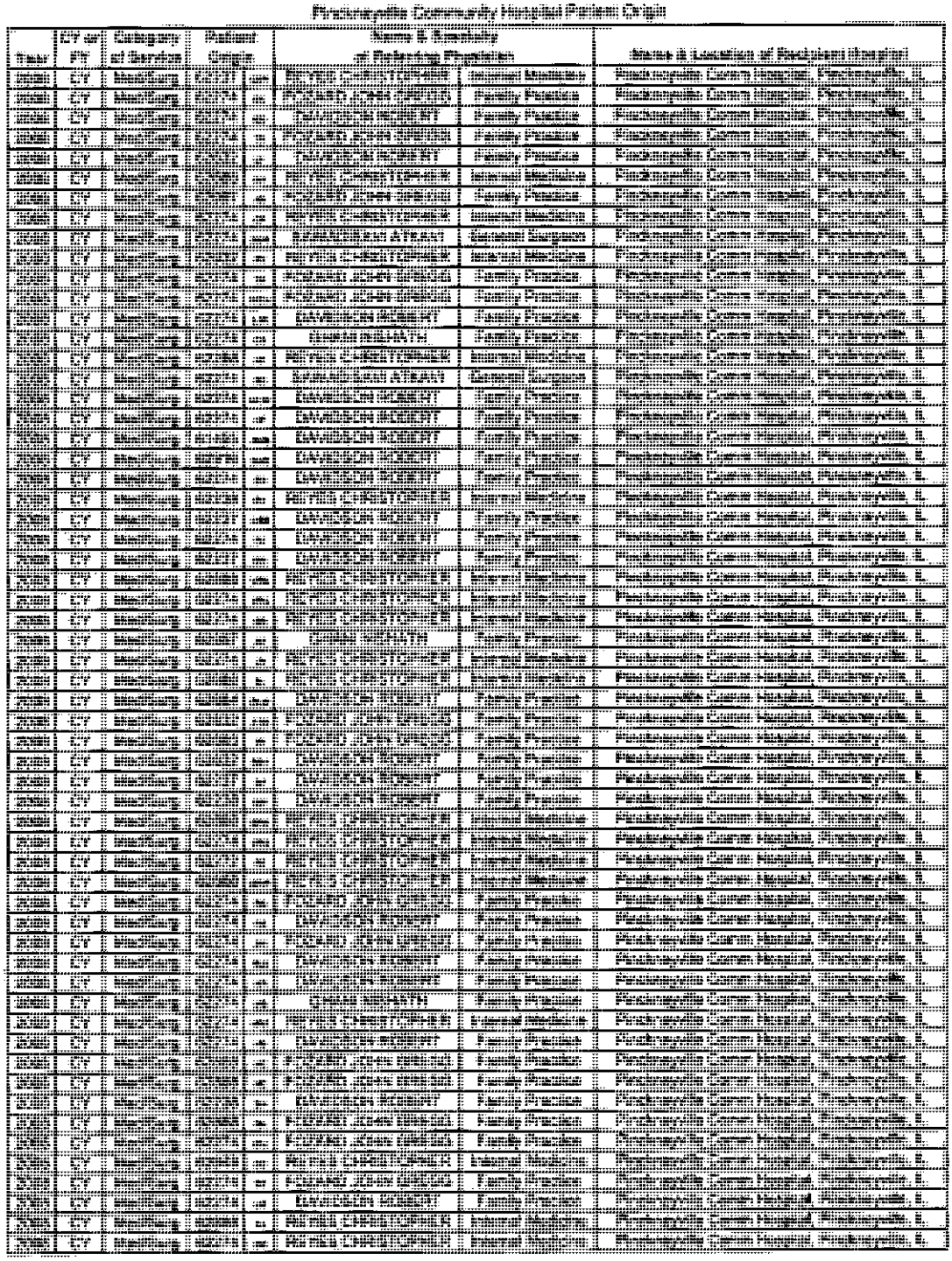


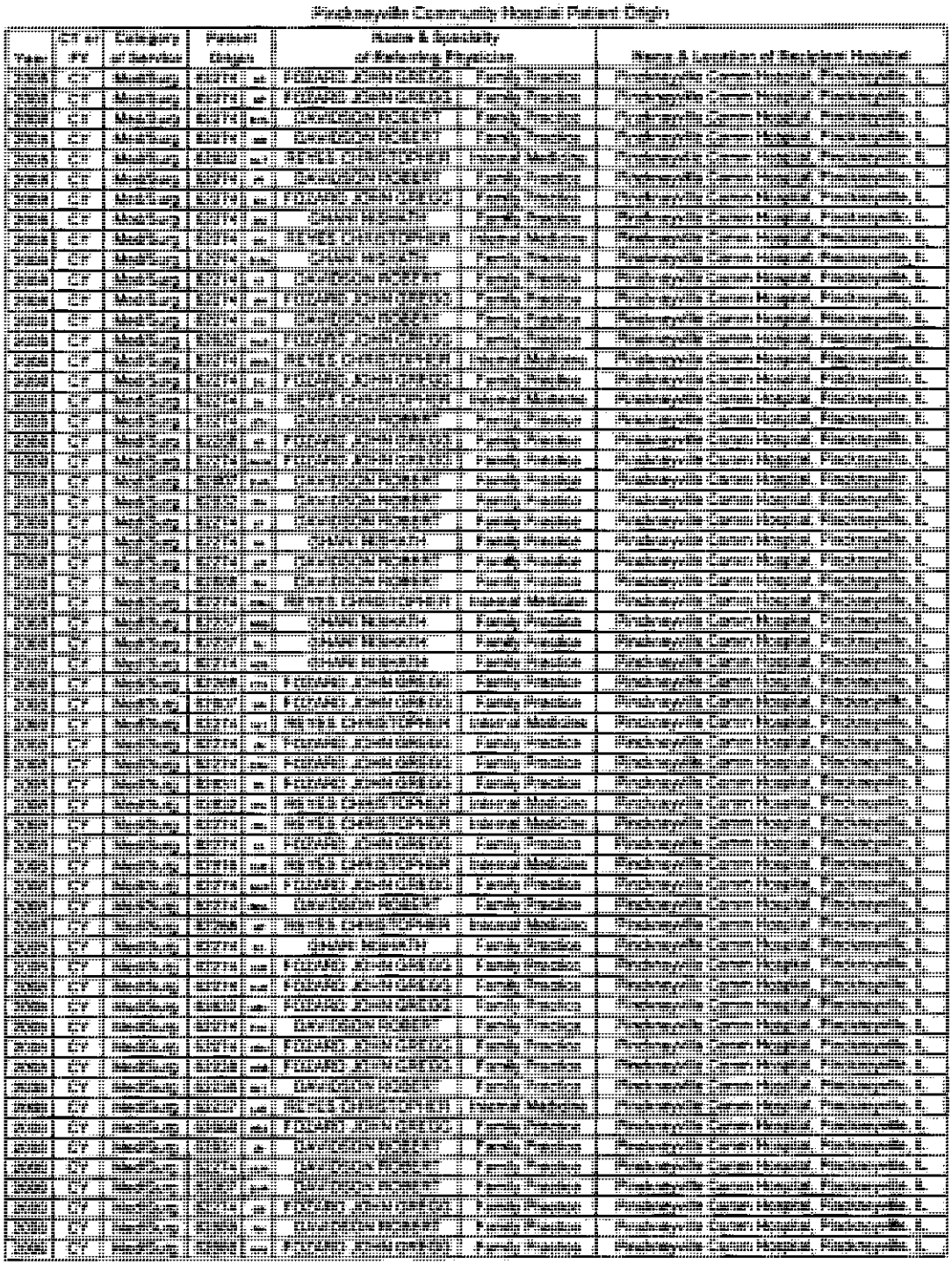


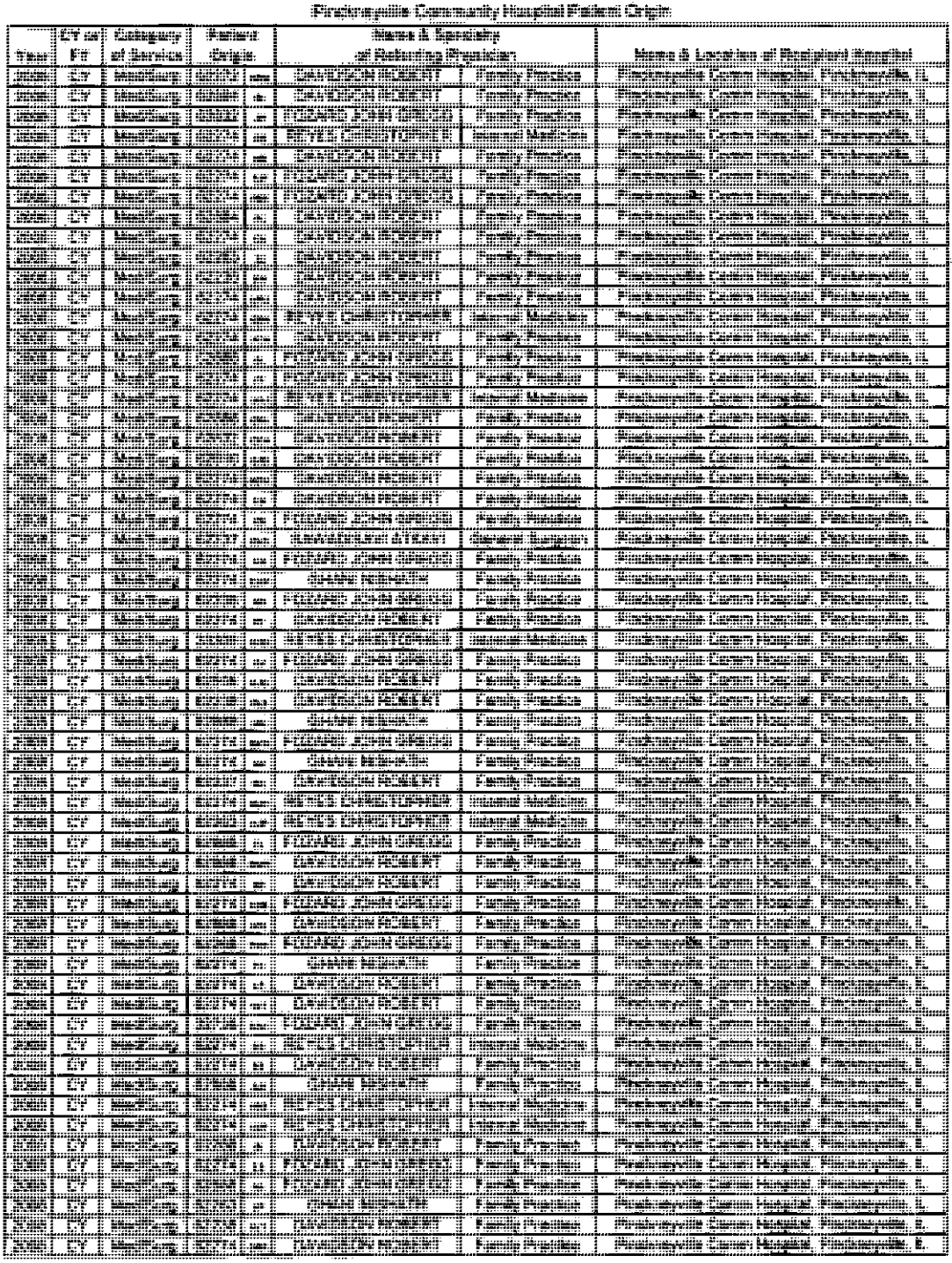


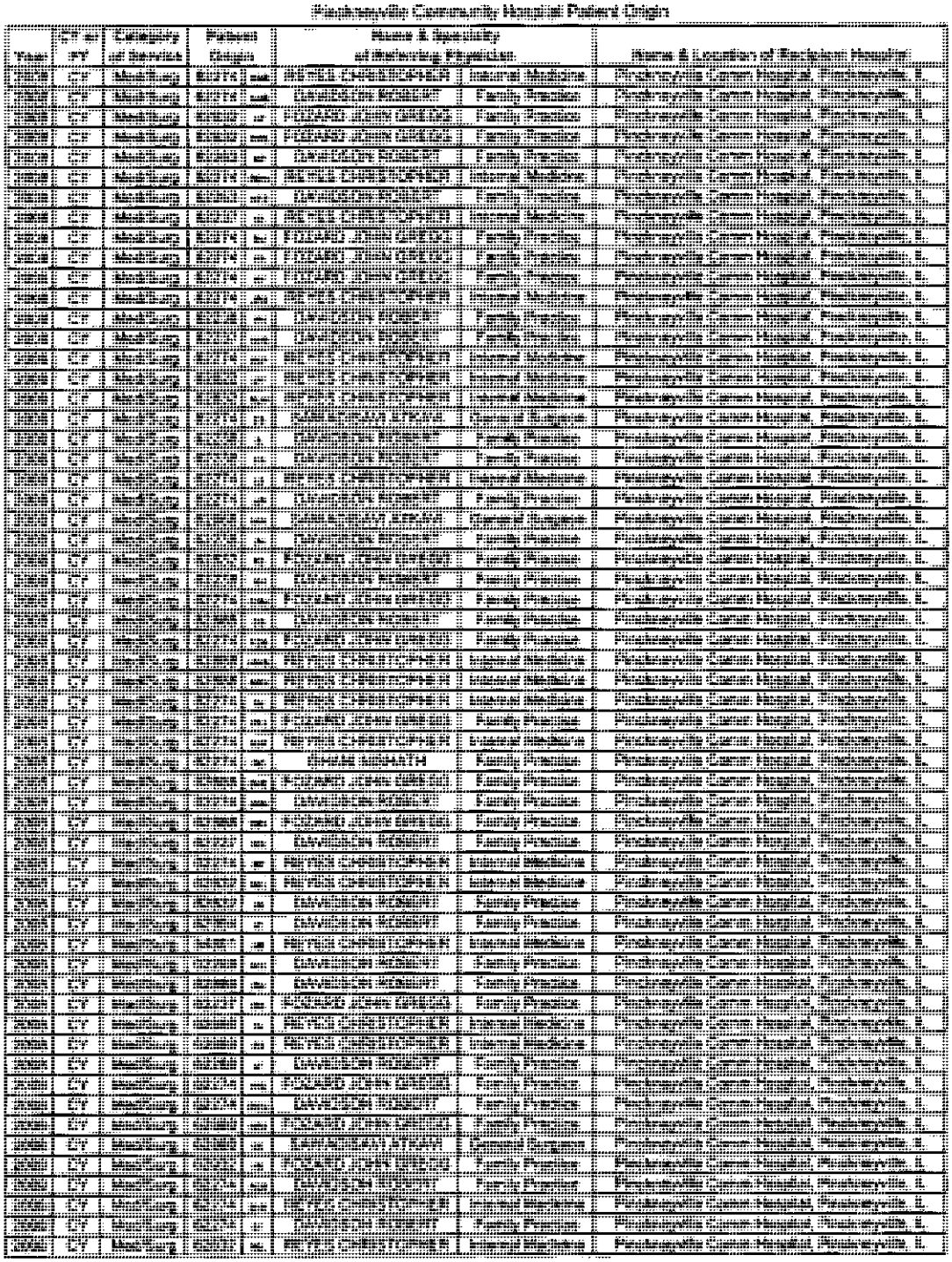




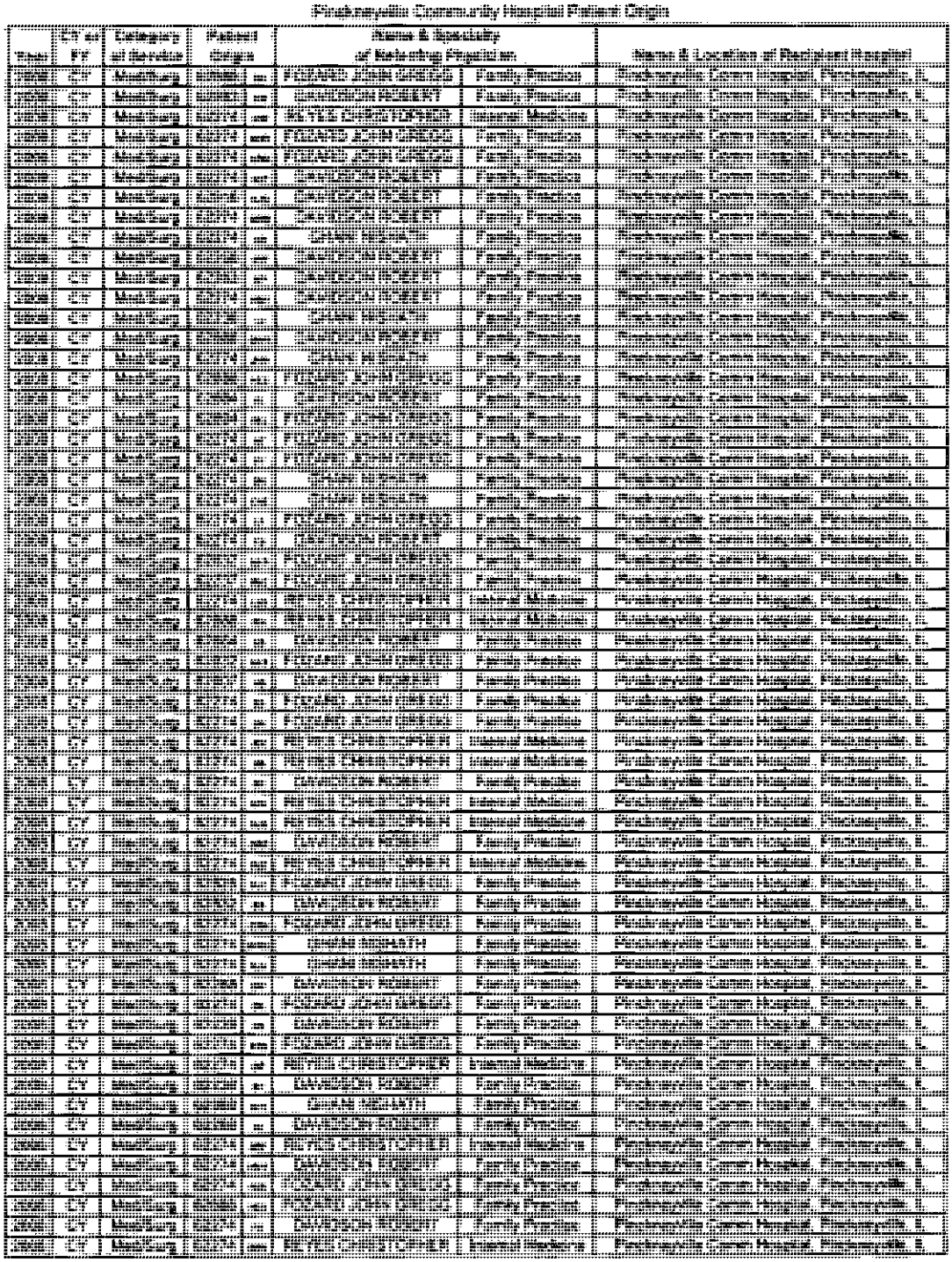


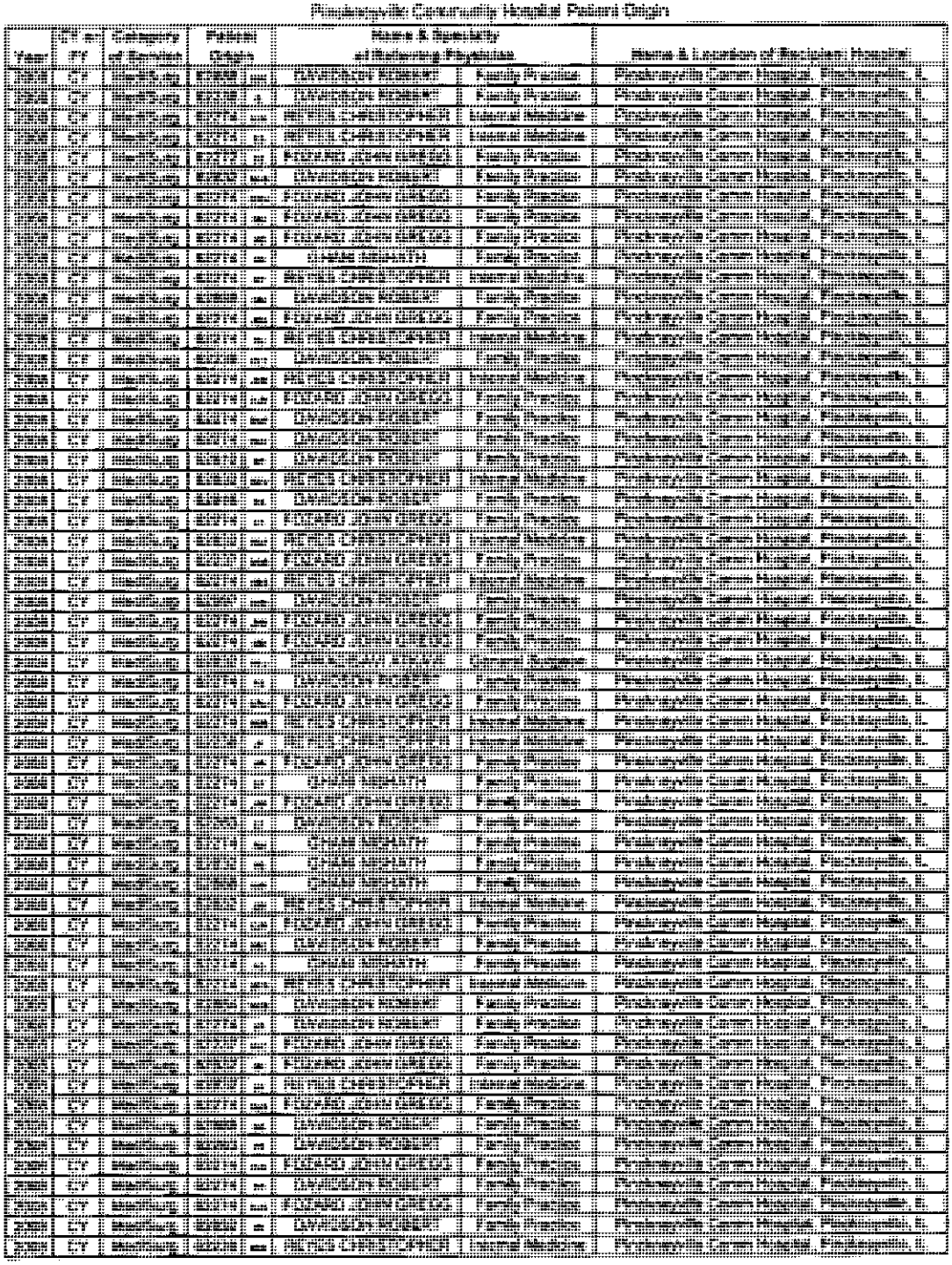


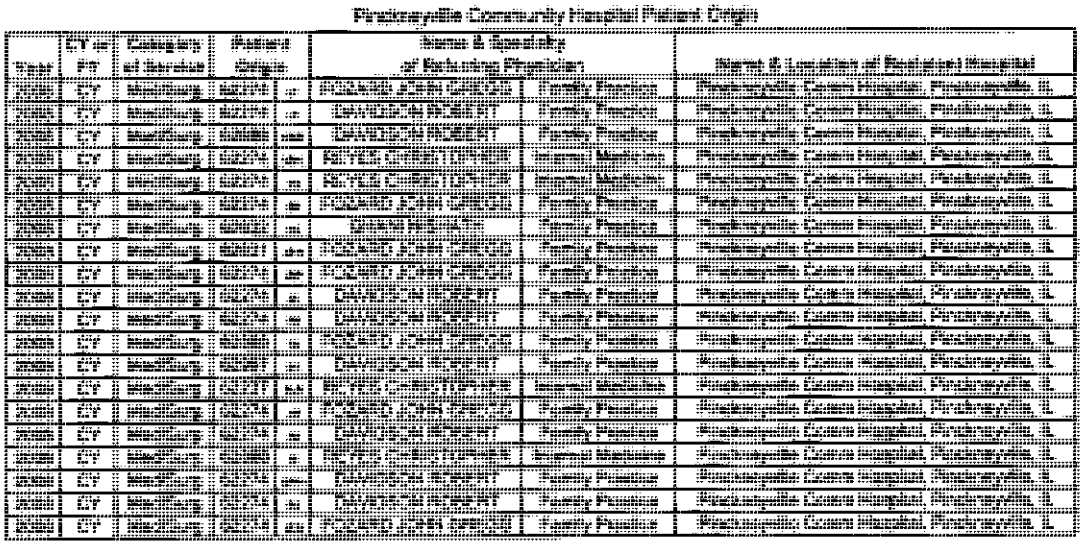


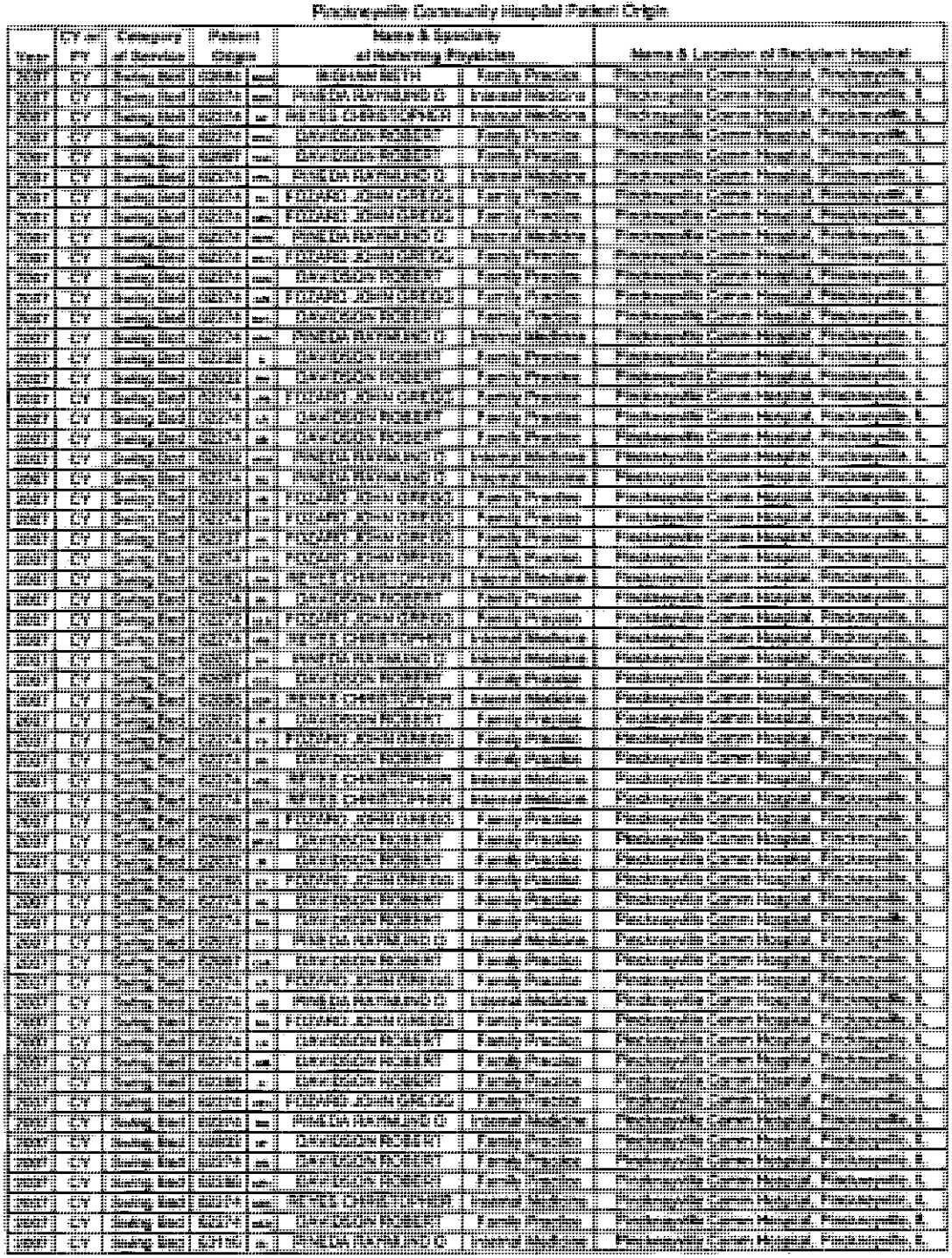


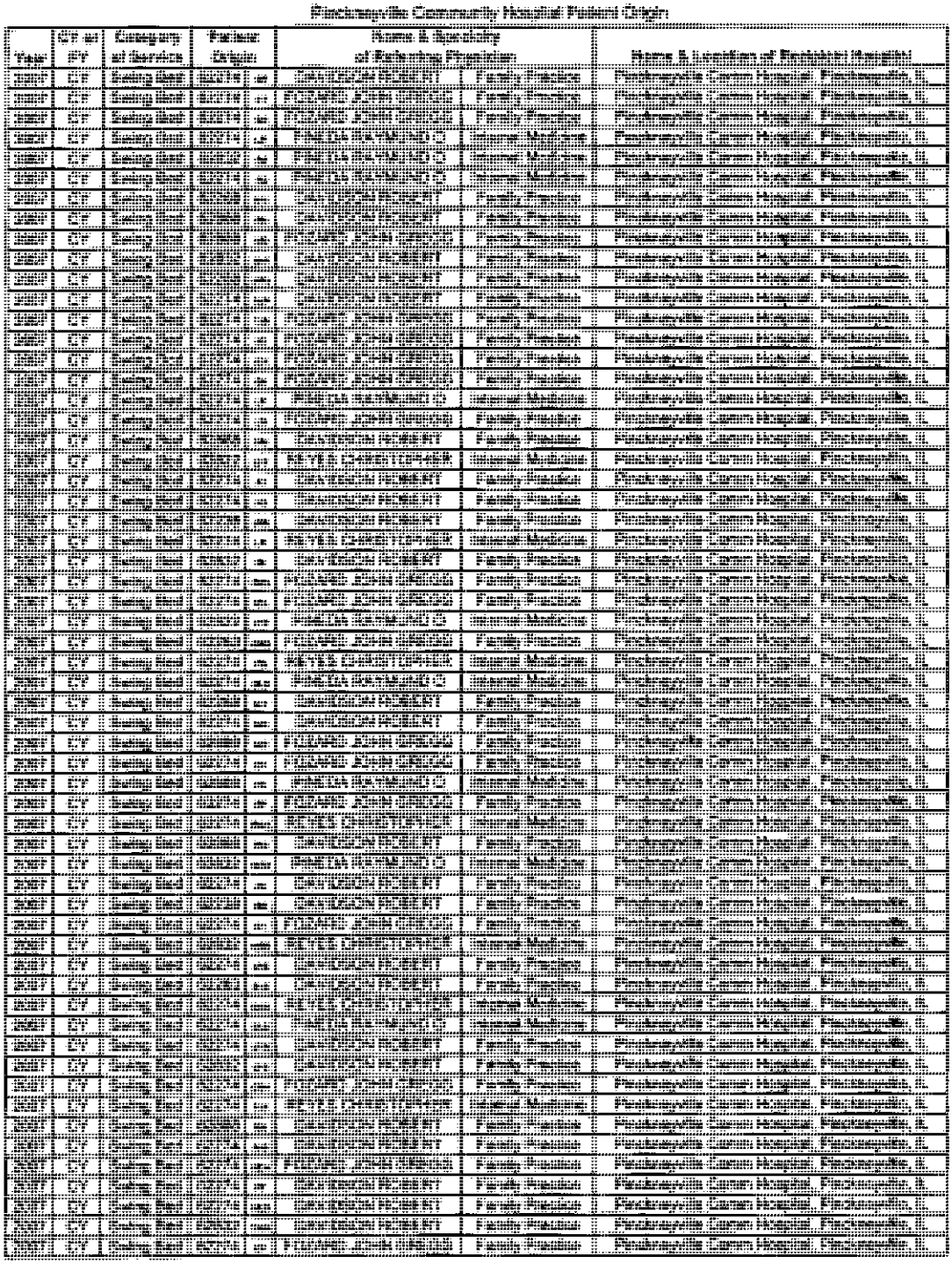
Pinckneyville Community Hospital Patient Origin

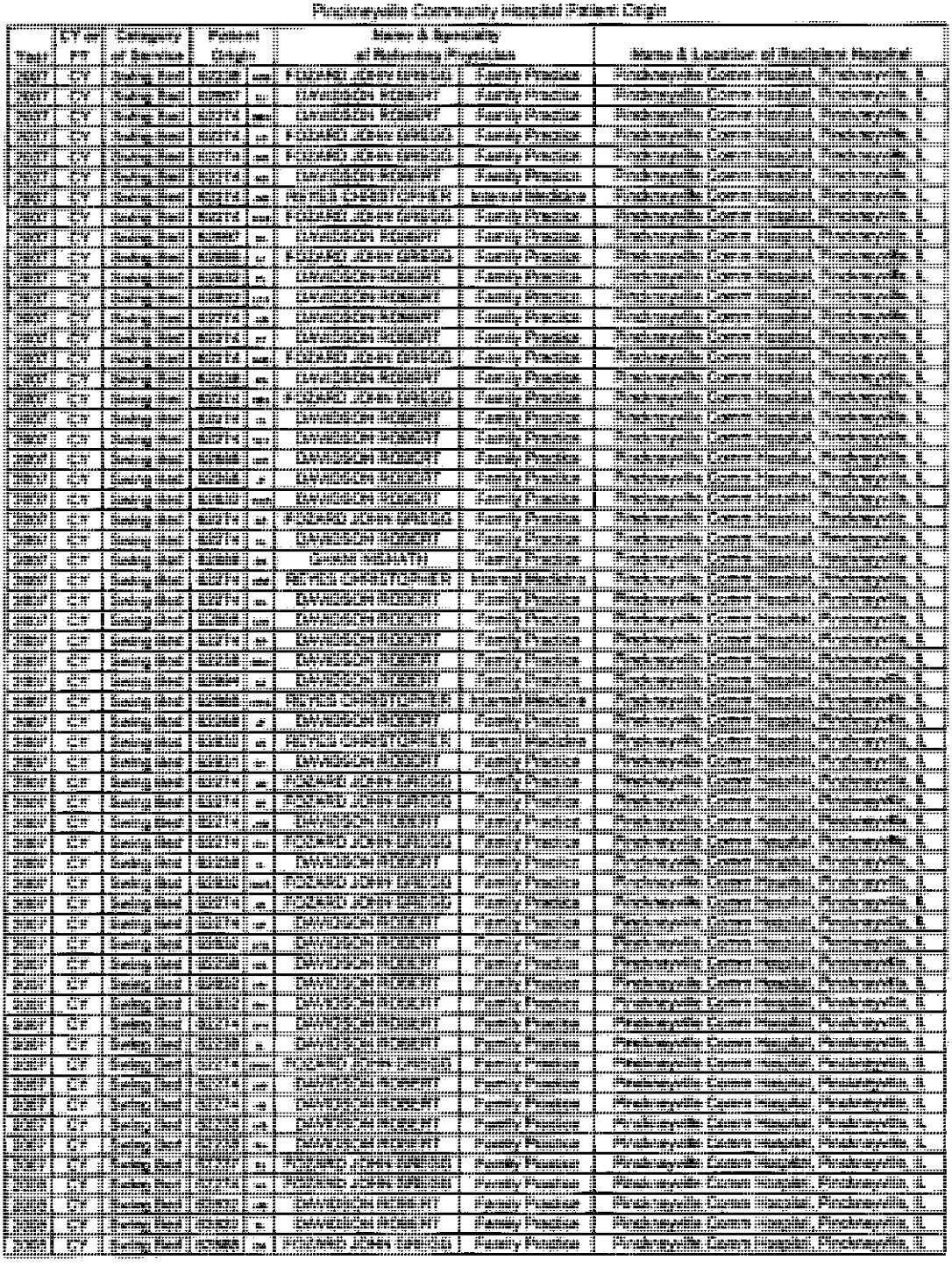


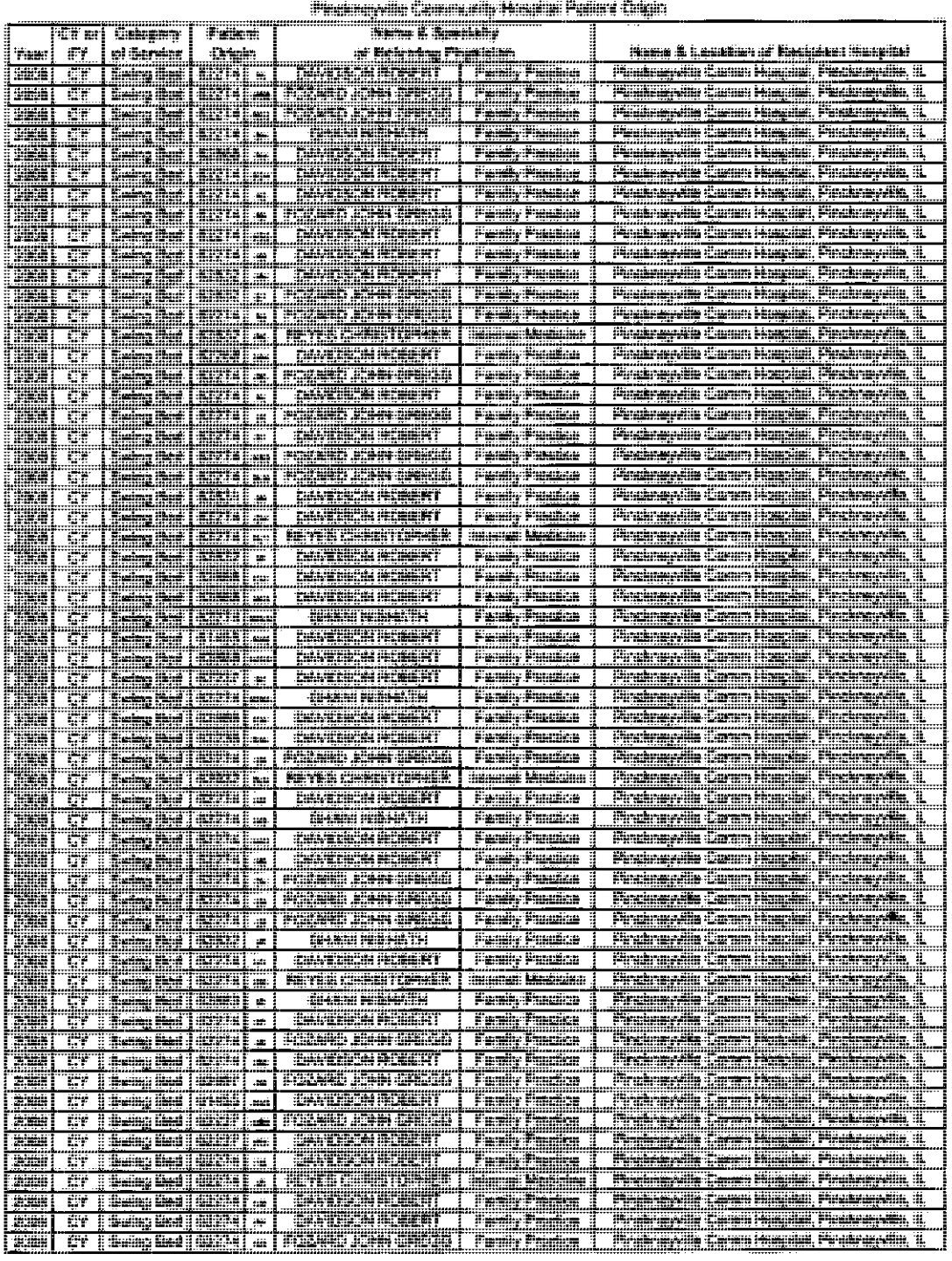


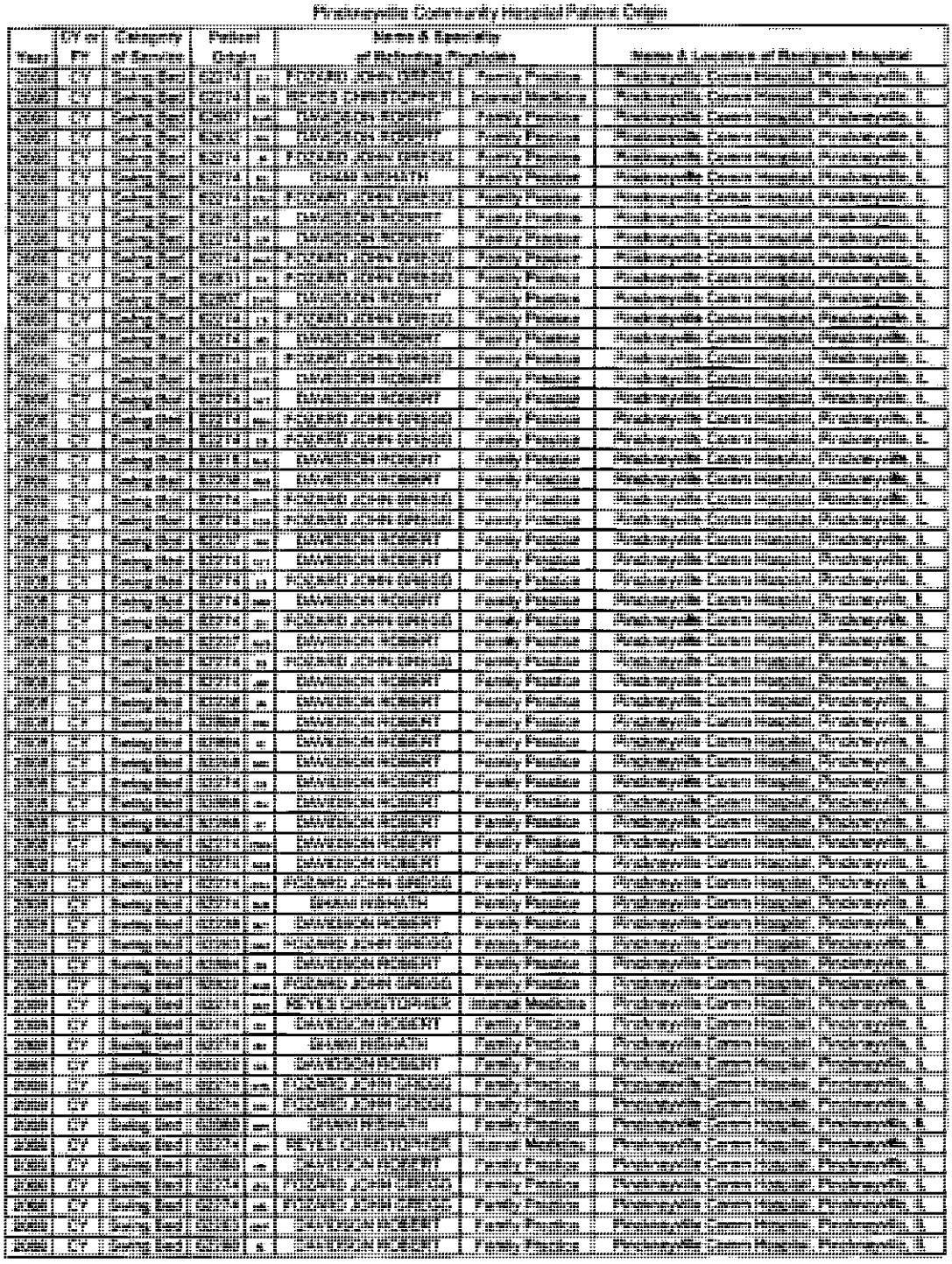












Pinckneyville Community Hospital Patient Origin

Year	CY or FY	Category of Service	Patient Origin		Name & Specialty of Referring Physician		Name & Location of Recipient Hospital
2008	CY	Swing Bed	62274	FS	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	CRM	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	MP	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	JRP	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	ELR	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62288	IE	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	LR	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	REC	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	JP	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	RLK	FOZARD JOHN GREGG	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62901	EW	GHANI NISHATH	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	LC	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL
2008	CY	Swing Bed	62274	JS	DAVIDSON ROBERT	Family Practice	Pinckneyville Comm Hospital, Pinckneyville, IL

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

May 7, 2009

Mr. Jeffrey S. Mark
Executive Director
Illinois Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Re: Establishment of Bed Category of Service (Replacement Hospital)
Pinckneyville Community Hospital and Pinckneyville Community Hospital District

Dear Mr. Mark,

Pinckneyville Community Hospital District, operating as Pinckneyville Community Hospital, is proposing to develop a replacement hospital on a new site and discontinue all services at its existing location.

In accordance with Illinois Administrative Code 1110.530b)3)B, I do herby attest that I have referred the patients referenced in Attachment 20 for the periods CY2007 and CY 2008 to Pinckneyville Community Hospital.

Furthermore, I anticipate the number of patients that I will refer to the Hospital's new replacement facility annually, within the 24-month period after project completion, will not exceed the annual referrals in the attached documentation. However, the service area population is aging and in my experience, this will lead to roughly an average annual hospital services growth exceeding 3% annually. The new hospital expects to open in mid-2011; thus, my estimation covers the period mid-2011 though mid-2013.

In addition, my referrals, as referenced herein as attached, have not been used to support another pending or approved CON application for the subject services.

Sincerely,

Dr. Christopher Reyes, MD
Internal Medicine
101 N Walnut St., Pinckneyville, Illinois, 62274

Subscribed and Sworn to before me
this 20th day of May, 2009
Phyllis M. Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/13/13

101 N. Walnut St.; Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

May 7, 2009

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Executive Director
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525 W. Jefferson Street, Second Floor
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In addition, my referrals, as referenced herein as attached, have not been used to support another pending or approved CON application for the subject services.

Sincerely,

A. Sawadisavi, M.D.

Dr. Atkavi Sawadisavi, MD
General Surgeon
101 N Walnut St., Pinckneyville, Illinois, 62274

Subscribed and Sworn to before me
this 19th day of May, 2009

Phyllis M Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 02/13/13

101 N. Walnut St.; Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville
Community
Hospital

leading the way to a healthier tomorrow

May 7, 2009

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Executive Director
Illinois Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

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In addition, my referrals, as referenced herein as attached, have not been used to support another pending or approved CON application for the subject services.

Sincerely,

Dr. Nishath Ghani, MD
Family Practice
101 N Walnut St., Pinckneyville, Illinois, 62274

Subscribed and Sworn to before me
this 20th day of May, 2009
Phyllis M. Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

May 7, 2009

Mr. Jeffrey S. Mark
Executive Director
Illinois Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

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Pinckneyville Community Hospital and Pinckneyville Community Hospital District

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In addition, my referrals, as referenced herein as attached, have not been used to support another pending or approved CON application for the subject services.

Sincerely,

John Gregg Fozard

Dr. John Gregg Fozard, MD
Family Practice
101 N Walnut St., Pinckneyville, Illinois, 62274

Subscribed and Sworn to before me
this 20 day of May, 2009

Phyllis M. Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/7/2013

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA
E. Service Accessibility - Service Restrictions

1. The applicant shall document that at least one of the factors listed in subsection (b)(5) of the criteria for subject service(s) exists in the planning area.

A) Service Restrictions

The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 45-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

2. Provide documentation, as applicable, listed in subsection (b)(5) of the criteria for the subject service(s), concerning existing restrictions to service access:

B) Supporting Documentation

The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist; and

vii) Most recently published IDPH Hospital Questionnaire

SECTION VII. – SERVICE ACCESSIBILITY

Introduction

Pinckneyville Community Hospital, a designated CAH, has been deemed a necessary health services provider by IDPH and the Department of Health and Human Services (See Attachment 22, Exhibit 1 and Attachment 22, Exhibit 2. Thus, its continued presence in Pinckneyville is necessary to retain access for planning area residents. The Hospital proposes to relocate its existing facility within the city limits. By Agency rules this requires meeting discontinuation and establishment criterion. If "establishment" is not approved, discontinuation will not occur.

Service Restrictions

The Hospital is in Perry County and over 85% of its patients originate from the county (COMPdata). Perry County meets several of the requirements in the Illinois State Rural Health Plan which allows Pinckneyville Community Hospital District d.b.a. Pinckneyville Community Hospital be designated as a necessary health services provider as supported by: (See also Attachment 22, Exhibits 1, 2 and 3)

- Perry County has a larger proportion of residents 65 years and older than the State average.
- Perry County is designated a State Physician Shortage Area.
- There is a Health Professions Shortage Area in Perry County.
- Perry County has a higher proportion of residents with incomes at or below 200 percent of the federal poverty level than the States' proportion.

Thus, there are existing service restrictions.

Documentation

The Hospital is designated a necessary provider of health services by IDPH as confirmed by the following support letters, Attachment 22, Exhibit 4, document community leadership perspective.

Illinois Department of
Public Health

George H. Ryan, Governor · John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street · Springfield, Illinois 62761-0001

July 18, 2000

Mr. Jerry Bolandis, CEO
Pinckneyville Community Hospital District
101 N. Walnut Street
Pinckneyville, IL 62274

Dear Mr. Bolandis:

A review has been completed of your application to be designated as a necessary provider of health services, authorized by the Medicare Rural Hospital Flexibility Program. This application is the first step in the process of becoming certified as a critical access hospital. The information you submitted documents the importance of the services Pinckneyville Community Hospital District provides to the residents of its primary service area, Perry County. The information identifies that Perry County meets several of the requirements in the ILLINOIS STATE RURAL HEALTH PLAN to be designated as a necessary provider and is supported by the following statements.

- Perry County has a larger proportion of residents 65 years of age and over (17.1%) than the state's proportion (12.5%) of residents for that same age group.
- Perry County is designated as a state Physician Shortage Area.
- A population group within Perry County is designated as a Health Professional Shortage Area.
- Perry County has a higher proportion of residents with incomes at or below 200 percent of the federal poverty level than the state's proportion.

I am notifying you of the designation of your facility as a necessary provider of health services. The Division of Health Care Facilities and Programs will be notified of this action. I am pleased you are pursuing this new opportunity for rural hospitals to maintain an array of services necessary for the well-being of area residents and be reimbursed at a reasonable cost level. Should you have any questions about your application, please contact Mary Ring, Chief of the Center for Rural Health at 217.782.1624.

Sincerely,

John R. Lumpkin, M.D.
Director of Public Health

JRL:ps

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Region V
Health Care Financing
Administration

233 N. Michigan Ave.
Suite 600
Chicago, Illinois 60601

Mr. Jerry Bolandis, CEO
Pinckneyville Community Hospital
101 N Walnut
Pinckneyville, IL 62274

November 16, 2000

Dear Mr. Bolandis:

We are pleased to notify you that Pinckneyville Community Hospital meets the requirements at 42 Code of Federal Regulations (CFR), Part 485, for participation in the Medicare Program as a Critical Access Hospital (CAH). The effective date of this approval is, November 3, 2000.

Effective with this approval, Pinckneyville Community Hospital's participation as an acute care hospital under the provider number 140055 has been canceled effective November 3, 2000. Your new provider number for your CAH is 141307. This provider number should be used on all correspondence and billing for the Medicare program starting November 3, 2000.

The change in status of Pinckneyville Community Hospital will require that limited services begin no later than November 3, 2000. As of that date, you may operate no more than 25 beds (with no more than 15 used for acute care).

Your fiscal intermediary is AdminiStar. Questions concerning billings and other fiscal matters should be directed to them. Questions related to the Conditions of Participation should be directed to your state agency.

Welcome to the CAH program.

Sincerely,

Dorsey C. LeCompte
Health Program Evaluation Officer

cc: IL Department of Health
AdminiStar

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

February 23, 2009

Mr. Tom Hudgins, CEO
Pinckneyville Community Hospital
101 N. Walnut St.
Pinckneyville, IL 62274

Dear Mr. Hudgins:
One of the requirements for an acute care hospital to be eligible for critical access hospital designation is that the facility must be located in a state or federal codified rural area as identified in its State Rural Health Plan for Implementation of the Critical Access Hospital Program. The plan identified the following state rural definition:

TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER g: GRANTS TO DENTAL AND MEDICAL STUDENTS
PART 590 FAMILY PRACTICE RESIDENCY CODE; SECTION 590.20 DEFINITIONS

"Rural" means any geographic area not located in a U.S. Bureau of the Census Metropolitan Statistical Area; or a county located within a Metropolitan Statistical Area but having a population of 60,000 or less; or a community located within a Metropolitan Statistical Area but having a population of 2,500 or less.

Pinckneyville Community Hospital, 101 N. Walnut Street, Pinckneyville, IL is located in Perry County which is defined as a rural county according to the State of Illinois's above accepted definition. Pinckneyville Community Hospital was able to apply and subsequently be designated as a critical access hospital by the Centers for Medicare & Medicaid Services (CMS) in November 2000.

Pinckneyville Community Hospital plans to build a replacement facility which will also be located in Perry County. Thus, Pinckneyville Community Hospital will continue to meet the rural location requirement as defined by 485.610 (b) interpretive guidelines for critical access hospital under the Medicare program.

Sincerely,

Julie Casper

Julie Casper
Center for Rural Health

City of Pinckneyville

104 South Walnut Street
Pinckneyville, Illinois 62274
(618) 357-6916

Frances I. Thomas
City Clerk

JOSEPH M. HOLDER
Mayor

May 15, 2009

Donald Jones, Supervisor
Project Review Section
Illinois Health Facility Planning Board
525 West Jefferson Street – 2nd Floor
Springfield IL 62761

RE: Pinckneyville Community Hospital's Certificate of Need Application

To Whom It May Concern:

As Mayor of the City of Pinckneyville, it is my duty to provide a written position regarding the construction of a new hospital for the community.

Our community has experienced a series of difficult and challenging problems over the last few years. We have lost our largest employer. We have lost businesses and many jobs. Our community is at a lower level of confidence among our citizens. Many people are very concerned about their financial well being as well as the community as a whole.

Adding to this, a new hospital would have to disconnect itself from another community service; skilled care. That would create more displacement among jobs and citizen service.

However, these events are short-term in nature and have less relevance on a long-term improvement, like this hospital. This new facility will service the next two generations or more. Pinckneyville went hopelessly in debt during the Great Depression of the 1930's to install sanitary sewer collection and processing in the City. This improvement was not well received in the short-term. The long-term benefits were obviously crucial to the growth of Pinckneyville. A new hospital is no less important to this community at this time.

In my opinion, this community needs a new hospital, and I hope its certificate of need is granted. Few remember what makes a community's future promising. Now is the time since the hospital board has taken special care in planning a financial solution to the creation of this new facility.

Sincerely,

Joseph M. Holder, Mayor
City of Pinckneyville

Cc: Tom Hudgins, Administrator
Pinckneyville Community Hospital

Perry County Health Department

P.O. Box 48
907 South Main
Pinckneyville, Illinois 62274

Working to Keep You Healthy

Telephone
(618) 357-5371

May 15, 2009

Thomas J. Hudgins, FACHE
Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, IL 62274

Dear Mr. Hudgins:

The Perry County Health Department fully supports your efforts to obtain a Certificate of Need from the Illinois Health Facilities Planning Board for the replacement of the existing Pinckneyville Community Hospital.

The Pinckneyville Community Hospital provides access to quality care for the local citizens and many people from surrounding counties that depend on the accessibility of this hospital. Without the care and services that are locally provided, people would have to travel to obtain needed healthcare, and with today's current economy, the low socioeconomic status of the county and rising gas prices it would be difficult for many to access necessary healthcare provided by the hospital.

The health department would also support the addition of an Obstetric unit. Currently the citizens of Perry County must travel to other hospitals that are out of county to deliver babies. This service would be of great benefit to the community along with the other valued healthcare services the Pinckneyville Community Hospital continually provides. Thank you for your commitment and dedication to the community.

Sincerely,

Jodi Schoen
Administrator
Perry County Health Department

The friendly little city

Pinckneyville!

Chamber of Commerce

Mr. Tom Hudgins
Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut St.
Pinckneyville, IL 62274

Dear Tom:

I am pleased to write a letter of support for the replacement of the Pinckneyville Community Hospital. The Chamber of Commerce is in unanimous support of this worthy project.

As you well know, the key to providing economic growth is the infrostructure of the community. Individuals and entities desiring to relocate to an area look at several key strengths of any given region. One of the most important is state of the art medical facilities. In recruiting new business to locate in Pinckneyville it is critical that medical care is of the standard that is expected in the United States. Without it, you cannot recruit people to locate in your area nor can you recruit outstanding physicians to practice in the facility.

The development of the new hospital also does not require additional taxation of residents. It is admirable that the Board at your facility has chosen to fund the project from revenues generated by the hospital. Not only will the new facility offer the necessary health care, it is not at the expense of the taxpayer. This is a refreshing change in the current economic climate.

Pinckneyville Community hospital is an important asset to our area and economic development. The hospital's effort to provide modern facilities is emphatically supported by the Pinckneyville Chamber of Commerce.

Sincerely,

Larry S. West

Larry S. West
President

No. 4 South Walnut Street, Pinckneyville, Illinois 62274
Telephone: 618 357-3243 • Fax: 618-357-2688
www.pinckneyville.com

Pinckneyville Ambulance Service
Shane Malawy, Administrator
508 South Main
Pinckneyville IL.
62274

(618) 357-2222 ext.3

May 12, 2009

To Whom It May Concern:

Pinckneyville Ambulance Service began operations in 1976. Since that time, Pinckneyville Community Hospital has been a tremendous asset to the community as well as to the Ambulance Service.

As an Ambulance Service, we responded to 3,028 calls in 2008. The majority of those patients were transported into or out of Pinckneyville Community Hospital. As the call volume for Pinckneyville Ambulance Service increases, so does the demand for training for the Paramedics at the Ambulance Service.

Pinckneyville Community Hospital has become a local source for our Paramedics to become ACLS (Advanced Cardiac Life Support) certified by providing several courses a year. Without this resource, our Medics would have to leave the community for training. With the Medics out of town, staffing an ambulance truly becomes an issue.

Being a rural Ambulance provider, it is crucial to keep our ambulances in service and at the ready to respond to emergencies. Pinckneyville Community Hospital facilitates this by allowing for restock of ambulance supply and pharmaceuticals at any time of the day or night allowing our ambulances to stay available and provide emergency coverage for the people of Pinckneyville and surrounding area.

Currently, the Pinckneyville Community Hospital does not have a landing area for helicopters. If a patient needs rapid air transport to a trauma center or tertiary care center, the aircraft must land at the local High School and the ambulance must transport the flight crew to the hospital to receive the patient and then be transported back to the aircraft. This significantly delays patient transport to a Level 1 trauma center. The need for a new hospital with adequate property to support a helipad is in of itself a priority.

With the current floor plan at Pinckneyville Community Hospital, there is very little individual privacy in the Emergency Room. It is very problematic for EMS providers to give a patient report to hospital staff without another patient in the same room. Also it is not uncommon for EMS providers to wait with a patient in the hallway until rooms can be arranged to accommodate additional patients. There is also no space available for EMS providers to complete the patient care report in private. EMS providers frequently must stand in the hallway and complete paperwork in a very public environment.

The City of Pinckneyville and the surrounding area would definitely benefit from the construction of a new hospital. The patients would see the most return, however, the

Ambulance Service and the rest of the community will benefit as well. Pinckneyville Community Hospital has the full support of the Pinckneyville Ambulance Service to construct a new facility.

With the call volume increasing here at the Ambulance Service, more and more patients will be transported into and out of Pinckneyville Community Hospital. Without a new, updated, and modern facility, it will become increasingly difficult for the Ambulance Service to handle these calls in a timely manner.

Thank you,

Shane Mahaffy

ARCH
AIR MEDICAL SERVICE
Owned and Operated by: Air Methods®

May 14, 2009

Tom Hudgins
Pinckneyville Community Hospital
101 N. Walnut
Pinckneyville, IL 62274

Dear Tom,

Air Methods Corporation dba ARCH Air Medical Service and the Pinckneyville Community Hospital have had a long history providing the highest quality healthcare to the residents of Pinckneyville and its surrounding communities. We understand the challenges faced in the ever changing medical field, and realize the importance of meeting those challenges to keep up with the changes in technology and advanced care. We commend you on your facility plan as you look to the future needs of your community, and look forward to serving you and your residents for years to come. It is with great pride that we offer the Pinckneyville Community Hospital our support and best wishes for your project.

Sincerely,

Randall Reiman

Randall Reiman

Flight Paramedic
ARCH Air Medical Services

SOUTHERN ILLINOIS EYECARE

Joseph F. Grasso, O.D.
Lawrence G. Soellner, O.D.
W. Eric Jones, O.D.
Carolyn C. Gibson, O.D.

May 14, 2009

To Whom It May Concern:

Southern Illinois EyeCare is in support of replacing the current Pinckneyville Community Hospital facility. An updated structure and surgery suite would greatly enhance the out come of our patients undergoing eye surgery along with all other out patient procedures.

Please consider granting our community this much needed update to our hospital. If I can be of any further assistance in deciding the need for a new hospital, please call or write.

Sincerely,

Joseph F. Grasso, O.D.

CHESTER EYECARE
1209 Swanwick St.
Chester, IL 62233
(618) 826-4521
(618) 826-4520 Fax

DUQUOIN EYECARE
7909 State Rte. 14
Suite 200 P.O. Box 109
DuQuoin, IL 62832
(618) 542-6677
(618) 542-6688 Fax

MARISSA EYECARE
521 B North Borders St.
Marissa, IL 62257
(618) 295-1600
(618) 295-1607 Fax

PINCKNEYVILLE EYECARE
15 North Locust St.
Pinckneyville, IL 62274
(618) 357-6117
(618) 357-3406 Fax

SPARTA EYECARE
215 South Burns St.
Sparta, IL 62286
(618) 443-5252
(618) 442-2850 Fax

SEMC PATHOLOGY
1270 MERCANTILE DRIVE
HIGHLAND, IL 62249
P.S. Gronemeyer, M.D., Director

(618) 651-8097, toll free (866) 657-8747, fax (618) 651-8097

May 15, 2009

Illinois Health Facility Planning Board

Dear Sirs:

I am writing a letter in support of the construction of a new hospital to replace the current Pinckneyville Community Hospital. I have been a Pathologist in the southern Illinois area since 1981. In 2001, my pathology service began to provide services to Pinckneyville Community Hospital. Over the last 8 years, I have seen how much the community needs the hospital, and the caring health care services provided by the employees at the facility. Rural America is currently suffering from a lack of adequate health care. It is critical that every means possible be used to support the development and maintenance of health care services and facilities in these areas. The current Pinckneyville Community Hospital is outdated, and is desperately in need of replacement. As a Pathologist who is on the staff of multiple hospitals, and is familiar with the diverse communities that I serve, I know that this hospital is needed.

If you have any questions please contact me at my office number above, or through my cellular, (618)-973-3584.

Sincerely,

Pamella S. Gronemeyer, M.D.

FNB
First National Bank
in Pinckneyville

May 6, 2009

Mr. Thomas J. Hudgins
Administrator/CEO
Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, IL 62274

Dear Mr. Hudgins:

I am writing this letter in support of the proposed replacement facility that your Hospital is trying to secure for our community and region. Our bank, as a member of the financial community, knows firsthand how important an asset your Hospital is to our entire region. With a budget of over 20 million dollars your facility has a huge economic impact in an area that is one of the most economically depressed in the State of Illinois. Our county consistently is in the top five for the highest unemployment rates in our state. Your facility, as one of the biggest employers of quality jobs in our area provides a significant economic impact.

If economic impact were the only reason in itself I would be for your new facility. However, having used your hospital services over the years it has become apparent that the aging facility is now in need of replacement. Upon a recent visit I saw many signs of a facility that was designed for medical care of years past and that has been pushed to its limit of use for today's needs. Medical staff is utilizing every possible space, but it is obvious that today's equipment does not fit into space designed for 1960's era needs.

In conclusion, I want to commend you and your medical staff for providing a valuable service to our community for so many years. In our rural area it would be difficult for families to have the same quality of life without the medical care you have consistently provided. For this reason, I firmly believe that a new facility is not only needed, but absolutely necessary for our area to exist and prosper into the future.

Sincerely,

David R. Pirsein,
President & CEO

210 S. Main St. • P.O. Box 208 • Pinckneyville, Illinois 62274-0208 • (618) 357-9393
fnbpville.com • Fax (618) 357-3917

MURPHY-WALL
State Bank and Trust Company
Member FDIC

May 14, 2009

To Whom It May Concern:

Re: Pinckneyville Hospital Project

As a business having many employees who are citizens of Pinckneyville and Perry County Illinois, we are very concerned regarding the availability of proper health care in the immediate area. We have been presented with the issues regarding the status of the current medical facility and see the need for improvement. Information leads us to believe that it will be ideal and cost effective to construct a complete new facility and not to renovate the existing physical plant.

Therefore, we fully support the need for a new medical facility to be constructed.

If you have any questions please do not hesitate to contact me.

Sincerely,

Marty L. Davis
President/CEO

PINCKNEYVILLE OFFICE
105 E Water Street • PO Box 128
Pinckneyville, IL 62274-0128
TEL: (618) 357-5373 FAX: (618) 357-3757
http://www.murphywall.com

MURPHYSBORO OFFICE
105 N Williams Street • PO Box 129
Murphysboro, IL 62966
TEL: (618) 687-2265 (BANK)
FAX: (618) 687-4329 (IFAX)

McDaniel's Furniture & Appliances, Inc.

5565 ST. RT. 154
[redacted] PINCKNEYVILLE, IL. 62274 PHONE: 357-2165
27 S. DIVISION DU QUOIN, IL. 62832 PHONE: 542-4746
207 E. ST. LOUIS NASHVILLE, IL. 62263 PHONE: 327-4482

To Whom It May Concern,

I am writing in support of the proposed new Pinckneyville Community Hospital. I trust the administration and board of directors of the hospital and believe they have come to a decision based on the facts of the situation with the old hospital facility. As I get older I want to believe we have the best services a small town hospital can offer should I need them, so I am for the new hospital. Thank you.

Tom McDaniel

RAYMOND JAMES
FINANCIAL SERVICES, INC.
Member NASD/SIPC

Chad M. Rushing
Financial Advisor

May 7, 2009

Thomas J. Hudgins, FACHE
Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut St.
Pinckneyville, IL 62274

Dear Mr. Hudgins,

I am writing this letter to express my support for the construction of a new hospital for our community.

In many instances, a hospital is like a business – its facilities and equipment must be improved constantly. Our present facility is no longer adequate to provide the quality of health care for our community. The present building has seen past renovations and is beyond any further expansion at its present location. While medical equipment has been updated, the space is quite limited. We need to keep up with expanding technology to provide the best possible health care.

The construction of a new facility is vital to the infrastructure and growth of this community. A new facility would certainly be an incentive for health care professionals to relocate to our area and would also provide much needed career opportunities for our area.

Best regards,

Chad M. Rushing

vkd

208 South Walnut St. • Pinckneyville, IL 62274 • 618-357-5226 • Fax 618-357-9010
Chad.Rushing@RaymondJames.com

Mark S. McDaniel

5-8-9

Dear Tom,

My wife Ruth and I feel a new hospital for Pinckneyville is essential. We have two young daughters as well as a local business that depend on the medical care you provide.

We support you 100%,

Sincerely,

Mark & Ruth McDaniel

McDaniel's Furniture

Pinckneyville True Value
205 East Randolph
Pinckneyville, IL 62274

Tuesday, May 12, 2009

Illinois Health Facilities Planning Board

Gentlemen:

As a business owner in Pinckneyville, Illinois, I am writing this letter to support the application by Pinckneyville Community Hospital for the replacement of the existing hospital. A modern, up-to-date health facility is essential to maintain the quality of life in our local community. It is the foundation necessary for growth and development and is an important factor when making the decision of where to live and work.

As a local business, we understand that the 200 workers employed at the hospital helps keep our local economy intact. From a personal perspective, my family and I have appreciated having the convenience of a quality hospital in our hometown and the travel time it has saved, especially during the many emergency room visits we made with our growing family.

Pinckneyville Community Hospital has served the community well and its modernization and expansion is vital to our future.

Sincerely,

Roger G. Denton, Owner

Wright's Collision Center

3691 Sap Rd. Route 154 – Pinckneyville, IL. 62274
618-357-6000– 618-357-6001fax– 618-357-1508cell

May 6, 2009

We at WCC Inc. DBA Wright's Collision Center are in favor of a new Hospital facilities in the area. We feel like our community is a growing area that has been hit hard in the past but we still survive. By building a new facilities it should bring new jobs to the area and more revenue as well. We are in favor of this.

Thanks

Matthew L Wright President
Wright's Collision Center
3691 Sap Rd
Pinckneyville, IL. 62274

Pinckneyville Community High School
PCHS Panthers
Brent Kreid, Superintendent www.pchspanthers.com Jonathan D. Green, Principal
PCHS District No. 101 600 East Water Street Pinckneyville, IL 62274 Phone: (618) 357-5013 Fax: (618) 357-6045

May 12, 2009

Tom Hudgins, Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut St.
Pinckneyville, Il 62274

Dear Mr. Hudgins,

On behalf of Pinckneyville Community High School District No. 101, I am writing to express support to Pinckneyville Community Hospital (PCH) and its current capital improvement endeavors of replacing the existing PCH facility. Please allow this letter to serve as such support respective to your filing of a Certificate of Need with the Illinois Health Facilities Planning Board, and application to the Housing and Urban Development Program Section 242 for guaranteed financial support.

Respectfully,

Brent Kreid, Superintendent
Pinckneyville Community High School

Kevin R. Pyatt
John S. Wallace
Larry Cole

Email: wecare@pyattfuneralhome.com

PYATT
FUNERAL HOME
"People Helping People Since 1935"

Richard M. Pyatt
Maurice J. Pyatt
(1900-1985)

Website: www.pyattfuneralhome.com

May 13, 2009

Illinois Health Facilities Planning Board

Housing and Urban Development Program Section 242

To the Staff of the Urban Development and Planning Board,

Please accept this letter as my strong endorsement for the replacement of the current Pinckneyville Community Hospital. The community of Pinckneyville is a small but vital town that has always placed a strong emphasis on its health care facilities.

Our current hospital has served the community of Pinckneyville well over the years. However, as medical procedures change and become more technologically advanced , it becomes necessary for facilities to modernize. Pinckneyville's hospital has become outdated and now needs to be replaced in order to keep up with modern health care.

Pinckneyville is poised and ready to continue providing excellent healthcare to the community and surrounding areas. Allowing the New Pinckneyville Community Hospital Project to move forward is the right thing to do and now is the right time to do it.

Thank you for your consideration in this process.

Sincerely

Kevin Pyatt

Owner, Pyatt Funeral Homes

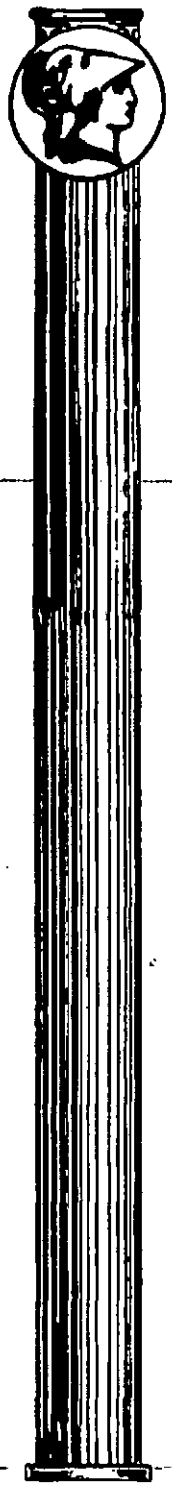
Pinckneyville, DuQuoin, Coulterville and Oakdale

309 South Main St., P.O. Box 318
Pinckneyville, Illinois 62274
Phone 618-357-2136
Fax 618-357-3252

138 E. Perry
DuQuoin, IL 62832
Phone 618-542-4225
Fax 618-542-2670

Oakdale, Illinois 62268
Phone 618-357-2136 or
Phone 618-758-2511
Fax 618-357-3252

204 E. Locust, P.O. Box 458
Coulterville, Illinois 62237
Phone 618-758-2511
Fax 618-357-3252



GRECIAN
STEAK
& SEAFOOD HOUSE

Highway 127 & 13 South
(502 South Main)
Pinckneyville, Illinois 62274
(618) 357-3809

To Whom It May Concern:

I have been asked to write a letter of support for the new Pinckneyville Illinois Health Facility. As a local business owner and community member of over twenty years, I can see first hand the need for said project. It would most certainly be in the best interest of the community in terms of necessary and effective health care, improvement of the local economy, and the overall morale of our citizens.

Pinckneyville is a thriving area. Overlooking this much needed project would hinder the growth and success of our society. We need local, effective healthcare! Citizens should have faith in the facilities available, thus said project would reinforce our populations faith in the local health care system. The young, the elderly, the meek, the mild, we all need a place to go where we know our needs can and will be meet in an expedient and accurate fashion.

Furthermore, the local economy needs stable positions for the many hard working individuals who pride themselves on meeting the health needs of our community. To reject this proposal would have adverse effects on not only the hospital employees, but all who support this institution. We can not afford to suffer the loss of over 200 positions. All local businesses would be affected, resulting in their employees being affected. This could cause a chain effect which would be detrimental to our way of life.

Finally, I would like to reinforce my FULL support for a new and improved hospital facility in Pinckneyville. The city's morale could not withstand a loss of employment. A new hospital would most certainly bring with it a sense of pride and accomplishment.

Sincerely,

Angelos Sandravelis
Grecian Steak & Seafood House, Owner

RED HAWK GOLF CLUB
6204 St. Rte. 154
Tamaroa, IL 62888
E-Mail: redhawk@accessus.net

Clubhouse: 618-357-8712
Pro Shop: 618-357-9704
Fax: 618-357-8108
Website: redhawkgc.net

May 10, 299

To Whom It May Concern:

As a small business owner in the Pinckneyville area, I can tell you firsthand how supportive my neighbors and I are with regards to constructing a new hospital. Our whole community has taken a proactive stance on replacing our obsolete facility.

Our Community Hospital must be modernized to offer quality services for the long run, everyone agrees. We believe (residents) the community deserves quality, affordable medical services. If we don't replace the existing facility, the hospital will ultimately result in limiting the services it provides, and perhaps even eventually forcing its closing.

In conclusion, we need a new hospital to provide us with quality, affordable medical service well into the next century and to make the area much more attractive to potential residents and small business areas. Our present Community Hospital is antiquated and does not meet the needs or demand of the residents proficiently.

Sincerely,

Dan Breslin
Managing Partner

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

F. Unnecessary Duplication/Maldistribution

1. Document that the project will not result in an unnecessary duplication, and provide the following information:

   a. A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;

   b. The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and

   c. The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2. Document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as presented in subsection (c)(1) and (2) of the criteria for the subject service(s).

3. Document that, within 24 months after project completion, the proposed project:

   A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

   B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

F. Unnecessary Duplication/Maldistribution

1. Unnecessary Duplication

a. Pinckneyville Community Hospitals' service area was derived through analyzing COMPdata. It is defined in Attachment 23, Exhibit 1 and mapped in Attachment 23, Exhibit 2; Exhibit 3 details each facility. These exhibits indicate both the 30 minute drive time and the corresponding zip codes.

b. Various sources were researched to evaluate historical and future Perry County population trends. Perry County essentially defines the Hospital's primary and secondary service areas (PSA and SSA). Based on a five (5) year historical analysis for the period 2004-2008, Perry County accounts for approximately 86% of the Hospital's inpatient medical / surgical utilization.

Attachment 23, Exhibits 4 and 5 profile historical trends and future Perry County population projections by age cohorts. These exhibits indicate:

1. The 2000 baseline census approximates 23,100 people. (DCEO/various sources) (Exhibit 4)
2. The total population has declined by approximately 180 people, or less than 1% in the period 2000 through 2008. (Exhibit 4)
3. The population decline in expected to stabilize and the Perry County population is expected to match the 2000 census population by 2011. In the period 2008 through 2020 it is expected to grow by 914 people or approximately 4%. (Exhibit 4)
4. The population is aging. In 2000 approximately 16% of the population was 65+. This population cohort is expected to be in the range of 20% by 2020. (Exhibit 5)
5. The majority of healthcare morbidity occurs in the population aged 45+. Within Perry County this age cohort accounted for 38.49% of the population in 2000, 42.12% in 2008, and is estimated to be 46.41% in 2020. (Exhibit 6)
6. Exhibit 5 profiles corresponding business characteristics.

By way of summary, these aging trends, coupled with stable to moderate growth in total population, indicates increasing demand and the need for locally based healthcare services.

c. Approved healthcare facilities within 30-minute drive time are:

1. Washington County Hospital
2. Sparta Community Hospital
3. Marshall Browning Hospital

Note: each of these is a CAH; Washington County is outside 30-minute drive time form the new site which is 1.8 miles east of the existing.

2. Maldistribution

This project proposes to replace an existing critical access hospital within its current service area. No maldistribution of services will occur. Not withstanding the assumed excess of beds within PA F-07, the Hospital has been designated a necessary provider by IDPH. If it were to close, access to healthcare services would be constrained and a maldistribution would occur.

3. Lowered Utilization

The Hospital proposed no new services. It is solely a replacement hospital project. Replacing existing beds and services is not expected to have an impact on other area health facilities utilization.

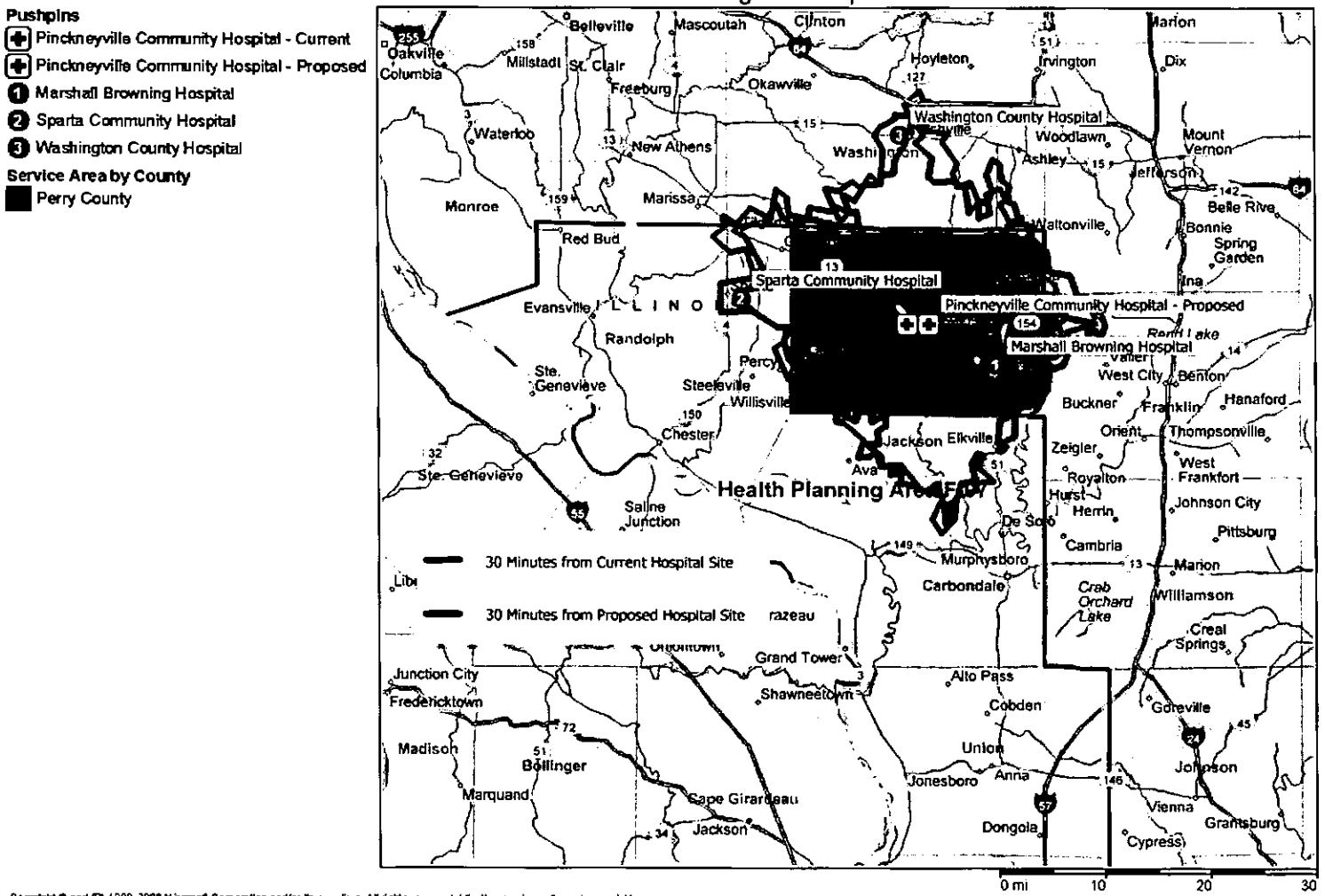
Pinckneyville Community Hospital Adult Medical Surgical Patient Origin by Zip Code
Excluding Swing Beds and Observation

		2004		2005		2006		2007		2008		Average	
Zip Code	Municipality	PCH	% Dist.	PCH	% Dist.	PCH	% Dist.	PCH	% Dist.	PCH	% Dist.	PCH	% Dist.
Primary Service Area (PSA)													
62274	Pinckneyville	440	58.36%	499	59.83%	428	54.11%	397	60.43%	305	56.17%	414	57.81%
Subtotal PSA within Perry County		440	58.36%	499	59.83%	428	54.11%	397	60.43%	305	56.17%	414	57.81%
Secondary Service Area (SSA)													
62832	Du Quoin	79	10.48%	86	10.31%	110	13.91%	80	12.18%	51	9.39%	81	11.34%
62888	Tamaroa	67	8.89%	60	7.19%	74	9.36%	44	6.70%	57	10.50%	60	8.44%
62238	Cutler	29	3.85%	29	3.48%	36	4.55%	24	3.65%	27	4.97%	29	4.05%
62237	Coulterville	20	2.65%	28	3.36%	26	3.29%	18	2.74%	22	4.05%	23	3.19%
62997	Willisville	11	1.46%	8	0.96%	9	1.14%	4	0.61%	6	1.10%	8	1.06%
Subtotal SSA within Perry County		206	27.32%	211	25.30%	255	32.24%	170	25.88%	163	30.02%	201	28.08%
Subtotal Perry County		646	85.68%	710	85.13%	683	86.35%	567	86.30%	468	86.19%	615	85.89%
62268	Oakdale*	10	1.33%	13	1.56%	11	1.39%	10	1.52%	13	2.39%	11	1.59%
Subtotal SSA		216	28.65%	224	26.86%	266	33.63%	180	27.40%	176	32.41%	212	29.67%
Subtotal PSA and SSA		656	87.00%	723	86.69%	694	87.74%	577	87.82%	481	88.58%	626	87.48%
Other Areas													
Subtotal Other Illinois Zip Codes		98	13.00%	108	12.95%	88	11.13%	80	12.18%	57	10.50%	86	12.04%
Total Illinois		754	100.00%	831	99.64%	782	98.86%	657	100.00%	538	99.08%	712	99.53%
Subtotal Out of State		0	0.00%	3	0.36%	9	1.14%	0	0.00%	5	0.92%	3	0.47%
Grand Total		754	100.00%	834	100.00%	791	100.00%	657	100.00%	543	100.00%	716	100.00%

* Located mostly in Washington County

Source: COMPdata (other areas adjusted to reflect annual admissions consistent with AHQ data)

PCH 30 Drive Time from the Exisiting and Proposed Sites



Hospital Facilites within 30 Minutes Normal Travel Time of the Current Pinckneyville Community Hospital Site

Facility	CAH	Administrator	Address	Municipality	Zip Code	MapQuest Miles	MapQuest Minutes
Pinckneyville Community Hospital - Current	Yes	Thomas J. Hudgins	101 N. Walnut St.	Pinckneyville	62274	--	--
Pinckneyville Community Hospital - Proposed	Yes	Thomas J. Hudgins	White Walnut Rd & State Route 154	Pinckneyville	62274	1.75	3
Marshall Browning Hospital	Yes	William J. Huff	900 N. Washington St	Du Quoin	62832	12.03	21
Sparta Community Hospital	Yes	Joann Emge	Sparta Community Hospital	Sparta	62286	18.35	24
Washington County Hospital*	Yes	Nancy Newby	705 South Grand Ave	Nashville	62263	18.74	28

Hospital Facilites within 30 Minutes Normal Travel Time of the Proposed Pinckneyville Community Hospital Site

Facility	CAH	Administrator	Address	Municipality	Zip Code	MapQuest Miles	MapQuest Minutes
Pinckneyville Community Hospital - Proposed	Yes	Thomas J. Hudgins	White Walnut Rd & State Route 154	Pinckneyville	62274	--	--
Pinckneyville Community Hospital - Current	Yes	Thomas J. Hudgins	101 N. Walnut St.	Pinckneyville	62274	1.75	3
Marshall Browning Hospital	Yes	William J. Huff	900 N. Washington St	Du Quoin	62832	10.29	16
Sparta Community Hospital	Yes	Joann Emge	818 E Broadway St	Sparta	62286	20.00	28

* Travel time is more than 30 minutes from the proposed new site.

Source: MapQuest.com as of March 19, 2009

Exhibit 4.1
Perry County Population Projections by Age Cohort

Age Cohort	2000	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
0-14	4,148	3,936	3,883	3,824	3,766	3,707	3,649	3,590	3,554	3,518	3,481	3,445	3,409	3,371	3,333	3,294	3,256	3,218
15-44	10,079	9,790	9,718	9,680	9,643	9,605	9,568	9,530	9,524	9,518	9,512	9,506	9,500	9,519	9,539	9,558	9,578	9,597
45-64	5,205	5,663	5,778	5,878	5,977	6,077	6,176	6,276	6,291	6,306	6,321	6,336	6,351	6,339	6,328	6,316	6,305	6,293
65+	3,698	3,557	3,522	3,551	3,581	3,610	3,640	3,669	3,763	3,858	3,952	4,047	4,141	4,274	4,407	4,539	4,672	4,805
All	23,130	22,947	22,901	22,934	22,967	22,999	23,032	23,065	23,132	23,199	23,267	23,334	23,401	23,503	23,606	23,708	23,811	23,913

Source: Illinois Department of Economic Opportunity (DCEO)

Exhibit 4.2
Perry County Population % Distribution by Age Cohort

Age Cohort	2000	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
0-14	17.93%	17.15%	16.96%	16.68%	16.40%	16.12%	15.84%	15.56%	15.36%	15.16%	14.96%	14.76%	14.57%	14.34%	14.12%	13.90%	13.68%	13.46%
15-44	43.58%	42.66%	42.43%	42.21%	41.99%	41.76%	41.54%	41.32%	41.17%	41.03%	40.88%	40.74%	40.60%	40.50%	40.41%	40.32%	40.22%	40.13%
45-64	22.50%	24.68%	25.23%	25.63%	26.03%	26.42%	26.82%	27.21%	27.20%	27.18%	27.17%	27.15%	27.14%	26.97%	26.81%	26.64%	26.48%	26.32%
65+	15.99%	15.50%	15.38%	15.49%	15.59%	15.70%	15.80%	15.91%	16.27%	16.63%	16.99%	17.34%	17.70%	18.18%	18.67%	19.15%	19.62%	20.09%

Source: Illinois Department of Economic Opportunity (DCEO)

Exhibit 3.2

Perry County Business Characteristics

Personal income ($ million)	483
Personal income per capita, 2005	$21,191
Civilian labor force, 2006	10,296
Unemployment rate, 2006	6.8%
Full-time and part-time employment by place of work, 2005	9,246
Full-time and part-time employment, net change 2000 to 2005	-34
Employment in government, 2005	1,426
Earnings, 2005 ($1000)	261,725
Average earnings per job, 2005	$28,307
Private nonfarm establishments, 2005	437
Private nonfarm employment, 2005	5,391
Private nonfarm employment , percent change, 2000-2005	-6.0%
Total number of firms, 2002	1, 359
Manufacturers shipments, 2002 ($1000)	284,112

Source: Bureau of Economic Analysis, Bureau of Labor Statistics, National Agricultural Statistics Service, National Center for Health Statistics, U.S. Census Bureau

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

G. Category of Service Modernization

1. Document that the inpatient beds areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, citing factors, as listed in subsection (d)(1) of the criteria for the subject service(s), but not limited to the reasons cited in the rule.

2. Provide the following documentation of the need for modernization:

   A. the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports;
   B. the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports;

3. Include other documentation, as applicable to the factors cited above:

   A. Copies of maintenance reports;
   B. Copies of citations for life safety code violations; and
   C. Other pertinent reports and data.

4. Provide the annual occupancy for each category of service to be modernized, for each of the last three years.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

G. Category of Service Modernization

1. Deteriorated Facilities

   Please refer to Attachment 9, Reasons for Discontinuation Detailed Infrastructure Analysis.

2. Inspection Documentation

   See Attachment 24, Exhibit 1. Pinckneyville relies on IDPH for required compliance inspections for both the State and CMS. It has not sought Joint Commission accreditation since 1995. The attached exhibit is the cover letter from the last inspection. There were no facility citations. Those operational areas requiring correction have been purposely omitted.

3. Other Documentation

   Please refer to Attachment 9, Discontinuation of Medical / Surgical Category of Service.

4. Annual Occupancy (IDPH Hospital Profiles)

	Based on 25 Medical/Surgical Beds	
Utilization Year	Without Swing Beds	With Swing Beds
2006	31.7%	67.6%
2007	26.9%	53.5%
2008	23.6%	43.1%

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street · Springfield, Illinois 62761-0001 · www.idph.state.il.us

October 29, 2009

Pinckneyville Community Hospital
101 North Walnut St.
Pinckneyville, Il 62274

Dear Administrator,

The Illinois Department of Public Health appreciates the courtesies extended to the Department's surveyors. The *Statement of Deficiencies and Plan of Correction* (POC) must be completed and returned within ten (10) calendar days after receipt to:

Karen Senger, R.N., Supervisor
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson Street, 4th Floor
Springfield, IL 62761-0001

An acceptable POC must contain the following elements:

- The procedure for implementing the plan of correction for each deficiency cited, typed in the right-hand column of the original *Statement of Deficiencies*.
- The title of the individual responsible for implementing and monitoring the plan of correction
- Evidence the facility has incorporated systemic improvement efforts into its quality assessment and performance improvement program in order to prevent the recurrence of the deficient practice
- Supporting documentation as evidence of correction
- Procedures for monitoring and tracking to ensure the plan of correction is effective
- A completion date for correction of each deficiency cited, along with interim dates for any phases or intermediate steps
- Date and signature of the authorized representative, on the bottom of page one of the original *Statement of Deficiencies and Plan of Correction*

If you have any questions, please contact the supervisor at the address listed above, or by phone at 217/782-0381. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

Maria Lynn Schaefer RN BSN MFSW for

Gloria McDowell, Administrator
Field Operations Section
Division of Health Care Facilities and Programs

Improving public health, one community at a time

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

H. Staffing Availability

1. For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met.

2. Provide the following documentation:

    a. The name and qualification of the person currently filling the position, if applicable; and
    b. Letters of interest from potential employees; and
    c. Applications filed for each position; and
    d. Signed contracts with the required staff; or
    e. A narrative explanation of how the proposed staffing will be achieved.

H. Staffing Availability

1. Professional Staffing

This project is for a replacement hospital on a new site. There is no change proposed in categories of service nor related clinical / ancillary services. The existing staff will relocate to the new site. Currently the Hospital meets all licensing and related staffing requirements and will continue to do so. Attachment 25, Exhibit 1 profiles current staffing.

2. Documentation

Not applicable in that current staffing exists as demonstrated by ongoing operations and the appended analysis.

Pinckneyville Community Hospital
COMPARE Staffing Review

Executive Summary

May 05, 2009

Introduction

Any hospital's long term success is determined by its performance in five critical outcome areas:

- **Cost**
- **Quality**
- **Physician and patient satisfaction**
- **Community image**
- **Employee relations**

Hundreds of interrelated factors are constantly at work to diminish performance in these critical outcome areas in all health care organizations. No hospital, however well managed, is immune from these factors, especially in a climate of rapid change.

Financial pressures have brought improving the cost outcome to the top of the management agenda for hospitals across the United States. Unfortunately, many hospital cost reduction efforts start from faulty premises. There is a tendency to treat 'over staffing' as the cause of something (excessive costs) rather than the result of something (effectiveness barriers within the hospital). Consequently some hospitals have initiated FTE reductions without fully taking the effect on other critical outcome areas into account and without making the changes required to sustain lower staffing levels. This can produce unintended adverse consequences.

It does not have to be so. The five critical result areas that define organizational effectiveness are not competitive and mutually exclusive, but complementary. The factors that limit effectiveness are not independent, but synergistic. *Most importantly, the same factors that work together to produce unacceptable cost outcomes also produce unacceptable outcomes in quality, physician and patient satisfaction, community image, and employee relations. When those factors are identified and dealt with, performance improves in all critical outcome areas.*

This COMPARE staffing review is provided to aid in the identification of departments and units falling outside the range of expected activity-based staffing levels. COMPARE's activity-based expected staffing ranges are derived from a database of information from more than 24,000 hospital departments. COMPARE reports are activity driven. They take into account hospital size and service configuration, teaching status, setting (urban vs. rural), and severity of illness inferences, with the latter drawn from the relationship between patient days, length of stay and inpatient ancillary resource consumption. Department activity levels and operating characteristics are used to further define compare groups. Within each compare group, comparative ranges are defined by the ratio of paid hours to workload at the mean and at -1 standard deviation levels. Although the COMPARE staffing review cannot by itself project optimum staffing levels for this or any other hospital, the ranges shown in this analysis have been achieved by departments with

similar characteristics and workloads within the compare group.

This report is the result of data provided by Pinckneyville Community Hospital. No attempt has been made to evaluate the systems and processes, architectural design, or technology currently available to the hospital, nor have conclusions been drawn about the appropriateness of services provided. Definitive recommendations are beyond the scope of this COMPARE staffing review. Top management's primary use of this report should be to focus effectiveness improvement efforts. Departments and units falling outside the compare group range deserve further study to identify and quantify the effect of variance-producing factors. Systematically identifying, prioritizing, and resolving these factors will help the hospital attain new levels of effectiveness in all critical outcome areas, including cost. This COMPARE report is the first step in that process.

Data Considerations

To facilitate comparison, "roll up" reports were provided in addition to individual department COMPARE reports in the following areas:

Rollup
Nuclear Medicine (022)
Imaging (018)-Diagnostic Radiology Function
Imaging (018)-Ultrasonography Function
CT (023)
Imaging (018)-Mammography Function
Rollup
Central Service (035)
Operating Room (012)
Rollup
Occupational & Speech Therapy (017)-Speech Component
Occupational & Speech Therapy (017)-OT Component
Rollup
Respiratory Therapy (015)-Cardiology Function
Respiratory Therapy (015)-Respiratory Therapy Function
Rollup
Rural Health Clinic Reception, Nursing, and Providers (079)
Rural Health Clinic Billing (079)

Overtime Utilization

The subject of overtime must be approached with caution. There are times when judicious use of overtime is a cost-effective, business-decision alternative to the addition of staff. Too little overtime can be an indication of an "over staffed" situation. As a rule of thumb, overtime utilization typically ranges from approximately 0.0 to 1.5% for most support units; up to 2.5% for general nursing and most ancillary units; and up to 3.5% for "critical" units such as surgery, labor and delivery and ICU. Because the following departments exceed the typically observed range of overtime utilization, we recommend a review of *workload distribution and staffing and scheduling practices*.

Department	Overtime
Admitting (060)	1.63%
Dietary (045)	2.05%
Housekeeping (048)	2.38%
Maintenance (046)	2.43%
Laundry (049)	2.76%
Administration (001)	2.79%
Education (070)	2.80%
Medical Records (052)	3.27%
Nursing Administration (003)	4.80%
Medical/Surgical Nursing (005)	4.93%
Info Systems (002)	5.43%
Utilization Review (067)	6.15%
Infection Control (006)	6.70%
Emergency Room (009)	10.50%

Hours Worked to Hours Paid Ratio

In U.S. acute-care hospitals, hours worked as a percentage of paid hours generally lie in the range of 87% to 91%, hospital-wide. Typical causes of lower than expected ratios can include *call back policy*, including plans providing partial payment for non-work in critical units during periods of low utilization; an unusually *high number of long term employees in the employee population; high absenteeism; and employee benefit program design*. Conversely, departments demonstrating significantly higher than expected ratio should be scrutinized to assure that hours are being charged appropriately and that staffing patterns and scheduling practices are adequate. The following departments are listed because reported worked hours as a percent of paid hours are below the typically observed range.

Department	Work//Paid
Social Service (044)	85.74%
Nursing Administration (003)	86.04%
Laundry (049)	86.45%
Medical Staff (041)	86.57%

The following departments are listed because reported worked hours as a percent of paid hours exceed the typically observed range.

Department	Work//Paid
Housekeeping (048)	91.21%
Quality Assurance & Risk Management (068)	91.43%
General Accounting (055)	91.73%
Maintenance (046)	91.89%
Laboratory (032)	91.90%
Education (070)	92.83%
Info Systems (002)	92.83%
Admitting (060)	93.51%
Personnel (063) (includes Payroll (056)	97.91%
Cashiering (059)	99.13%
Emergency Room (009)	99.26%
Utilization Review (067)	99.49%
EEG (021)	100.00%
Specialty Clinics (038) (Annualized by extrapolation)	100.00%
Infection Control (006)	100.00%

COMPARE classifies operating departments and units as Group "A" departments if the activity-based comparison shows them to be operating with at least one FTE less than the COMPARE group mean. Classification of a department as a Group "A" department should not be construed as meaning there is no opportunity for improving effectiveness.

The following Pinckneyville Community Hospital departments are classified as Group "A" Departments.

TABLE 1. DEPARTMENTAL FTE COMPARISON (GROUP "A")

	Comparative Variances at Reported Volumes	
Departments	Over (under) Mean	Over (under) -1 SD
Medical/Surgical Nursing (005)	(4.01)	3.80
Patient Accounting (Billing Office) (057)	(3.26)	(0.40)
Nursing Administration (003)	(2.85)	(0.34)
Purchasing (065)	(2.82)	(2.23)
(Rollup)/Respiratory Therapy (015)-Cardiology Function/Respiratory Therapy (015)-Respiratory Therapy Function	(2.26)	1.54
Admitting (060)	(1.97)	(0.67)
(Rollup)/Central Service (035)/Operating Room (012)	(1.95)	0.32
Personnel (063) (includes Payroll (056)	(1.89)	(0.56)
Medical Staff (041)	(1.79)	(0.36)
EEG (021)	(1.59)	(1.31)
Administration (001)	(1.56)	(0.06)
Medical Records (052)	(1.51)	2.05
General Accounting (055)	(1.39)	0.85
Quality Assurance & Risk Management (068)	(1.25)	0.32
Specialty Clinics (038) (Annualized by extrapolation)	(1.14)	(0.80)
Group A Department Totals:	(31.25)	2.16

Departments operating at less than one FTE under or over the activity-based mean are classified as Group "B" departments and include the following. This classification does not mean there is no opportunity for improvement.

The following Pinckneyville Community Hospital departments are classified as Group "B" Departments.

TABLE 2, DEPARTMENTAL FTE COMPARISON (GROUP "B")

Departments	Comparative Variances at Reported Volumes Over (under) Mean	Over (under) -1 SD
Education (070)	(0.95)	(0.26)
Info Systems (002)	(0.85)	0.77
Utilization Review (067)	(0.82)	0.52
Maintenance (046)	(0.77)	0.98
Infection Control (006)	(0.58)	(0.14)
Physical Therapy (016)	(0.41)	1.20
Social Service (044)	(0.31)	0.51
Cashiering (059)	(0.29)	0.01
Laundry (049)	(0.17)	0.57
(Rollup)/Nuclear Medicine (022)/Imaging (018)-Diagnostic Radiology Function/Imaging (018)-Ultrasonography Function/CT (023)/Imaging (018)-Mammography Function	0.77	4.17
Group B Department Totals:	(4.37)	8.32

The Group "C" departments are those departments and units that employed at least one (1) FTE more than the projected activity-based COMPARE group mean during the period studied.

The following Pinckneyville Community Hospital departments are classified as Group "C" Departments.

TABLE 3, DEPARTMENTAL FTE COMPARISON (GROUP "C")

Departments	Comparative Variances at Reported Volumes Over (under) Mean	Over (under) -1 SD
(Rollup)/Occupational & Speech Therapy (017)-Speech Component/Occupational & Speech Therapy (017)-OT Component	1.19	1.70
(Rollup)/Rural Health Clinic Reception, Nursing, and Providers (079)/Rural Health Clinic Billing (079)	1.65	9.86
Laboratory (032)	1.86	3.71
Pharmacy (030)	1.97	3.02
Emergency Room (009)	2.02	2.75
Housekeeping (048)	3.26	5.81
Dietary (045)	3.65	6.88
Group C Department Totals:	15.60	33.72

Table 4, below, shows the salary and wage cost variance for the Group "A" Departments, based on salary and wage rates at Pinckneyville Community Hospital.

TABLE 4. DEPARTMENTAL SALARY/WAGE COST COMPARISON (GROUP "A")

Departments	Comparative Variances at Reported Volumes	
	Mean	-1 SD
Medical/Surgical Nursing (005)	($155,393.94)	$147,355.54
Nursing-Administration (003)	($149,639.05)	($17,940.60)
Administration (001)	($119,192.11)	($4,749.45)
(Rollup)/Respiratory Therapy (015)-Cardiology Function/Respiratory Therapy (015)-Respiratory Therapy Function	($108,002.61)	$73,455.48
Purchasing (065)	($91,470.60)	($72,121.36)
(Rollup)/Central Service (035)/Operating Room (012)	($83,407.28)	$13,787.21
Patient Accounting (Billing Office) (057)	($80,139.45)	($9,750.29)
General Accounting (055)	($73,124.89)	$44,629.02
EEG (021)	($69,256.88)	($56,999.33)
Personnel (063) (includes Payroll (056)	($63,553.02)	($18,724.86)
Quality Assurance & Risk Management (068)	($57,116.48)	$14,481.60
Medical Staff (041)	($55,761.62)	($11,390.27)
Specialty Clinics (038) (Annualized by extrapolation)	($53,254.98)	($37,214.91)
Admitting (060)	($43,563.92)	($14,863.81)
Medical Records (052)	($39,869.04)	$54,219.59
Group A Department Totals:	($1,242,745.86)	$104,173.57

Table 5, below, shows the salary and wage cost variance for the Group "B" Departments, based on salary and wage rates at Pinckneyville Community Hospital.

TABLE 5, DEPARTMENTAL SALARY/WAGE COST COMPARISON (GROUP "B")

Departments	Comparative Variances at Reported Volumes	
	Mean	-1 SD
Education (070)	($49,262.31)	($13,586.30)
Utilization Review (067)	($45,154.61)	$28,595.39
Info Systems (002)	($37,808.20)	$34,230.03
Maintenance (046)	($29,504.86)	$37,495.62
Infection Control (006)	($28,162.91)	($6,931.61)
Physical Therapy (016)	($17,129.69)	$49,844.65
Social Service (044)	($11,001.25)	$18,331.66
Casbiering (059)	($5,503.59)	$100.30
Laundry (049)	($4,093.01)	$13,860.46
(Rollup)/Nuclear Medicine (022)/Imeging (018)-Diagnostic Radiology Function/Imaging (018)-Ultrasonography Function/CT (023)/Imaging (018)-Mammography Function	$13,036.36	$70,298.94
Group B Department Totals:	($214,584.07)	$232,239.13

Table 6, below, shows the salary and wage cost variance for the Group "C" Departments, based on salary and wage rates at Pinckneyville Community Hospital.

TABLE 6, DEPARTMENTAL SALARY/WAGE COST COMPARISON (GROUP "C")

Departments	Comparative Variances at Reported Volumes Mean	-1 SD
(Rollup)/Occupational & Speech Therapy (017)-Speech Component/Occupational & Speech Therapy (017)-OT Component	$66,829.17	$95,132.26
Housekeeping (048)	$69,742.32	$124,182.17
Laboratory (032)	$70,775.85	$141,388.49
Dietary (045)	$82,728.12	$156,086.07
(Rollup)/Rural Health Clinic Reception, Nursing, and Providers (079)/Rural Health Clinic Billing (079)	$95,202.76	$569,242.16
Emergency Room (009)	$102,502.15	$139,513.02
Pharmacy (030)	$106,104.65	$162,179.30
Group C Department Totals:	$593,885.03	$1,387,723.46

Table 7, below, displays the total number of FTEs in departments reviewed at Pinckneyville Community Hospital and compares that number against two "virtual" hospitals. The virtual hospitals were created by projecting FTEs in all reviewed departments at the COMPARE group mean and -1 standard deviation paid-hours per unit of service at Pinckneyville Community Hospital's reported activity levels. Table 7 also reports total FTEs per Adjusted Occupied Bed in the participating departments.

TABLE 7, FTE SUMMARY, ACTUAL VS. COMPARE MEAN AND -1 STANDARD DEVIATION

Benchmarked Departments	Paid FTEs Actual	Paid FTEs Mean	Paid FTEs -1 SD
Medical/Surgical Nursing (005)	27.73	31.74	23.93
Nursing Administration (003)	2.72	5.56	3.06
Administration (001)	2.60	4.16	2.66
(Rollup)/Respiratory Therapy (015)-Cardiology Function/Respiratory Therapy (015)-Respiratory Therapy Function	5.31	7.58	3.77
Purchasing (065)	1.00	3.82	3.22
(Rollup)/Central Service (035)/Operating Room (012)	4.63	6.58	4.31
Patient Accounting (Billing Office) (057)	7.71	10.97	8.11
General Accounting (055)	2.97	4.36	2.12
EEG (021)	0.01	1.60	1.32
Personnel (063) (includes Payroll (056)	1.02	2.91	1.58
Quality Assurance & Risk Management (068)	1.62	2.88	1.31
Medical Staff (041)	0.54	2.33	0.90
Specialty Clinics (038) (Annualized by extrapolation)	1.27	2.41	2.07
Education (070)	0.75	1.70	1.01
Utilization Review (067)	1.51	2.33	0.99
Admitting (060)	3.82	5.79	4.49
Medical Records (052)	10.48	11.99	8.43
Info Systems (002)	2.09	2.94	1.33
Maintenance (046)	4.67	5.44	3.69
Infection Control (006)	0.37	0.95	0.51
Physical Therapy (016)	6.93	7.34	5.73
Social Service (044)	1.70	2.01	1.19
Cashiering (059)	0.93	1.23	0.93
Laundry (049)	3.14	3.31	2.57
(Rollup)/Nuclear Medicine (022)/Imaging (018)-Diagnostic Radiology Function/Imaging (018)-Ultrasonography Function/CT (023)/Imaging (018)-Mammography Function	9.71	8.93	5.54

(Rollup)/Occupational & Speech Therapy (017)-Speech Component/Occupational & Speech Therapy (017)-OT Component	3.93	2.74	2.23
Housekeeping (048)	11.53	8.26	5.72
Laboratory (032)	10.38	8.52	6.67
Dietary (045)	14.92	11.28	8.04
(Rollup)/Rural Health Clinic Reception, Nursing, and Providers (079)/Rural Health Clinic Billing (079)	23.81	22.17	13.95
Emergency Room (009)	6.46	4.44	3.71
Pharmacy (030)	5.48	3.51	2.47
Total FTEs:	181.75	201.38	137.56
Adjusted Average Daily Census	46.12	46.12	46.12
FTEs Per Adjusted Occupied Bed	3.94	4.38	2.98

In aggregate, Pinckneyville Community Hospital's reviewed departments employed 20.03 fewer hours-paid FTEs than would have been the case had all reviewed departments staffed at the COMPARE group mean during the review period.

Although Pinckneyville Community Hospital's total number of FTEs is 44.19 FTEs greater than would have been the case had all reviewed departments staffed at the COMPARE group -1 SD level, it should be remembered that only about 17% of departments typically come in below the -1 SD and that performing at the -1 SD is not necessarily something to be desired.

Seven departments or functional areas are operating with at least one FTE above the activity-based PROFILE mean in terms of paid hours per reported unit of service. We recommend that efforts be continued to identify factors that may be acting as barriers to optimum effectiveness, beginning in these Group "C" departments.

It should also be noted that the data provided by the hospital to Brady & Associates covered a one (1) year period. To the extent the administration and management team have taken interim actions to improve productivity, the full year effect of those actions will not be reflected in the COMPARE staffing review.To better assist you in your evaluation of the potential for productivity improvement, the balance of this report consists of departmental statistical data. Bear in mind that projected COMPARE group staffing levels shown are driven by volume. If current volumes vary significantly from those used in this review, projected staffing levels will change.

We appreciate the opportunity to be of service to Pinckneyville Community Hospital. Please contact us if you have questions about the content of this report or if we can be of additional assistance.

Brady & Associates
7667 N.W. Prairie View Road
Suite 204
Kansas City, Missouri 64151
(816) 587-2120

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

I. Performance Requirements – Not Applicable

Pinckneyville Community Hospital and the proposed replacement site for Pinckneyville Community Hospital are not located within a Metropolitan Service Area (MSA), therefore the Hospital is not required to meet the 100 bed minimum bed capacity.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

K. Assurances

Submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy/utilization standards specified in 77 Ill. Adm Code 1100 for each category of service involved in the proposal.

Pinckneyville
Community
Hospital

leading the way to a healthier tomorrow

November 16, 2009

Ms. Courtney R. Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

Pinckneyville Community Hospital District (Legal entity) and Pinckneyville Community Hospital (License holder) will attempt to achieve and maintain a bed occupancy / utilization standard of 60%, based on 25 Medical Surgical Beds, by 2014, which follows the second full operational year of the replacement hospital and also any applicable targets for ancillary services.

However, as a rural based critical access hospital, it may be difficult to achieve / maintain these targets on a regular basis. We are primarily supported by an employed medical staff but fluctuations in provider availability may impact our utilization at any given time.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize General Long Term Care must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms	# to Establish	# to Expand	# to Modernize
☒ Central Sterile Supply Department	NA	NA	NA		
☒ Diagnostic Imaging (Radiology and Nuclear Medicine)	6	6	6		
☒ Emergency Services	4	5	5		
☒ Laboratory	NA	NA	NA		
☒ Pharmacy	NA	NA	NA		
☒ Physical & Occupational Therapy (Inpatient)	1	1	1		
☒ Surgery and Recovery	2 + 6 = 8	2+ 7 = 9	2+ 7 = 9		

3. READ the applicable review criteria outlined below and SUBMIT all required information:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility

APPEND DOCUMENTATION AS INDICATED BELOW, IN NUMERIC SEQUENCIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM:

APPLICABLE REVIEW CRITERIA	Attachment Number
Need Determination - Establishment	62
Service Demand	63
Referrals from Inpatient Base	64
Physician Referrals	65
Historical Referrals to Other Providers	66
Population Incidence	67
Impact of Project on Other Area Providers	68
Utilization	69
Deteriorated Facilities	70
Necessary Expansion	71
Utilization -Major Medical Equipment	72
Utilization - Service or Facility	73

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

Introduction

The proposed replacement hospital facility will have a single category of service; namely medical surgical beds. Attachments 19 through 25 provide information in response to the applicable criterion for this category of service.

Clinical Service Areas other than Categories of Service are defined as "components of projects (including major medical equipment) concerning Clinical Service Areas (CSA's) that are not "categories of service", but for which utilization standards are listed in Appendix B".

This particular replacement hospital project has the following CSA's, by definition (see also Attachment 13 Project Scope / Size).

R.1 Central Sterile Supply

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

R.3 Emergency Services

R.4 Laboratory

R.5 Pharmacy

R.6 Physical and Occupational Therapy (Inpatient)

R.7 Surgery / Recovery

The following project components are clinical in nature but are, by definition, not considered CSA's in that there are no associated departments nor norms listed in Section 1110. Appendix B.

- Oncology infusion
- Physician offices (Rural Health Clinic, Physician Specialty Clinic, and General Surgeon office)
- Outpatient Rehabilitation
- Sleep Laboratory
- Cardio Pulmonary Diagnostics
- Pre-Admission Services

The historical and projected utilization and rates by bed category and ancillary service are shown on Attachment 62, Exhibits 1 and 2.

Pinckneyville Community Hospital Historical Utilization (Calendar Year)

Service	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Medical/Surgical										
Admissions	577	648	647	728	837	754	834	791	657	544
Patient Days*	2,315	2,306	2,173	2,447	3,093	2,979	3,169	2,891	2,454	2,153
Swing Beds [1]										
Admissions - new service 02/06/01	0	0	228	320	323	308	301	268	216	147
Patient Days*	0	0	3,428	5,193	4,794	4,593	3,806	3,282	2,430	1,775
Subtotal										
Admissions	577	648	875	1,048	1,160	1,062	1,135	1,059	873	691
Patient Days*	2,315	2,306	5,601	7,640	7,887	7,572	6,975	6,173	4,884	3,928
Emergency Visits	3,365	3,313	3,573	3,526	3,615	3,299	3,745	3,688	3,649	3,494
Hospital Admissions for ED	370	469	478	446	478	449	502	515	458	411
Laboratory Tests (AHQ totals)	40,159	59,830	29,868	45,870	52,977	58,110	68,172	67,799	68,974	64,638
Lab I/P & O/P excluding double count of ref lab tests	38,272	58,119	27,618	42,971	49,574	53,739	61,979	62,652	63,830	64,638
Surgery**										
Inpatient Case	85	78	78	84	74	64	69	69	29	34
Inpatient Hours	345	133	146	255	121	136	99	123	69	78
Outpatient Cases	305	362	449	435	425	389	421	421	437	382
Outpatient Hours	702	406	511	1,039	443	347	368	393	533	410
Total Cases	390	440	527	519	499	453	490	490	466	416
Total Hours	1,047	539	657	1,294	564	483	467	516	602	488
Diagnostic Exams										
Computerized Tomography	512	682	817	1,111	1,093	1,577	2,006	1,869	1,948	1,680
Fluoroscopy/Radiography	5,682	5,452	5,432	5,401	6,592	5,190	6,088	5,910	5,467	5,346
Mammography****	708	826	769	803	748	787	784	774	839	747
MRI	258	330	352	362	415	404	453	461	433	448
Nuclear Medicine	***	***	***	***	***	1,268	1,080	1,206	1,128	756
PET*****	0	0	0	0	0	0	0	12	16	28
Ultrasound	1,028	884	1,063	1,450	1,496	1,650	1,671	1,935	1,685	1,677

* Includes Observation Days

** Includes Gastroenterology

*** Nuclear Medicine statistics where included on the same line of the AHQ as Fluoroscopy/Radiology for reporting years 1999 - 2003.

**** Excludes Mammography CAD testing which is a separate charge for almost every mammogram but not a separate procedure for the patient. It involves running the mammogram film through the CAD to identify areas of concern.

*****Pinckneyville Hospital does not bill the patient claims for PET scans. The mobile unit pays a pad rental fee and they bill the patient claims. We just assist in coordinating scheduling.

[1] Swing bed services include Medicare Certified days from the Long-term Care Unit that were previously reported along with non-certified long-term care admits and patient days.

Source: Illinois Department of Public Health Hospital Profiles, 2001-2007; 2008 Annual Hospital Questionnaire

Pinckneyville Community Hospital High Level Medical/Surgical Bed Projection

Perry County	2015	2020	Change	Percent Change
Population Estimates				
15-44	9,500	9,587	87	0.92%
45-64	6,351	6,293	-58	-0.91%
65+	4,141	4,805	664	16.03%
Total Adult (Excludes 0-14)	19,992	20,685	693	3.47%
Derived Use Rate/1,000 Population (Based on 5-Year Average 2004-2008)				
15-44	58.46	58.46	0.00	0.00%
45-64	97.98	97.98	0.00	0.00%
65+	383.66	383.66	0.00	0.00%
Expected Total Medical Surgical Admissions				
15-44	556	561	5	0.90%
45-64	623	617	-6	-0.96%
65+	1,589	1,844	255	16.05%
Total (Exculding Peds and OB)	2,768	3,022	254	9.18%
PCH Average Market Share - Perry County	22.18%	22.18%	0.00%	--
PCH Expected Medical Surgical Admissions - Perry County Only	614	670	56	9.12%

Source: Illinois Department of Economic Opportunity; COMPdata

Pinckneyville Community Hospital High Level Medical/Surgical Bed Projection

	Actual		Projected		2007 - 2015		2015 - 2020	
	CY 2007	CY 2008	2015	2020	Change	Percent Change	Change	Percent Change
PCH Expected Total Medical Surgical Admissions								
Perry County	567	468	614	670	47	8.29%	56	9.12%
Oakdale (62268)	10	13	12	13	2	20.00%	1	8.33%
Subtotal PSA and SSA (88%)	577	481	626	683	49	8.49%	57	9.11%
Other Illinois/Out of State (12%)	80	62	86	93	6	7.50%	7	8.14%
Total Med/Surg Admissions (100%)	657	543	712	776	55	8.37%	64	8.99%
Total Expected Admissions								
Adult Medical/Surgical (74%)	657	543	712	776	55	8.37%	64	8.99%
Swing Beds (26%)	216	237	250	273	34	15.74%	23	9.20%
Total Admissions (100%)	873	780	962	1,049	89	10.19%	87	9.04%
Expected Patient Days								
Med/Surg @ 3.79 ALOS*	2,454	1,619	2,698	2,941	244	9.94%	243	9.01%
Swing Patients @ 12.76 ALOS	2,430	1,775	3,190	3,483	760	31.28%	293	9.18%
Total Days	4,884	3,394	5,888	6,424	1,004	20.56%	536	9.10%
Average Daily Census	13.38	9.30	16.13	17.60	2.75	20.56%	1.47	9.10%
Beds @ 60% Occupancy	23	16	27	29	4	17.39%	2	7.41%
Beds @ 70% Occupancy	20	14	23	25	3	15.00%	2	8.70%

*Includes Observation Days
Source: 2004-2007 Hospital Data

Pinckneyville Community Hospital High Level Ancillary Services
Utilization Rates / Medical Surgical Admission

Ancillary Service	Low (10-Year Historical Low)	Expected Range: Probable (10-Year Historical Average)	Expected Range: High (10-Year Historical Peak)
Emergency Department	4.40	4.94	6.41
Surgery Cases	0.58	0.67	0.81
Laboratory Tests	56.86	79.43	111.32
Radiology	6.26	7.97	13.44
Magnetic Resonance Imaging	0.45	0.59	0.68
Computerized Tomography	1.05	2.48	2.91
Nuclear Medicine	0.99	1.45	1.56
Ultrasound	1.41	2.40	2.60
Mammography	0.96	2.04	2.36
Physical Therapy/Work Hardenin	6.84	11.26	13.02
Occupational Therapy	3.30	6.60	7.62
Speech Therapy	0.34	0.80	1.37
Oncology	2.19	4.37	5.38
Pharmacy	64.19	95.44	118.83
Respiratory Therapy	6.02	11.15	12.19
EEG's	0.02	0.03	0.05
EKG's	1.78	2.70	3.44
Cardio-Pulmonary Rehabilitation*	0.07	0.69	2.82
Sleep Studies	0.04	0.12	0.14

*to be verified
Source: Hospital Data

Pinckneyville Community Hospital High Level Ancillary Services
2015 Projected Utilization

Ancillary Service	Expected Range			Actual	
	Low (10-Year Historical Low)	Probable (10-Year Historical Average)	High (10-Year Historical Peak)	FY 2007	FY 2008
Emergency Department	3,133	3,517	4,564	3,653	3,622
Surgery Cases	413	477	577	462	453
Laboratory Tests	40,484	56,554	79,260	62,667	62,897
Radiology	4,457	5,675	9,569	5,919	4,917
Magnetic Resonance Imaging	320	420	484	464	387
Computerized Tomography	748	1,766	2,072	1,934	1,642
Nuclear Medicine	705	1,032	1,111	1,217	882
Ultrasound	1,004	1,709	1,851	1,970	1,467
Mammography	684	1,452	1,680	1,346	1,332
Physical Therapy/Work Hardening	4,870	8,017	9,270	8,082	7,365
Occupational Therapy	2,350	4,699	5,425	5,349	4,307
Speech Therapy	242	570	975	632	773
Oncology	1,559	3,111	3,831	2,661	3,041
Pharmacy	45,703	67,953	84,607	64,813	67,138
Respiratory Therapy	4,286	7,939	8,679	8,415	6,260
EEG's	14	21	36	15	15
EKG's	1,267	1,922	2,449	2,020	1,943
Cardio-Pulmonary Rehabilitation	50	491	2,008	78	40
Sleep Studies	28	85	100	51	81

Source: Hospital Data; Hospital Profiles

Pinckneyville Community Hospital High Level Ancillary Services
2020 Projected Utilization

Ancillary Service	Expected Range			Actual	
	Low (10-Year Historical Low)	Probable (10-Year Historical Average)	High (10-Year Historical Peak)	FY 2007	FY 2008
Emergency Department	3,414	3,833	4,974	3,653	3,622
Surgery Cases	450	520	629	462	453
Laboratory Tests	44,123	61,638	86,384	62,667	62,897
Radiology	4,858	6,185	10,429	5,919	4,917
Magnetic Resonance Imaging	349	458	528	464	387
Computerized Tomography	815	1,924	2,258	1,934	1,642
Nuclear Medicine	768	1,125	1,211	1,217	882
Ultrasound	1,094	1,862	2,018	1,970	1,467
Mammography	745	1,583	1,831	1,346	1,332
Physical Therapy/Work Hardenin	5,308	8,738	10,104	8,082	7,365
Occupational Therapy	2,561	5,122	5,913	5,349	4,307
Speech Therapy	264	621	1,063	632	773
Oncology	1,699	3,391	4,175	2,661	3,041
Pharmacy	49,811	74,061	92,212	64,813	67,138
Respiratory Therapy	4,672	8,652	9,459	8,415	6,260
EEG's	16	23	39	15	15
EKG's	1,381	2,095	2,669	2,020	1,943
Cardio-Pulmonary Rehabilitation	54	535	2,188	78	40
Sleep Studies	31	93	109	51	81

Source: Hospital Data; Hospital Profiles

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Need Determination

Pinckneyville Community Hospital has been designated a necessary provider of services by IDPH. Hence, there is a need for a local hospital with those services required for licensure.

The Hospital provides surgical services, thus a central sterile supply department is necessary to process instruments and related surgical supplies, not only for surgery, but also for other hospital departments like emergency.

The technical review criterion pertaining to market based incidence rates and strategic plans do not apply to this ancillary support service designated by State Agency rules as a CSA.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Service Demand

Demand for central supply services is directly related to surgical and procedural cases requiring reprocessed instruments and/or supplies.

The technical review criterion based on referrals dos not apply to this internal ancillary support service designated as a CSA by State Agency rules.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Referrals from Inpatient Base

Not applicable; see Attachment 63, Service Demand narrative.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Physician Referrals

Not applicable; see Attachment 63, Service Demand narrative

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Historical Referrals to Other Providers

Not applicable; see Attachment 63, Service Demand narrative. This CSA as defined by State Agency criterion is an internal support department.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Population Incidence

Not applicable; see Attachment 63, Service Demand narrative.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Impact of the Proposed Project on Other Area Providers

Not applicable; this is an internal Hospital support service.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.1 Central Sterile Supply

Utilization

Utilization will be determined by surgical suite cases, applicable emergency department cases, and those Hospital departments requiring reprocessed instruments and supplies.

R.1 Central Sterile Supply

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Need Determination

Diagnostic Imaging is an internal component of a hospital. As a necessary provider of health services, Pinckneyville Community Hospital requires these services. Projected utilization was based on 10-year historical use rate ratios benchmarked on inpatient admissions.
(See Attachment 62, Need Analysis)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Service Demand

Diagnostic Imaging is an adjunct service to both inpatients and outpatients. The projected utilization, based on historical use rates derived based on inpatient admissions, is as follows: (See also Attachment 62, Need)

	Mid Range Estimates (Procedures)	
Modality	2015	2050
Radiology	7,622	8,307
MRI	452	493
CT	1,919	2,091
Nuclear	1,072	1,168
Ultrasound	1,780	1,940
Mammography	1,566	1,707
Total	14,411	15,706

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Referrals from Inpatient Base

See Attachment 63 for associated projections methodology.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Physician Referrals

See Attachment 63, the projections methodology, which accounts for physician referrals.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Historical Referrals to Other Providers

Not applicable, data not available.

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Population Incidence

The projection methodology inherently accounts for population incidence rates as expressed by admissions per 1,000 population and the associated diagnostic imaging procedure rates derived from admissions and their respective / derived utilization by modality as profiled in Attachment 62, Need.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Impact of the Proposed Project on Other Area Providers

No impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Utilization

The following compares projected 2015 utilization to Appendix B norms.

Modality	State Norm	Projected Utilization	Rooms Justified
Radiology	6,500 proc / room	7,622	2
MRI	2,000 visits / MRI	452	1
CT	2,000 visits / room	1,919	1
Nuclear	2,000 visits / unit	1,072	1
Ultrasound	2,000 visits / room	1,780	1
Mammography	2,000 visits / unit	1,566	1
Total		14,411	7

The design provides for 6 major imaging rooms. Ultrasound will be performed on a mobile basis and in available exam rooms.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.2 Diagnostic Imaging (Radiology and Nuclear Medicine)

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

R.3 Emergency Services

Need Determination

Emergency Services are an integral part of a hospital. As a necessary provider of health services, Pinckneyville Community Hospital is required to provide this service. Projected utilization was based both on locally derived use rates approximating 175 ED visits / 1,000 population to the Hospital in 2008 and a ratio of ED visits to hospital admissions which ranged from 4.94 to 6.41 over the most recent 10 year period (see Attachment 62, Need); projected mid range estimates for the ED are 4,041 visits in 2015 and 4,403 visits in 2020. Utilization was 3,494 visits in 2008, of which 411 or approximately 12% were admitted to the Hospital.

R.3 Emergency Services

Service Demand

Emergency Services are required to be provided for licensure. Data herein documents the historical utilization which ranges from 3,365 visits in 1999 to 3,494 in 2008. Mid-range projections for 2015 are 4,040 visits and for 2020, 4,403 visits; see also Attachment 62, Emergency Service need determination factors.

R.3 Emergency Services

Referrals from Inpatient Base

Not applicable; the ED refers internally to the inpatient beds. The ED is a prime access point for inpatient services. In 2008, approximately 12% or 411 inpatient admissions emanated from the ED (Hospital Profiles data).

R.3 Emergency Services

Physician Referrals

Patients typically self-refer to an emergency department (ED) for emergency services; thus, referral letters are not applicable in this case. Ambulance transports typically account for 8 to 12% of the visits to an ED.

R.3 Emergency Services

Historical Referrals to Other Providers

Data not available; based on a "typical" use rate of 340 to 390 ED visits / 1,000 population, the Hospital's actual derived experience of 175 ED visits / 1,000 population within its service area indicates, at minimum, 165 pts / 1,000 population are seeking emergency services elsewhere or the local use rate is low which would not be expected given he proportionately higher 65 and over population..

R.3 Emergency Services

Population Incidence

The local use rate for ED services, as derived from Hospital data and service area population estimates is 175 ED visits / 1,000 population to Pinckneyville Community Hospital. This does not account for out migration which would raise the local incidence rate.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.3 Emergency Services

Impact of the Proposed Project on Other Area Providers

No impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.3 Emergency Services

Utilization

The following compares the projected utilization to Appendix B norms.

Year	Emergency Department Estimated Visits	State Norm	Rooms Justified
2015	3,517 – 4,564	2,000 visits / room	2 - 3
2020	3,833 – 4,974	2,000 visits / room	2 - 3

Currently, the department has 4 rooms, which, at peak times, are fully utilized. Five (5) rooms are proposed in the replacement facility to provide for peak services and also respond to local disaster preparedness. CAH's have wide swings in utilization which require space which exceed State norms due, in part, to their smaller bed size and market use characteristics.

R.3 Emergency Services

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.4 Laboratory

Need Determination

Pinckneyville Community Hospital has been designated a necessary provider of services by IDPH. Hence, there is a demonstrable need for a local hospital. Laboratory services are required for licensure.

Technical review criteria pertaining to market incidence rates do not apply to this required ancillary support service designated by State Agency criterion as a CSA.

R.4 Laboratory

Service Demand

Mid-range projections for laboratory services based on use rates derived from 10-year historical ratios to inpatient admissions are:

Year	Tests
2015	67,902
2020	74,011

Laboratory tests were 64,638 in 2008.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.4 Laboratory

Referrals from Inpatient Base

Laboratory services are an adjunct to inpatient and outpatient services. 10-year historical utilization is profiled in Attachment 62 (Need).

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.4 Laboratory

Physician Referrals

Not applicable; laboratory services are related to inpatient and outpatient utilization.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.4 Laboratory

Historical Referrals to Other Providers

Not applicable, data not available for general tests; send-out or referral laboratory studies are less than 5% of the current procedure volume.

R.4 Laboratory

Population Incidence

Not applicable.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.4 Laboratory

Impact of the Proposed Project on Other Area Providers

No impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.4 Laboratory

Utilization

Appendix B does not have a utilization standard for laboratory services. The guideline is based on FTE's. The project allocates 2,173 gsf to the laboratory department. 10.59 FTE are proposed to staff this area. Based on the State Agency norm of 225 gsf / FTE, 2,383 gsf is allowable. The allocated space is 210 gsf below the standard.

R.4 Laboratory

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

R.5 Pharmacy

Need Determination

Pinckneyville Community Hospital has been designated a necessary provider of services by IDPH. Hence, there is a demonstrable need for a local hospital. Pharmacy services are required for licensure.

Technical review criteria pertaining to market incidence rates do not apply to this required ancillary support service designated by State Agency criterion as a CSA.

R.5 Pharmacy

Service Demand

Pharmacy services support inpatient and outpatient care as an adjunct / supportive service. Service demand projections are based on historical utilization analysis expressed as a ratio of prescriptions to inpatient admissions. The anticipated demand, based on this 10-year historical analysis, is:

Year	Prescriptions
2015	67,953 – 84,607
2020	74,061 – 92,212

For comparison purposes, there were 64,638 prescriptions filled in 2008.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.5 Pharmacy

Referrals from Inpatient Base

Pharmacy services are an adjunct to inpatient and outpatient services. 10-year historical utilization is profiled in Attachment 62 (Need).

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.5 Pharmacy

Physician Referrals

Not applicable; this is a support department.

R.5 Pharmacy

Historical Referrals to Other Providers

Not applicable

R.5 Pharmacy

Population Incidence

Not applicable

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.5 Pharmacy

Impact of the Proposed Project on Other Area Providers

No impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.5 Pharmacy

Utilization

Appendix B standards are based on 12 gsf / bed and not a service volume / utilization norm.

1,351 gsf are proposed for this department. 300 gsf is allowable based on the current standard of 12 gsf / bed. Again, according to the AIA guidelines, space for receiving, break-down, inventory, drug storage, IV prep, compounding, dispensing, and records must be provided. Compliance with Federal Standard 729 is also required. The current State standard does not allow sufficient area to comply with necessary requirements and the new State standards do not have guidelines for pharmacy.

R.5 Pharmacy

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.6 Physical and Occupational Therapy (Inpatient)

Need Determination

Pinckneyville Community Hospital has been designated a necessary provider of services by IDPH. Hence, there is a demonstrable need for a local hospital. Physical and occupational therapy services are required for adequate inpatient care services and for licensure.

Technical review criteria pertaining to market incidence rates do not apply to this required ancillary support service designated by State Agency criterion as a CSA.

R.6 Physical and Occupational Therapy (Inpatient)

Service Demand

Inpatient PT/OT services account for approximately 10% of the department's utilization. The projections, derived from 10-year historical utilization analysis with ratios expressed as rates per inpatient admission projects the future volume to be:

	Estimated Procedures	
Service	2015	2020
PT	802 - 927	874 – 1,010
OT	470 – 542	512 – 591
Speech	57 - 98	62 – 106
Total / Range	1,329 – 1,567	1,448 – 1,707

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.6 Physical and Occupational Therapy (Inpatient)

Referrals from Inpatient Base

PT / OT services are an adjunct to inpatient services; see Attachment 63 for estimated volumes.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.6 Physical and Occupational Therapy (Inpatient)

Physician Referrals

Department procedures are based on physician orders emanating from hospital admissions.

R.6 Physical and Occupational Therapy (Inpatient)

Historical Referrals to Other Providers

Not applicable.

R.6 Physical and Occupational Therapy (Inpatient)

Population Incidence

Not applicable.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.6 Physical and Occupational Therapy (Inpatient)

Impact of the Proposed Project on Other Area Providers

Not applicable; no impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.6 Physical and Occupational Therapy (Inpatient)

Utilization

Two multi-use rooms are proposed for this necessary service. They will operate as a single function or one combined functional area.

1,209 gsf is allocated to this department. Current State Agency Standards allow 27.3 total gsf / bed or 682 gsf for this clinical function. There is no proposed future standard for this area. Additional space (527 gsf) is justified by the fact Pinckneyville Hospital's elderly patient population utilizes this critical ancillary support area proportionately greater than a younger population thereby necessitating additional space to provide the clinical service.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.6 Physical and Occupational Therapy (Inpatient)

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

R.7 Surgery / Recovery

Need Determination

Surgical services comprising operating rooms, procedure rooms, pre and post surgical patient holding and recovery space comprise a typical "surgery suite" in a CAH hospital setting. Surgical services are an integral component of a hospital providing for both emergency and elective surgery and procedure cases. Surgical services are required for hospital licensure. Hence, given that the Hospital has been deemed a necessary provider of health services by IDPH, one purpose for surgical services is to provide care to planning area residents.

R.7 Surgery / Recovery

Service Demand

Documentation herein profiles 10-years of surgical utilization by inpatient / outpatient and hours / case. Data from 2008 indicates:

	Cases	Hours	Hours / Case
Inpatient	34	78	2.29
Outpatient	382	410	1.07
Total / Average	416	488	1.17

Projected cases based on an analysis of the 10-year historical and projected ratios of cases to inpatient admissions are:

	Estimated	
Year	Total Cases	Total Hours
2015	477 – 577	588 - 675
2020	520 - 629	608 - 736

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.7 Surgery / Recovery

Referrals from Inpatient Base

Historical utilization is profiled in Attachment 62, Exhibit 1, Page 233.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.7 Surgery / Recovery

Physician Referrals

See Attachment 20 for physician referral attestations.

R.7 Surgery / Recovery

Historical Referrals to Other Providers

Not applicable; data is not available. However, the expected total surgical cases / 1,000 population averages 90-100. In a separate analysis of COMPdata for the 12 month period April 2008 – March 2009, there were 9,580 surgical cases in the Hospital's service area. Extrapolating from this data, the service area generated approximately 9,160 surgical cases referrals to other providers (assuming Pinckneyville had 416 cases in 2008).

R.7 Surgery / Recovery

Population Incidence

According to 2008 AHA data, there were approximately 32.1 inpatient surgeries / 1,000 population and 56.3 hospital-based outpatient surgeries / 1,000 population in Illinois or a total 88.4 hospital-based surgical cases. Comparable data has not been published by IDPH.

Regardless, the Hospital's specific incidence rate, Attachment 66, is less by comparison due to its relatively small case load.

SECTION VIII. – R. Clinical Service Areas (CSA's)

R.7 Surgery / Recovery

Impact of the Proposed Project on Other Area Providers

No impact is expected. The project proposes to replace an existing CAH with no change in categories of service nor adjunct ancillary services.

R.7 Surgery / Recovery

Utilization

Appendix B norms for surgery and associated recovery area allow for 2,078 gsf / room and 1,500 procedure hours; maximum recovery beds are 4 / room at 180 gsf each.

The current and proposed procedures and hours justify 1 operating room which leaves no backup capacity.

6,661 gsf are proposed for this integrated surgical program which also supports endoscopy. Two operating / procedure and 7 total prep / recovery and PACU beds are proposed. 5,596 gsf is allowable under the current guidelines and 7,820 under the proposed new standards assuming 2 OR / procedure rooms and 4 prep / recovery beds / room. Hence the space allocation is below proposed standards and above the current. Two OR / procedure rooms are proposed to provide both a "sterile" and "clean" environment for surgical vs. procedural cases and also back-up for surgical capabilities, if one room is being utilized or shut down for maintenance purposes. Two operating / procedure rooms with associated recovery support are above the State norm, but justifiable by peak use and disaster preparedness factors.

R.7 Surgery / Recovery

Deteriorated Facilities

Please reference the discontinuation narrative and infrastructure analysis, Attachment 9, which delineates deteriorated facilities considerations leading to the District / Hospital Board decision to seek State Agency approval to develop a Replacement Hospital on a new site within the city of Pinckneyville.

Section 1120 Introduction

Pinckneyville Community Hospital District d.b.a. Pinckneyville Community Hospital is a Critical Access Hospital (CAH) deemed a necessary provider of health services by IDPH.

Multiple analyses have been completed demonstrating the market necessity and feasibility of replacing the Hospital on a new campus 1.8 miles east of the existing site.

Project financing is expected to occur utilizing a bond issue with an associated HUD 242 mortgage insurance commitment. The HUD process requires a valid CON to go forward and project feasibility is dependent on HUD mortgage insurance. HUD has previously indicated insurance can be secured if there is a viable project (see attached letter). Both a valid CON and HUD mortgage insurance commitment are necessary for a viable project.

This situation poses a dilemma which must be resolved in the CON permitting process. State Agency staff recommended submitting the required replacement hospital Permit Application including the draft financial feasibility analysis and HUD invitation letters as essential documentation necessary to resolve this timing conundrum ... HUD 242 insurance is necessary to demonstrate financial feasibility yet a CON permit is required to secure the required HUD commitment.

We look forward to working with the State Agency to resolve this dilemma and trust the project can be approved by the State Agency in order to then secure the required HUD commitment.

The draft Financial Forecast (feasibility study) prepared by McGladrey & Pullen is included in Attachment 75 along with the Hospital's audited financial standards for the periods FY 2006 through FY 2009.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-8000

JUL 9 2009

OFFICE OF HOUSING

Mr. E. Timothy King
Vice President
BMO Capital Markets GKST Inc.
233 South Wacker Drive, Suite 300
Chicago, IL 60606

Re: Pinckneyville Community Hospital District
Pinckneyville, Illinois

Dear Mr. King:

Our staff has reviewed the list of preliminary information you have submitted and conducted a pre-application meeting. At this stage, if we have reason to believe an application would be rejected, we inform the applicant in order to avoid any unnecessary expenditure of time and money. Our staff thinks the subject proposal worthy of further study and consideration should you decide to submit an application for a commitment for mortgage insurance.

As advised at the pre-application meeting, to provide you and the project architect with assistance in the development of a proposal that meets HUD standards, maintain contact with Nicholas D'Antona, of our Division of Architects and Engineers, to discuss the design of the proposal. In addition, he is to be consulted regularly during the development of the plans and specifications of the project so that as few problems occur as possible at subsequent stages of processing.

You have received a copy of the Applicant's Guide for hospital mortgage insurance under Section 242 of the National Housing Act. A fee of $1.50 per $1000.00 of requested mortgage must accompany your application. In addition, schematic drawings and outline specifications, an American Society of Testing Materials Phase I Environmental Assessment and State Historic Preservation Approval must be included as part of the application.

It is important to understand that this letter is not to be construed as a commitment on the part of HUD to insure a mortgage for your proposal. It should be understood that this letter places upon you the responsibility to develop a viable project. The conclusions recited above do not reflect any cost estimates, operating expense estimates, credit, or financial analysis. These determinations will be made upon receipt of your application. Please be advised that if HUD does not receive a complete application within one year following the date of this letter, another Preliminary Review may be required, at HUD's discretion, before the application process may proceed.

Sincerely,

Charles Y. Davis, Ph.D., FACHE
Director of Operations/Asset Management Officer
Office of Insured Health Care Facilities

cc: Roger E. Miller, HUD/OIHCF
Joe B. Nathan III, HUD/OIHCF

SECTION IX. Financial Feasibility

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

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assuming applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No ☒.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2007	FY 2008	FY 2009	FY 2013
Current Ratio	3.45	4.60	4.33	2.43
Net Margin Percentage	4.75%	- 0.29%	0.27%	0.14%
Percent Debt to Total Capitalization	11.28%	8.94%	8.07%	78.63%
Projected Debt Service Coverage	4.40	3.14	5.23	1.16
Days Cash on Hand	140.82	161.86	155.65	79.27
Cushion Ratio	16.93	26.99	45.05	1.27

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

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)
(continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

$ 5,699,405 Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

$40,925,000 Debt Financing (indicate type(s)Bond Issue associated with HUD mortgage guarantee)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations
Provide a copy of the appropriation act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

$ _____ Other Funds and Sources – Debt Service Reserve Fund
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

$46,624,405 TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☒ No ☐. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

Start-up costs are estimated at $250,000 and include such costs as select equipment relocation expenses, moving expenses, patient transportation costs, etc. Sufficient cash resources are available to fund this operating expense (see financial feasibility analysis and attached financial statement for details).

PINCKNEYVILLE COMMUNITY HOSPITAL
Viability Ratios, Attachment 75

	Audited Statements			Financial Forecast	
	4/30/2007	4/30/2008	4/30/2009	4/30/2013	4/30/2015
Current Ratio					
Total Current Assets	$ 6,568,562	$ 6,601,935	$ 6,835,054	$ 8,741,829	$ 8,674,935
Total Current Liabilities	$ 1,906,111	$ 1,434,163	$ 1,580,079	$ 3,590,713	$ 3,734,008
Current Ratio	3.45	4.60	4.33	2.43	2.32
Net Margin Percentage					
Change in net assets from continuing operations	$ 937,937	$ (50,661)	$ 48,950	$ 34,606	$ 854,506
Total operating income	$ 19,746,642	$ 17,249,312	$ 17,956,197	$ 24,342,933	$ 27,216,300
Net Margin Percentage	4.75%	-0.29%	0.27%	0.14%	3.14%
Percent Debt to Total Capitalization					
Current maturities of long-term debt	$ 206,029	$ 120,000	$ 130,000	$ 1,093,000	$ 1,087,000
Long-term debt, less current maturities	$ 1,184,000	$ 1,064,000	$ 943,000	$ 39,404,000	$ 37,175,000
	$ 1,390,029	$ 1,184,000	$ 1,073,000	$ 40,497,000	$ 38,262,000
Total long-term debt	$ 1,390,029	$ 1,184,000	$ 1,073,000	$ 40,497,000	$ 38,262,000
Invested in capital assets, net of related debt	$ 2,187,400	$ 2,646,319	$ 3,498,628	$ 2,304,660	$ 1,771,250
Unrestricted net assets	$ 8,747,203	$ 9,415,655	$ 8,726,640	$ 8,703,286	$ 8,941,974
	$ 12,324,632	$ 13,245,974	$ 13,298,268	$ 51,504,946	$ 48,975,224
Percent Debt to Total Capitalization	11.28%	8.94%	8.07%	78.63%	78.13%
Projected Debt Service Coverage					
Change in net assets from continuing operations	$ 937,937	$ (50,661)	$ 48,950	$ 34,606	$ 854,506
Depreciation	$ 837,478	$ 858,327	$ 771,573	$ 1,596,705	$ 1,646,705
Interest and amortization	$ 88,067	$ 75,250	$ 56,555	$ 3,104,599	$ 2,955,552
	$ 1,863,482	$ 882,916	$ 877,078	$ 4,735,910	$ 5,456,763
Principal paid on long-term debt	$ 335,320	$ 206,209	$ 111,000	$ 1,036,000	$ 1,142,000
Interest	$ 88,067	$ 75,250	$ 56,555	$ 3,057,541	$ 2,905,752
	$ 423,387	$ 281,459	$ 167,555	$ 4,093,541	$ 4,047,752
Projected Debt Service Coverage	4.40	3.14	5.23	1.16	1.35
Days Cash on Hand					
Cash	$ 930,810	$ 903,149	$ 2,330,819	$ 700,000	$ 700,000
Short-term cash and investments	$ 1,522,127	$ 2,045,295	$ 1,337,576	$ 3,258,161	$ 2,742,387
Board designated instruments	$ 4,716,895	$ 4,647,564	$ 3,880,039	$ 1,260,244	$ 1,860,244
	$ 7,169,832	$ 7,596,008	$ 7,548,434	$ 5,218,405	$ 5,302,631
Operating expense	$ 19,420,948	$ 17,987,747	$ 18,473,126	$ 25,625,843	$ 27,639,631
Depreciation	$ (837,478)	$ (858,327)	$ (771,573)	$ (1,596,705)	$ (1,646,705)
	$ 18,583,470	$ 17,129,420	$ 17,701,553	$ 24,029,138	$ 25,992,926
Days	365	365	365	365	365
	$ 50,914	$ 46,930	$ 48,497	$ 65,833	$ 71,213
Days Cash on Hand	140.82	161.86	155.65	79.27	74.46
Cushion Ratio					
Cash	$ 930,810	$ 903,149	$ 2,330,819	$ 700,000	$ 700,000
Short-term cash and investments	$ 1,522,127	$ 2,045,295	$ 1,337,576	$ 3,258,161	$ 2,742,387
Board designated instruments	$ 4,716,895	$ 4,647,564	$ 3,880,039	$ 1,260,244	$ 1,860,244
	$ 7,169,832	$ 7,596,008	$ 7,548,434	$ 5,218,405	$ 5,302,631
Maximum annual debt service	$ 423,387	$ 281,459	$ 167,555	$ 4,093,541	$ 4,047,752
Cushion Ratio	16.93	26.99	45.05	1.27	1.31

Source: Hospital Audited Financials; Feasibility Analysis

McGladrey & Pullen
Certified Public Accountants

Pinckneyville Community Hospital District

Financial Forecast Related to the Proposed Hospital Construction and Replacement Program

Contents

McGladrey & Pullen
Certified Public Accountants

Independent Accountant's Report

Pinckneyville Community Hospital District

We have examined the accompanying forecasted schedule of debt service coverage and other ratios, statements of revenues, expenses and changes in net assets, statements of cash flows and balance sheets of Pinckneyville Community Hospital District as of April 30, 2010 and the six years ending April 30, 2010 through April 30, 2015. Pinckneyville Community Hospital District's management is responsible for the forecast. Our responsibility is to express an opinion on the forecast based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included such procedures as we considered necessary to evaluate both the assumptions used by management and the preparation and presentation of the forecast. We believe that our examination provides a reasonable basis for our opinion.

The forecast presents the estimated cost of constructing and equipping an approximately 103,000 square-foot replacement Critical Access Hospital (CAH) and attached rural health clinic. The forecasted construction costs were estimated by the construction manager based on a preliminary architectural design and specifications. The Hospital has not yet received a guaranteed maximum price contract from the construction manager as the final drawings and specifications are not yet complete and the construction manager has not yet begun the bidding process for subcontractors. The Hospital intends to enter into a guaranteed maximum price contract with the construction manager. If the contract is entered into at a price that exceeds the forecasted cost, the source of funds required to fund the project would increase and there is no guarantee that such funds would be available to the Hospital. In addition, the Hospital has not yet received the Certificate of Need approval from the Illinois Health Facilities Planning Board. The construction project cannot go forward without this approval.

Legislation and regulation at all levels of government have affected and may continue to affect the revenue and expenses of the Hospital. Health care reform is a subject of great national debate. This debate may lead to a variety of changes having an effect on the short-term and long-term operations and financial results of health care organizations. The scope of the elements under debate is far-reaching and comprehensive. While the President and congressional leaders are committed to enacting health care reform, this commitment will require a significant amount of consensus. Consequently, the composition of what will ultimately be legislated is unknown. The financial forecast has been made considering legislation currently in effect. If new legislation related to the Hospital's operations is subsequently enacted, this legislation could have a material effect on future operations.

The interest rates, principal payments, the hospital construction and replacement program, and other financial assumptions are described in the section entitled "Summary of Significant Accounting Policies and Forecast Assumptions." If actual interest rates, principal payments and funding requirements are different from those assumed in this study, the amount of the bonds and debt service requirements would require adjustments. If such interest rates, principal payments and funding requirements are lower than those assumed in this study, then such adjustments would not adversely affect the forecast.

In our opinion, the accompanying forecast is presented in conformity with guidelines for presentation of a financial forecast established by the American Institute of Certified Public Accountants, and the underlying assumptions provide a reasonable basis for management's forecast and indicates that sufficient funds could be generated to meet the Hospital's operating expenses, working capital needs and other financial requirements, including the debt service requirements associated with the proposed financing, during the forecast period. However, there will usually be differences between the forecasted and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material. We have no responsibility to update this report for events and circumstances occurring after the date of this report.

We have compiled Note 6, "Recast of historical statements of revenues and expenses" and the historical information in the accompanying CAH Fast Tables presented in the Appendix, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. A compilation is limited to presenting information that is the representation of management. We have not audited or reviewed the historical information in Note 6 and the Appendix and, accordingly, do not express an opinion or any other form of assurance on them.

We have compiled the forecasted information in the accompanying CAH Fast Tables presented in the Appendix, forecasted in accordance with the Attestation Standards established by the American Institute of Certified Public Accountants. A compilation is limited to presenting forecasted information that is the representation of management and does not include evaluation of the support for the assumptions underlying the forecasted information. We have not examined this forecasted information and, accordingly, do not express an opinion or any other form of assurance on the forecast or assumptions.

Springfield, Illinois
November 18, 2009

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT

FORECASTED DEBT SERVICE COVERAGE RATIO
Years ended April 30, 2010 through 2015

	Projected					
	2010	2011	2012	2013	2014	2015
Debt service coverage:						
Change in net assets	$ (27,747)	$ 438,081	$ (782,396)	$ 34,608	$ 328,884	$ 854,506
Add back:						
Loss on disposal of existing building	-	-	-	-	-	-
Interest expense	41,011	34,843	2,074,113	3,046,666	2,972,057	2,893,752
Depreciation and amortization	1,147,631	1,172,631	1,394,002	1,654,638	1,681,569	1,708,505
Other sources:						
Debt service provided by bond proceeds	-	755,516	1,082,650	-	-	-
Net income and other sources available for debt service	$ 1,160,895	$ 2,401,070	$ 3,768,367	$ 4,735,909	$ 4,980,641	$ 5,456,763
Annual debt service requirements - bonds:						
Principal	-	-	-	870,000	915,000	960,000
Interest	-	755,516	2,617,338	3,036,751	2,969,813	2,899,500
Total annual debt service payments - bonds	$ -	$ 755,516	$ 2,617,338	$ 3,906,751	$ 3,884,813	$ 3,859,500
Number times debt service covered-bonds	NA	3.18	1.44	1.21	1.28	1.41
Annual debt service requirements - total debt:						
Principal	130,000	160,000	475,000	1,035,000	1,093,000	1,142,000
Interest	41,011	790,359	2,045,200	3,057,641	2,983,505	2,905,752
Total annual debt service payments - total	$ 171,011	$ 950,359	$ 2,520,200	$ 4,093,641	$ 4,076,505	$ 4,047,752
Number times debt service covered-total debt	6.79	2.53	1.34	1.16	1.22	1.35
Days unrestricted cash and equivalents and funded depreciation on hand:						
Cash and cash equivalents	$ 3,898,316	$ 4,690,427	$ 4,638,806	$ 3,958,161	$ 3,469,110	$ 3,442,387
Funded depreciation	3,091,073	850,244	960,244	1,260,244	1,560,244	1,860,244
Cash and cash equivalents and funded depreciation	$ 6,989,389	$ 5,540,671	$ 5,599,050	$ 5,218,405	$ 5,029,354	$ 5,302,631
Total expenses	$ 18,977,785	$ 19,835,219	$ 24,008,030	$ 25,625,843	$ 26,608,833	$ 27,639,631
Less: Depreciation and amortization	(1,147,631)	(1,172,631)	(1,394,002)	(1,654,638)	(1,681,589)	(1,708,505)
Operating expenses	$ 17,830,154	$ 18,702,601	$ 22,614,028	$ 23,971,205	$ 24,927,244	$ 25,931,126
Days unrestricted cash and equivalents and funded depreciation on hand	143	108	84	79	74	75

See Summary of Significant Accounting Policies and Forecast Assumptions.

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT

FORECASTED STATEMENTS OF REVENUE, EXPENSES, AND CHANGES IN NET ASSETS
Years ended April 30, 2010 through 2015

	Projected					
	2010	2011	2012	2013	2014	2015
Operating revenue:						
Net patient service revenue	$ 18,482,225	$ 19,647,375	$ 21,867,286	$ 24,150,715	$ 25,447,346	$ 27,024,082
Other operating revenue, other than tax revenue	192,218	192,218	192,218	192,218	192,218	192,218
Total operating revenue other than tax revenue	18,674,443	19,839,593	22,059,504	24,342,933	25,639,564	27,216,300
Operating expenses:						
Salaries	7,972,706	8,251,751	8,884,339	9,328,556	9,794,983	10,284,733
Employee benefits	2,391,812	2,475,525	2,665,302	2,798,567	2,938,495	3,085,420
Specialist fees	1,356,097	1,423,902	1,495,097	1,569,852	1,648,344	1,730,762
Supplies and minor equipment	1,109,275	1,164,738	1,222,975	1,284,124	1,348,330	1,415,747
Repairs and service	516,140	541,947	569,044	597,496	627,371	658,740
Utilities and telephone	314,820	330,561	347,090	364,444	382,666	401,800
Drugs	2,137,884	2,244,757	2,356,995	2,474,845	2,598,587	2,728,516
Purchased service	878,675	923,659	969,842	1,018,334	1,069,251	1,122,713
Training, dues, travel, recruitment	221,410	232,481	244,105	256,310	269,126	282,582
Marketing	88,827	93,268	97,932	102,828	107,970	113,368
Rent and leases	160,579	168,608	177,038	185,890	195,184	204,944
Other expenses	289,721	304,207	319,418	335,389	352,156	369,766
Insurance	350,217	367,728	386,114	405,420	425,691	446,975
Interest	41,011	34,843	2,074,113	3,046,666	2,972,067	2,893,752
Depreciation	1,147,631	1,172,631	1,361,119	1,596,705	1,621,705	1,646,705
Amortization	-	-	32,884	57,933	59,884	61,800
Mortgage insurance		204,625	204,625	202,485	197,020	191,310
Demolition and asbestos abatement			600,000	-	-	-
Total operating expenses	18,977,785	19,935,232	24,008,030	25,625,843	26,608,833	27,639,631
Income (loss) from operations	(303,342)	(95,639)	(1,948,526)	(1,282,910)	(969,269)	(423,331)
Nonoperating revenue (expenses):						
Interest earnings	53,615	56,124	56,615	68,102	69,487	74,860
Grant revenue		255,616	885,533	1,027,434	1,004,767	980,998
County tax revenue	217,842	217,842	217,842	217,842	217,842	217,842
Gifts	4,138	4,138	4,138	4,138	4,138	4,138
	275,595	533,720	1,166,128	1,317,516	1,296,254	1,277,838
Change in net assets	(27,747)	438,081	(782,398)	34,606	326,984	854,506
Net assets:						
Beginning	12,763,642	12,735,895	13,173,976	12,391,577	12,426,183	12,753,168
Ending	$ 12,735,895	$ 13,173,976	$ 12,391,577	$ 12,426,183	$ 12,753,168	$ 13,607,674

See Summary of Significant Accounting Policies and Forecast Assumptions.

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT

FORECASTED STATEMENTS OF CASH FLOWS
Years Ended April 30, 2010 through 2015

	Projected					
	2010	2011	2012	2013	2014	2015
Cash Flows from Operating Activities:						
Receipts from and on behalf on patients	$ 17,989,575	$ 19,488,785	$ 21,565,131	$ 23,839,015	$ 25,270,860	$ 26,809,470
Payments to supplier and contractors	(7,331,624)	(7,992,248)	(8,979,051)	(8,787,250)	(9,210,889)	(9,655,942)
Payments to employees	(10,174,830)	(10,700,147)	(11,488,138)	(12,093,934)	(12,688,131)	(13,322,538)
Other receipts, net	192,218	192,218	192,218	192,218	192,218	192,218
Net cash provided by operating activities	675,339	988,607	1,290,159	3,160,948	3,563,957	4,023,208
Cash Flows from Non-capital Financing Activities:						
Property taxes supporting operations	217,842	217,842	217,842	217,842	217,842	217,842
Capital grants and gifts	4,138	259,754	889,671	1,031,572	1,008,925	985,135
Net cash provided by non-capital financing	221,980	477,596	1,107,513	1,249,414	1,226,767	1,202,977
Cash Flows from Capital and Related Financing Activities:						
Principal paid on long-term debt	(130,000)	(160,000)	(175,000)	(1,036,000)	(1,093,000)	(1,142,000)
Interest paid	(41,011)	(34,843)	(1,562,550)	(3,057,541)	(2,983,505)	(2,905,752)
New debt borrowings	-	27,510,977	13,414,023	-	-	-
Purchase of capital assets	(1,338,966)	(26,719,753)	(13,199,399)	(250,000)	(250,000)	(250,000)
Financing fees	-	(1,567,428)	(10,000)	-	-	-
Net cash (used in) capital and related financing	(1,509,977)	(2,971,047)	(1,532,926)	(4,343,541)	(4,326,505)	(4,297,752)
Cash Flows from Investing Activities:						
Interest earnings	53,615	50,124	58,615	68,102	69,487	74,850
(Purchase of) proceeds from investments	788,966	2,436,829	(964,983)	(1,015,568)	(1,022,757)	(1,030,016)
Net cash provided by (used in) investing activities	842,581	2,486,953	(906,368)	(947,466)	(953,270)	(955,167)
Increase (decrease) in cash	229,923	992,109	(41,621)	(880,645)	(489,050)	(26,723)
Cash and short-term investments:						
Beginning	3,668,395	3,898,318	4,890,427	4,838,806	3,958,161	3,469,110
Ending	$ 3,898,318	$ 4,890,427	$ 4,838,806	$ 3,958,161	$ 3,469,110	$ 3,442,387
Reconciliation of Operating Income (Loss) to Net Cash Provided by Operating Activities:						
Operating income (loss)	$ (303,342)	$ (95,639)	$ (1,948,526)	$ (1,282,910)	$ (969,269)	$ (423,331)
Depreciation	1,147,831	1,172,831	1,361,119	1,596,705	1,621,705	1,646,705
Interest and amortization	41,011	34,843	2,106,996	3,104,699	3,031,051	2,955,551
Changes in operating assets and liabilities:						
Patient accounts receivable, net	(492,650)	(156,590)	(332,155)	(310,800)	(176,466)	(214,611)
Other assets and liabilities	(24,212)	(25,180)	(20,188)	(27,235)	(28,325)	(29,458)
Accounts payable and accrued expenses	785,709	36,503	75,991	56,751	59,589	62,568
Other liabilities	21,182	22,040	22,922	23,838	24,792	25,784
Net cash provided by operating activities	$ 675,339	$ 988,607	$ 1,290,159	$ 3,160,948	$ 3,563,957	$ 4,023,208

See Summary of Significant Accounting Policies and Forecast Assumptions.

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT

FORECASTED BALANCE SHEETS
April 30, 2010 through 2015

ASSETS	Projected 2010	2011	2012	2013	2014	2015
Current Assets:						
Cash	$ 700,000	$ 700,000	$ 700,000	$ 700,000	$ 700,000	$ 700,000
Short-term cash and investments - current	3,198,318	4,180,427	4,138,806	3,258,161	2,769,110	2,742,387
Assets limited as to use or restricted, current	538,374	538,374	788,374	788,374	788,374	788,374
Patient accounts receivable, net	2,515,636	2,674,226	2,876,361	3,287,161	3,463,660	3,678,278
Inventories	204,074	212,237	220,726	229,555	238,738	248,287
Prepaid expenses and other	425,437	442,454	460,153	478,559	497,701	517,609
Total current assets	7,681,839	8,747,719	9,284,439	8,741,829	8,457,589	8,674,935
Assets limited as to use or restricted:						
Board designated	3,091,073	660,244	900,244	1,260,244	1,560,244	1,880,244
Restricted by donor	152,516	152,516	152,516	152,516	152,516	152,516
Working capital reserve	-	-	250,000	250,000	250,000	250,000
Mortgage reserve fund	385,858	385,858	800,841	1,516,409	2,239,186	2,968,184
	3,629,447	1,198,618	2,163,601	3,179,169	4,201,926	5,231,944
Less amount required to meet current obligations	(538,374)	(538,374)	(788,374)	(788,374)	(788,374)	(788,374)
	3,091,073	660,244	1,375,227	2,390,795	3,413,552	4,443,570
Capital assets, net	4,782,963	32,310,085	44,148,365	42,801,660	41,429,855	40,033,250
Financing costs, net	-	1,567,428	1,544,584	1,486,612	1,426,728	1,364,928
	$ 15,435,875	$ 43,285,476	$ 56,352,576	$ 55,420,896	$ 54,727,824	$ 54,516,682
LIABILITIES AND NET ASSETS						
Current Liabilities:						
Current maturities of long-term debt	$ 160,000	$ 175,000	$ 1,038,000	$ 1,083,000	$ 1,142,000	$ 1,087,000
Accounts payable	245,411	256,785	271,274	284,837	299,079	314,033
Accrued payroll and related expenses	776,174	802,254	863,755	906,943	952,290	999,905
Estimated amounts due to third party payors	185,447	185,447	185,447	185,447	185,447	185,447
Accrued interest	-	-	511,563	500,688	489,250	477,250
Other	550,998	573,038	595,960	619,788	644,590	670,374
Total current liabilities	1,916,980	1,992,523	3,463,998	3,590,713	3,712,656	3,734,008
Long-term debt, less current maturities	783,000	28,118,977	40,497,000	39,404,000	38,262,000	37,175,000
Total liabilities	2,699,980	30,111,500	43,960,998	42,994,713	41,974,656	40,909,008
Net assets						
Invested in capital assets, net of related debt	3,819,963	4,016,108	2,615,365	2,304,660	2,025,855	1,771,250
Restricted:						
Under bond indenture	385,858	385,858	539,278	1,265,722	1,999,916	2,741,934
Specific operating activities	152,516	152,516	152,516	152,516	152,516	152,516
Unrestricted	8,377,558	8,619,493	9,084,418	8,703,286	8,574,781	8,941,974
	12,735,895	13,173,976	12,391,577	12,426,183	12,753,168	13,607,674
Total liabilities and net assets	$ 15,435,875	$ 43,285,476	$ 56,352,576	$ 55,420,896	$ 54,727,824	$ 54,516,682

See Summary of Significant Accounting Policies and Forecast Assumptions.

Summary of Significant Accounting Policies and Forecast Assumptions

This financial forecast presents the schedules of debt service coverage and other ratios, the related statements of revenues, expenses and changes in net assets, cash flows and balance sheets of Pinckneyville Community Hospital District (the Hospital) for the forecast period, to the best of the Hospital's knowledge. Accordingly, the forecast reflects the Hospital's judgment as of November 18, 2009, the date of this forecast, of the expected conditions and the Hospital's expected course of action. The assumptions disclosed herein are those that the Hospital believes are significant to the forecast. Even if the assumptions were to be realized, however, there will usually be differences between forecasted and actual results because events and circumstances frequently do not occur as expected, and those differences may be material. The financial forecast was prepared in connection with the initial application for the Hospital Mortgage Insurance Program under Section 242 of the National Housing Act and the Certificate of Need Application to the Illinois Health Facilities Planning Board.

Note 1. Summary of significant accounting policies

Nature of business: The Hospital will continue to operate as a critical access hospital with 25 acute care beds and a physician clinic in Pinckneyville, Illinois. The Hospital's home health and hospice operations, durable medical equipment operations and long-term care operations were discontinued in April 2008, August 2008 and September 2008, respectively. The Hospital primarily earns revenue by providing inpatient, outpatient and physician clinic services to area residents. The Hospital is exempt from income taxes under provisions of the Internal Revenue Code as a political subdivision of the State of Illinois.

Reporting entity: The financial statements include all funds of the Hospital. Accordingly, the criteria specified by the Governmental Accounting Standards Board have been applied in determining the reporting entity for financial reporting purposes. Specifically, those agencies, offices, organizations, commissions and public authorities over which the Hospital's governing board exercises oversight responsibility are included in the financial statements. Manifestations of oversight responsibility over an entity include: (1) financial interdependency, (2) selection of governing authority, (3) designation of management, (4) ability to significantly influence operations and (5) accountability for fiscal matters. The Hospital has no component units which meet the Governmental Accounting Standards Board criteria.

Significant accounting policies:

Basis of accounting. The accompanying forecasted financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenue is recognized when earned and expenses are recorded when the liability is incurred.

The Hospital prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the *Governmental Accounting Standards Board* (GASB). Pursuant to GASB Statement No. 20, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB) that were issued on or before November 30, 1989, and do not conflict with or contradict GASB pronouncements.

The significant accounting policies used in this forecast are consistent with those used in the historical financial statements of the Hospital.

Patient accounts receivable and patient service revenue: The Hospital grants credit to its patients, most of who are local residents or employed by businesses of Perry County and the surrounding area.

The Hospital has agreements with third-party payers, which provide reimbursement to the Hospital at amounts different from its established rates. The primary payers are Medicare for inpatient services and Medicare, Blue Cross Blue Shield and Healthlink for outpatient services.

Summary of Significant Accounting Policies and Forecast Assumptions

Patient accounts receivable, where a third-party is responsible for paying the amount, are carried at the estimated net realizable amount determined by the original charge for the service provided, less an estimate made for contractual adjustments or discounts provided to third-party payers.

Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payers and less an estimated allowance for doubtful receivables based on a review of all outstanding amounts. The Hospital does not charge interest on patient receivables. Patient receivables are written off as bad debt expense when deemed uncollectible. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

The Hospital has agreements with third-party payers which provide reimbursement at amounts different from its established rates. There are no individual third-party commercial payers that significantly contribute to inpatient revenues; however, Blue Cross Blue Shield and Healthlink are significant payers with respect to outpatient services. Blue Cross Blue Shield reimburses the hospital on a per diem basis for inpatient, swing bed and observation services and on a percentage of charge basis for outpatient services. Set payments are made on a weekly basis via the Uniform Payment Program, which is based on prior payment activity and updated every month. Healthlink reimburses the hospital on a per diem basis for inpatient and swing bed services and on a percentage of charge basis for outpatient services. The Hospital contracts with both the preferred provider organization (PPO) and health maintenance organization (HMO) Healthlink products. Claims are submitted to Healthlink for "pricing" and Healthlink forwards the claims to individual payers for payment. Healthlink charges a separate administrative fee for the claim pricing. The Hospital has also entered into reimbursement programs with other commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined per diem rates.

The Hospital is recognized by Medicare as a Critical Access Hospital (CAH), and the physician clinic is recognized by Medicare as a provider-based Rural Health Clinic (RHC). Under CAH status, hospital services provided to Medicare beneficiaries are paid based upon a cost reimbursement methodology. Under provider-based RHC status, the RHC services provided to Medicare beneficiaries are paid based upon a cost per visit methodology. Interim rates are paid during the year on all inpatient, outpatient and RHC services, and final settlement is determined after submission of an annual cost report.

Retroactive contractual adjustments arising under reimbursement agreements with third-party payers are recognized on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

The laws and regulations under which the Medicare program operates are complex, subject to frequent change and subject to interpretation. As part of operating under the Medicare program, there is a possibility that governmental authorities may review the Hospital's compliance with these laws and regulations. Such review may result in adjustments to Medicare reimbursement previously received and subject the Hospital to fines and penalties. Although no assurances can be given, management believes they have and will continue to comply with the requirements of the Medicare program.

Cash and cash equivalents: For purposes of reporting cash flows, the Hospital considers all highly liquid debt instruments, excluding assets limited as to use or restricted, which are purchased with a maturity of three months or less to be cash equivalents.

Summary of Significant Accounting Policies and Forecast Assumptions

Investments: Illinois State statues authorize the Hospital to make deposits and investments in interest-bearing depository accounts in federally insured and/or state chartered banks and savings and loans associations, or other financial institutions as designated by ordinances, and to invest available funds in direct obligations of, or obligations guaranteed by, the U.S. Treasury or agencies of the United States, money market mutual funds whose portfolios consist of government securities, the Illinois Public Treasury's Investment Pool, and the Illinois Funds Investment Pool. Historically, the Hospital has invested in the Illinois Funds Investment Pool and certificates of deposit which have been carried at amortized cost, which approximates market value.

Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to the Hospital. State law allows collateralization of deposits in excess of federal depository insurance. The Hospital's deposit policy for custodial credit risk is to obtain a pledge of collateral for deposits substantially in excess of federal depository insurance. The Hospital has historically maintained a substantial portion of its deposits in two financial institutions. The Hospital has not experienced any losses in such amounts and believes it is not exposed to any significant credit risk on its deposits.

The Illinois Funds Investment Pool (Fund) is not registered with the SEC. The Fund is administered by the Illinois State Treasurer and oversight is provided by the State Auditor General's Office. The fair value of the positions in the pool is the same as the value of the pool shares. The Fund currently has a Standard & Poor's credit rating of AAAm and a weighted average maturity of 7 years.

Investment income consists of interest income.

Inventories: Inventories are valued at the lower of cost (first-in, first-out method) or market.

Assets limited as to use or restricted. Assets limited as to use or restricted include assets restricted by bond ordinance, donor-restricted assets and assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Under the proposed financing (Note 4), the following funds are required to be established and maintained.

Working Capital Reserve (WCR): The WCR is required to be established as an "Allowance for Making Nonprofit Projects Operational". Use of the funds must be approved by the Director of Housing Development and only for such items as additional costs due to unavoidable construction delays, necessity change orders, cost of the second year mortgage insurance premium or permanent property insurance and other costs incidental to projection operations.

Mortgage Reserve Fund (MRF): The MRF is required to be established to provide monies in the event of a financial emergency to cure or prevent a default, engage a consultant, or implement a turnaround plan. The MRF required deposits are structured to achieve a balance equal to 12 months and 24 months of the insured mortgage debt service at five and ten years, respectively, from the commencement of the debt amortization. The deposits are to be made in equal annual contributions that, when coupled with investment income, reach 12 months of maximum debt service at the end of five years and 24 months of maximum debt service at the end of ten years. During the next five years the fund is allowed to build, and starting in the 16th year the fund will be phased out by annual withdrawals that, when added to a level annual amount from operations, will equal the annual principal repayment. A table illustrating the forecasted cash flow from this arrangement is as follows:

MRF Cash Flow				
Year	Deposits	Earnings	Withdrawals	Balance
Through year 5	$ 3,245,663	$ 75,014	$ -	$ 3,320,677
Year 5 through year 10	3,654,325	325,904	-	7,300,906
Year 10 through 15	-	297,829	-	7,598,736
Year 16 through 20	-	297,965	3,780,718	4,115,982
Year 20 through 25	-	111,156	4,227,138	-

Capital assets: Property, plant and equipment are stated at cost, if purchased, or at fair value on the date received, if donated, less accumulated depreciation. Interest expense incurred during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Depreciation is provided on a straight-line basis over the estimated useful lives of the property. Major renewals and improvements are recorded in the property accounts and depreciated accordingly. Replacements, maintenance and repairs that do not improve or extend the lives of assets are expensed in the period incurred.

Depreciation is computed by the straight-line method over estimated useful lives as follows:

Land improvements	8 - 20 years
Buildings and building improvements	5 - 40 years
Equipment	3 - 20 years

In connection with the construction of the replacement hospital and rural health clinic, the Hospital has considered various plans and alternative strategies as to the disposition of the existing hospital and medical clinic capital assets. Based on such considerations, including the location, age and structural deficiencies of the current capital assets, the Board has determined the most likely scenario is abandonment or donation of the current facilities. For purposes of the forecast, the net book value of the existing property at the date that the Hospital moves to the replacement facility (placed into service date) has been assumed to be zero. As a result, additional depreciation expense on the building and attached equipment of approximately $453,000, $458,000 and $116,000 respectively, has been recognized in the years ending April 30, 2010, 2011 and 2012 Management anticipates costs of approximately $600,000 for asbestos remediation and demolition of the existing facility. These costs have been recognized as an expense in fiscal year ending April 30, 2012.

Net assets: Net assets of the Hospital are defined as follows:

Invested in capital assets, net of related debt – This component of net assets consists of capital assets, including any restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net assets consists of constraints placed on net assets through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted net assets – This component of net assets consists of net assets that do not meet the definition of "restricted" or "invested in capital assets, net of related debt," above.

Summary of Significant Accounting Policies and Forecast Assumptions

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

Operating revenues and expenses: The Hospital distinguishes operating revenue and expenses from nonoperating items. Operating revenue and expenses generally result from the primary purpose of the Hospital, which is to provide medical services to the region. Operating expenses consist of salaries and wages, employee benefits, purchased services and professional fees, depreciation, interest and supplies and other. All revenue and expenses not meeting these criteria are considered nonoperating.

Grant revenue: The American Recovery and Reinvestment Act of 2009 created the Build American Bond program, which authorizes state and local governments to issue taxable bonds in 2009 and 2010 to finance any capital expenditures for which they otherwise could issue tax-exempt governmental bonds. State and local governments receive a direct federal subsidy payment from the Treasury Department for a portion of their borrowing costs equal to 35% of the total coupon interest paid to investors. The Hospital will file Form 8038-CP, Return of Credit Payments to Issuers of Qualified Bonds, at least 30 days prior to the interest due dates such that the payments are received prior to payment to bondholders. These payments would be received in March and September and are recognized as revenue when interest expense is recognized or capitalized.

Tax revenue: Property taxes are recognized as assets in the period an enforceable legal claim to the assets arises and are recognized as revenue in the period for which the taxes are levied. Property taxes are collected by the county and are primarily received by the Hospital in October, November and December. Other state property tax revenue is recognized as revenue when received by the Hospital. Property taxes that are not available for current year operations, if any, are recognized as deferred revenue.

Deferred financing costs: Financing costs associated with the issuance of long-term debt are amortized over the life of the related debt using the effective interest method.

Note 2. Background of the Hospital

The Hospital is a 25 bed Critical Access Hospital licensed by the State of Illinois. Hospital based services include medical/surgical care, swing bed program, ambulatory surgery, emergency care and ancillary services. In addition, the Hospital hosts a number of specialty clinics on a regularly scheduled basis. Prior to April 30, 2009, the Hospital also operated a 50 bed-long term care unit, a home health agency, a hospice agency and a home medical equipment agency. These services were discontinued over the period April to September 2008. The Hospital also operates a Rural Health Clinic. The residents of Perry County, Illinois voted to establish the Pinckneyville Community Hospital District in 1950. The Hospital, which is operated by Pinckneyville Community Hospital District, is a municipal corporation and the appointed Board is charged with the operation of the District.

The Balanced Budget Act (BBA) of 1997 enacted certain legislation authorizing states to establish State Medicare Rural Hospital Flexibility Programs under which select facilities participating in Medicare could become Critical Access Hospitals (CAH) assuming they met the criteria for this separate provider type. Pinckneyville Community Hospital District became a CAH in November 2000. The Hospital's market area is designated as a health professions shortage area.

The Hospital currently occupies a multi-level concrete frame structure developed in two major phases. The original Hospital was constructed in 1964 with a second phase in 1976.

Note 3. Project Description

The proposed hospital construction and replacement program consists of constructing and equipping a replacement community hospital facility and rural health clinic in Pinckneyville, Illinois (the Project).

The Project: In 2003, Gresham Smith and Partners conducted a Master Plan Assessment and Analysis for the Hospital which concluded that a replacement facility, on a green field site, would best serve the Hospital's service area, over time, given the high cost of renovating the existing facilities to meet contemporary health delivery standards and codes.

The Hospital purchased approximately 30 acres of land located 2 miles east of the current facilities in 2006. The Project consists of the construction and equipping of an approximately 103,000 square-foot replacement Critical Access Hospital (CAH) and attached rural health clinic. The proposed construction will be single story and include 25 medical/surgical beds. It is anticipated the current facility will be demolished.

The construction manager for the Project is Robins Morton and the architect for the Project is Gresham, Smith and Partners both of Nashville, Tennessee.

The Hospital is not using a general contractor for the Project. They have hired Robins Morton as the construction manager for the Project. Robins Morton will negotiate contracts with various subcontractors to construct the Project. The Hospital has entered into a Standard Form of Agreement between Owner and Construction Manager (where the Construction Manager is also the Constructor). In this agreement, the construction manager is to propose a Guaranteed Maximum Price, which is the estimated Cost of the Work and the Construction Manager's Fee, when drawings and specifications are sufficiently complete. The Guaranteed Maximum Price has not yet been formally established. The Hospital anticipates the final drawings and specifications to be finalized in December 2009 and the contractor anticipates the bidding process to be complete by January 2010 at which time the Guaranteed Maximum Price will be established. The preconstruction services fee is capped at $80,000.

Construction schedule: Construction is anticipated to begin in May 2010 and be substantially completed in September 2011. Illinois Department of Public Health and other required inspections and approvals will be obtained by November 2011 and the projected placed in service date is December 2011.

Note 4. Proposed Financing

A summary of the estimated sources and uses of funds for the Project is presented below:

Sources of Funds	
Cash reserves of Hospital	$ 3,819,795
Land - purchased in 2006 by Hospital	345,271
Construction costs paid by Hospital	1,304,020
Owned equipment	1,304,332
Debt	40,925,000
	$ 47,698,418
Uses of Funds	
Land	$ 345,271
Construction and site work	33,920,116
Architect fees	1,967,700
Contingency	1,684,851
Other	1,096,213
Equipment	3,285,091
Capitalized interest	1,838,165
Total construction	44,157,408
Owned equipment	1,304,332
Total project	45,461,740
Financing costs	1,577,428
Mortgage insurance premium	409,250
Working capital reserve	250,000
	$ 47,698,418

It is assumed the Project is financed under the Build America Bond program. The American Recovery and Reinvestment Act of 2009 created the Build America Bond program, which authorizes state and local governments to issue taxable bonds in 2009 and 2010 to finance any capital expenditures for which they otherwise could issue tax-exempt governmental bonds. State and local governments receive a direct federal subsidy payment from the Treasury Department for a portion of their borrowing costs equal to 35% of the total coupon interest paid to investors.

The planned method of financing the Project will be through the use of a 'draw-down' bond structure. Initially, the bonds are authorized at a specific interest rate to the buyer(s) at the beginning of the construction period. As construction is completed, there is a process by which the architect/contractor certifies completion of the work to the mortgagor who then obtains a Government National Mortgage Association (GNMA) certificate evidencing a federal guarantee of an equal amount of a mortgage. This allows the mortgagor to make a federally guaranteed GNMA mortgage loan to the hospital. The mortgagor draws funds from the buyer(s) on the authorized bonds in order to obtain the money to make the mortgage loan. All the bonds are authorized at closing (projected June 1, 2010) but only become outstanding as they are drawn to make mortgage loans during the construction period.

This is the most common method of funding Federal Housing Administration (FHA) projects in recent years given the small spread between taxable and tax exempt bonds as well as low investment rates that otherwise would result in negative arbitrage during construction if all bonds were issued at the inception of the construction period. This financing method also meets the FHA requirement that the interest rate be locked in at the time of FHA approval.

It is assumed an interest rate of 7.5% is charged monthly on the outstanding balance, which includes .25% servicing fee. The total interest charged during the construction period is capitalized in arriving at total construction cost and is included in the total amount of permanent financing. The Bonds are assumed to be fully issued as of September 1, 2011.

The Bonds will require varying annual principal payments from $870,000 to $2,735,000 and the Hospital will be required to make level monthly deposits to service the bonds. The average coupon rate is assumed to be 7.25 percent and paid semiannually on March 1 and September 1. The Hospital will be required to file Form 8038-CP, Return of Credit Payments to Issuers of Qualified Bonds at least 30 days prior to the interest due dates such that the subsidy is received prior to payment to bondholders. The federal subsidy payment from the Treasury Department is recorded as grant revenue.

The Bonds and interest thereon are payable solely and only from Gross Revenues (as defined in the Loan Agreement) of the Project Facilities. Project Facilities are defined as the hospital and rural health clinic, consisting of the land, the project building and the project equipment located therein or thereon. The Project Facilities and substantially all other assets of the Hospital are collateral pledged under the Indenture along with cash and investments held by the Trustee in a fund or account appropriated to the payment of the Bonds under the Indenture.

Pursuant to the proposed mortgage insurance agreement between the Secretary of the U.S. Department of Housing and Urban Development (HUD) and the Hospital (the Mortgage Agreement), the Hospital has covenanted, and reasonably expects, to provide from the Gross Revenues, the amounts needed to pay all Operating Expenses, as defined in the Loan Agreement, and the debt service on the Bonds in a full and timely manner. Upon the occurrence of an event of default under the Loan Agreement, all Gross Revenues will be deposited with the Trustee for the payment of debt service and operating expenses.

See the long-term debt section (Note 9) of the Summary of Significant Accounting Policies and Forecast Assumptions for a summary of the long-term debt obligations for the forecast period.

Note 5. Analysis of Demand

The assessment of facility utilization is based on an analysis of the potential demand for future health care services. This forecast of utilization was performed by an independent third party, PRISM Consulting Services, Inc. Their forecast of utilization serves as a basis for the financial forecast. Utilization is based on a number of factors, several of which are qualitative in nature and include the following:

- Service area analysis, including the definition of the service area and patient origin data
- Projected population in the service area
- Socioeconomic profile
- Payer mix trends
- Service area hospitals
- Market share trends
- Hospital's medical staff profile
- Medical staff and community support for the Project
- Historical and forecasted utilization, including use rate trends by type of service

When qualitative factors are involved, judgment is required to determine their impact on demand. Judgment is naturally subject to uncertainty.

Summary of Significant Accounting Policies and Forecast Assumptions

Service Area Analysis

The Hospital is located in Pinckneyville, Illinois. Pinckneyville is the county seat of Perry County, Illinois and is located an hour and fifteen minutes southeast of St. Louis, Missouri and thirty minutes northwest of Carbondale, Illinois. The area is primarily agrarian with a strong history of coal mining that had been in decline, but is now beginning to see resurgence.

Over the period 2004 through 2008, the Hospital derived approximately 88% of its total inpatient acute care discharges from what the Hospital defines as its primary service area (PSA) and secondary service area (SSA). The PSA is defined as Pinckneyville, zip code 62274. This geographic area accounted for, on the average, approximately 58% of the Hospital's patients in this period. The Hospital defines its SSA as the remainder of zip codes in Perry County and one zip code, Oakdale, which is located in Washington County. This geographic area accounted for, on average, 30% of the Hospital's patients (excluding Pinckneyville zip code) in this period. The remaining 12% of inpatient discharges in this period originated from other Illinois zip codes and out-of-state admissions.

The table below shows the Hospital's historical inpatient discharges by zip code for the PSA and SSA as reported by the Hospital to the Illinois Hospital Association. Hospital discharges for patients originating from the PSA zip codes have declined since a peak in 2005. From 2004 through 2008, the decline was 175 discharges or approximately 26.7%. Management attributes this decline to:

- Disruption of community support caused by the closure of the long-term care unit
- Limitation of physician/caregiver availability in Pinckneyville which constrained local access
- Marketing by other healthcare providers in the area

PSA Historical Patient Origin

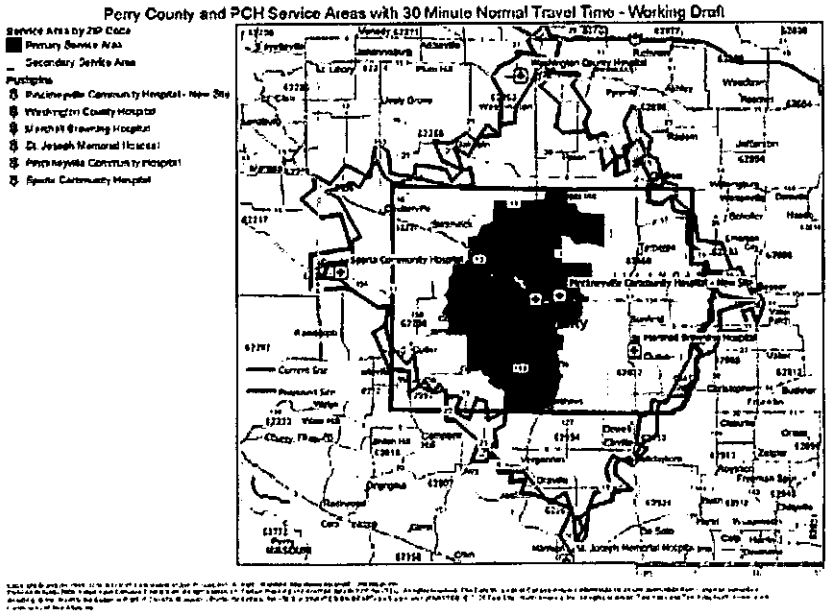
	2004		2005		2006		2007		2008	
ZIP code Cities	Discharges	Percent of PSA and SSA Total	Discharges	Percent of PSA and SSA Total	Discharges	Percent of PSA and SSA Total	Discharges	Percent of PSA and SSA Total	Discharges	Percent of PSA and SSA Total
Primary Service Area										
62274 Pinckneyville	440	67.1%	499	69.0%	428	61.7%	397	68.8%	305	63.4%
Secondary Service Area										
62832 Du Quoin	78	12.0%	83	11.5%	110	15.9%	83	13.9%	51	10.6%
62863 Tamaroa	67	10.2%	60	8.3%	74	10.7%	44	7.6%	57	11.5%
62733 Cutler	29	4.4%	29	4.0%	35	5.2%	24	4.2%	27	5.6%
62737 Coulterville	20	3.0%	28	3.9%	26	3.7%	18	3.1%	22	4.6%
62897 Willisville	11	1.7%	8	1.1%	8	1.2%	4	0.7%	6	1.2%
Subtotal SSA-Perry County	205	31.4%	211	29.2%	255	36.7%	170	29.5%	163	33.9%
62268 Oakdale*	10	1.5%	13	1.8%	11	1.6%	10	1.7%	13	2.7%
Total	216	32.9%	224	31.0%	266	38.3%	180	31.2%	176	35.6%
Total PSA and SSA Discharges	656	100.0%	723	100.0%	694	100.0%	577	100.0%	481	100.0%
*Located in Washington County										

Source: Illinois Hospital Association

Summary of Significant Accounting Policies and Forecast Assumptions

The map below outlines the Hospital's service area, its present location, the location of the proposed replacement hospital and the locations of selected service area hospitals.

Service Area Map



Summary of Significant Accounting Policies and Forecast Assumptions

Projected Population in the Service Area

Current and projected population estimates were provided by U.S. Census Bureau and ESRI Business Solutions and are based on 2000 census data and updated by these sources periodically. Population projections by service area and community are presented below.

Historical and Projected Population By Zip Code

	Census 2000	Estimate 2008	Projection 2013	Growth Rate 2000-2008	Growth Rate 2008-2013	Average Annual Compound Growth Rate 2000-2008	Average Annual Compound Growth Rate 2008-2013
Primary Service Area	8,384	8,472	8,531	1.05%	0.70%	0.13%	0.14%
Secondary Service Area	17,148	17,023	17,013	-0.73%	-0.06%	-0.09%	-0.01%
Total Service Area	25,532	25,495	25,544	-0.14%	0.19%	-0.02%	0.04%
Total Illinois *	12,419,293	13,114,513	13,412,757	5.60%	2.27%	0.61%	0.45%
United States *	281,421,906	309,731,508	324,062,684	10.06%	4.63%	1.07%	0.91%
Primary Service Area							
62274 Pinckneyville	8,384	8,472	8,531	1.05%	0.70%	0.13%	0.14%
Secondary Service Area							
62832 Du Quoin	9,681	9,366	9,299	-3.25%	-0.72%	-0.41%	-0.14%
62888 Tamaroa	2,201	2,254	2,279	2.41%	1.11%	0.30%	0.22%
62238 Cutler	817	822	827	0.61%	0.61%	0.08%	0.12%
62237 Coulterville	2,907	3,012	3,036	3.61%	0.80%	0.44%	0.16%
62997 Willisville	663	661	657	-0.30%	-0.61%	-0.04%	-0.12%
Subtotal SSA-Perry County	16,269	16,115	16,099	-0.95%	-0.11%	-0.12%	-0.02%
62268 Oakdale	879	908	915	3.30%	0.77%	0.41%	0.15%
Total	17,148	17,023	17,013	-0.73%	-0.06%	-0.09%	-0.01%
Total Service Area	25,532	25,495	25,544	-0.14%	0.19%	-0.02%	0.04%

Source: US Census Bureau; ESRI Business Solutions

* Illinois and US Estimates are for 2009 and 2014 (2008 and 2013 data no longer available), Average Annual Compound Growth Rate

The PSA (Pinckneyville) is projected by these sources to experience small growth while the SSA is expected to remain flat or, in total, decline slightly. Overall, the total service area is expected to remain stable, but with no significant growth.

Historical and Projected Population By Age							
	Census 2000	Estimate 2008	Projection 2013	Growth Rate 2000-2008	Growth Rate 2008-2013	Average Annual Compound Growth Rate 2000-2008	Average Annual Compound Growth Rate 2008-2013
Primary Service Area							
0-14	1,330	1,147	1,136	-13.76%	-0.66%	-1.83%	-0.19%
15-44	4,040	3,947	3,793	-2.30%	-3.90%	-0.29%	-0.79%
45-64	1,799	2,170	2,317	20.62%	6.77%	2.37%	1.32%
65-74	594	609	657	2.53%	7.88%	0.31%	1.53%
75-84	424	368	404	-8.49%	4.12%	-1.10%	0.81%
85+	197	211	224	7.11%	6.16%	0.86%	1.20%
Total	8,384	8,472	8,531	1.05%	0.70%	0.13%	0.14%
Secondary Service Area							
0-14	3,328	2,879	2,838	-13.48%	-1.42%	-1.80%	-0.29%
15-44	6,756	6,326	5,997	-6.36%	-5.20%	-0.82%	-1.06%
45-64	4,091	4,509	4,773	10.22%	5.85%	1.22%	1.14%
65-74	1,542	1,336	1,416	-13.36%	5.99%	-1.78%	1.17%
75-84	1,070	902	891	-15.70%	-1.22%	-2.11%	-0.25%
85+	361	440	472	21.88%	7.27%	2.50%	1.41%
Total	17,148	16,392	16,387	-4.41%	-0.03%	-0.56%	-0.01%
Total Service Area							
0-14	4,656	4,026	3,974	-13.57%	-1.29%	-1.81%	-0.26%
15-44	10,796	10,273	9,790	-4.84%	-4.70%	-0.62%	-0.96%
45-64	5,890	6,679	7,090	13.40%	6.15%	1.58%	1.20%
65-74 (65+)	2,136	1,945	2,073	-8.94%	6.56%	-1.16%	1.28%
75-84	1,494	1,270	1,295	-14.99%	1.98%	-1.82%	0.08%
85+	558	651	696	16.67%	6.91%	1.95%	1.35%
Total	25,532	24,864	24,918	-2.62%	0.22%	-0.33%	0.04%

Source: US Census Bureau; ESRI Business Solutions

The decline in population is most significant in the 0 to 14 age cohort. The PSA's population under 14 years of age decreased at a rate of 13.8% between 2000 and 2008. In comparison, the population for the same age cohort in Illinois increased by 8% and increased 3.7% for the entire United States (2009 to 2014). During the five-year period from 2008 to 2013, the population in this age cohort is projected to decrease less than 1% percent in the PSA, increase less than 1% in Illinois and the entire United States.

Overall, while the total population in the PSA is basically unchanged in the projection period, it is expected to increase in the age cohorts 44 years of age and above. This is generally consistent with the projection for Illinois and the entire United States, except in these comparisons the growth is more concentrated in the 65 to 74 age cohort. The growth in the 44+ age cohorts is expected to continue to support the future demand for health care services.

Socioeconomic Profile

Major area employers: The following table presents major employers in the PSA. The Hospital is the second largest employer in the PSA.

Major Employers

Employer	City	Product/Service	Number Employees
Pinckneyville Correction Center	Pinckneyville	Secure medium level 2 facility	325
Pinckneyville Community Hospital	Pinckneyville	Healthcare	236
Cooper B-Line (GS Metals)	Pinckneyville	Manufacturing site, support systems and enclosurers	119
District 50 Grade School and Junior High	Pinckneyville	School District	77
Craig Williams Creative-Community Link	Pinckneyville	Chamber publishing	59
District 101 High School	Pinckneyville	School district	55
Perry County Marketplace	Pinckneyville	Grocery	45
City of Pinckneyville	Pinckneyville	Government	40
Pinckneyville Healthcare	Pinckneyville	Nursing care facilities	36
First National Bank	Pinckneyville	Financial institution	35
Community Consolidated 204	Pinckneyville	School district	33
Murphy-Wall Bank and Trust	Pinckneyville	Financial institution	28
Manor at Mason Woods	Pinckneyville	Assisted living facilities	26

Sources: City of Pinckneyville
Chamber of Commerce
Illinois Workforce Information Center
Info USA, Inc.
Southern Illinois Workforce Investment Board

In addition, the following is a list of coal mines currently active in Perry County area:

- Black Beauty Coal Gateway Mine, in service 2005, active
- Knight Hawk Coal
  - Red Hawk Mine, in service 2003, active
  - Pioneer, in service 2003, active
  - Prairie Eagle (strip mine), in service 2005, active
  - Prairie Eagle (underground), in service 2006, active

The employment base has remained relatively stable since the March 2007 closure of Technicolor Universal Multimedia which resulted in 440 southern Illinois jobs lost.

Rate of Unemployment: Another indicator of economic stability of an area is the rate of unemployment. The table below includes unemployment information for Perry County, the primary county in the PSA and SSA.

Unemployment Rates

Area	2004	2005	2006	2007	2008	April 2009
Perry County	7.4%	6.9%	7.1%	8.7%	10.2%	11.1%
State of Illinois	6.2	5.8	4.6	5.0	6.5	9.3
United States	5.5	5.1	4.6	4.6	5.8	8.9

Source: 2009 Real Estate Center at Texas A&M University
Illinois Department of Commerce and Economic Opportunity (DCEO)
US Bureau of Labor Statistics

Perry County has historically exceeded the Illinois unemployment rate by approximately 1% with the gap widening to over 3% in recent years, prior to the escalating unemployment rate for Illinois due to the economic crisis beginning in late 2008. While several new businesses have opened in the area, not the least of which is the new mine-mouth generating plant, the unemployment rate, like that of Illinois has continued to climb during the economic downturn. Nonetheless, Pinckneyville's proximity to Carbondale, Rend Lake, and St. Louis provides attractions for enhanced recreation and physician recruitment to the area. A replacement hospital will also anchor healthcare in the Pinckneyville/Perry County market thereby enhancing local economic development. The hospital competes for talent with other employers in Pinckneyville and other rural hospitals by offering a tuition reimbursement program open to all employees to advance to the next degree level. More than 30 Hospital employees have accessed this benefit since the program began in 2000.

Median Household Income: Another indicator of economic stability of an area is the median household income for the service areas and comparison to surrounding counties, the state of Illinois and the United States. The table below indicates median household income for Perry County and the comparisons to surrounding area.

Median Household Income	
County	2007
Perry County	$38,983
Surrounding Counties:	
Washington	$48,727
Jefferson	$41,705
Franklin	$33,963
Jackson	$31,146
Randolph	$42,980
State of Illinois	$54,141
United States	$50,740

Source: United States Department of Agriculture, Economic Research Service

Perry County is near the middle with respect to its surrounding area, with only Washington County far exceeding Perry County's median household income. As a whole, this area of Illinois is below the median household income for both the state of Illinois and the United States, which is not unexpected given it is a rural area.

Impact of Replacement Hospital: The primary objective of the proposed replacement hospital is to eliminate the use of multiple, older and inefficient facilities in order to bring the Hospital up to the current safety and privacy standards. While it is not anticipated the number of employees will significantly change, the Hospital is a major employer in Pinckneyville as well as Perry County and therefore, considered essential to the local economy. In addition, the Hospital is the healthcare anchor in the community thereby enhancing local economic development. Management believes a more efficient and aesthetic facility will enhance the Hospital's physician and employee recruitment program as well as patient utilization.

Summary of Significant Accounting Policies and Forecast Assumptions

Payer Mix Trends

The Hospital has had a fairly stable payer mix over the last three years, and the forecasted payer mix reflects the historical payer mix. Payer mix is not expected to impact the future demand for services because the Hospital expects to remain in the network for all current payers. Medicare may grow as a percentage of the total gross revenue with the population aging in the PSA and SSA. As a Critical Access Hospital (CAH), the Hospital receives hospital reimbursement from Medicare under a 101 percent of reasonable cost methodology. The Hospital is reimbursed based on the reasonable costs it incurs to care for each patient, rather than being reimbursed based on a specific diagnosis methodology (diagnostic-related groups (DRGs) or ambulatory payment categories (APCs)), which is the payment basis for most non-CAH hospitals. The CAH status enables the Hospital to predict the expected recovery of capital-related costs (including depreciation and interest expense) associated with services provided to Medicare patients.

Historical Patient Mix - Inpatient Services

	2007				2008				2009			
Payer	Discharges	%	Net Revenues	%	Discharges	%	Net Revenues	%	Discharges	%	Net Revenues	%
Acute Care												
Medicare	576	72.6%	2,408,631	81.4%	474	75.3%	1,900,874	84.7%	432	73.2%	1,973,759	83.8%
Medicaid	44	5.5%	97,414	3.3%	35	5.2%	85,159	3.8%	33	5.6%	74,542	3.2%
Other Commercial Insurance	153	19.2%	449,700	15.2%	91	16.2%	289,332	12.9%	89	15.0%	305,007	13.0%
Private Pay	21	2.6%	1,255	0.0%	13	2.3%	696	0.0%	15	2.7%	1,171	0.0%
Total	794	100.0%	2,955,270	100.0%	563	100.0%	2,316,057	100.0%	549	100.0%	2,355,478	100.0%
Swing Bed												
Medicare	205	95.8%	1,723,788	97.0%	154	95.1%	2,814,728	97.1%	124	95.4%	1,617,876	98.1%
Medicaid	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other Commercial Insurance	9	4.2%	53,516	3.0%	8	4.9%	68,454	2.9%	6	4.6%	31,293	1.9%
Private Pay	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Total	214	100.0%	1,777,304	100.0%	162	100.0%	2,885,182	100.0%	130	100.0%	1,649,169	100.0%
Total												
Medicare	782	77.5%	4,130,659	87.3%	628	79.7%	4,715,602	93.5%	556	77.5%	3,591,635	89.3%
Medicaid	44	4.4%	97,414	2.1%	35	4.4%	85,159	1.7%	33	4.6%	74,542	1.9%
Other Commercial Insurance	162	16.0%	503,216	10.6%	99	12.7%	357,786	7.0%	105	14.6%	336,300	8.4%
Private Pay	21	2.1%	1,255	0.0%	13	1.6%	696	0.0%	15	2.1%	1,171	0.0%
Total	1,010	100.0%	4,732,574	100.0%	775	100.0%	5,159,243	100.0%	719	100.0%	4,004,648	100.0%

Years Year Ending April 30

Source: Hospital Records

Historical Patient Mix - Outpatient Services

	2007				2008				2009			
Payer	Registrations	%	Net Revenues	%	Registrations	%	Net Revenues	%	Registrations	%	Net Revenues	%
Outpatient Services												
Medicare	12,136	50.3%	4,780,227	40.6%	12,456	51.4%	5,779,665	48.6%	11,828	51.2%	5,231,557	42.5%
Medicaid	1,853	7.7%	249,211	2.1%	2,300	9.5%	417,125	3.5%	2,557	11.1%	577,795	4.7%
Blue Cross Blue Shield	2,499	10.4%	1,857,951	15.9%	2,552	10.5%	1,853,902	15.6%	2,475	10.7%	1,850,253	15.0%
HealthNet	4,118	17.1%	1,749,351	14.9%	3,640	15.0%	1,715,748	14.4%	2,830	12.3%	1,560,894	12.7%
Other Commercial Insurance	2,918	12.1%	2,959,537	25.3%	3,138	12.9%	1,977,685	16.6%	2,794	12.1%	2,882,916	23.6%
Private Pay	614	2.5%	142,523	1.2%	788	3.2%	165,005	1.4%	599	2.6%	202,952	1.6%
Total	24,136	100.0%	11,714,910	100.0%	24,253	100.0%	11,912,316	100.0%	23,083	100.0%	12,316,347	100.0%
Rural Health Clinic	16,617	NA	1,282,687	NA	16,640	NA	1,381,082	NA	16,433	NA	1,488,595	NA
Total	40,753	NA	12,997,777	NA	40,893	NA	13,293,398	NA	39,516	NA	13,804,837	NA

Years Year Ending April 30

Source: Hospital Records

Swing bed designation was applied for through the State of Illinois certificate of need process. The Department of Health and Human Services notified the Hospital it met the requirements of 43 Code of Federal Regulations (CFR), Part 483, for participation in the Medicare Program as a Critical Access swing-bed facility effective February 1, 2001. To qualify for a swing bed admission, the patient must have a prior 3-day qualifying acute care inpatient stay and must require skilled services as part of the swing bed stay. All 25 of the Hospital's acute care hospital beds can be utilized interchangeably for swing bed services.

A Hospital Provider Fund was created under 305 ILCS 5/ of the Illinois Public Aid Code. Under this provision, hospitals receive equal monthly payments based on certain criteria in addition to rates paid for inpatient hospital services. Payments received by the Hospital under this provision were $174,848, $349,836, and $183,358 in fiscal years ending April 30, 2007 through 2009, respectively. According to the code, this section is scheduled to be repealed July 1, 2013. The Hospital is exempt under 89 Ill. Adm. Code 140.80(j) from assessments imposed on certain hospitals for payments into the Hospital Provider Fund.

To be conservative, the forecast assumes that the future payer mix remains constant at historical levels and assumes that the Illinois Hospital Provider Fund will be repealed effective July 1, 2013.

While it is impossible to predict future actions by Congress that could negatively impact reimbursement for CAHs, the Hospital is aware of the possible consequences that could result from changes in the current CAH reimbursement methodology or from the loss of the CAH status, as these changes could significantly alter certain underlying assumptions in the financial forecast.

Service Area Hospitals

Pinckneyville Community Hospital District is the sole hospital provider physically located in the PSA. The SSA contains one other acute-care hospital in DuQuoin. The following table presents an inventory of available beds by facility. CAHs may have more than 25 licensed beds, yet their designation as a CAH limits their capacity to 25 beds. Some CAHs may elect to staff for fewer than 25 beds based on the availability of nursing staff and patient demand. There are four other CAHs within 30 miles of the Hospital, two of which have obstetrics services, while the Hospital, Marshall Browning Hospital and St. Joseph Memorial Hospital do not.

Service Area Hospitals

Hospital	City	County	Current Available Acute Beds	Miles From PCH
Pinckneyville Community Hospital	Pinckneyville	Perry	25	-
Marshall Browning Hospital	DuQuoin	Perry	25	12.02
Sparta Community Hospital District	Sparta	Randolph	25	18.35
Washington County Hospital	Nashville	Washington	25	18.74
St. Joseph Memorial Hospital	Murphysboro	Jackson	25	23.14
Memorial Hospital of Carbondale	Carbondale	Jackson	144	31.76
Herrin Hospital	Herrin	Williamson	94	38.00
St. Mary's Good Samaritan-Mt. Vernon	Mt. Vernon	Jefferson	154	40.68
Heartland Regional Medical Center	Marion	Williamson	92	43.30
St. Mary's Good Samaritan-Centralia	Centralia	Marion	180	44.27
St. Elizabeth's Hospital	Belleville	St. Clair	260	50.86
Memorial Hospital	Belleville	St. Clair	316	83.47

Sources: American Hospital Directory
Mapquest.com

Summary of Significant Accounting Policies and Forecast Assumptions

The Hospital is primarily comparable to the four other CAHs within 30 miles of Pinckneyville and it currently ranks third with respect to the number of admissions, acute-care patient days and average daily census. The Hospital's average length of stay is comparable to the other CAHs. The major competitors to the Hospital vary by service and by community as outlined in the Market Share Trends section. Of the four CAHs, two have recently completed expansion or renovations. Marshall Browning Hospital completed a $7.7 million expansion in early 2008 to add a 22,000 square foot addition housing 25 private patient rooms, surgery, laboratory, pharmacy, and inpatient rehabilitation. The space in the existing building now houses administrative and support functions. Sparta Community Hospital completed a renovation which included a new emergency department, redesigned surgical services and laboratory. In addition, Memorial Hospital of Carbondale announced a $13 million expansion which will be a two-floor addition over the existing obstetrics unit. The expansion will bring the total licensed medical/surgical beds to 85, 67 private and 18 semi-private for a total bed count at the hospital of 140 (the total beds above include 26 special care beds). It will provide an additional 22,239 square feet of new space and 19,103 square feet of remodeled space. The hospital administrator indicated the expansion was necessary due to significant growth in recent years. The utilization information for the select competitor facilities for 2007 (most recent available) is presented below.

Service Area Hospital Utilization

Hospital	Reporting Period	CON Authorized Beds*	Acute** Admissions	Acute** Inpatient Days	Average Length of Stay	Average Daily Census	Occupancy Based on CON Beds	Average Available Beds
Pinckneyville Community Hospital	2007	25	657	2,121	3.2	5.8	23.28%	19
Marshall Browning Hospital	2007	25	710	2,542	3.6	7.0	27.86%	18
Sparta Community Hospital District	2007	25	1,140	3,784	3.3	10.4	41.58%	14
Washington County Hospital	2007	25	1,230	839	2.8	1.7	6.90%	23
St. Joseph's Memorial Hospital	2007	25	1,204	4,185	3.5	11.5	45.88%	13
Memorial Hospital of Carbondale	2007	140	6,734	29,781	3.4	81.6	58.28%	58
Herrin Hospital	2007	85	2,607	12,481	4.4	47.8	73.63%	17
Good Samaritan Regional Health Center	2007	134	7,725	29,791	3.9	81.6	60.91%	52
Heartland Regional Medical Center	2007	92	7,026	23,995	3.4	65.7	71.46%	26
St. Mary's Hospital-Centralia	2007	168	6,595	24,777	3.8	67.9	40.40%	100
St. Elizabeth's Hospital	2007	332	11,886	47,852	4.0	131.2	39.51%	200
Memorial Hospital (Belleville)	2007	319	15,761	62,692	4.1	171.8	54.68%	141

*Based on Updated Bed Inventory July 20, 2009; includes reserve, and transitional beds for Acute Services
**Excludes Long Term Care, Swing Beds, Acute Mental Illness, Rehabilitation, and Observation, as applicable.

Source: Illinois Department of Public Health Hospital Profiles, 2007, Update to Inventory of Hospital Services, 7/20/09

Market Share Trends

Prior to 2007, the Hospital had the second highest discharges for the combined PSA and SSA. In 2007, the Hospital's market share experienced some erosion which continued into 2008. Management believes this is attributable to the following factors:

1. Disruption of community support caused by the closure of the long-term care unit which is believed to cause some residents to self-direct their care to other area providers.
2. Limitation of physician /caregiver availability in Pinckneyville which constrained local access
3. Marketing by other healthcare providers in the area

Summary of Significant Accounting Policies and Forecast Assumptions

Local residents seek care at over nine area hospitals within the surrounding area. These hospitals account for slightly over 91% of inpatient medical/surgical care for residents from the combined PSA and SSA (essentially Perry County) who are discharged from Illinois based providers. Accordingly, the market is considered competitive and diffused. Since the total market share for the nine hospitals has been relatively consistent over the period, there were shifts in relative market position among the providers, not a significant increase in outmigration from the defined PSA/SSA. The hospitals that materially increased market share are Memorial Hospital of Carbondale and St. Elizabeth's Hospital in Belleville.

In summary, the total market, expressed by total inpatient hospital discharges of residents in the PSA/SSA, declined by approximately 4.4% (2,867 in 2004 to 2,740 in 2008) and the market share of the nine identified hospitals for these residents declined approximately 5.4% (2,645 in 2004 to 2,501 in 2008).

PCH Combined PSA and SSA Market Share by Hospital

	2004		2005		2006		2007		2008	
Hospital	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Memorial Hospital of Carbondale	729	25.4%	747	26.0%	733	25.1%	801	28.5%	833	30.6%
Pinckneyville Community Hospital	656	22.9%	723	25.2%	694	23.7%	577	20.5%	481	17.6%
Marshall Browing Hospital	554	19.7%	576	20.1%	637	21.8%	582	20.7%	537	19.6%
Sparta Community Hospital	315	11.0%	244	8.5%	241	8.2%	228	8.1%	234	8.5%
St. Elizabeth's Hospital-Belleville	99	3.5%	98	3.4%	115	3.9%	130	4.6%	132	4.8%
Memorial Hospital-Belleville	68	2.1%	68	2.3%	60	2.1%	61	2.2%	71	2.6%
Herrin Hospital	71	2.5%	58	2.0%	68	2.3%	70	2.5%	76	2.8%
Heartland Regional Medical Center	61	2.1%	45	1.6%	63	2.2%	69	2.5%	87	3.2%
Good Samaritan Regional Health Center	62	2.2%	52	1.8%	44	1.5%	66	2.3%	45	1.6%
Subtotal	2645	92.3%	2606	90.9%	2655	90.9%	2584	92.0%	2501	91.3%
Other Hospital Facilities*	222	7.7%	260	9.1%	268	9.2%	225	8.0%	239	8.7%
Total PSA and SSA	2867	100.0%	2869	100.0%	2923	100.0%	2809	100.0%	2740	100.0%

Source: COMPdata

*Washington County Hospital and St. Joseph Memorial Hospital have less than 2% market share in the combined PSA and SSA for Pinckneyville Community Hospital; the other hospital facility category in this table includes 46 hospitals which provided care to the PSA/SSA residents during this period.

A new replacement hospital facility is expected to reverse recent declines in utilization and market share, assist in physician recruitment and demonstrate to the community discontinuing select historical departments was in the best economic interest of the Hospital. The new facility is designed to exceed patient and patient family expectations in terms of technological advancement, quality, comfort, and positive patient- and family-oriented health care experience.

The Hospital focuses on providing primary hospital care (e.g. general medicine and surgery) to the residents of its service areas. The market share for each of these services is expected to return to historical levels as the active medical staff of the Hospital are replaced and as access to medical staff improves. Access to the active medical staff physicians and the allied health providers has been constrained in recent years primarily due to physician availability.

As indicated in the table the Hospital's market share decreased approximately 5% from 2004 through 2008 causing the Hospital to slip from the number two provider in 2004 in the PSA/SSA to third in 2008, 2% behind Marshall Browning Hospital. Memorial Hospital of Carbondale has enjoyed the largest market share for all periods presented, but has increased its market share in recent years. Additional active medical staff members will assist the Hospital in re-establishing its former market share for these services as greater and easier access to physician and allied health services will result in greater utilization of local health care resources. Market share is also expected to increase as current patients and their families share their positive experiences with the new facility and its staff with members of the community that access care outside of the community. The new replacement hospital will also enhance the Hospital's ability to compete with the other CAH's that have recently undergone additions or renovations.

Hospital Medical Staff Profile

Medical staff composition: As of April 30, 2009, the Hospital's medical staff consisted of five active and nineteen courtesy staff and a radiology group. The active physicians consisted of 3 employed and two independent physicians. The Hospital had one employed physician leave in May 2009 and hired a replacement physician effective August 1, 2009. Effective July 1, 2009, one of the independent physicians relinquished his admitting privileges. Accordingly, the physician medical staff composition as of July 1, 2009, by specialty is outlined below. As with most CAHs, the specialists are courtesy staff and most specialty services are provided through on-site outreach clinics. The active medical staff accounted for 100 percent of the inpatient admissions in fiscal year ending April 30, 2009 and 98 percent of the swing bed admissions. The independent physician no longer utilizing the Hospital effective July 1, 2009 accounted for approximately 36% of the inpatient admissions in fiscal year ending April 30, 2009 and approximately 48% of the swing bed admissions. This factor has been considered in forecasted utilization.

Medical Staff Composition

Active	Number	Courtesy	Number
Family Practice	3	Allergy and Immunology	1
General Surgery	1	Cardiology	3
	4	Dentistry	2
		Gynecology	1
		Hematology/Oncology	2
		Neurologist/Rheumatologist	1
		Ophthalmology	1
		Pathology	3
		Podiatry	1
		Psychiatry & Neurology	1
		Pulmonology	1
		Radiology	1
		Sleep Medicine	1
		Urology	1
			20
		Group	

Source: Hospital Records

There have been no significant changes in medical staff composition from August 1, 2009 through the date of this report.

The outreach physicians are available in the Pinckneyville clinic site as follows:

Outreach Clinics

	Availability
Allergy and Immunology	16 hours/month
Cardiology	40 hours/month
Gynecology	4 hours/week
Hematology/Oncology, physician	56 hours/month
Hematology/Oncology, clinic	168 hours/month
Neurologist/Rheumatologist	6 hours/month
Ophthalmology, surgery	4 hours/month
Podiatry	7 hours/week
Pulmonology	7 hours/month
Sleep Medicine	2-3 nights/month
Urology	8 hours/month
Wound Care/Ostomy Nurse	6 hours/week

Source: Hospital Records

Summary of Significant Accounting Policies and Forecast Assumptions

All of the active staff members of the Hospital are located in the same clinic space. The Hospital owns the clinic building and physical assets and employs the non-physician staff, including two physician assistants. The Hospital employs the three family practice physicians and the general surgeon is independent. The allied health providers have their own clinic practice, but do not admit patients. A summary of historical admissions and outpatient service by physician is as follows:

Inpatient Admissions by Physician

Physician	Age	Status	Date Left	FY 2007 Admissions	FY 2007 Percentage	FY 2008 Admissions	FY 2008 Percentage	FY 2009 Admissions	FY 2009 Percentage
Acute Care:									
Family Practice	60	Employed	NA	192	24.8%	176	32.8%	158	28.7%
Family Practice	45	Employed	NA	133	17.2%	117	21.8%	124	22.5%
Family Practice*	37	Employed	NA	-	0.0%	-	0.0%	-	0.0%
Family Practice	55	Independent	07/01/2009	244	31.5%	212	39.5%	201	36.5%
General Surgeon	67	Independent	NA	12	1.5%	12	2.2%	9	1.6%
Family Practice/Internal Medicine	<45	Employed	Various	194	25.0%	20	3.7%	58	10.5%
				775	100.0%	537	100.0%	550	100.0%
Swing Bed:									
Family Practice	60	Employed	NA	60	28.4%	47	30.7%	48	37.5%
Family Practice	45	Employed	NA	14	6.6%	14	9.2%	7	5.5%
Family Practice*	37	Employed	NA	-	0.0%	-	0.0%	-	0.0%
Family Practice	55	Independent	07/01/2009	91	43.1%	85	55.6%	63	49.2%
General Surgeon	67	Independent	NA	-	0.0%	-	0.0%	-	0.0%
Family Practice/Internal Medicine	<45	Employed	Various	45	21.8%	7	4.6%	10	7.8%
				211	100.0%	153	100.0%	128	100.0%

Source: Hospital Records
*Started August 2009

Outpatient Gross Revenues by Physician

Physician	Age	Status	Date Left	FY 2007 Gross Revenue	FY 2007 Percentage	FY 2008 Gross Revenue	FY 2008 Percentage	FY 2009 Gross Revenue	FY 2009 Percentage
Family Practice	60	Employed	NA	$ 1,926,603	8.6%	$ 2,119,144	8.4%	$ 2,370,325	9.7%
Family Practice	45	Employed	NA	1,453,679	6.5%	1,868,150	8.3%	2,231,615	9.2%
Family Practice*	37	Employed	NA	-	0.0%	-	0.0%	-	0.0%
Family Practice	55	Independent	07/01/2009	936,280	4.2%	907,947	4.0%	783,476	3.2%
General Surgeon	67	Independent	NA	1,373,923	6.1%	1,374,318	6.1%	1,438,203	5.9%
Family Practice/Internal Medicine	<45	Employed	Various	1,906,909	8.5%	505,648	2.2%	757,207	3.1%
Other	Var	Other	NA	14,877,383	66.2%	15,759,628	69.9%	16,757,331	68.9%
				$ 22,476,727	100.0%	$ 22,534,835	100.0%	$ 24,338,157	100.0%

Source: Hospital Records
*Started August 2009

The age composition of the physicians as of July 1, 2009 is as follows:

Active Physican Medical Staff by Age

	Family Practice	General Surgery
Under 40	1	-
40-49	1	-
50-59	-	-
Over 59	1	1
Total	3	1

Source: Hospital Records

The general surgeon is considering retirement in the summer of 2010. The Hospital has been actively recruiting for a general surgeon for the last two years, but has passed on the identified candidates. If a general surgeon is not recruited, the Hospital plans to either hire locums or sublet coverage from Washington County Hospital which currently employs a non-boarded general surgeon who currently operates and provides primary care in Washington County Hospital's rural health clinic. It is anticipated this individual could provide two days a week coverage which would currently meet the Hospital's needs. The eldest family practice physician has indicated an intention to work approximately ten more years and needs at least seven to reach full social security age. Management indicated the employed physicians have been supportive of the Project.

Medical staff tenure and turnover: Two of the family practice physicians have been with the Hospital for most of their medical careers. The youngest family practice physician started in August 2009 replacing a previous physician who was with the hospital for two years and left because her husband relocated to Chicago, Illinois. In the last ten years, the Hospital has had two other family practice physicians who were employed by the Hospital for six and two years, respectively. One of the physicians left to join a colleague's practice in Kansas and the other left for a lifestyle change, primarily to eliminate inpatient attendance. The independent family practice physician who relinquished admitting privileges in July 2009 was previously a long-time user of the Hospital's inpatient and outpatient services. Accordingly, the peak in medical staff occurred in the 2005-2007 time frame in which the Hospital's active staff included four family practice physicians, one internal medicine physician and a general surgeon. In fiscal years ending April 30, 2008 and 2009, the Hospital's active medical staff included four family practice physicians, three employed and one independent, and the general surgeon. The Hospital is actively recruiting to replace the independent family practice physician with an employed physician.

Physician recruitment: The Hospital recruitment plan is to return to four full-time primary care physicians and potentially add a third physician assistant. The Hospital is currently working with over a dozen recruiters to identify primary care candidates with the expectation of commitment by the end of 2010. If this fails, the Hospital will look toward recruiting a primary care physician that needs a J-1 visa waiver and would be available by July 1, 2010. In the event this avenue is pursued the Hospital would be looking for a three to five year commitment. The last two physicians were recruited between two to twelve months of initial contact. The Hospital has been actively recruiting for a general surgeon for the last two years, but has passed on the identified candidates, as noted above, and acknowledges it is difficult to recruit a general surgeon to a rural area. The alternative is to either hire locums or sublet coverage from Washington County Hospital which currently employs a non-boarded general surgeon who operates and provides primary care in Washington County Hospital's rural health clinic. It is anticipated this individual could provide two days a week coverage which would currently meet the Hospital's needs. Management believes the new facility will assist recruitment of additional medical staff members and in increasing the outreach services available to the community.

Community: Community support has been mixed primarily due to the emotional aspects of the closure of the 50-bed long-term care unit. Essentially, the residents of the long-term care unit were receiving a very high level of care within the Hospital. The closure required placement of residents at alternative care facilities as well as some loss in jobs, both of which caused some dissention in the community. At the same time, the Hospital has received at least eighteen letters of support from business leaders, healthcare entities, and municipal organizations. A review of these letters indicates the following common themes:

- The Hospital is essential to the community's economic, employment and growth prospects.
- A new facility will further enhance the community's attractiveness to people and small business.
- The residents of the community want to maintain local, quality healthcare.
- The current facility is antiquated with respect to design and space such that it does not suit current medical practice well and in certain areas, such as ER, patient privacy is an issue.

In summary, the Hospital believes that the emotional aspect of the long-term care closure will fade and the Project will be supported by the community for the aforementioned reasons.

Historical and Forecasted Utilization

In estimating future demand for health care services, historical trends in utilization are evaluated and factors that may impact the historical pattern are considered. The specific utilization rates and volume assumptions by type of service are outlined in this section.

Inpatient services: The base level considers historical and forecasted utilization based on the projected population for the PSA and SSA, the expected use rates within the PSA and the effect of the independent physician relinquishing admitting privileges but before adding the impact of the Hospital's physician recruitment plans. Specific assumptions used to develop the utilization forecast for the base level include the following:

- Population levels within the PSA and SSA are expected to be consistent with estimates published by ESRI Business Solutions and the population is expected to be stable during the forecast period.
- Given the aging population in the PSA and SSA and the fact the Hospital is a major employer in its PSA, inpatient services are expected to remain at the overall volume of inpatient services in fiscal year 2009, except for the expected decreese of admissions associated with the recently departed independent physician. The Hospital's plan for physician recruitment to replace the volume of the independent physician, however, the overall volume of inpatient services is expected to decrease approximately 29% in fiscal year 2010 and to be conservative, is expected to remain constant at that level through the forecast period. This will result in further erosion in the Hospital's market share for inpatient services.
- The percentage of discharges the Hospital receives from outside the PSA and SSA is expected to remain at its current level.
- Physicians on the Hospital's medical staff are expected to continue to support the Hospital.
- The Hospital is successful in implementing its physician recruitment plans. However, no volume is forecast in the accompanying forecasted financial statements.

Summary of Significant Accounting Policies and Forecast Assumptions

Following is the base level of discharges, patient days, average length of stay, and average daily census for the Hospital before the impact of the Hospital's physician recruitment plan.

Historical and Forecasted Inpatient Utilization - Forecast Level

Year	Discharges	Patient Days	Average Length of Stay	Average Daily Census
Acute Care:				
Historical				
2007	796	2,486	3.1	6.8
2008	563	1,930	3.4	5.3
2009	549	1,941	3.5	5.3
Forecast				
2010	390	1,360	3.5	3.7
2011	390	1,360	3.5	3.7
2012	390	1,360	3.5	3.7
2013	390	1,360	3.5	3.7
2014	390	1,360	3.5	3.7
2015	390	1,360	3.5	3.7
Swing Bed:				
Historical				
2007	214	1,968	9.2	5.4
2008	162	1,649	10.2	4.5
2009	130	1,343	10.3	3.7
Forecast				
2010	78	806	10.3	2.2
2011	78	806	10.3	2.2
2012	78	806	10.3	2.2
2013	78	806	10.3	2.2
2014	78	806	10.3	2.2
2015	78	806	10.3	2.2

Source: Hospital Records

The employed physician that left in May 2009 had unusually low discharges as compared to the other employed physicians and the predecessor employed physicians with service lengths of two to six years. The average discharge rate excluding this physician and the independent physician has generally ranged from 125 to 150 over the past five years. Management expects the physician beginning employment in August 2009 will reach a level slightly below this in approximately two years. It is anticipated a replacement physician will be located and potentially start in July 2011. Based on discussions with management, the new physicians and the new facility are expected to attract patients seeking medical/surgical care and appeal to residents of the PSA and SSA who have been leaving the area for care. The potential increase in discharges per year for family practice are detailed below including the new physician that joined the medical staff at the start of the first forecast year. To be conservative, we have assumed the Hospital will share a general surgeon with Washington County Hospital and, therefore, there will be no increases in the surgery- generated discharges during the forecast period (9 discharges in fiscal year ending April 30, 2009).

Pinckneyville Community Hospital District

Summary of Significant Accounting Policies and Forecast Assumptions

Increase in Inpatient Discharges for Family Practice

Year Recruited	Physician FTE		2010	2011	2012	2013	2014	2015
2010	0	Note 1	-	-	60	90	90	90
2011	0		-	-	-	-	-	-
2012	1	Note 2	-	75	125	150	150	150
2013	0		-	-	-	-	-	-
2014	0		-	-	-	-	-	-
2015	0		-	-	-	-	-	-
Additional Discharges			-	75	185	240	240	240

Source: Hospital Records, excludes swing beds.

Notes:

1. Physician started August 2009 and is a replacement. The increases represent a gradual increase to the historical average because the prior physician had low discharges and was only on medical staff two years.

2. Replacement FTE, however, since the discharges of the independent physician lost have been assumed to be lost in the base projection discharges related to a new physician would be expected to increase.

To be conservative, the Hospital has not included the anticipated recovery of inpatient discharges in the forecast. The total discharges with these increases remain below the historical levels in 2004 through 2006 when the Hospital had a full medical staff. To achieve the increases, the Hospital must be successful in physician recruitment and retention such that market share can be recovered.

The differences between the discharges for forecast level and the physician recruitment level are presented below.

Impact of Physician Recruitment on Inpatient Discharges

Forecast Year	Population Driven Discharges (1)	Difference Due to Physician Recruitment (2)	Physician Recruitment Driven Discharges
2010	390	-	390
2011	390	75	465
2012	390	185	575
2013	390	240	630
2014	390	240	630
2015	390	240	630

Source: Hospital Records, excludes swing beds.

(1) Includes effect of departure of independent physician
(2) Includes new physician (8/09) increasing practice

Historical and Forecasted Utilization — Outpatient Services

The forecast level of utilization considers historical and forecasted utilization based on population growth, expected capture rates within the PSA and SSA and the current and planned medical staff as discussed above.

Historical and Forecasted Outpatient Utilization - Forecast Level

Year	Outpatient Surgeries	Specialty Clinic Registrations	Emergency Room Registrations	Rural Health Clinic Registrations	Other Registrations
Historical					
2007	415	3,086	3,567	16,617	17,070
2008	418	3,294	3,622	16,640	16,919
2009	423	2,927	3,366	16,433	16,367
Forecast					
2010	410	2,839	3,265	16,433	15,876
2011	427	2,953	3,395	16,433	16,510
2012	444	3,071	3,531	16,433	17,170
2013	462	3,193	3,672	16,433	17,857
2014	480	3,321	3,819	16,433	18,571
2015	499	3,454	3,972	16,433	19,314

Source: Hospital Records

The Hospital has assumed the same conservative approach to forecasted outpatient utilization as with inpatient utilization in that utilization will be affected by the departure of the independent physician and other turnover in the medical staff as previously discussed. However, the impact on outpatient utilization is less severe because there is essentially no impact on the rural health clinic registrations and the outpatient registrations attributable to the independent physician represent approximately 3.5% of total registrations. In total, the employed physicians, independent primary care physician and independent surgeon accounted for approximately 50% of the total outpatient registrations. Historically, outpatient registrations have experienced significant growth prior to fiscal year ending April 30, 2007 and fairly stable (other than the general impact of current economic conditions) since that time. Management believes that the residents in the PSA prefer to have testing and ongoing outpatient treatment locally and this trend will continue particularly as the PSA population ages. In addition, based on discussions with management, the new physician and the new facility are expected to attract patients seeking outpatient services and appeal to residents of the PSA and SSA who have been leaving the area for care.

Note 6. Recast of Historical Statements of Revenues and Expenses (Compiled; See Accountant's Report)

The Hospital's home health and hospice operations, durable medical equipment operations and long-term care operations were discontinued in April 2008, August 2008 and September 2008, respectively. In November 2000, the Hospital was designated as a CAH and while this change afforded the Hospital more stable revenue from Medicare, it also resulted in overhead being reallocated to non-hospital services and hence lowering reimbursement. The home health, hospice and durable medical equipment's contributions to overhead were positive, but declining and the long-term care unit was running at an operational deficit. Management and the Board of Directors engaged in several studies of the situation and concluded the closure of these services was in the best economic interest of the Hospital for a sustainable and viable future. Since these services were discontinued in late fiscal year ended April 30, 2008 or early fiscal year April 30, 2009, the historical statements have been recast as if these services were not provided in the historical years presented. The recasting considers, the elimination of direct revenue and expenses attributable to these services, other reductions in supporting services revenue and supporting expenses such as dietary, laundry, supplies, and pharmacy. In addition, the reimbursement from Medicare was recalculated based on the recast cost methodology. The discontinued services are recast assuming discontinuance as of April 30, 2006 to exclude all identifiable affects of these operating departments for the fiscal years presented below.

Pinckneyville Community Hospital District

Summary of Significant Accounting Policies and Forecast Assumptions

In fiscal year ended April 30, 2008, the Hospital received an $899,500 reimbursement settlement from Medicare related to amended cost reports filed for fiscal years ended April 30, 2003 through 2006. This settlement primarily related to professional fee revenues and related expenses, mismatching of oncology revenue and expenses with radiology and corrections to the rural health clinic lab and physician productivity calculations. It is a one time event related to prior periods and has been adjusted out of the recast financial statements presented below as a quality of earnings adjustment.

The recast historical statement of revenues and expenses is below:

Historical Statements of Revenue and Expenses, Recast for Discontinued Services

	2007	2008	2009
Operating revenue:			
Net patient service revenue (1)	$ 17,730,352	$ 16,785,138	$ 17,809,585
Other operating revenue, other than tax revenue	94,711	144,087	192,218
Total operating revenue other than tax revenue	17,825,063	16,929,225	18,001,803
Operating expenses:			
Salaries	6,946,888	7,246,957	7,714,197
Employee benefits	2,124,463	2,092,361	2,281,844
Specialist fees	958,143	1,196,384	1,291,521
Supplies and minor equipment	1,071,036	935,319	1,056,452
Repairs and service	508,724	461,766	597,275
Utilities and telephone	337,508	337,624	298,629
Drugs	2,159,677	2,042,479	2,036,061
Purchased service	885,586	766,326	837,786
Training, dues, travel,recruitment	157,767	196,009	210,867
Marketing	92,743	101,016	84,597
Rent and leases	105,307	145,491	152,932
Other expenses	235,819	399,364	357,612
Insurance	494,460	337,531	333,540
Interest	68,057	75,250	56,555
Depreciation	837,478	858,327	771,574
Amortization	-	-	-
Loss on disposal of capital assets	-	-	-
Total operating expenses	16,857,656	17,143,184	18,082,643
Income (loss) from operations	967,407	(213,959)	(80,840)
Nonoperating revenue (expenses):			
Interest earnings	345,089	375,553	264,888
County tax revenue	217,334	216,730	217,842
Gain (loss) on disposal of capital assets	(8,105)	(2,176)	391
Gifts	57,945	92,822	82,756
	612,243	684,839	565,879
Change in net assets, as recast	$ 1,579,650	$ 470,880	$ 485,039
Change in net assets, as audited	$ 1,234,867	$ 608,880	$ 181,987
Less: Quality of earnings adjustment	-	(899,500)	-
Change in net assets, as audited, less prior year Medicare reimbursements	$ 1,234,867	$ (90,620)	$ 181,987

Source: Hospital Records

Note 1: Includes adjustment for quality of earnings.

Note 7. Forecasted Revenue Assumptions

Gross patient revenue: Gross patient revenue is based on the forecasted charge structure, occupancy levels and units of service. The forecasted utilization is based on the Hospital's assumptions for each of the existing service areas. The forecasted charge structure is developed by applying assumed annual rate increases to the average charges per unit of service. Gross revenue is forecast as follows:

Gross Revenue

	2010	2011	2012	2013	2014	2015
Gross revenue:						
Hospital	$ 26,981,183	$ 29,254,035	$ 31,724,448	$ 34,402,672	$ 37,321,839	$ 40,495,759
Clinic	1,337,118	1,390,603	1,446,227	1,504,076	1,564,239	1,626,809
Total	$ 28,318,301	$ 30,644,638	$ 33,170,675	$ 35,906,748	$ 38,886,078	$ 42,122,568

Net patient revenue reflects the gross charges forecast to be billed less contractual adjustments and discounts provided to various third-party payers and uncollectible accounts (bad debts). Contractual adjustments and discounts apply to the Medicare and Medicaid programs and the various insurance contracts in which the Hospital expects to participate. It is forecast that the significant contracts with insurance companies provide for reimbursement at a discounted amount from gross charges, which is consistent with the current contracts with these payers.

The annual price increases for the Hospital are forecasted to occur at the beginning of the year and will approximate 5 percent for each of the years ending April 30, 2010 through 2015. The total net revenue is expected to increase as a result of price increases implemented by the Hospital or as provided by regulation and negotiations. To be conservative, it is assumed that price increases will not increase net revenue from Medicaid or self pay payer classes.

Annual utilization is forecast as follows:

Forecasted Utilization - Hospital

Year forecasted	Discharges	Patient Days	Average Length of Stay	Average Daily Census
Acute Care:				
2010	390	1,360	3.5	3.7
2011	390	1,360	3.5	3.7
2012	390	1,360	3.5	3.7
2013	390	1,360	3.5	3.7
2014	390	1,360	3.5	3.7
2015	390	1,360	3.5	3.7
Swing Bed:				
2010	78	806	10.3	2.2
2011	78	806	10.3	2.2
2012	78	806	10.3	2.2
2013	78	806	10.3	2.2
2014	78	806	10.3	2.2
2015	78	806	10.3	2.2

Forecasted Utilization - Outpatient Services

Year forecasted	Outpatient Surgeries	Specialty Clinic Visits	Emergency Room Procedures	Rural Health Clinic Visits	Outpatient Visits
2010	410	2,839	3,265	16,433	15,876
2011	427	2,953	3,395	16,433	16,510
2012	444	3,071	3,531	16,433	17,170
2013	462	3,193	3,672	16,433	17,857
2014	480	3,321	3,819	16,433	18,571
2015	499	3,454	3,972	16,433	19,314

Gross Charge Per Unit of Service

	2010	2011	2012	2013	2014	2015
Hospital-Per Patient Day (1)						
Room and Board	$ 520	$ 543	$ 566	$ 593	$ 620	$ 648
Ancillary Services (2)	1,007	1,053	1,100	1,149	1,201	1,255
Outpatient services						
Surgery, per case	2,414	2,527	2,648	2,774	2,911	3,052
Emergency room, per visit	674	707	741	776	814	853
Outpatient other, per visit	1,094	1,147	1,202	1,259	1,319	1,382
Rural health clinic	81	85	88	92	95	99

(1) Includes swing bed revenue
(2) Per room and board patient day

The forecasted third-party payer mix is based on historical net patient revenue with third-party payers as presented in the historical financial statements. It is forecast that the third-party payer mix for inpatient and outpatient services will remain consistent throughout the forecast period as follows:

Forecasted Payer Mix

Payer	Inpatient	Outpatient
Medicare	89.7%	42.5%
Medicaid	1.9%	4.7%
Blue Cross Blue Shield	*	15.0%
Healthlink	*	12.7%
Other Commercial Payers	8.4%	23.5%
Self-pay	*	1.6%

*Individually not significant

Medicare: Government payers are a significant source of the forecasted revenues for the Hospital, as noted above. The laws and regulations of these government programs are complex, subject to frequent change and subject to interpretation. The forecast has been prepared using the regulations in effect at the date of the forecast. Medicare regulations are subject to change, and such future changes may have an adverse impact on the forecast.

Provision for doubtful accounts: This expense includes primarily financial-need based adjustments, or charity care, and uncollected accounts. The provision for doubtful accounts is forecasted as a percent of gross revenue and is based on historical results. The provision for doubtful accounts is included in the overall calculation of net revenue by service and payer and approximate 3% of gross revenue during the forecast period as follows:

Historical and Forecast Provision for Doubtful Accounts

Year	Gross Revenue	Provision for Doubtful Accounts	Percentage of Gross Revenue
Historical			
2007	$ 28,799,461	$ 220,154	0.8%
2008	27,556,292	947,178	3.4%
2009	29,216,581	876,933	3.0%
Forecast			
2010	28,318,301	849,549	3.0%
2011	30,644,638	919,339	3.0%
2012	33,170,675	995,120	3.0%
2013	35,906,748	1,077,202	3.0%
2014	38,866,078	1,166,582	3.0%
2015	42,122,568	1,263,677	3.0%

Other operating revenue: Other operating revenue is comprised of fitness center fees, rebates and other miscellaneous receipts. No growth is expected in other operating revenue.

Historical and Forecast Other Operating Revenue

Year	Annual Revenue	Increase
Historical		
2007	$ 94,711	
2008	144,087	52.1%
2009	192,218	33.4%
Forecast		
2010	192,218	0.0%
2011	192,218	0.0%
2012	192,218	0.0%
2013	192,218	0.0%
2014	192,218	0.0%
2015	192,218	0.0%

Grant revenue: As explained in Note 4, the forecast assumes the Hospital will receive a direct federal subsidy payment from the Treasury Department for a portion of their borrowing costs equal to 35% of the total coupon interest paid to investors. Current Medicare regulations do not require that grant revenue be offset against the related expense, however the laws and regulations are complex, subject to frequent change and subject to interpretation. We have been unable to confirm that these payments are in compliance with Medicare grant revenue definitions. To be conservative, we have presented the gross grant revenue as non-operating income, but have assumed that Medicare cost reimbursements would be reduced for a portion of these payments. The reductions are assumed to be in the same proportion as the related interest expense that is cost eligible for Medicare cost reimbursement methodology. The impact of the federal subsidy associated with the Build American Bond program is forecast as follows:

Interest Subsidy Effects

Year	Federal Subsidy Grant Revenue	Reduction in Medicare Reimbursement	Forecasted Net Increase in Income
Forecast			
2010	$ -	$ -	$ -
2011	255,616	(107,614)	148,002
2012	885,533	(459,591)	425,941
2013	1,027,434	(549,677)	477,757
2014	1,004,787	(537,561)	467,226
2015	980,998	(524,834)	456,164

If this subsidy meets the Medicare regulations for grant revenue, the impact would not adversely affect the forecast.

County tax revenue: While the Pinckneyville Community Hospital District has taxing authority, the forecast assumes there will be no increases in county tax revenues.

Note 8. Forecasted Operating Expense Assumptions

Salaries and benefits: Salaries and expense is forecasted on an average salary per full-time-equivalent employee (FTE). Estimates were developed by the Hospital based on historical staffing levels and forecasted staffing patterns and have been adjusted for anticipated operating levels and the Hospital's expectations. The historical employee FTEs have been recast to eliminate the discontinued operations. Following is a summary of the historical and forecast FTEs:

Historical and Forecast Physician and Employee (FTEs)

Year	FTEs	Average Annual Salary per FTE	Increase in Average Salary
Physicians:			
Historical			
2007	3.28	$ 220,931	
2008	3.00	228,832	3.6%
2009	2.92	232,355	1.5%
Forecast			
2010	3.00	234,074	0.7%
2011	3.00	242,267	3.5%
2012	4.00	237,535	-2.0%
2013	4.00	249,412	5.0%
2014	4.00	261,883	5.0%
2015	4.00	274,877	5.0%
Employees:			
Historical			
2007	178.42	34,874	
2008	180.61	36,323	4.2%
2009	180.80	38,814	6.9%
Forecast			
2010	180.00	40,392	4.1%
2011	180.00	41,805	3.5%
2012	181.00	43,835	4.9%
2013	181.00	46,027	5.0%
2014	181.00	48,328	5.0%
2015	181.00	50,745	5.0%

The average salary rate is assumed to increase approximately 3.5% per year for 2010 and 2011 and 5.0% thereafter. The Hospital is currently recruiting for an additional primary care physician and the cost for an entry-level physician and a licensed practical nurse to support the physician has been included in 2012. Management and the Board of Directors do not anticipate significant, broad based market adjustments in the current economic environment, due to the low in-patient volumes and the high unemployment rate in the area. Market rate adjustments may be considered if these conditions were to change.

Employee fringe benefits include Social Security taxes, unemployment compensation, workers' compensation, group health insurance,, and other. The total of these items has been forecasted to approximate 30 percent of total payroll expense in each fiscal year and remain at that level throughout the forecast period. The Hospital does not expect to implement any additional new major fringe benefit programs during the forecast period. The actual benefits for those FTEs associated with the discontinued operations have been eliminated from the historical data. The following is a summary of the historical and forecast employee benefits:

Historical and Forecast Benefits

Year	Salary	Benefits	Benefits Percentage of Salary
Historical			
2007	$ 6,946,888	$ 2,124,463	30.6%
2008	7,246,957	2,092,361	28.9%
2009	7,714,197	2,281,844	29.6%
Forecast			
2010	7,972,708	2,391,812	30.0%
2011	8,251,751	2,475,525	30.0%
2012	8,884,339	2,665,302	30.0%
2013	9,328,556	2,798,567	30.0%
2014	9,794,983	2,938,495	30.0%
2015	10,284,733	3,085,420	30.0%

Specialist fees: Specialist fees include medical coverage for emergency room, pathology and oncology services as well as various consultant and legal fees. While some of the items included are considered one time or infrequent expenditures, however to be conservative, the Hospital has assumed a 5% annual increase in the forecast. A summary of the major items included in specialist fees is as follows:

Historical and Forecast Specialist Fees

Year	Emergency Coverage	FTEs	Oncology Coverage	FTEs	Pathology Coverage	FTEs	Other Consulting	Total
Historical								
2007	$ 656,513	4.2	$ 194,000	0.2	$ 9,525	0.1	$ 108,105	$ 968,143
2008	745,104	4.3	259,500	0.3	15,178	0.1	178,582	$ 1,198,364
2009	784,770	4.2	320,000	0.3	15,687	0.1	171,064	$ 1,291,521
Forecast								
2010	824,009	4.2	336,000	0.3	16,471	0.1	179,617	$ 1,356,097
2011	865,209	4.2	352,800	0.3	17,295	0.1	188,598	$ 1,423,902
2012	908,469	4.2	370,440	0.3	18,160	0.1	198,028	$ 1,495,097
2013	953,893	4.2	388,962	0.3	19,068	0.1	207,929	$ 1,569,852
2014	1,001,587	4.2	408,410	0.3	20,021	0.1	218,326	$ 1,648,344
2015	1,051,667	4.2	428,831	0.3	21,022	0.1	229,242	$ 1,730,762

Supplies and minor equipment: This expense includes general supplies, medical and administrative, and small equipment under the Hospital's capitalization policy. Leases, rentals and purchased services are accounted for separately. The Hospital has assumed a 5% annual increase in the forecast.

Summary of Significant Accounting Policies and Forecast Assumptions

Purchased services: Purchased services includes temporary nursing and other staff, anesthesia services, mobile imaging services, outside laboratory fees, a dietary consultations and a wide range of contracted maintenance and administrative services. Maintenance and administrative services include such items as waste disposal, inspection fees, paper-shredding services, collection agency fees, and certain patient claim and statement processing fees. The Hospital has assumed a 5% annual increase in the forecast. A summary of the major items included in purchased services is as follows:

Historical and Forecast Purchased Services

Year	Anesthesia Services	FTEs	Temporary Staff	FTEs	Mobile Imaging	Lab Services	Admin Services	Other	Total
Historical									
2007	$ 248,888	1.0	$ 167,779	2.2	$ 173,410	$ 115,979	$ 83,732	$ 95,698	$ 885,586
2008	259,000	1.0	28,677	0.3	168,930	156,727	75,956	77,036	766,326
2009	270,055	1.0	46,722	0.5	179,418	183,779	61,564	96,248	837,786
Forecast									
2010	283,558	1.0	49,058	0.5	188,389	192,968	64,642	101,060	879,675
2011	297,736	1.0	51,511	0.5	197,808	202,616	67,874	106,113	923,659
2012	312,622	1.0	54,087	0.5	207,699	212,747	71,268	111,419	969,842
2013	328,254	1.0	56,791	0.5	218,084	223,385	74,831	116,990	1,018,334
2014	344,666	1.0	59,630	0.5	228,988	234,554	78,573	122,840	1,069,251
2015	361,900	1.0	62,612	0.5	240,437	246,281	82,502	128,982	1,122,713

Rent and leases: Rent and leases includes operating leases for various equipment such as postage machine, copier machine, and telephone system. The Hospital also rents off-site medical record storage and records software licensing fees in this expense account. The Hospital has assumed a 5% annual increase in the forecast.

Insurance expense: Insurance expense primarily includes general liability, fidelity, directors and officers, property, earthquake and employed physician's malpractice insurance. A significant decrease was realized between fiscal year ending April 30, 2007 and April 30, 2008 which can be primarily attributable to a decrease in the number of employed physicians. Fiscal year ending April 30, 2007 also included a $75,000 adjustment to increase the reserve for incurred but not reported professional liability claims. The Hospital has assumed a 5% annual increase in the forecast. A summary of the major items in insurance expense is as follows:

Historical and Forecast Insurance Expense

Year	General Liability	Incr	Property	Incr	Earthquake	Incr	Physican Malpractice	Incr	Other	Incr	Total
Historical											
2007	$ 229,440		$ 36,227		$ 30,588		$ 104,664	0.0	$ 93,521	0.0	$ 494,460
2008	227,892	-0.7%	32,279	-10.9%	23,001	-24.8%	40,606	-61.2%	13,753	-85.3%	337,531
2009	235,338	3.3%	30,669	-5.0%	16,523	-28.2%	34,609	-14.8%	16,401	19.3%	333,540
Forecast											
2010	247,105	5.0%	32,202	5.0%	17,349	5.0%	36,339	5.0%	17,221	5.0%	350,217
2011	259,460	5.0%	33,813	5.0%	18,217	5.0%	38,156	5.0%	18,082	5.0%	367,728
2012	272,433	5.0%	35,503	5.0%	19,127	5.0%	40,064	5.0%	18,986	5.0%	386,114
2013	286,055	5.0%	37,278	5.0%	20,084	5.0%	42,067	5.0%	19,936	5.0%	405,420
2014	300,358	5.0%	39,142	5.0%	21,088	5.0%	44,171	5.0%	20,932	5.0%	425,691
2015	315,375	5.0%	41,099	5.0%	22,142	5.0%	46,378	5.0%	21,979	5.0%	446,975

Interest expense: Interest expense includes interest on existing debt and expected interest on the proposed financing for the project as follows:

Historical and Forecast Interest Expense

Year	Existing Debt	Project Financing	Total
Historical			
2007	$ 88,067	$ -	$ 88,067
2008	75,250	-	75,250
2009	56,555	-	56,555
Forecast			
2010	41,011	-	41,011
2011	34,843	-	34,843
2012	27,862	2,046,251	1,357,925
2013	20,790	3,025,676	1,987,609
2014	13,692	2,958,375	1,936,635
2015	6,252	2,887,500	1,883,127

Interest expense is forecast based on the payment terms as described in Note 9.

The U.S. Department of Housing and Urban Development required mortgage insurance premiums are presented separately on the statement of revenues and expenses and are based on the financing costs as described in Note 9.

Additional financing costs may be incurred as a result of a delay in the final endorsement by the U.S. Department of Housing and Urban Development primarily due to interest-rate sensitivity and inflation risk as it relates to construction costs. In addition, the Build America Bond program is only in effect for taxable bonds issued in 2009 and 2010.

Depreciation and amortization: Forecasted land improvements, buildings, and equipment and the depreciation expense related to such property consists of assets included in the Project (see Note 3), the Hospital's anticipated capital expenditures (renewal and replacements) during the forecast period, and the equipment expected to be retained from current operations. An estimated useful life is assigned to each category of asset and depreciated on a straight-line basis over the useful life of the asset.

Deferred financing costs are amortized to expense over the term of the debt using the effective-interest method.

Other operating expenses: All other operating expenses as detailed on the statement of revenues and expenses are assumed to increase 5% annually based on the Hospital's historical levels and the Hospital's cost estimates applied to forecasted utilization. Inflation for other expenses is assumed to approximate 3 percent per year and is included in the total annual increase.

Note 9. Forecasted Balance Sheet Assumptions

Cash and cash equivalents: Management estimates the Hospital requires $700,000, which approximates 15 days operating expenses excluding depreciation, amortization and interest, for operations. Cash flows generated from operations in excess of this amount are assumed to be invested in accordance with the Hospital's investment policies and are recorded on the balance sheet as short-term investments.

Summary of Significant Accounting Policies and Forecast Assumptions

Assets limited as to use or restricted – current: Prior to the issuance of bonds for the Project, the amount of current assets limited or restricted is equal to the current principal portion of bonds outstanding and donor restricted funds. Subsequent to September 1, 2011, it also includes a $250,000 working capital reserve required by the U.S. Department of Housing and Urban Development.

Patient accounts receivable, net: Patient accounts receivable are stated net of allowances for bad debts and contractual adjustments from third-party payers. Net patient and third-party payer accounts receivable are forecast based on day's revenue outstanding, as follows:

Historical and Forecast Days Receivables

Year	Days' Net Revenue Outstanding
Historical	
2007	55.6
2008	47.8
2009	41.6
Forecast	
2010	49.0
2011	49.0
2012	49.0
2013	49.0
2014	49.0
2015	49.0

The days net revenue in has been declining over the historical period indicating more timely collection and receipt. Management believes 49 days is a conservative estimate during the forecast period.

Inventories: Inventory is forecast to increase 4% annually, primarily due to inflation of cost.

Prepaid expenses and other: Prepaid expenses and other are forecast to increase 4% annually, primarily due to inflation cost. There are no individual items greater than $100,000 with the exception of prepaid insurance.

Non-current cash and investments: Non-current cash and investments are comprised of Board designated funds for capital expenditures, donor restricted funds and funds restricted for debt service.

Board designated funds: The Hospital deposits $25,000 per month as a reserve for capital improvements. Management anticipates using a portion of this fund for the Project and continuing to deposit $25,000 per month as a reserve for capital improvements and replacements. The historical and forecast Board designated funds are as follows:

Historical and Forecast Board Designated Funds	
Year	End of Year Balance
Historical	
2007	$ 4,716,895
2008	4,647,564
2009	3,880,039
Forecast	
2010	3,091,073
2011	660,244
2012	960,244
2013	1,260,244
2014	1,560,244
2015	1,860,244

Donor restricted funds: No change in donor restricted funds is forecast.

Mortgage Reserve Fund: Management is not forecasting any significant change in debt service reserves for debt in place as of April 30, 2009. The debt service fund related to the financing associated with the Project is forecast as required by the U.S. Department of Housing and Urban Development. The requirement is to fund one year's debt service (principal and interest) in equal installments over five years and increase the reserve over the next five years to equal two year's debt service (principal and interest). The historical and forecast debt service fund is as follows:

Historical and Forecast Mortgage Reserve Funds	
Year	End of Year Balance
Historical	
2007	$ 712,644
2008	373,483
2009	385,858
Forecast	
2010	385,858
2011	385,858
2012	800,841
2013	1,516,409
2014	2,239,166
2015	2,969,184

Summary of Significant Accounting Policies and Forecast Assumptions

Capital assets: Property, furnishings and equipment are stated at estimated cost. Capital expenditures, apart from the Project (see Note 3), are forecast to be:

Historical and Forecast Capital Expenditures

Year	Major Purchase	Notes	Normal Replacement	End of Year Total
Historical				
2007	$ 706,939	1	$ 279,494	$ 986,433
2008	-		508,738	508,738
2009	341,887	2	196,165	538,052
Forecast				
2010	-	3	250,000	250,000
2011	-		250,000	250,000
2012	-		250,000	250,000
2013	-		250,000	250,000
2014	-		250,000	250,000
2015	-		250,000	250,000

Note 1: Point of care equipment and software, $489,019 and automated medicine dispensing equipment $220,920.
Note 2: CT scanner $341,887.
Note 3: The cost of certain new equipment is included in the Project cost estimates.

Management anticipates reduced outlay for capital improvements due to the new facility and equipment.

A summary of capital asset activity for the forecast period follows:

Summary Property and Equipment

Asset	Balance, April 30, 2009	Additions	Transfers and Retirements	Balance April 30, 2015	Estimated Useful Life
Capital assets not being depreciated:					
Land	$ 581,385	$ -	$ 236,114	$ 345,271	N/A
Construction in process	1,304,020		1,304,020		
Total capital assets not being depreciated	1,885,405	-	1,540,134	345,271	
Capital assets being depreciated:					
Land improvements	246,028	-	246,028	-	8 to 20
Building and building improvements	5,651,524	40,383,118	5,651,524	40,383,118	5 to 40
Equipment	5,706,378	4,929,019	-	10,635,397	3 to 20
Total other capital assets at historical cost	11,603,930	45,312,137	5,897,552	51,018,515	
Less total accumulated depreciation	8,917,707	8,546,495	6,133,666	11,330,536	
Other capital assets, net	2,686,223	36,765,642	(236,114)	39,687,979	
Total capital assets, net	$ 4,571,628	$ 36,765,642	$ 1,304,020	$ 40,033,250	

Deferred financing costs, net of accumulated amortization: The issuance costs related to the Bonds are capitalized and then amortized to expense over the life of the debt using the effective-interest method.

Accounts payable: Accounts payable are forecast based on nine days of average daily supplies and other expense.

Accrued payroll and related expenses: Accrued payroll and related expenses includes vacation accrual and is forecast based on 35 days of average daily salaries and wages expense.

Estimated amounts due third parties: This is related to the Hospital's third party payers, primarily Medicare. To be conservative, no change in the balance is forecast.

Accrued interest: Accrued interest on the existing bonds and during Project construction is minimal because the existing bonds are paid in April (the Hospital's year end) and October each year and it is assumed interest during Project's construction period is paid monthly. Accrued interest upon completion of the Project represents the amount of interest due on the Bonds, related to the Project, based on semiannual interest payments due on March 1 and September 1.

Other liabilities: Other current liabilities are forecast to increase 4% annually, primarily due to inflationary cost.

Long-term debt and interest expense: Long-term debt consists of existing debt (bonds) and the Bonds related to the Project (Note 4.).

The existing debt is comprised of the following:

Existing Debt

	Maturity Date	Interest Rate	Balance at April 30, 2009
1976 revenue bonds	04/08/2015	5.00%	$ 540,000
1983 revenue bonds	08/20/2012	5.00%	31,000
2008 general obligation bonds	11/01/2015	6.20%	502,000
			$ 1,073,000

A summary of long-term debt for the forecast period is as follows:

Summary of Debt

Asset	Balance, April 30, 2009	Additions	Retirements	Balance April 30, 2015
Existing bonds	$ 1,073,000	$ -	$ 991,000	$ 82,000
Project bonds	-	40,925,000	2,745,000	38,180,000
	$ 1,073,000	$ 40,925,000	$ 3,736,000	$ 38,262,000

Actual interest rates and other financing requirements may be different than forecast.

The terms of the Project bonds are assumed to be 25 years at a fixed interest rate of 7.50%, including a mortgage servicing fee of .25%, with semi-annual payments of interest and annual payments of principal. It is assumed that the Hospital will receive a subsidy of 35% of the interest costs from the Treasury Department under the Build America Bond program which is included in this forecast as grant revenue. The Bonds will be secured by substantially all of the assets of the Hospital.

The existing debt and Project bonds mature as follows:

Maturity Schedule

Years Ending April 30	1976 Revenue Bonds	1983 Revenue Bonds	2008 GO Bonds	2010 Project Bonds
2010	$ 80,000	$ 9,000	$ 41,000	$ -
2011	80,000	10,000	70,000	-
2012	90,000	12,000	73,000	-
2013	90,000	-	76,000	870,000
2014	100,000	-	78,000	915,000
2015	100,000	-	82,000	960,000
2016-2020	-	-	82,000	5,545,000
2021-2025	-	-	-	7,040,000
2026-2030	-	-	-	8,930,000
2031-2035	-	-	-	11,325,000
2036-2037	-	-	-	5,340,000
TOTAL	540,000	$ 31,000	$ 502,000	$ 40,925,000

Note 10. Commitments and Contingencies

Risk management: The Hospital is exposed to various risks of loss from medical malpractice claims and judgments; torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illness; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Litigation: The Hospital is involved in occasional lawsuits arising in the ordinary course of its operations. In the opinion of management, the ultimate resolution of these matters is not expected to have a material adverse effect on the Hospital's financial position or change in net assets.

Note 11. Sensitivity Analysis

Because forecasts are based on assumptions about circumstances and events that have not yet occurred, they are subject to unanticipated events and circumstances that may arise as future operations actually occur. Accordingly, the actual results achieved during the forecast periods will vary from the forecasts, and the variations may be material.

Summary of Significant Accounting Policies and Forecast Assumptions

Some events or conditions may occur which would adversely affect the forecast results and affect the Hospital's ability to meet debt service requirements. Events may include, among others, changes in assumptions concerning utilization, competition, payer rates, financing terms, inflation, operating costs and legislative changes.
Utilization and competition: The Hospital has forecasted net revenues based on its marketing plan, demand analysis for its services, competitors, current and forecasted physicians that are employed, and historical relationships. There are several factors that could adversely affect the Hospital's ability to obtain the forecasted volume. Competition from other health care facilities, changes in demographics, loss of physicians and/or ability to recruit physicians, the Hospital's rates and marketing are among these factors.

Rates and payer mix: The Hospital has forecasted net revenues based on expected rates that it will negotiate or obtain from the various payers and the percentage of business with each payer. Gross rates are forecasted to increase as described in the "Gross Patient Revenue" section of Note 7.

Financing: The forecast assumes that long-term debt will be obtained at a percentage rate of 7.5 percent and the Hospital will receive a subsidy of 35% of its borrowing costs under the Build America Bond program. If the long-term debt is issued at an interest rate higher than the assumed rate or the Build America Bond program is not available, it may affect the Hospital's ability to meet debt service requirements.

Construction costs and duration of construction: The construction, design, engineering, landscaping, equipping and furnishing costs are forecasted to be completed and the Project ready for occupancy as of December 1, 2011. An increase in the cost or length of construction may cause additional cash requirements or impact the Hospital's ability to meet debt service requirements. The impact of any construction requirements associated with the Build America Bond program has not been determined.

Operating costs: The Hospital has forecasted operating expenses using various assumptions, including staffing and other costs as detailed in the forecast. Expenses are forecasted to increase based on utilization and estimated inflation rates. If expenses are higher than expected, the Hospital may experience difficulty in meeting its working capital requirements.

Legislative changes: Governmental legislation and regulation, particularly Medicare and Medicaid, may affect revenues and expenses of the Hospital. If future legislation or regulations related to the Hospital's operations are enacted, such legislation or regulations could have a material effect on the forecasted financial statements.

Sensitivity analysis: The sensitivity of changes to critical variables is an important consideration in evaluating the forecasted financial statements. The following analysis contrasts the sensitivity of certain variables assuming that only the variable being considered will change, and all other assumptions or relationships will remain as originally forecasted. The extent of increases or decreases of other variables associated with the one variable being considered has not been determined, except as noted.

Build America Bond interest subsidy recorded as grant revenue: The expected 35% of interest paid to bondholders subsidy has been included in grant revenue. The following table shows the effects not receiving the 35% subsidy from the Treasury Department, less the Medicare impact (Note 8) assuming all other factors remain static.

Years Ending 30-Apr	Net Income (Loss) As Forecast	Net Income (Loss) Sensitivity	Annual Debt Service Coverage As Forecast	Annual Debt Service Coverage Sensitivity	Cash and ST Investments As Forecast	Cash and ST Investments Sensitivity
2010	$ (27,747)	$ (27,747)	6.8X	6.8X	$ 3,898,318	$ 3,898,318
2011	438,081	290,079	2.5X	2.4X	4,880,427	4,717,778
2012	(782,398)	(1,209,966)	1.3X	1.2X	4,838,806	4,200,681
2013	34,606	(449,532)	1.2X	1.0X	3,958,161	2,823,636
2014	326,984	(151,587)	1.2X	1.1X	3,469,110	1,857,663
2015	854,506	382,228	1.3X	1.2X	3,442,387	1,360,394

Change in utilization: The forecast was prepared assuming the Hospital has a decrease in acute inpatient volume of approximately 30% and swing bed inpatient volume of approximately 40% in 2010 and no growth thereafter. Outpatient volume is forecast to decrease approximately 3% in 2010 and grow approximately 4% annually thereafter. The following table shows the effects of no additional outpatient utilization in the forecasted periods, assuming all other factors remain static.

Years Ending 30-Apr	Net Income (Loss) As Forecast	Net Income (Loss) Sensitivity	Annual Debt Service Coverage As Forecast	Annual Debt Service Coverage Sensitivity	Cash and ST Investments As Forecast	Cash and ST Investments Sensitivity
2010	$ (27,747)	$ (27,747)	6.8X	6.8X	$ 3,898,318	$ 3,898,318
2011	438,081	122,381	2.5X	2.2X	4,880,427	4,607,698
2012	(782,398)	(1,464,512)	1.3X	1.1X	4,838,806	3,933,465
2013	34,606	(1,069,108)	1.2X	.9X	3,958,161	2,005,630
2014	326,984	(1,207,071)	1.2X	.9X	3,469,110	44,280
2015	854,506	(1,211,012)	1.3X	.8X	3,442,387	(1,981,343)

Change in costs reimbursed by Medicare: The forecast was prepared based on the legislation and regulations currently in effect. The following table shows the effect in the event Medicare only reimbursed 95% of eligible costs, assuming all other factors remain static.

Summary of Significant Accounting Policies and Forecast Assumptions

Years Ending 30-Apr	Net Income (Loss) As Forecast	Net Income (Loss) Sensitivity	Annual Debt Service Coverage As Forecast	Annual Debt Service Coverage Sensitivity	Cash and ST Investments As Forecast	Cash and ST Investments Sensitivity
2010	$ (27,747)	$ (569,564)	6.8X	3.6X	$ 3,898,318	$ 3,430,248
2011	438,081	(127,864)	2.5X	1.9X	4,880,427	3,849,059
2012	(782,396)	(1,426,923)	1.3X	1.1X	4,838,806	3,172,842
2013	34,606	(698,578)	1.2X	1.0X	3,958,161	1,570,217
2014	326,984	(442,023)	1.2X	1.0X	3,469,110	316,052
2015	854,506	51,638	1.3X	1.2X	3,442,387	(509,450)

Change in operating expenses: The forecast was prepared using various assumptions, including staffing and other costs as detailed in the forecast. Expenses are forecasted to increase based on utilization and estimated inflation rates. The following table shows the effect of a 5 percent increase in operating expenses related to patient care in fiscal year 2012 upon completion of the new facility, assuming all other factors remain static.

Years Ending 30-Apr	Net Income (Loss) As Forecast	Net Income (Loss) Sensitivity	Annual Debt Service Coverage As Forecast	Annual Debt Service Coverage Sensitivity	Cash and ST Investments As Forecast	Cash and ST Investments Sensitivity
2010	$ (27,747)	$ (27,747)	6.8X	6.8X	$ 3,898,318	$ 3,898,318
2011	438,081	438,081	2.5X	2.5X	4,880,427	4,880,427
2012	(782,396)	(1,233,648)	1.3X	1.2X	4,838,806	4,175,868
2013	34,606	(705,113)	1.2X	1.0X	3,958,161	2,789,618
2014	326,984	(219,462)	1.2X	1.1X	3,469,110	1,722,863
2015	854,506	274,762	1.3X	1.2X	3,442,387	1,116,109

McGladrey & Pullen
Certified Public Accountants

Pinckneyville Community Hospital District

Financial Report
04.30.09

Contents

McGladrey & Pullen
Certified Public Accountants

Independent Auditor's Report

To the Board of Directors
Pinckneyville Community Hospital District
Pinckneyville, Illinois

We have audited the accompanying basic financial statements of Pinckneyville Community Hospital District (Hospital) as of and for the years ended April 30, 2009 and 2008, as listed in the table of contents. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Pinckneyville Community Hospital District as of April 30, 2009 and 2008, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The management's discussion and analysis on pages 3 through 10 is not a required part of the basic financial statements, but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required 2009 and 2008 supplementary information. However, we did not audit the information and express no opinion on it.

Our audits were conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Hospital's basic financial statements. The supplementary information on pages 28 through 30 is presented for purposes of additional analysis and is not a required part of the basic financial statements. The supplementary information on pages 28 and 29 for the years ended April 30, 2009 and 2008 has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole. The supplementary information on page 30 marked "unaudited" has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we express no opinion on it.

McGladrey & Pullen, LLP

Springfield, Illinois
July 17, 2009

Management's discussion and analysis of the Pinckneyville Community Hospital District's (Hospital) financial performance provides an overall review of the Hospital's financial activities for the fiscal years ended April 30, 2009, 2008 and 2007. The intent of this discussion is to provide an overview of the Hospital's performance for the years and should be read in conjunction with the accompanying financial statements and notes thereto.

Pinckneyville Community Hospital District operates a critical access hospital with 25 acute care beds and a physician clinic in Pinckneyville, Illinois. Pinckneyville Community Hospital District serves the citizens of the Perry County area and particularly the residents of Pinckneyville, Illinois.

Financial Highlights

During 2009, Hospital's assets exceeded its liabilities by $12,763,642 or approximately a 1.5% increase from April 30, 2008 and the Hospital's assets exceeded its liabilities by $12,581,655 or approximately a 7% increase from April 30, 2007 to April 30, 2008.

During 2009, Hospital's total assets increased by $206,903 or approximately 1% from April 30, 2008 and increased $216,932 or approximately 1% from April 30, 2007 to April 30, 2008.

During 2009, Hospital's total liabilities increased by $24,916 or approximately 1% from April 30, 2008 and decreased by $591,948 or approximately 19% from April 30, 2007 to April 30, 2008.

Overview of Financial Statements

The audited financial statements include: Balance Sheets, Statements of Revenue, Expenses and Changes in Net Assets, and Statements of Cash Flows plus the Notes to the Basic Financial Statements.

Our financial position is measured in terms of resources (assets) we own and obligations (liabilities) we owe at a given date. This information is reported in the Balance Sheets, which reflect the Hospital's assets in relation to its debts to bondholders, suppliers, employees, and other creditors. The excess of our assets over our liabilities is reported as Net Assets.

Information regarding the results from operations during the year is reported in the Statements of Revenue, Expenses and Changes in Net Assets. This statement shows how much our net assets increased during the year as a result of our operations, nonoperating activities, and other changes.

The Statement of Cash Flows discloses the flow of cash resources into and out of the Hospital during the year. It identifies all cash received during the year from operating activities, contributions and other sources, and how we applied those funds (for example, payment of expenses, repayment of debt, purchases of new property and equipment, and additions to and sales from the investment accounts).

The Notes to Basic Financial Statements provide additional information that is essential to a full understanding of the data provided in the financial statements.

Condensed Balance Sheets

Condensed versions of the Balance Sheets as of April 30, 2009, 2008, and 2007 follow:

	April 30,		
	2009	2008	2007
Assets			
Cash and short-term investments	$ 3,668,395	$ 2,948,444	$ 2,452,937
Restricted cash and investments	538,374	519,717	838,172
Board designated instruments	3,880,039	4,647,564	4,716,895
Total cash and investments	8,086,808	8,115,725	8,008,004
Patient accounts receivable, net	2,022,986	2,236,786	2,648,402
Other current assets	605,299	894,988	629,051
Capital assets, net	4,571,628	3,830,319	3,577,429
Total assets	$ 15,286,721	$ 15,079,818	$ 14,862,886
Liabilities			
Current liabilities	$ 1,580,079	$ 1,434,163	$ 1,906,111
Long-term debt	943,000	1,064,000	1,184,000
Total liabilities	2,523,079	2,498,163	3,090,111
Net Assets			
Invested in capital assets, net of related debt	3,498,628	2,646,319	2,187,400
Restricted	538,374	519,717	838,172
Unrestricted	8,726,640	9,415,619	8,747,203
Total net assets	12,763,642	12,581,655	11,772,775
Total liabilities and net assets	$ 15,286,721	$ 15,079,818	$ 14,862,886

Year Ended April 30, 2009: Total assets increased in 2009 due to the changes discussed below.

Capital assets of the Hospital increased $741,309 or 19% from April 30, 2008 and was primarily attributable to the architect, design, and consulting fees related to the planned construction of the new hospital building. This large increase was offset by a decrease in net patient accounts receivable of $215,800 or 10% and a decrease in inventories of $89,494 or 31% due to the discontinued operations of the Durable Medical Equipment and Skilled Care services in August and September 2008, respectively.

Year Ended April 30, 2008: Total assets increased in 2008 due to the increases discussed below.

The Hospital experienced a slight increase in cash and investments of $107,721 or 1% from April 30, 2007. Capital assets of the Hospital increased $252,890 or 7% from April 30, 2007 and was primarily attributable to the purchase of real estate for the relocation of the Hospital. The hospital also experienced an increase in estimated third party payor settlements of $220,429 or 110% from April 30, 2007.

Long-Term Debt

Long-term debt at April 30, 2009 includes revenue bonds issued in 1976 and 1982 and general obligation bonds issued in 2008 that are detailed in Note 6 to the basic financial statements. On May 1, 2008, the Hospital refunded its 1995 general obligation bonds with the issuance of 2008 general obligation refunding bonds. In addition, the Hospital made its final principal and interest payment on its 1995 revenue bonds as detailed in Note 6 to the basic financial statements.

Capital Assets

Year Ended April 30, 2009: At April 30, 2009, the Hospital had $4,571,628 invested in capital assets. This represents an increase of $741,309 in comparison to April 30, 2008 due to approximately $1,011,000 in additions to the construction in progress account relating to consulting services and fees attributable to the design and construction of the new hospital facility. Approximately $538,000 in equipment was purchased during the year and was primarily the result of the Hospital's upgrade to a more advanced and sophisticated CT scanner. The Hospital disposed of approximately $683,221 (historical cost) in equipment due to the CT scanner upgrade and also the disposal of assets related to the discontinued operations of the Skilled Care Unit as detailed in Note 10 to the basic financial statements. The majority of the disposed equipment was fully depreciated resulting in a net gain on the disposal of capital assets, including discontinued operation results, of $6,282.

Year Ended April 30, 2008: At April 30, 2008, the Hospital had $3,830,319 invested in capital assets. This represents an increase of $252,890 in comparison to April 30, 2007 due to approximately $327,000 in equipment and software purchases due to needed upgrades and replacements of older equipment, less applicable depreciation. In addition, the Hospital purchased land for the new hospital for approximately $325,000. Approximately $36,000 worth of assets were retired during the year and two pieces of equipment under capital lease became fully depreciated in 2008.

Condensed Statements of Revenue, Expenses and Changes in Net Assets

A summary version of the Statements of Revenue, Expenses and Changes in Net Assets for the years ended April 30, 2009, 2008, and 2007 (including certain reclassifications to the April 30, 2008 and 2007 originally-reported amounts due to discontinued operations) follows:

	Year Ended April 30,		
	2009	2008	2007
Net patient service revenue	$ 17,763,979	$ 17,108,060	$ 17,381,146
Other operating revenue	192,218	141,252	94,710
Total operating revenue	17,956,197	17,249,312	17,475,856
Total nonoperating revenue, net	565,879	687,774	612,243
Gain on discontinued operations	133,037	859,541	983,672
Total revenue	18,655,113	18,796,627	19,071,771
Expenses			
Salaries and wages and employee benefits	10,421,031	9,993,590	9,761,402
Purchased services and professional fees	2,193,902	2,134,329	1,928,942
Depreciation	771,573	858,327	837,478
Other operating expenses	5,030,065	4,926,251	5,221,015
Interest and amortization	56,555	75,250	88,067
Total expenses	18,473,126	17,987,747	17,836,904
Change in net assets	181,987	808,880	1,234,867
Net assets:			
Beginning	12,581,655	11,772,775	10,537,908
Ending	$ 12,763,642	$ 12,581,655	$ 11,772,775

Operations

Year Ended April 30, 2009: 2009 operating revenue showed an increase compared to the prior year. Net operating revenue increased $706,885 to $17,956,197 in 2009 from $17,249,312 in 2008, approximately 4% increase. The increase in net operating revenue was primarily attributable to an increase in outpatient service revenue of $1,829,668 or 8%. This was driven by an increase in laboratory, radiology, and physical therapy services. The increase in expenses of $485,379 was primarily driven by an increase in laboratory supplies expense, an increase in various departments' salary expense due to pay rate market adjustments, an increase in other radiology expense due to repairs and maintenance on the Hospital's CT scanner before the new CT machine was installed, and an increase in purchased services related to oncologist fees, laboratory fees, and radiology fees.

Salary expense from continuing operations was up $369,645 from prior year, an increase of 5%. Average annual merits account for 3% to 3.5% of the adjustments while pay rate market adjustments account for the remaining increase. Employee benefit expense increased $57,795 from prior year and was mainly attributable to an increase in employee health claims, as detailed in Note 7 to the basic financial statements, and partially due to increased unemployment expense given the closure of the Skilled Care Unit.

Charity care (financial need) write-offs were down $273,000 from prior year, a decrease of 64%. The large decrease in write-offs is mainly attributable to an insurance company denying an oncology claim in fiscal year 2008 due to a pre-existing condition that resulted in a large write-off in prior year. The patient's spouse filed a lawsuit but the judge upheld the insurance plan's denial. Charity care write-offs were $155,000, $428,000, and $170,000 for the years ended April 30, 2009, 2008, and 2007, respectively. This demonstrates that the unusual circumstance described previously resulted in a large increase in write-offs for the year ended April 30, 2008.

During fiscal year 2008, the Hospital discontinued the operations of its Home Health and Hospice services and during fiscal year 2009, the Hospital discontinued the operations of its Durable Medical Equipment and Skilled Care services (collectively referred to as the "discontinued services"). Net patient revenue and other operating revenue of $617,980 and $1,137 and $3,142,512 and $5,481 for the years ended April 30, 2009 and 2008, respectively, has been reported separately in the Statement of Revenue, Expenses, and Changes in Net Assets. Operating expenses in the amount of $523,458 and $2,381,537 for the years ended April 30, 2009 and 2008, respectively, have also been reported separately. Operating expenses include separately identifiable costs attributable to the operations of the discontinued services and do not include general overhead expenses, employee benefit expenses, and third party payor settlements.

Net proceeds from the sale of the Home Health and Hospice services were $100,000 resulting in a gain on disposal of $93,085. Capital assets included in the sale had a book value of $6,915 and consisted primarily of office furniture and equipment. Net proceeds from the sale of the Durable Medical Equipment and discontinuation of Skilled Care services were $84,139 resulting in a gain on disposal of $37,378. Capital assets and inventory supplies included in the sale had a book value of $46,761 and consisted primarily of equipment supplies, beds, wheelchairs, and other furniture.

During fiscal year 2008, the Hospital discontinued the operations of the Home Health and Hospice services, but contractual allowance adjustments made in fiscal year 2009 on patient receivables that were outstanding at April 30, 2008 resulted in additional amounts being reported in the Statement of Revenue, Expenses, and Changes in Net Assets for fiscal year 2009. No additional patient service revenue attributable to the Home Health and Hospice services was recognized for the year ended April 30, 2009.

Year Ended April 30, 2008: 2008 operating revenue showed a decrease compared to the prior year. Net operating revenue decreased $226,544 to $17,249,312 in 2008 from $17,475,856 in 2007, approximately 1% decrease. The decrease in net operating revenue was primarily attributable to a decrease in inpatient service revenue of $1,457,217 or 23%. This was driven by a decrease in swing bed and inpatient pharmacy revenues. The increase in expenses of $126,330 was primarily driven by an increase in purchased services related to ER professional fees and Oncologist fees.

Salaries were up $319,246 from prior year, an increase of 4.5%. Average annual merits account for 3 to 3.5% of the adjustments. Employee benefits were $87,057 under prior year.

Charity care (financial need) write-offs were up $258,000 from prior year, an increase of 152%. The large increase in write-offs is mainly attributable to an insurance company denying an oncology claim due to a pre-existing condition. The patient's spouse filed a lawsuit but the judge upheld the insurance plan's denial.

During fiscal year 2008, the Hospital submitted a revised cost report for fiscal years 2003, 2004 and 2005. The revised settlements had a favorable impact on income from operations. Prior years' third party payor settlements included in the Statement of Revenue, Expenses, and Changes in Net Assets have been shown separately below. The effect on income from operations without prior years' third party payor settlements is shown as follows:

	2008 As Reported	Prior Years' Third Party Payor Settlements	2008 Exclusive Of Prior Years' Settlements
Net patient service revenue	$ 17,108,060	$ 899,519	$ 16,208,541
Other operating revenue	141,252	-	141,252
Total operating revenue	17,249,312	899,519	16,349,793
Total expenses	17,987,747	-	17,987,747
Income (loss) from operations	(738,435)	899,519	(1,637,954)
Total nonoperating revenue, net	687,774	-	687,774
Change in net assets from continuing operations	$ (50,661)	$ 899,519	$ (950,180)

Condensed Statements of Cash Flows

A summary version of the Statements of Cash Flows for the years ended April 30, 2009, 2008, and 2007 (including certain reclassifications to the April 30, 2008 and 2007 originally-reported amounts due to discontinued operations) follows:

	Year Ended April 30,		
	2009	2008	2007
Cash provided by operating activities	$ 1,048,263	$ 719,358	$ 1,616,598
Cash provided by non-capital financing activities	300,600	293,681	275,279
Cash (used in) capital and related financing activities	(1,638,698)	(1,301,587)	(1,416,466)
Cash provided by (used in) investing activities	2,349,944	(645,000)	793,818
Net increase (decrease) in cash	2,060,109	(933,548)	1,269,229
Cash:			
Beginning	1,634,245	2,567,793	1,298,564
Ending	$ 3,694,354	$ 1,634,245	$ 2,567,793

Years Ended April 30, 2009, 2008 and 2007: Changes in the Hospitals cash flows are consistent with changes in operating income and nonoperating revenues and expense.

Economic Factors

Year Ended April 30, 2009: The Hospital is continuing its physician recruitment efforts to replace a family practice physician who left the rural health clinic in fiscal year 2007. The Hospital also continues to recruit for a new surgeon who would transition in before the retirement of the existing surgeon.

Acute Care inpatient admissions dropped by only 2.7%, representing 15 admissions. Admissions from the ER improved by 0.7% from last year; however, overall ER visits were down by 286 or 7.9% from prior year. Swing bed services experienced a larger decline, with 31 less admissions from prior year, a decrease of 19.4%. Swing beds had seen an even larger decrease from FY07 to FY08, with a drop of 54 admissions equating to a decline of 25.2%. When the Skilled Care Unit was closed, some referring hospitals incorrectly assumed that we no longer offered those same services in our swing bed unit. We responded with direct communications to referring hospitals on the continued availability of services and weekly notices regarding available beds continue to be sent. Other than that, there are no apparent reasons behind the drop in inpatient and swing bed admissions, other than patients being treated in the outpatient setting and not requiring admission.

Based on gross hospital revenues, insurance payer mix increased by 6.7% and Medicaid increased by 28.5% from prior year. The major driver appears to be an increase in Oncology services being provided to these insured individuals. In recent years, there have been new start-up mines in the Perry County area which has brought more insured individuals into the community. With private pay decreasing by 10.6%, we are seeing a shift of uninsured patients to Medicaid and emergency services for Medicaid covered individuals are also on the rise. Medicare payer mix dropped 7.3%, primarily due to the drop in inpatient and swing bed activity which is primarily Medicare.

The increase in Medicaid services during the current fiscal year had a negative impact on days outstanding in accounts receivable. Gross days in accounts receivable grew from 57.5 in fiscal year 2008 (FY08) to 61.34 in FY09. During the current fiscal year, Illinois Medicaid took an average of 151 days to pay outstanding claims. For the month ending April 2009, outstanding Medicaid gross charges totaled $1,408,172, representing approximately 196 days of outstanding unpaid claims. As part of the new federal economic stimulus law, State Medicaid programs are required to pay 90% of clean claims within 30 days and 99% of clean claims within 90 days in order to receive federal matching funds. Thus, Illinois Medicaid paid a majority of the claims after fiscal year end, bringing the outstanding Medicaid gross charges as of May 31, 2009 to $473,290, representing approximately 62 days of outstanding unpaid claims. For the first month in the new FY10, gross days in accounts receivable had dropped to 49 days outstanding, compared to the 61.34 average for FY09.

Year Ended April 30, 2008: The Hospital is continuing its physician recruitment efforts to replace a family practice physician who left the rural health clinic in fiscal year 2007. The Hospital also continues to recruit for a new surgeon who would transition in before the retirement of the existing surgeon.

Acute Care inpatient admissions dropped by 28.4%. The primary factor appears to be a change in case mix since admissions from the ER dropped 21.6% even though ER visits increased by 1.5%. ER Level 1 & 2 visits, typically involving patients who are treated and released, increased an average of 11% for each level. Whereas ER Level 4 & 5 visits, typically involving cases that would require inpatient admission or transfer, decreased an average of 12% each. Level 3 ER visits increased by 5%, but was not enough to offset the decreases in other ER treatment levels that also typically require admission. Having only 3 physicians instead of 4 appears to have some impact given that admissions did increase by 7.4% from FY05 to FY06 when a fourth physician was at the rural health clinic for a full year.

The Medicare percentage mix increased by 3%, meaning that a greater portion of the Hospital's cost will be reimbursed via the cost report. Insurance payer mix has steadily declined over the years, which is a factor of local plant closings and the growing unemployment rate in Perry County. Likewise, Medicaid payer mix has been increasing.

Contacting the Hospital's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the Hospital's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Hospital Administrator at Pinckneyville Community Hospital District, 101 N. Walnut Street, Pinckneyville, Illinois 62274-1099.

Pinckneyville Community Hospital District

Balance Sheets
April 30, 2009 and 2008

	2009	2008
ASSETS		
Current Assets:		
Cash	$ 2,330,819	$ 903,149
Short-term cash and investments - current	1,337,576	2,045,295
Restricted by donor for specific operating activities - investments	152,516	146,234
Held by trustee for debt service - investments	385,858	373,483
Patient accounts receivable, less allowances for contractual adjustments and doubtful accounts, 2009 $3,004,581; 2008 $2,719,032	2,022,986	2,238,786
Estimated third party payor settlements, net	-	420,429
Inventories	196,225	285,719
Prepaid expenses and other	409,074	188,840
Total current assets	6,835,054	6,601,935
Board designated instruments	3,880,039	4,647,564
Capital assets, not being depreciated	1,896,201	885,603
Capital assets, being depreciated, net	2,675,427	2,944,716
	4,571,628	3,830,319
Total assets	$ 15,286,721	$ 15,079,818
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Current maturities of long-term debt	$ 130,000	$ 120,000
Accounts payable	149,390	230,891
Estimated third party payor settlements, net	185,447	-
Accrued payroll and related expenses	585,436	720,805
Other	529,806	362,467
Total current liabilities	1,580,079	1,434,163
Long-term debt, less current maturities	943,000	1,064,000
Total liabilities	2,523,079	2,498,163
Commitments and Contingencies (Note 7)		
Net Assets:		
Invested in capital assets, net of related debt	3,498,628	2,646,319
Restricted:	-	
Under bond indenture	385,858	373,483
Specific operating activities	152,516	146,234
Unrestricted	8,726,640	9,415,619
	12,763,642	12,581,655
Total liabilities and net assets	$ 15,286,721	$ 15,079,818

See Notes to Financial Statements.

Pinckneyville Community Hospital District

Statements of Revenue, Expenses and Changes in Net Assets
Year Ended April 30, 2009 and 2008

	2009	2008
Operating revenue:		
Net patient service revenue	$ 17,763,979	$ 17,108,060
Other operating revenue	192,218	141,252
Total operating revenue	17,956,197	17,249,312
Operating expenses:		
Nursing services	3,023,830	2,795,822
Other professional services	8,068,207	7,710,088
General services and administration	6,407,727	6,407,610
Other administrative expenses	145,234	139,650
Depreciation	771,573	858,327
Total operating expenses	18,416,571	17,912,497
Loss from operations	(460,374)	(663,185)
Nonoperating revenue (expense):		
Investment income	264,888	375,563
Tax revenue	217,842	218,730
Gifts, grants, donations, and other	82,758	95,657
Interest and amortization	(56,555)	(75,250)
Gain (loss) on disposal of capital assets	391	(2,176)
	509,324	612,524
Change in net assets from continuing operations	48,950	(50,661)
Discontinued operations (Note 10):		
Gain from operations of discontinued Skilled Nursing Services	106,909	501,757
Gain (loss) from operations of discontinued Durable Medical Equipment	46,719	(22,290)
Gain (loss) from operations of discontinued Home Health Services	(46,371)	301,546
Gain from operations of discontinued Hospice Services	25,780	78,528
Gain on discontinued operations	133,037	859,541
Change in net assets	181,987	808,880
Net Assets:		
Beginning	12,581,655	11,772,775
Ending	$ 12,763,642	$ 12,581,655

See Notes to Financial Statements.

Pinckneyville Community Hospital District

Statements of Cash Flows
Year Ended April 30, 2009 and 2008

	2009	2008
Cash Flows from Operating Activities:		
Receipts from and on behalf of patients	$ 19,203,635	$ 20,439,759
Payments to suppliers and contractors	(7,386,697)	(7,774,678)
Payments to employees	(10,962,030)	(12,092,456)
Other receipts, net	193,355	146,733
Net cash provided by operating activities	1,048,263	719,358
Cash Flows from NonCapital Financing Activities:		
Property taxes supporting operations	217,842	218,730
Gifts, grants, donations, and other	82,758	74,951
Net cash provided by noncapital financing activities	300,600	293,681
Cash flows from Capital and Related Financing Activities:		
Principal paid on long-term debt	(620,000)	(206,029)
Proceeds from issuance of long-term debt	509,000	-
Interest paid	(51,096)	(75,250)
Purchase of capital assets	(1,548,650)	(1,120,308)
Proceeds from disposal of capital assets	1,000	-
Proceeds from disposal of discontinued operations	71,048	100,000
Net cash (used in) capital and related financing activities	(1,638,698)	(1,301,587)
Cash Flows from Investing Activities:		
Interest on investments	311,519	375,563
Purchase of investments	(3,903,475)	(6,321,822)
Proceeds from disposition of investments	5,941,900	5,301,259
Net cash provided by (used in) investing activities	2,349,944	(645,000)
Increase (decrease) in cash	2,060,109	(933,548)
Cash:		
Beginning	1,634,245	2,567,793
Ending, including cash included in current investments, 2009 $1,363,535; 2008 $731,096	$ 3,694,354	$ 1,634,245

(Continued)

Pinckneyville Community Hospital District

Statements of Cash Flows (Continued)
Year Ended April 30, 2009 and 2008

	2009	2008
Reconciliation of operating income to net cash provided by operating activities:		
Operating (loss)	$ (460,374)	$ (663,185)
Depreciation	771,573	858,327
Bad debts	876,933	947,178
Gain on discontinued operations	95,659	766,456
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(661,133)	(537,562)
Estimated amounts due to and from third-party payors	605,876	(220,429)
Accounts payable, accrued expenses, and other liabilities	(49,531)	(385,919)
Inventories, prepaids, and other assets	(130,740)	(45,508)
Net cash provided by operating activities	$ 1,048,263	$ 719,358

See Notes to Financial Statements.

Note 1. Nature of Business and Summary of Significant Accounting Policies

Nature of business: Pinckneyville Community Hospital District (the Hospital) operates a critical access hospital with 25 acute care beds and a physician clinic in Pinckneyville, Illinois. The Hospital is established in accordance with provisions of the Illinois Hospital District Law and is located in Pinckneyville, Illinois.

The Hospital primarily earns revenue by providing inpatient, outpatient, and physician clinic services to area residents. During the year ended April 30, 2009, the Hospital sold the operations of its durable medical equipment services and discontinued the operations of its skilled care services. During the year ended April 30, 2008, the Hospital sold the operations of its hospice and home health services (See Note 10).

The Hospital is exempt from income taxes under provisions of the Internal Revenue Code as a political subdivision of the State of Illinois.

A summary of the Hospital's significant accounting policies is as follows:

Basis of accounting: The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenue is recognized when earned and expenses are recorded when the liability is incurred.

Accounting pronouncements: The Hospital prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB). Pursuant to GASB Statement No. 20, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB) that were issued on or before November 30, 1989, and do not conflict with or contradict GASB pronouncements. The Hospital has elected not to follow FASB statements issued after 1989.

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

Cash and short-term investments: Cash and short-term investments include investments in highly liquid debt instruments with a maturity of twelve months or less, excluding amounts whose use is limited by board designation or other arrangements under trust agreements, with third-party payors or donors.

For purposes of the statement of cash flows, the Hospital considers only cash, including amounts whose use is limited by board designation or other arrangements under trust agreements, with third-party payors or donors.

Patient receivables: Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by identifying troubled accounts, by historical experience applied to an aging of accounts, and by considering the patient's financial history, credit history and current economic conditions. The Hospital does not charge interest on patient receivables. Patient receivables are written off as bad debt expense when deemed uncollectible and when transferred to outside collection agencies and attorneys. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

Inventories: Inventories are valued at the lower of cost (first-in, first-out method) or market.

Assets limited as to use or restricted: Assets limited as to use or restricted include assets restricted by revenue bond ordinance, donor-restricted assets and assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Note 1. Summary of Significant Accounting Policies (Continued)

Investments: Investments include certificates of deposit and pooled investment accounts and are carried at amortized cost, which approximates market value. Investment income consists of interest income and is recognized as revenue when earned.

Capital assets: Capital assets are recorded at cost or fair value if donated. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives. Amortization of assets under capital leases is included with depreciation expense on owned capital assets. Depreciation is computed by the straight-line method over estimated useful lives as follows:

	Years
Land Improvements	8 - 20
Buildings and building improvements	5 - 40
Equipment	3 - 20

The Hospital has recorded construction in progress relating to the architect, design, and consulting fees for the planned construction of the new hospital building with no interest capitalized as of April 30, 2009 and 2008.

Donations of capital assets are reported at fair value as an increase in unrestricted net assets unless use of the asset is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted net assets The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

Compensated absences: Employees accrue vacation time based upon years of service and hours worked. Accrued vacation time can be cashed-out by an employee at any during the year subject to a maximum amount of hours, which is based upon the employee's years of service.

Net patient service revenue: Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Net patient service revenue is reported net of provision for uncollectible accounts.

Operating income: The Hospital distinguishes operating revenue and expenses from nonoperating items. Operating revenue and expenses generally result from the primary purpose of the Hospital, which is to provide medical services to the region. Operating expenses consist of salaries and wages, employee benefits, purchased services and professional fees, depreciation, supplies and other. All revenue and expenses not meeting these criteria are considered nonoperating.

Tax revenue: Property taxes are recognized as assets in the period an enforceable legal claim to the assets arises and are recognized as revenue in the period for which the taxes are levied. The county levies property taxes during August for property owned as of January 1 of the previous year. Property taxes are due in two installments, the first by September and the second by October. Property taxes are collected by the county and are primarily received by the Hospital in October, November and December. Property taxes that are not available for current year operations, if any, are recognized as deferred revenue and included in other current liabilities.

Net assets: Net assets of the Hospital are defined as follows:

Invested in capital assets, net of related debt – This component of net assets consists of capital assets, including any restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. If there are significant unspent related debt proceeds at year-end, the portion of the debt attributable to the unspent proceeds is not included in the calculation of invested in capital assets component as the unspent proceeds.

Note 1. Summary of Significant Accounting Policies (Continued)

Restricted – This component of net assets consists of constraints placed on net assets through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation. The Hospital applies restricted resources when an expense is incurred for purposes for which both restricted and unrestricted net assets are available.

Unrestricted net assets – This component of net assets consists of net assets that do not meet the definition of "restricted" or "invested in capital assets, net of related debt," above.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care for the years ended April 30, 2009 and 2008 was approximately $155,000 and $428,000, respectively, based on prevailing charges.

Reclassifications: Certain 2008 data has been reclassified to conform to the 2009 presentation, with no effect on previously-reported net assets or change in net assets.

Note 2. Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare: The Hospital is designated as a critical access hospital. This designation provides for inpatient and outpatient services to be reimbursed on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. Inpatient nonacute services related to Medicare beneficiaries are paid at prospectively determined rates per day. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors.

The Hospital's Medicare cost reports have been audited and finalized by the Medicare fiscal intermediary through April 30, 2008.

Medicaid: Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under prospectively determined fee schedules.

Approximately 53% and 58% of net patient service revenue is from participation in the Medicare and state-sponsored Medicaid programs for the years ended April 30, 2009 and 2008, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

On November 21, 2006, the Federal Centers for Medicare and Medicaid Services (CMS) approved State of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program) relating to the period June 30, 2006 to June 30, 2008. On August 19, 2008, CMS approved State legislation for an extension of the Program to June 30, 2013. Under the Program, the Hospital receives additional Medicaid reimbursement from the State. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $245,376 and $349,836 during the Hospital's years ended April 30, 2009 and 2008, respectively, and is included in net patient service revenue on the statements of revenue, expenses, and changes in net assets. As a governmental entity, the Hospital did not incur any assessments related to this Program. The laws and regulations authorizing this Program expire on June 30, 2013.

Note 2. Net Patient Service Revenue (Continued)

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates. Net patient service revenue for the years ended April 30, 2009 and 2008 is as follows:

	2009	2008
Gross patient service revenue	$ 29,216,582	$ 27,556,290
Less discounts, allowances and estimated contractual adjustments under third-party reimbursement programs	10,575,670	9,501,052
Less provision for doubtful accounts	876,933	947,178
Net patient service revenue	$ 17,763,979	$ 17,108,060

Congress passed the Medicare Modernization Act in 2003, which among other things established a demonstration of The Medicare Recovery Audit Contractor (RAC) program. In 2006, Congress passed the Tax Relief and Health Care Act of 2006 which authorized the expansion of the RAC program to all 50 states. CMS is in the progress of rolling out this program nationally. As such, the Hospital may be subject to such an audit at some time in the future.

Note 3. Deposits and Investments

Authorized investments: Illinois state statues authorize the Hospital to make deposits and investments in interest-bearing depository accounts in federally insured and/or state chartered banks and savings and loan associations, or other financial institutions as designated by ordinances, and to invest available funds in direct obligations of, or obligations guaranteed by, the U.S. Treasury or agencies of the United States, money market mutual funds whose portfolios consist of government securities, the Illinois Public Treasury's Investment Pool, and the Illinois Funds Investment Pool. The Hospital's investments consist entirely of certificates of deposit and the Illinois Funds Investment Pool.

Custodial credit risk: Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to the Hospital. State law allows collateralization of deposits in excess of federal depository insurance. The Hospital's deposit policy for custodial credit risk is to obtain a pledge of collateral for deposits substantially in excess of federal depository insurance.

At April 30, 2009 and 2008, respectively, the Hospital's deposit bank balances, less federal depository insured amounts, were exposed to custodial credit risk as follows:

	2009	2008
Uninsured, collateral held by pledging financial institution's trust department or agent in other than the Hospital's name	$ 7,214,788	$ 8,136,471

The Hospital maintains a substantial portion of its deposits in two financial institutions. The Hospital has not experienced any losses in such amounts and believes it is not exposed to any significant credit risk on its deposits.

Note 3. Deposits and Investments (Continued)

The total deposits and investments in the balance sheets that are exposed to custodial credit risk, a portion of which is insured by federal depository insurance, at April 30 are as follows:

	2009	2008
Included in the following balance sheet captions:		
Cash	$ 2,314,887	$ 882,570
Short-term cash and investments - current	1,337,576	2,045,295
Board designated instruments	3,880,039	4,647,564
Restricted by donor for specific operating activities - investments	152,516	146,234
Held by trustee for debt service - investments	385,858	373,483
	$ 8,070,876	$ 8,095,146

Other information: The Illinois Funds Investment Pool (Fund) is not registered with the SEC. The Illinois Funds Investment Pool is administered by the Illinois State Treasurer and oversight is provided by the State Auditor General's Office. The fair value of the positions in the pool is the same as the value of the pool shares. The Hospital held approximately $15,400 and $20,000 in this fund at April 30, 2009 and 2008, respectively. The fund has a Standard & Poor's credit rating of AAAm and a weighted average maturity of .07 years.

Note 4. Patient Accounts Receivable

The Hospital grants credit without collateral to its patients, most of who are area residents and are insured under third-party payor agreements. Patient accounts receivable at April 30 are as follows:

	2009	2008
Medicare	$ 701,120	$ 1,018,508
Medicaid	330,476	343,684
Other third-party payors	906,313	685,935
Patients	647,863	599,941
	2,585,772	2,648,068
Less allowance for uncollectible accounts	562,786	409,282
Patient accounts receivable, net	$ 2,022,986	$ 2,238,786

Changes in the allowance for uncollectible accounts were as follows:

	Years Ended April 30,	
	2009	2008
Balance, beginning of year	$ 409,282	$ 763,039
Provision charged to operating expense	766,171	664,104
Account balances charged off	(612,667)	(1,017,861)
Balance, ending of year	$ 562,786	$ 409,282

Note 5. Capital Assets

Capital assets activity for the years ended April 30, 2009 and 2008 is as follows:

	2009				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 581,385	$ -	$ -	$ -	$ 581,385
Construction in progress	304,218	1,010,598	-	-	1,314,816
Total capital assets, not being depreciated	885,603	1,010,598	-	-	1,896,201
Capital assets, being depreciated:					
Land improvements	246,028	-	-	-	246,028
Buildings and building improvements	5,640,728	-	-	-	5,640,728
Equipment	5,851,547	538,052	-	683,221	5,706,378
Total capital assets, being depreciated	11,738,303	538,052	-	683,221	11,593,134
Less accumulated depreciation for:					
Land improvements	205,402	6,155	-	-	211,557
Buildings and building improvements	4,443,430	144,696	-	-	4,588,126
Equipment	4,144,755	620,722	-	647,453	4,118,024
Total accumulated depreciation	8,793,587	771,573	-	647,453	8,917,707
Total capital assets, being depreciated, net	2,944,716	(233,521)	-	35,768	2,675,427
Capital assets, net	$ 3,830,319	$ 777,077	$ -	$ 35,768	$ 4,571,628

	2008				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 236,114	$ 324,800	$ 20,471	$ -	$ 581,385
Construction in progress	37,922	456,932	(190,636)	-	304,218
Total capital assets, not being depreciated	274,036	781,732	(170,165)	-	885,603
Capital assets, being depreciated:					
Land improvements	246,028	-	-	-	246,028
Buildings and building improvements	5,459,107	11,456	170,165	-	5,640,728
Equipment	5,560,445	327,120	-	36,018	5,851,547
Total capital assets, being depreciated	11,265,580	338,576	170,165	36,018	11,738,303
Less accumulated depreciation for:					
Land improvements	199,247	6,155	-	-	205,402
Buildings and building improvements	4,293,575	149,855	-	-	4,443,430
Equipment	3,469,365	702,317	-	26,927	4,144,755
Total accumulated depreciation	7,962,187	858,327	-	26,927	8,793,587
Total capital assets, being depreciated, net	3,303,393	(519,751)	170,165	9,091	2,944,716
Capital assets, net	$ 3,577,429	$ 261,981	$ -	$ 9,091	$ 3,830,319

Note 6. Notes Payable

The following is a summary of long-term obligation transactions for the Hospital for the years ended April 30, 2009 and 2008:

	2009				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 620,000	$ -	$ 80,000	$ 540,000	$ 80,000
1982 Revenue bonds	39,000	-	8,000	31,000	9,000
1995 Revenue bonds	25,000	-	25,000	-	-
1995 General obligation bonds	500,000	-	500,000	-	-
2008 General obligation bonds	-	509,000	7,000	502,000	41,000
Total long-term obligations	$ 1,184,000	$ 509,000	$ 620,000	$ 1,073,000	$ 130,000

	2008				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 690,000	$ -	$ 70,000	$ 620,000	$ 80,000
1982 Revenue bonds	47,000	-	8,000	39,000	8,000
1995 Revenue bonds	85,000	-	60,000	25,000	25,000
1995 General obligation bonds	500,000	-	-	500,000	7,000
Capital lease obligations	68,029	-	68,029	-	-
Total long-term obligations	$ 1,390,029	$ -	$ 206,029	$ 1,184,000	$ 120,000

The 1976 revenue bonds bear interest at 5% payable semi-annually; maturing through April 2015.

The 1982 revenue bonds bear interest at 5% payable semi-annually; maturing through August 2012.

The 1995 revenue bonds bear interest at 5.6% to 6.05% payable semi-annually; maturing through May 2009. The 1995 revenue bonds can be paid prior to scheduled maturity at par on any interest payment date beginning November 1, 2006. The 1995 revenue bonds final principal payment along with all accrued interest due was made on April 17, 2009.

The revenue bonds are payable solely from the revenues of the facility and are not secured by the Hospital's taxing authority. The rights of the 1995 revenue bond holders are subordinated to the rights of the holders of the 1976 and 1982 revenue bonds. The 1976 and 1982 revenue bonds can be paid prior to scheduled maturity at par.

The 1995 general obligation bonds bear interest at 6.05% to 6.35% payable semi-annually maturing from November 2009 through November 2015. These bonds are secured by the Hospital's full faith and credit and taxing authority, and can be paid prior to maturity at par on any interest payment date beginning November 1, 2006. On May 1, 2008, the Hospital entered into a bond ordinance to issue $509,000 of general obligation hospital refunding bonds for the refunding of the 1995 general obligation bonds, which had an outstanding balance of $500,000 at April 30, 2008.

Note 6. Notes Payable (Continued)

The 2008 general obligation refunding bonds bear interest at 2.30% to 3.80% payable semi-annually maturing from November 2008 through November 2015. These bonds are secured by the Hospital's full faith and credit and taxing authority. The bonds were issued in an amount to satisfy the outstanding principal balance of the 1995 general obligation bonds at May 1, 2008 and to cover bond issuance costs incurred.

The bonds place limits on the incurrence of additional borrowings and requires the Hospital to satisfy certain earnings performance measures prior to early extinguishment.

Under the terms of the revenue bond indentures, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets held by trustee for debt service.

The debt service requirements as of April 30, 2009, are as follows:

Year Ending April 30,	Total to be Paid	Principal	Interest
2009	$ 174,591	$ 130,000	$ 44,591
2010	198,613	160,000	38,613
2011	206,985	175,000	31,985
2012	190,537	166,000	24,537
2013	195,456	178,000	17,456
2014 - 2018	275,209	264,000	11,209
	$ 1,241,391	$ 1,073,000	$ 168,391

Note 7. Self Insurance and Contingent Liabilities

The Hospital is a party to certain claims and legal proceedings arising in the ordinary course of its business. It is the opinion of management that any liability of the Hospital with respect to these actions will not materially affect its financial position. The Hospital is also a defendant in various lawsuits which, in the opinion of management, are covered by insurance.

Laws and regulations: The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not limited to, accreditation, licensure, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in exclusion from government health care program participation, together with the imposition of significant fines and penalties, as well as significant repayment for past reimbursement for patient services received. While the Hospital is subject to similar regulatory reviews, management believes the outcome of any such regulatory review will not have a material adverse effect on the Hospital's financial position.

Note 7. Self Insurance and Contingent Liabilities (Continued)

Medical Malpractice and General Liability Insurance: Pinckneyville Community Hospital District purchases general and professional liability insurance coverage from the Illinois Provider Trust (IPT). IPT is a pooled self-insurance trust program organized under Illinois Statutes for the purpose of providing general and professional liability insurance to member hospitals on a claims-made basis (IPT was on the occurrence-basis until January 1, 2005). Premium rates have been established based on the loss experiences of the insured hospitals and includes a provision for retrospective premium adjusted based on incurred losses, which management has determined to be approximately $100,000 at April 30, 2009 and 2008.

The Hospital also purchases claims-made medical malpractice insurance coverage for all employee physicians. These policies contain loss limits of $1,000,000 per claim and an annual limit of $3,000,000, with no deductible.

The medical malpractice insurance costs of the Hospital totaled approximately $35,000 and $41,000 for the years ended April 30, 2009 and 2008, respectively. Settled claims from these risks have not exceeded insurance coverage in any of the past three fiscal years.

Workers compensation: The Hospital is self-insured for a portion of its exposure to risk of loss from employee health claims. Annual estimated provisions are accrued for the self-insured portion of employee health claims and include an estimate of the ultimate costs for both reported claims and claims incurred but not yet reported. Workers' compensation claims outside of employee health claims are covered under the Hospitals workers' compensation insurance coverage, which contains loss limits up to statutory limits enacted by the State of Illinois.

Employee health claims: Substantially all of the Hospital's employees and their dependents are eligible to participate in the Hospital's self-insurance program for health insurance. Self-insurance is in effect up to an individual stop-loss amount of $60,000 and aggregate stop-loss amount of $2,000,000 with coverage from a private insurance company maintained for all claims in excess of the stop/loss amounts. All claim handling procedures are performed by an independent claims administrator.

A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Hospital's estimate will change by a material amount in the near term.

Activity in the Hospital's accrued employee health claims liability during the years ended April 30, 2009 and 2008 is summarized as follows:

	2009	2008
Balance, beginning of year	$ 177,000	$ 224,190
Current year claims incurred and changes in estimates for claims incurred in prior years	1,355,750	1,196,811
Claims and expenses paid	(1,332,750)	(1,244,001)
Balance, end of year	$ 200,000	$ 177,000

Note 7. Self Insurance and Contingent Liabilities (Continued)

Pension Plan: The Hospital contributes to a defined contribution pension plan covering substantially all employees. Pension expense is recorded for the amount of the Hospital's required contributions, determined in accordance with the terms of the plan. The plan is administered by the Hospital. The plan provides retirement and death benefits to plan members and their beneficiaries. Benefit provisions are contained in the plan document and were established and can be amended by action of the Hospital's governing body. Contribution rates for the Hospital were 3.5% for the years ended April 30, 2009, 2008 and 2007. Contributions made by the Hospital totaled $201,251, $204,158, and $193,411 for the years ended April 30, 2009, 2008 and 2007, respectively.

Hospital Uninsured Patient Discount Act: On May 30, 2008, the Illinois legislature passed a bill titled the "Hospital Uninsured Patient Discount Act" (Act), with provisions beginning April 1, 2009. This Act requires hospitals to provide certain mandated discounts from charges to uninsured Illinois patients that meet certain eligibility criteria. Charges are to be discounted to at least 135% of cost. Furthermore, a hospital may not collect more than 25% of an uninsured's annual family income in any one year provided that the uninsured meets certain eligibility criteria and does not have significant assets. The Hospital implemented the Act on January 1, 2009. Discounts provided to uninsured patients for the year ended April 30, 2009 approximated $28,400 and is included in net patient service revenue.

Compensated absences: Activity in the Hospital's accrued vacation liability is as follows:

	Years Ended April 30,	
	2009	2008
Balance, beginning of year	$ 434,655	$ 449,477
Earned	420,356	449,122
Used or cashed-out	(433,476)	(463,944)
Balance, ending of year	$ 421,535	$ 434,655

Note 8. Restricted and Designated Net Assets

At April 30, 2009 and 2008, restricted expendable net assets were available for the following purposes:

	2009	2008
Debt service	$ 385,858	$ 373,483
Specific operating activities	152,516	146,234
Total restricted expendable net assets	$ 538,374	$ 519,717

At April 30, 2009 and 2008, $3,880,039 and $4,647,564, respectively, of unrestricted net assets has been designated by the Hospital's Board of Directors for capital acquisitions. Designated net assets remain under the control of the Board of Directors which may, at its discretion, later use these net assets for other purposes.

Note 9. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross patient receivables from patients and third-party payors at April 30, 2009 and 2008 was as follows:

	2009	2008
Medicare	29%	43%
Commercial insurance and other	30%	22%
Private pay	13%	12%
Medicaid	28%	23%
	100%	100%

Note 10. Discontinued Operations

On March 17, 2008, the Hospital entered into an asset purchase agreement with an unrelated third-party to sell the Hospital's Home Health and Hospice services (servicing lines) for $100,000. Assets sold in conjunction with this asset purchase agreement include various office equipment, the servicing lines' training materials, policy and procedural manuals, office supply inventory, and the medical records for active patients. Patient receivables for the servicing lines for services performed up to the date of the sale were retained by the Hospital in accordance with the asset purchase agreement. The patient receivable balances for the servicing lines are included in the accompanying Balance Sheet in the amount of $80,045 at April 30, 2008. There were no outstanding patient receivables for the servicing lines at April 30, 2009. No liabilities or other obligations were assumed by the third-party. The results of the servicing lines' operations have been reported separately as discontinued operations in the Statements of Revenue, Expenses, and Changes in Net Assets.

On August 31, 2008, the Hospital entered into an agreement with an unrelated third-party to sell the Hospital's Durable Medical Equipment (DME) services for $30,000 in cash along with a $13,091 promissory note. Assets sold in conjunction with this agreement included DME's equipment and inventory supplies. Patient receivables for the DME unit for services performed up to the date of the sale were retained by the Hospital in accordance with the agreement. There were no net patient receivables outstanding at April 30, 2009.

On September 12, 2008, the Hospital discontinued its Skilled Care Unit (SCU) services. A portion of the fixed assets used by the SCU unit, which included beds, wheelchairs, tables, chairs, and other furniture and equipment, were sold for $41,048 to unrelated third-parties. Patient receivables were written off as bad debt expense when deemed uncollectible and when transferred to outside collection agencies and attorneys. At April 30, 2009, there were no net patient receivables outstanding.

The discontinued operations of the servicing lines, the DME unit, and the SCU unit are collectively known as "discontinued services."

Note 10. Discontinued Operations (Continued)

Gain on the disposal of the DME's and SCU's inventory and capital assets for the year ended April 30, 2009 is computed as follows:

	Amount
Net cash proceeds	$ 71,048
Promissory note	13,091
Net proceeds	84,139
Book value of inventory and equipment sold	46,761
Gain on disposal of inventory and capital assets	$ 37,378

Gain on the disposal of the servicing lines' capital assets for the year ended April 30, 2008 is computed as follows:

	Amount
Net cash proceeds	$ 100,000
Book value of equipment sold	6,915
Gain on disposal of capital assets	$ 93,085

Comparative statements of revenue, expenses, and changes in net assets for the discontinued services are as follows:

	2009	2008
Net patient service revenue	$ 617,980	$ 3,142,512
Other operating revenue	1,137	5,481
Total operating revenue	619,117	3,147,993
Less operating expenses:		
Nursing services	445,577	2,086,268
Other professional services	66,780	239,320
General services and administration	11,101	55,949
Total operating expenses	523,458	2,381,537
Gain on disposal of inventory and capital assets	37,378	93,085
Gain on discontinued operations	$ 133,037	$ 859,541

Note 11. New and Pending Pronouncements

As of April 30, 2009, the Governmental Accounting Standards Board (GASB) had issued the following statement that might impact the Hospital, but has yet to be implemented by the Hospital:

- GASB Statement No. 51, *Accounting and Financial Reporting for Intangible Assets*, issued June 2007, will be effective for the Hospital beginning with its year ending April 30, 2011. This Statement establishes accounting and financial reporting requirements for intangible assets. All intangible assets not specifically excluded by the scope of this statement should be classified as capital assets. All existing authoritative guidance for capital assets should be applied to these intangible assets, as appreciable.

The Hospital management has not yet determined the effect this Statement will have on the Hospital's financial statements.

Pinckneyville Community Hospital District

Net Patient Service Revenue
Years Ended April 30, 2009 and 2008

	2009			2008		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Daily Patient Services:						
Acute Care	$ 1,312,106	$ 206,876	$ 1,518,982	$ 1,312,849	$ 189,925	$ 1,502,774
Swing bed	273,768	-	273,768	380,919	-	380,919
	1,585,874	206,876	1,792,750	1,693,768	189,925	1,883,693
Other Nursing Services:						
Operating and recovery	192,683	970,349	1,163,032	213,220	902,049	1,115,269
Emergency services	81,095	2,157,948	2,239,043	62,035	1,898,640	1,960,675
	273,778	3,128,297	3,402,075	275,255	2,800,689	3,075,944
Other Professional Services:						
Laboratory	710,112	4,692,642	5,402,754	584,158	3,954,156	4,538,314
Radiology	410,998	4,729,936	5,140,934	374,898	4,293,652	4,668,550
Nuclear medicine	21,800	660,442	682,242	15,512	747,243	762,755
Oncology	3,172	543,739	546,911	2,923	398,452	401,375
Respiratory therapy	262,305	639,273	901,578	242,313	635,393	877,706
Pharmacy	917,477	6,896,445	7,813,922	1,227,901	6,884,589	8,112,490
Anesthesiology	48,760	349,584	398,364	50,039	314,431	364,470
Physical therapy	436,996	1,424,956	1,861,952	373,901	1,317,622	1,691,523
Social services	-	2,565	2,565	-	30	30
Clinic	-	1,270,535	1,270,535	-	1,179,440	1,179,440
	2,811,640	21,210,117	24,021,757	2,871,645	19,725,008	22,596,653
Gross patient service revenue	$ 4,671,292	$ 24,545,290	$ 29,216,582	$ 4,840,668	$ 22,715,622	$ 27,556,290
Less discounts, allowances, and estimated contractual adjustments, third-party reimbursement programs			10,575,670			9,501,052
Provision for uncollectible accounts			876,933			947,178
Net patient service revenue			$ 17,763,979			$ 17,108,060

Pinckneyville Community Hospital District

Operating Expenses
Years Ended April 30, 2009 and 2008

	2009			2008		
	Salaries and Wages	Supplies and Expense	Total	Salaries and Wages	Supplies and Expense	Total
Nursing Services:						
Nursing administration	$ 262,837	$ 15,080	$ 277,917	$ 220,850	$ 17,181	$ 238,031
Acute care	1,073,363	160,087	1,233,450	1,053,955	121,753	1,175,708
Operating and recovery	183,852	89,148	273,000	172,686	72,168	244,854
Central services and supply	19,027	2,556	21,583	18,799	2,903	21,702
Emergency services	354,002	863,878	1,217,880	315,958	800,569	1,116,527
	1,893,081	1,130,749	3,023,830	1,782,248	1,014,574	2,796,822
Other Professional Services:						
Laboratory	418,797	550,605	969,402	400,758	508,201	908,959
Radiology	496,809	495,674	992,483	451,224	393,024	844,248
Nuclear medicine	20,078	125,802	145,880	16,511	129,201	145,712
Oncology	224,677	344,731	569,408	198,693	284,004	482,697
Respiratory therapy	283,430	107,348	390,778	246,894	95,391	342,285
Pharmacy	297,540	2,075,168	2,372,708	289,835	2,165,901	2,455,736
Anesthesiology	-	278,400	278,400	-	263,667	263,667
Physical therapy	543,235	35,610	578,845	551,895	31,319	583,214
Social services	56,867	2,196	59,163	66,479	1,691	68,170
Clinic	1,291,709	85,539	1,377,248	1,235,401	67,081	1,302,482
Medical records	281,391	46,844	328,235	256,254	47,980	304,234
Retail pharmacy	4,171	1,486	5,657	2,674	6,010	8,684
	3,918,804	4,149,403	8,068,207	3,716,618	3,993,470	7,710,088
General Services:						
Dietary	303,195	139,028	442,223	381,842	224,727	606,569
Operation and maint. of plant	184,314	379,538	563,852	172,935	379,350	552,285
Housekeeping	251,452	47,464	298,916	198,928	64,419	263,347
Laundry and linen	69,889	18,765	88,654	89,647	18,175	107,822
	808,850	584,795	1,393,645	843,352	686,671	1,530,023
Administrative Services:						
Administrative	1,160,686	1,213,786	2,374,472	1,069,558	1,226,214	2,295,772
Employee benefits	-	2,639,610	2,639,610	-	2,581,815	2,581,815
	1,160,686	3,853,396	5,014,082	1,069,558	3,808,029	4,877,587
Other administrative expenses	-	145,234	145,234	-	139,650	139,650
Depreciation	-	771,573	771,573	-	858,327	858,327
	-	916,807	916,807	-	1,073,227	997,977
	$ 7,781,421	$ 10,635,150	$ 18,416,571	$ 7,411,776	$ 10,575,971	$ 17,912,497

Pinckneyville Community Hospital District

Service Statistics (Unaudited)
Years Ended April 30, 2009, 2008, 2007, 2006, and 2005

	2009	2008	2007	2006	2005
Hospital:					
Medical and surgical patient days	1,941	1,930	2,486	2,728	2,607
Medicare patient days	1,465	1,500	1,856	2,040	1,946
Medicare utilization	75.5%	77.7%	74.7%	74.8%	74.6%
Discharges	549	563	796	819	767
Average length-of-stay (days):					
Non-Medicare patients	3.24	3.09	2.89	3.03	3.10
Medicare patients	3.64	3.54	3.21	3.44	3.51
All acute patients	3.54	3.43	3.12	3.33	3.40
Skilled-Nursing Facility:					
Licensed available beds	-	50	50	50	50
Medicare certified area patient days	118	791	1,005	1,817	2,498
Noncertified area patient days	3,690	15,240	14,731	13,848	13,333
Total patient days	3,808	16,031	15,736	15,665	15,831
Medicare patient days	105	774	851	1,399	2,003
Medicare utilization	2.8%	4.8%	5.4%	8.9%	12.7%

McGladrey & Pullen
Certified Public Accountants

Pinckneyville Community Hospital District

Financial Report
04.30.08

Contents

McGladrey & Pullen
Certified Public Accountants

Independent Auditor's Report

To the Board of Directors
Pinckneyville Community Hospital District
Pinckneyville, Illinois

We have audited the accompanying basic financial statements of Pinckneyville Community Hospital District (Hospital) as of and for the years ended April 30, 2008 and 2007, as listed in the table of contents. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinions.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Pinckneyville Community Hospital District as of April 30, 2008 and 2007, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The management's discussion and analysis on pages 3 through 9 is not a required part of the basic financial statements, but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures which consisted principally of inquiries of management regarding the methods of measurement and representation of the required 2008 and 2007 supplementary information. However, we did not audit the information and express no opinion on it.

Our audits were conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Hospital's basic financial statements. The supplementary information on pages 28 through 29 is presented for purposes of additional analysis and is not a required part of the basic financial statements. The supplementary information on page 28 and 29 for the years ended April 30, 2008 and 2007 has been subjected to the auditing procedures applied in the audits of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole. The supplementary information on page 30 marked "unaudited" has not been subjected to the auditing procedures applied in the audits of the basic financial statements and, accordingly, we express no opinion on it.

McGladrey & Pullen, LLP

Springfield, Illinois
August 29, 2008

Management's discussion and analysis of the Pinckneyville Community Hospital District's (Hospital) financial performance provides an overall review of the Hospital's financial activities for the fiscal years ended April 30, 2008, 2007 and 2006. The intent of this discussion is to provide an overview of the Hospital's performance for the years and should be read in conjunction with the accompanying financial statements and notes thereto.

Pinckneyville Community Hospital District operates a critical access hospital with 25 acute care beds and 50 long-term care beds as well as a physician clinic in Pinckneyville, Illinois. Pinckneyville Community Hospital District serves the citizens of the Perry County area and particularly the residents of Pinckneyville, Illinois.

Financial Highlights

During 2008, Hospital's assets exceeded its liabilities by $12,581,656 or approximately 7% from April 30, 2007 and the Hospital's assets exceeded its liabilities by $11,772,775 or approximately 12% from April 30, 2006 to April 30, 2007.

During 2008, Hospital's total assets increased by $216,932 or approximately 1% from April 30, 2007 and increased $1,274,606 or approximately 9% from April 30, 2006 to April 30, 2007.

During 2008, Hospital's total liabilities decreased by $591,948 or approximately 19% from April 30, 2007 and increased by $39,739 or approximately 1% from April 30, 2006 to April 30, 2007.

Overview of Financial Statements

The audited financial statements include: Balance Sheets, Statements of Revenue, Expenses and Changes in Net Assets, Statements of Changes in Net Assets, and Statements of Cash Flows plus the Notes to the Basic Financial Statements.

Our financial position is measured in terms of resources (assets) we own and obligations (liabilities) we owe at a given date. This information is reported in the Balance Sheets, which reflect the Hospital's assets in relation to its debts to bondholders, suppliers, employees, and other creditors. The excess of our assets over our liabilities is reported as Net Assets.

Information regarding the results from operations during the year is reported in the Statements of Revenue, Expenses and Changes in Net Assets. This statement shows how much our net assets increased during the year as a result of our operations, nonoperating activities, and other changes.

The Statements of Cash Flows disclose the flow of cash resources into and out of the Hospital during the year. It identifies all cash received during the year from operating activities, contributions and other sources, and how we applied those funds (for example, payment of expenses, repayment of debt, purchases of new property and equipment, and additions to and sales from the investment accounts).

The Notes to Basic Financial Statements provide additional information that is essential to a full understanding of the data provided in the financial statements.

Condensed Balance Sheets

Condensed versions of the Balance Sheets as of April 30, 2008, 2007, and 2006 follow:

	April 30,		
	2008	2007	2006
Assets			
Cash and short-term investments	$ 2,948,444	$ 2,452,937	$ 2,026,251
Restricted cash and investments	519,717	838,172	753,388
Board designated instruments	4,647,564	4,716,895	4,407,885
Total cash and investments	8,115,725	8,008,004	7,187,524
Patient accounts receivable, net	2,238,786	2,648,402	2,541,046
Other current assets	894,988	629,051	429,777
Capital assets, net	3,830,319	3,577,429	3,429,933
Total assets	$ 15,079,818	$ 14,862,886	$ 13,588,280
Liabilities			
Current liabilities	$ 1,434,163	$ 1,906,111	$ 1,660,343
Long-term debt	1,064,000	1,184,000	1,390,029
Total liabilities	2,498,163	3,090,111	3,050,372
Net Assets			
Invested in capital assets, net of related debt	2,646,319	2,187,400	1,704,584
Restricted	519,717	838,172	753,388
Unrestricted	9,415,619	8,747,203	8,079,936
Total net assets	12,581,655	11,772,775	10,537,908
Total liabilities and net assets	$ 15,079,818	$ 14,862,886	$ 13,588,280

Year ended April 30, 2008: Total assets increased in 2008 due to the increases discussed below.

The Hospital experienced a slight increase in cash and investments of $107,721 or 1% from April 30, 2007. Capital assets of the Hospital increased $252,890 or 7% from April 30, 2007 and was primarily attributable to the purchase of real estate for the relocation of the Hospital. The hospital also experienced an increase in estimated third party payor settlements of $220,429 or 110% from April 30, 2007.

Year ended April 30, 2007: Total assets increased in 2007 due to the increases discussed below.

The Hospital experienced an increase in cash and investments of $820,480 or 11% from April 30, 2006. The build-up of cash and investments is primarily due to an increase of $2,095,112, or 10%, in hospital outpatient revenues (primarily Oncology) and an increase of $86,158 or 33%, in investment earnings due to higher interest rates achieved when the checking accounts were bid out around February/March of 2006 and due to growth in cash and investment balances. Net patient receivables increased by $107,356 (gross receivables decreased by $437,131, or 8%), in 2007, compared to an increase of approximately $75,000 experienced in 2006. In 2007, gross receivables decreased while net receivables increased due to a change in the methodology surrounding the calculation in the allowance for uncollectible accounts. Receivables, without factoring in the change in methodology previously described, have decreased due to activity drops in inpatient, swing bed and skilled care service areas and the consistent collection efforts on the increased outpatient account balances. A temporary improvement in Medicaid claim payments at our rural health clinic helped decrease their receivables from the prior year.

Long-Term Debt

Long-term debt includes revenue bonds issued in 1976, 1982, and 1995 and general obligation bonds issued in 1995 as well as capital lease obligations that are detailed in Note 6 to the basic financial statements. The Hospital did not issue any new debt during fiscal year 2008 or 2007. Subsequent to fiscal year end 2008, the Hospital refunded its 1995 general obligation bonds with the issuance of 2008 general obligation refunding bonds as detailed in Note 6 to the basic financial statements.

Capital Assets

Year Ended April 30, 2008: At April 30, 2008, the Hospital had $3,830,319 invested in capital assets. This represents an increase of $252,890 in comparison to April 30, 2007 due to approximately $327,000 in equipment and software purchases due to needed upgrades and replacements of older equipment, less applicable depreciation. In addition, the Hospital purchased land for the new hospital for approximately $325,000. Approximately $36,000 worth of assets were retired during the year and two pieces of equipment under capital lease became fully depreciated in 2008.

Year Ended April 30, 2007: At April 30, 2007, the Hospital had $3,577,429 invested in capital assets. This represents an increase of $147,496 in comparison to April 30, 2006 due to approximately $908,000 in equipment purchases for expansion of the CPSI system (including nursing Point-of-care, Electronic Forms, Physician Chartlink and Imagelink); the purchase of a CR Reader in the imaging department and Omnicell automated medication dispensing units for our Acute Care and Emergency Room departments, less applicable depreciation. Approximately $187,000 worth of assets were retired during the year and the CT scanner became fully depreciated in 2007. Furthermore, several other items of imaging equipment that were leased approximately 4 years ago will be nearing their fully depreciated life in the upcoming year.

Condensed Statements of Revenue, Expenses and Changes in Net Assets

A summary version of the Statements of Revenue, Expenses and Changes in Net Assets for the years ended April 30, 2008, 2007, and 2006 follows:

	Year Ended April 30,		
	2008	2007	2006
Net patient service revenue	$ 19,252,343	$ 19,649,004	$ 17,711,847
Other operating revenue	149,568	97,638	104,793
Total operating revenue	19,401,911	19,746,642	17,816,640
Total nonoperating revenue, net	684,939	612,243	549,046
Gain on discontinued operations	380,074	296,930	331,002
Total revenue	20,466,924	20,655,815	18,696,688
Expenses			
Salaries and wages and employee benefits	11,312,126	11,112,209	10,544,500
Purchased services and professional fees	2,134,329	1,928,942	1,633,422
Depreciation	858,327	837,478	807,848
Other operating expenses	5,278,012	5,454,252	4,785,743
Interest and amortization	75,250	88,067	106,594
Total operating expenses	19,658,044	19,420,948	17,878,107
Change in net assets	808,880	1,234,867	818,581
Net assets:			
Beginning	11,772,775	10,537,908	9,719,327
Ending	$ 12,581,655	$ 11,772,775	$ 10,537,908

Operations

Year Ended April 30, 2008: 2008 income from operations showed a decrease compared to the prior year. Net operating revenue decreased $344,731 to $19,401,911 in 2008 from $19,746,642 in 2007, approximately 2% decrease. The decrease in net operating revenue was primarily attributable to a decrease in inpatient service revenue of $1,314,842 or 15%. This was driven by a decrease in inpatient, swing bed and skilled care service revenues. The increase in operating expenses of $237,096 was primarily driven by an increase in purchased services related to ER professional fees, Oncologist fees and Skilled Care services.

Salaries were up $286,975 over prior year, an increase of 3.40%. Average annual merits account for 3 to 3.5% of the adjustments. Employee benefits were $87,057 under prior year.

Charity care (financial need) write-offs were up $258,000 over prior year, an increase of 152%. The large increase in write-offs is mainly attributable to an insurance company denying an oncology claim due to a pre-existing condition. The patient's spouse filed a lawsuit but the judge upheld the insurance plan's denial.

During 2008, the Hospital discontinued the operations of its Home Health services and Hospice services. Net patient revenue of $998,229 and $1,068,203 for the year ended April 30, 2008 and 2007, respectively, has been reported separately in the Statement of Revenue, Expenses, and Changes in Net Assets. Operating expenses in the amount of $711,240 and $771,273 for the year ended April 30, 2008 and 2007, respectively, have also been reported separately. Operating expenses include separately identifiable costs attributable to the operations of the Home Health and Hospice services and do not include general overhead expenses, employee benefit expenses, and third party payor settlements. Net proceeds from the sale of the discontinued operations were $100,000 resulting in a gain on disposal of $93,085. Capital assets included in the sale had a book value of $6,915 and consisted primarily of office furniture and equipment.

During fiscal year 2008, the Hospital submitted a revised cost report for fiscal years 2003, 2004 and 2005. The revised settlements had a favorable impact on income from operations. Prior years' third party payor settlements included in the Statement of Revenue, Expenses, and Changes in Net Assets have been shown separately below. The effect on income from operations without prior years' third party payor settlements is shown as follows:

	2008 As Reported	Prior Years' Third Party Payor Settlements	2008 Adjusted For Prior Years' Settlements
Net patient service revenue	$ 19,252,343	$ 899,519	$ 18,352,824
Other operating revenue	149,568	-	149,568
Total operating revenue	19,401,911	899,519	18,502,392
Total operating expenses	19,658,044	-	19,658,044
Income (loss) from operations	(256,133)	899,519	(1,155,652)
Total nonoperating revenue, net	684,939	-	684,939
Change in net assets from continuing operations	$ 428,806	$ 899,519	$ (470,713)

Year Ended April 30, 2007: 2007 income from operations showed an increase compared to the prior year. Net operating revenue increased $1,930,002 to $19,746,642 in 2007 from $17,816,640 in 2006, approximately 11% increase. The increase in net operating revenue was primarily due to an increase in Oncology services and related outpatient pharmacy revenues which grew by $2,039,626 in gross revenues. This was likely driven by an increase in cancer-related illnesses in our area and increased preference for area patients to utilize our facilities instead of traveling to metropolitan hospitals. Additionally, a portion of the increase in net revenues can be attributed to favorable cost report settlements during 2007, which also was a significant portion of the $416,286 increase in the change in net assets over prior years. Overall, outpatient gross revenues increased by $2,095,112, or 10%, helping compensate for the $1,365,772, or 13%, drop in inpatient and swing bed related services. The increase in operating expenses of $1,542,841 was primarily driven by a $434,194 increase in drug expenses related to the Oncology services.

Salaries were up $405,167 over prior year, an increase of 5.04%. Average annual merits account for 3 to 3.5% of the adjustments and market adjustments were implemented for nursing throughout the year, accounting for a portion of the remaining difference. Employee benefits were $162,542 over prior year. The primary increase in benefits from prior year was related to an $80,068 increase in worker's compensation premiums. With the annual increase in wages to account for merit and market adjustments, FICA taxes rose by $34,117 over prior year. Although health insurance claim experience was down by $43,065, prescription costs were up by $68,941, thereby creating an increase of $25,876 over prior year. We also spent $18,913 more on our employee wellness program with the implementation of the "Healthier Me" program.

Purchased services and professional fees were up $295,520 over prior year, driven by $84,269 in extra temp agency nursing staff in Acute Care and Skilled Care and $45,210 for a temporary contracted physical therapist. Professional fees were $193,733 over prior year, primarily driven by ER professional and Oncologist fees. Additional ER coverage was required while our ER physician assistant covered at the rural health clinic with the absence of one physician. Oncology physician fees were up due to negotiated fee increases, additional clinic days and added coverage by a physician assistant.

Condensed Statements of Cash Flows

	Year Ended April 30,		
	2008	2007	2006
Cash provided by operating activities	$ 722,183	$ 1,616,598	$ 1,168,870
Cash provided by non-capital financing activities	290,846	275,279	293,061
Cash (used in) capital and related financing activities	(1,301,587)	(1,416,466)	(1,164,260)
Cash provided by (used in) investing activities	(645,000)	793,818	(853,867)
Net increase (decrease) in cash	(933,548)	1,269,229	(556,196)
Cash:			
Beginning	2,567,793	1,298,564	1,854,760
Ending	$ 1,634,245	$ 2,567,793	$ 1,298,564

Years ended April 30, 2008, 2007 and 2006: Changes in the Hospitals cash flows are consistent with changes in operating income and nonoperating revenues and expense.

Economic Factors

Year Ended April 30, 2008: The Hospital is continuing its physician recruitment efforts to replace a family practice physician who left the rural health clinic in fiscal year 2007. The Hospital also continues to recruit for a new surgeon who would transition in before the retirement of the existing surgeon.

Acute Care inpatient admissions dropped by 28.4%. The primary factor appears to be a change in case mix since admissions from the ER dropped 21.6% even though ER visits increased by 1.5%. ER Level 1 & 2 visits, typically involving patients who are treated and released, increased an average of 11% for each level. Whereas ER Level 4 & 5 visits, typically involving cases that would require inpatient admission or transfer, decreased an average of 12% each. Level 3 ER visits increased by 5%, but was not enough to offset the decreases in other ER treatment levels that also typically require admission. Having only 3 physicians instead of 4 appears to have some impact given that admissions did increase by 7.4% from FY05 to FY06 when a fourth physician was at the rural health clinic for a full year.

The Medicare percentage mix increased by 3%, meaning that a greater portion of the Hospital's cost will be reimbursed via the cost report. Insurance payer mix has steadily declined over the years, which is a factor of local plant closings and the growing unemployment rate in Perry County. Likewise, Medicaid payer mix has been increasing.

Year Ended April 30, 2007: The Hospital is continuing its physician recruitment efforts to replace a family practice physician who left the rural health clinic in fiscal year 2007 and another internal medicine/pulmonologist who will be leaving the clinic in fiscal year 2008. The Hospital also continues to work with SSM Healthcare and Washington County Hospital regarding surgeon recruitment efforts.

Sleep studies declined with the opening of additional sleep labs in the area. A Nephrology clinic was added to the Specialty Clinic in February 2007 which has created additional service referrals to our laboratory and imaging departments.

The Technicolor plant located just east of Pinckneyville closed at the end of March 2007. The majority of the employees lived outside the Hospital's service area but the annual impact on cash receipts was estimated to be approximately $189,000.

In July 2007, management initiated the process toward a Certificate of Need application for a replacement hospital without the Skilled Care Unit as part of that project. Management also created a 501(c)3 not-for-profit corporation with the intent that that entity could look at options that might be available to sustain the skilled care unit either in the present building or to determine if there are other options available.

Contacting the Hospital's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the Hospital's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Hospital Administrator at Pinckneyville Community Hospital District, 101 N. Walnut Street, Pinckneyville, Illinois 62274-1099.

Pinckneyville Community Hospital District

Balance Sheets
April 30, 2008 and 2007

ASSETS	2008	2007
Current Assets:		
Cash	$ 903,149	$ 930,810
Short-term cash and investments - current	2,045,295	1,522,127
Restricted by donor for specific operating activities - investments	146,234	125,528
Held by trustee for debt service - investments	373,483	712,644
Patient accounts receivable, less allowances for contractual adjustments and doubtful accounts, 2008 $2,719,032; 2007 $2,832,180	2,238,786	2,648,402
Estimated third party payor settlements, net	420,429	200,000
Inventories	285,719	256,952
Prepaid expenses and other	188,840	172,099
Total current assets	6,601,935	6,568,562
Board designated instruments	4,647,564	4,716,895
Capital assets, not being depreciated	885,603	274,036
Capital assets, being depreciated, net	2,944,716	3,303,393
	3,830,319	3,577,429
Total assets	$ 15,079,818	$ 14,862,886

See Notes to Financial Statements.

LIABILITIES AND NET ASSETS	2008	2007
Current Liabilities:		
Current maturities of long-term debt	$ 120,000	$ 206,029
Accounts payable	230,891	229,533
Accrued payroll and related expenses	720,805	920,606
Other	362,467	549,943
Total current liabilities	1,434,163	1,906,111
Long-term debt, less current maturities	1,064,000	1,184,000
Total liabilities	2,498,163	3,090,111
Commitments and Contingencies (Note 7)		
Net Assets:		
Invested in capital assets, net of related debt	2,646,319	2,187,400
Restricted:		
Under bond indenture	373,483	712,644
Specific operating activities	146,234	125,528
Unrestricted	9,415,619	8,747,203
	12,581,655	11,772,775
Total liabilities and net assets	$ 15,079,818	$ 14,862,886

Pinckneyville Community Hospital District

Statements of Revenue, Expenses and Changes in Net Assets
Years Ended April 30, 2008 and 2007

	2008	2007
Operating revenue:		
Net patient service revenue	$ 19,252,343	$ 19,649,004
Other operating revenue	149,568	97,638
Total operating revenue	19,401,911	19,746,642
Operating expenses:		
Nursing services	4,291,806	4,242,698
Other professional services	7,968,967	7,837,260
General services and administration	6,324,044	6,285,699
Other administrative expenses	139,650	129,746
Interest and amortization	75,250	88,067
Depreciation	858,327	837,478
Total operating expenses	19,658,044	19,420,948
Income (loss) from operations	(256,133)	325,694
Nonoperating revenue (expense):		
Investment income	375,563	345,069
Tax revenue	218,730	217,334
Gifts, donations, other	92,822	57,945
Loss on disposal of capital assets	(2,176)	(8,105)
	684,939	612,243
Change in net assets from continuing operations	428,806	937,937
Discontinued operations (Note 11):		
Gain from operations of discontinued Home Health Services	301,546	221,729
Gain from operations of discontinued Hospice Services	78,528	75,201
Gain on discontinued operations	380,074	296,930
Change in net assets	808,880	1,234,867
Net Assets:		
Beginning	$ 11,772,775	$ 10,537,908
Ending	$ 12,581,655	$ 11,772,775

See Notes to Financial Statements.

Pinckneyville Community Hospital District

Statements of Cash Flows
Years Ended April 30, 2008 and 2007

	2008	2007
Cash Flows from Operating Activities:		
Receipts from and on behalf of patients	$ 20,439,759	$ 21,598,064
Payments to suppliers and contractors	(7,774,678)	(8,507,887)
Payments to employees	(12,092,456)	(11,571,217)
Other receipts, net	149,568	97,638
Net cash provided by operating activities	722,193	1,616,598
Cash Flows from Non-Capital Financing Activities:		
Property taxes supporting operations	218,730	217,334
Capital grants and gifts	72,116	57,945
Net cash provided by non-capital financing activities	290,846	275,279
Cash flows from Capital and Related Financing Activities:		
Principal paid on long-term debt	(206,029)	(335,320)
Interest paid	(75,250)	(88,067)
Purchase of capital assets	(1,120,308)	(993,079)
Proceeds from disposal of discontinued operations	100,000	-
Net cash (used in) capital and related financing activities	(1,301,587)	(1,416,466)
Cash Flows from Investing Activities		
Interest on investments	375,563	345,069
Purchase of investments	(6,321,822)	(5,326,500)
Proceeds from disposition of investments	5,301,259	5,775,249
Net cash provided by (used in) investing activities	(645,000)	793,818
Increase (decrease) in cash	(933,548)	1,269,229
Cash:		
Beginning	2,567,793	1,298,564
Ending, including cash included in current investments, 2008 $731,096; 2007 $1,636,983	$ 1,634,245	$ 2,567,793

(Continued)

Pinckneyville Community Hospital District

Statements of Cash Flows (Continued)
Years Ended April 30, 2008 and 2007

	2008	2007
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (256,133)	$ 325,694
Depreciation	858,327	837,478
Bad debts	947,178	220,154
Interest and amortization	75,250	88,067
Gain on discontinued operations	286,989	296,930
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(537,562)	(327,510)
Estimated amounts due to and from third-party payors	(220,429)	(220,000)
Accounts payable, accrued expenses, and other liabilities	(385,919)	395,059
Inventories, prepaids, and other assets	(45,508)	726
Net cash provided by operating activities	$ 722,193	$ 1,616,598

See Notes to Financial Statements.

Note 1. Nature of Business and Summary of Significant Accounting Policies

Nature of business: Pinckneyville Community Hospital District (the Hospital) operates a critical access hospital with 25 acute care beds and 50 long-term care beds as well as a physician clinic in Pinckneyville, Illinois. The Hospital is established in accordance with provisions of the Illinois Hospital District Law and is located in Pinckneyville, Illinois.

The Hospital primarily earns revenue by providing inpatient, outpatient, skilled nursing, physician clinic and home health care services to area residents. During the year ended April 30, 2008, the Hospital sold its operations in relation to its hospice and home health services (see Note 11).

The Hospital is exempt from income taxes under provisions of the Internal Revenue Code as a political subdivision of the State of Illinois.

A summary of the Hospital's significant accounting policies is as follows:

Basis of accounting: The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenue is recognized when earned and expenses are recorded when the liability is incurred.

Accounting pronouncements: The Hospital prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB). Pursuant to GASB Statement No. 20, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB) that were issued on or before November 30, 1989, and do not conflict with or contradict GASB pronouncements.

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

Cash and cash equivalents: Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months of less, excluding amounts whose use is limited by board designation or other arrangements under trust agreements, with third-party payors or donors.

Patient receivables: Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by identifying troubled accounts, by historical experience applied to an aging of accounts, and by considering the patient's financial history, credit history and current economic conditions. The Hospital does not charge interest on patient receivables. Patient receivables are written off as bad debt expense when deemed uncollectible and when transferred to outside collection agencies and attorneys. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

Inventories: Inventories are valued at the lower of cost (first-in, first-out method) or market.

Assets limited as to use or restricted: Assets limited as to use or restricted include assets restricted by revenue bond ordinance, donor-restricted assets and assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Investments: Investments in certificates of deposit are carried at amortized cost, which approximates market value. Investment income consists of interest income.

Note 1. Summary of Significant Accounting Policies (Continued)

Capital assets: Capital assets are recorded at cost or fair value if donated. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives. Amortization of assets under capital leases is included with depreciation expense on owned capital assets. Depreciation is computed by the straight-line method over estimated useful lives as follows:

	Years
Land improvements	8 - 20
Buildings and building improvements	5 - 40
Equipment	3 - 20

Donations of capital assets are reported at fair value as an increase in unrestricted net assets unless use of the asset is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted net assets. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

Compensated absences: Employees accrue vacation time based upon years of service and hours worked. Accrued vacation time can be cashed-out by an employee at any during the year subject to a maximum amount of hours based upon the employee's years of service.

Net patient service revenue: Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Net patient service revenue is reported net of provision for uncollectible accounts.

Operating income: The Hospital distinguishes operating revenue and expenses from nonoperating items. Operating revenue and expenses generally result from the primary purpose of the Hospital, which is to provide medical services to the region. Operating expenses consist of salaries and wages, employee benefits, purchased services and professional fees, depreciation, interest and supplies and other. All revenue and expenses not meeting these criteria are considered nonoperating.

Tax revenue: Property taxes are recognized as assets in the period an enforceable legal claim to the assets arises and are recognized as revenue in the period for which the taxes are levied. The county levies property taxes during August for property owned as of January 1 of the previous year. Property taxes are due in two installments, the first by September and the second by October. Property taxes are collected by the county and are primarily received by the Hospital in October, November and December. Other state property tax revenue is recognized as revenue when received by the Hospital. Property taxes that are not available for current year operations, if any, are shown as deferred revenue.

Net assets: Net assets of the Hospital are defined as follows:

Invested in capital assets, net of related debt – This component of net assets consists of capital assets, including any restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. If there are significant unspent related debt proceeds at year-end, the portion of the debt attributable to the unspent proceeds is not included in the calculation of invested in capital assets component as the unspent proceeds.

Note 1. Summary of Significant Accounting Policies (Continued)

Restricted – This component of net assets consists of constraints placed on net assets through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation. The Hospital applies restricted resources when an expense is incurred for purposes for which both restricted and unrestricted net assets are available.

Unrestricted net assets – This component of net assets consists of net assets that do not meet the definition of "restricted" or "invested in capital assets, net of related debt," above.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care for the years ended April 30, 2008 and 2007 was approximately $428,000 and $170,000, respectively, based on prevailing charges.

Reclassifications: Certain 2007 data has been reclassified to conform to the 2008 presentation, with no effect on previously-reported net assets or change in net assets.

Note 2. Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare: The Hospital is designated as a critical access hospital. This designation provides for inpatient and outpatient services to be reimbursed on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. Inpatient nonacute services related to Medicare beneficiaries are paid at prospectively determined rates per day. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors.

The Hospital's Medicare cost reports have been audited and finalized by the Medicare fiscal intermediary through April 30, 2007.

Medicaid: Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under prospectively determined fee schedules.

Approximately 39% and 30% of net patient service revenue is from participation in the Medicare and state-sponsored Medicaid programs for the years ended April 30, 2008 and 2007, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

On November 21, 2006, the Federal Centers for Medicare and Medicaid Services (CMS) approved State of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program) relating to the period June 30, 2006 to June 30, 2008. Under the Program, the Hospital receives additional Medicaid reimbursement from the State. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $349,836 and $174,848 during the Hospital's years ended April 30, 2008 and 2007, respectively, and is included in net patient service revenue on the statements of revenue, expenses, and changes in net assets. As a governmental entity, the Hospital did not incur any assessments related to this Program. The laws and regulations authorizing this Program expire on June 30, 2008.

Note 2. Net Patient Service Revenue (Continued)

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

	2008	2007
Gross patient service revenue	$ 30,412,756	$ 31,715,483
Less discounts, allowances and estimated contractual adjustments under third-party reimbursement programs	10,213,235	11,846,325
Less provision for doubtful accounts	947,178	220,154
Net patient service revenue	$ 19,252,343	$ 19,649,004

Congress passed the Medicare Modernization Act in 2003, which among other things established a demonstration of The Medicare Recovery Audit Contractor (RAC) program. During fiscal year 2007, the RAC's identified and corrected a significant amount of improper overpayments to providers. In 2006, Congress passed the Tax Relief and Health Care Act of 2006 which authorized the expansion of the RAC program to all 50 states. CMS is in the progress of rolling out this program nationally. As such, the Hospital may be subject to such an audit at some time in the future.

Note 3. Deposits and Investments

Authorized investments: Illinois state statues authorize the Hospital to make deposits and investments in interest-bearing depository accounts in federally insured and/or state chartered banks and savings and loan associations, or other financial institutions as designated by ordinances, and to invest available funds in direct obligations of, or obligations guaranteed by, the U.S. Treasury or agencies of the United States, money market mutual funds whose portfolios consist of government securities, the Illinois Public Treasury's Investment Pool, and the Illinois Funds Investment Pool. The Hospital's investments consist entirely of certificates of deposit and the Illinois Funds Investment Pool.

Custodial credit risk: Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to the Hospital. State law allows collateralization of deposits in excess of federal depository insurance. The Hospital's deposit policy for custodial credit risk is to obtain a pledge of collateral for deposits substantially in excess of federal depository insurance.

At April 30, 2008 and 2007, respectively, the Hospital's deposit bank balances of $8,136,471 and $8,093,818, respectively, were exposed to custodial credit risk as follows:

	2008	2007
Uninsured, collateral held by pledging financial institution's trust department or agent in other than the Hospital's name	$ 8,136,471	$ 8,093,818

The Hospital maintains a substantial portion of its deposits in two financial institutions. The Hospital has not experienced any losses in such amounts and believes it is not exposed to any significant credit risk on its deposits.

Note 3. Deposits and Investments (Continued)

The deposits and investments are included in the balance sheets as follows:

	2008	2007
Included in the following balance sheet captions:		
Cash	$ 882,570	$ 930,810
Short-term cash and investments	2,045,295	1,522,127
Board designated instruments	4,647,564	4,716,895
Restricted by donor for specific operating activities	146,234	125,528
Held by trustee for debt service	373,483	712,644
	$ 8,095,146	$ 8,008,004

Other Information: The Illinois Funds Investment Pool (Fund) is not registered with the SEC. The Illinois Funds Investment Pool is administered by the Illinois State Treasurer and oversight is provided by the State Auditor General's Office. The fair value of the positions in the pool is the same as the value of the pool shares. The Hospital held approximately $20,000 in this fund at April 30, 2008. The Hospital did not hold any balance in this fund at April 30, 2007. The fund has a Standard & Poor's credit rating of AAAm and a weighted average maturity of .01 years.

Note 4. Accounts Receivable

The Hospital grants credit without collateral to its patients, most of who are area residents and are insured under third-party payor agreements. Patient accounts receivable, at April 30, 2008 and 2007, are as follows:

	2008	2007
Medicare	$ 1,018,508	$ 992,434
Medicaid	343,684	219,520
Other third-party payors	685,935	1,070,024
Patients	599,941	1,129,463
	2,648,068	3,411,441
Less allowance for uncollectible accounts	409,282	763,039
Patient accounts receivable, net	$ 2,238,786	$ 2,648,402

Changes in the allowance for uncollectible accounts were as follows:

	Years Ended April 30,	
	2008	2007
Balance, beginning of year	$ 763,039	$ 1,417,958
Provision charged to operating expense	664,104	(19,016)
Account balances charged off	(1,017,861)	(635,903)
Balance, ending of year	$ 409,282	$ 763,039

Note 5. Capital Assets

Capital assets activity for the years ended April 30, 2008 and 2007 is as follows:

	2008				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 236,114	$ 324,800	$ 20,471	$ -	$ 581,385
Construction in progress	37,922	456,932	(190,636)	-	304,218
Total capital assets, not being depreciated	274,036	781,732	(170,165)	-	885,603
Capital assets, being depreciated:					
Land improvements	246,028	-	-	-	246,028
Buildings and building improvements	5,459,107	11,456	170,165	-	5,640,728
Equipment	5,560,445	327,120	-	36,018	5,851,547
Total capital assets, being depreciated	11,265,580	338,576	170,165	36,018	11,738,303
Less accumulated depreciation for:					
Land improvements	199,247	6,155	-	-	205,402
Buildings and building improvements	4,293,575	149,855	-	-	4,443,430
Equipment	3,469,365	702,317	-	26,927	4,144,755
Total accumulated depreciation	7,962,187	858,327	-	26,927	8,793,587
Total capital assets, being depreciated, net	3,303,393	(519,751)	170,165	9,091	2,944,716
Capital Assets, Net	$ 3,577,429	$ 261,981	$ -	$ 9,091	$ 3,830,319

	2007				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 236,114	$ -	$ -	$ -	$ 236,114
Construction in progress	31,275	37,922	(31,275)	-	37,922
Total capital assets, not being depreciated	267,389	37,922	(31,275)	-	274,036
Capital assets, being depreciated:					
Land improvements	246,028	-	-	-	246,028
Buildings and building improvements	5,390,016	78,505	-	9,414	5,459,107
Equipment	4,830,406	876,852	31,275	177,888	5,560,445
Total capital assets, being depreciated	10,466,450	955,157	31,275	187,302	11,265,580
Less accumulated depreciation for:					
Land improvements	192,830	6,417	-	-	199,247
Buildings and building improvements	4,149,875	149,513	-	5,813	4,293,575
Equipment	2,961,201	681,548	-	173,384	3,469,365
Total accumulated depreciation	7,303,906	837,478	-	179,197	7,962,187
Total capital assets, being depreciated, net	3,162,544	117,679	31,275	8,105	3,303,393
Capital Assets, Net	$ 3,429,933	$ 155,601	$ -	$ 8,105	$ 3,577,429

Note 6. Notes Payable

The following is a summary of long-term obligation transactions for the Hospital for the years ended April 30, 2008 and 2007:

	2008				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 690,000	$ -	$ 70,000	$ 620,000	$ 80,000
1982 Revenue bonds	47,000	-	8,000	39,000	8,000
1995 Revenue bonds	85,000	-	60,000	25,000	25,000
1995 General obligation bonds	500,000	-	-	500,000	7,000
Capital lease obligations	68,029	-	68,029	-	-
Total long-term obligations	$ 1,390,029	$ -	$ 206,029	$ 1,184,000	$ 120,000

	2007				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 760,000	$ -	$ 70,000	$ 690,000	$ 70,000
1982 Revenue bonds	54,000	-	7,000	47,000	8,000
1995 Revenue bonds	140,000	-	55,000	85,000	60,000
1995 General obligation bonds	500,000	-	-	500,000	-
Capital lease obligations	271,349	-	203,320	68,029	68,029
Total long-term obligations	$ 1,725,349	$ -	$ 335,320	$ 1,390,029	$ 206,029

The 1976 revenue bonds bear interest at 5% payable semi-annually; maturing through April 2015.

The 1982 revenue bonds bear interest at 5% payable semi-annually; maturing through August 2012.

The 1995 revenue bonds bear interest at 5.6% to 6.05% payable semi-annually; maturing through May 2009.

The revenue bonds are payable solely from the revenues of the facility and are not secured by the Hospital's taxing authority. The rights of the 1995 revenue bond holders are subordinated to the rights of the holders of the 1976 and 1982 revenue bonds. The 1976 and 1982 revenue bonds can be paid prior to scheduled maturity at par. The 1995 revenue bonds can be paid prior to scheduled maturity at par on any interest payment date beginning November 1, 2006.

The 1995 general obligation bonds bear interest at 6.05% to 6.35% payable semi-annually maturing from November 2009 through November 2015. These bonds are secured by the Hospital's full faith and credit and taxing authority, and can be paid prior to maturity at par on any interest payment date beginning November 1, 2006.

Note 6. Notes Payable (Continued)

The bonds place limits on the incurrence of additional borrowings and requires the Hospital to satisfy certain earnings performance measures, prior to early extinguishment. There was no additional borrowing or early extinguishment for the years ended April 30, 2008 and 2007, respectively.

Under the terms of the revenue bond indentures, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets held by trustee for debt service.

The debt service requirements as of April 30, 2008, are as follows:

Year Ending April 30,	Total to be Paid	Principal	Interest
2008	$ 171,096	$ 120,000	$ 51,096
2009	174,591	130,000	44,591
2010	198,613	160,000	38,613
2011	206,985	175,000	31,985
2012	190,537	166,000	24,537
2013 - 2017	470,665	442,000	28,665
	$ 1,412,486	$ 1,193,000	$ 219,486

Subsequent Event

On May 1, 2008, the Hospital entered into a bond ordinance to issue $509,000 of general obligation hospital refunding bonds for the refunding of the 1995 general obligation bonds, which had an outstanding balance of $500,000 at April 30, 2008. The 2008 general obligation refunding bonds bear interest at 2.30% to 3.80% payable semi-annually maturing from November 2008 through November 2015. These bonds are secured by the Hospital's full faith and credit and taxing authority. In addition, these bonds were issued in an amount to satisfy the outstanding principal balance of the 1995 general obligation bonds at May 1, 2008 and to cover bond issuance costs incurred. The debt service requirements disclosed above include the future principal and interest payments of the 2008 general obligation bonds. As a result, the total future principal payments on all bonds payable as disclosed above, differs from the amount stated on the face of the balance sheet by $9,000.

Capital Lease Obligations

The Hospital was obligated under leases for equipment that were accounted for as capital leases. Assets under capital leases at April 30, 2007 totaled $1,200,506, net of accumulated depreciation of $1,140,880. There were no assets under capital leases at April 30, 2008.

Note 7. Self Insurance and Contingent Liabilities

The Hospital is a party to certain claims and legal proceedings arising in the ordinary course of its business. It is the opinion of management that any liability of the Hospital with respect to these actions will not materially affect its financial position. The Hospital is also a defendant in various lawsuits which, in the opinion of management, are covered by insurance.

Note 7. Self Insurance and Contingent Liabilities (Continued)

Laws and regulations: The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not limited to, accreditation, licensure, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in exclusion from government health care program participation, together with the imposition of significant fines and penalties, as well as significant repayment for past reimbursement for patient services received. While the Hospital is subject to similar regulatory reviews, management believes the outcome of any such regulatory review will not have a material adverse effect on the Hospital's financial position.

Medical Malpractice and General Liability Insurance: Pinckneyville Community Hospital District purchases general and professional liability insurance coverage from the Illinois Provider Trust (IPT). IPT is a pooled self-insurance trust program organized under Illinois Statutes for the purpose of providing general and professional liability insurance to member hospitals on a claims-made basis (IPT was on the occurrence-basis until January 1, 2005). Premium rates have been established based on the loss experiences of the insured hospitals and includes a provision for retrospective premium adjusted based on incurred losses, which management has determined to be approximately $100,000 at April 30, 2008 and 2007.

The Hospital also purchases claims-made medical malpractice insurance coverage for all employee physicians. These policies contain loss limits of $1,000,000 per claim and an annual limit of $3,000,000, with no deductible.

The medical malpractice insurance costs of the Hospital totaled approximately $41,000 and $100,000 for the years ended April 30, 2008 and 2007, respectively. Settled claims from these risks have not exceeded insurance coverage in any of the past three fiscal years.

Workers compensation: The Hospital is self-insured for a portion of its exposure to risk of loss from employee health claims. Annual estimated provisions are accrued for the self-insured portion of employee health claims and include an estimate of the ultimate costs for both reported claims and claims incurred but not yet reported.

Employee health claims: Substantially all of the Hospital's employees and their dependents are eligible to participate in the Hospital's self-insurance program for health insurance. Self-insurance is in effect up to an individual stop/loss amount of $60,000 and aggregate stop/loss amount of $2,000,000 with coverage from a private insurance company maintained for all claims in excess of the stop/loss amounts. All claim handling procedures are performed by an independent claims administrator.

A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Hospital's estimate will change by a material amount in the near term.

Note 7. Self Insurance and Contingent Liabilities (Continued)

Activity in the Hospital's accrued employee health claims liability during the years ended April 30, 2008 and 2007 is summarized as follows:

	2008	2007
Balance, beginning of year	$ 224,190	$ 211,000
Current year claims incurred and changes in estimates for claims incurred in prior years	1,196,811	1,234,380
Claims and expenses paid	(1,244,001)	(1,221,190)
Balance, end of year	$ 177,000	$ 224,190

Pension Plan: The Hospital contributes to a defined contribution pension plan covering substantially all employees. Pension expense is recorded for the amount of the Hospital's required contributions, determined in accordance with the terms of the plan. The plan is administered by the Hospital. The plan provides retirement and death benefits to plan members and their beneficiaries. Benefit provisions are contained in the plan document and were established and can be amended by action of the Hospital's governing body. Contribution rates for the Hospital were 3.5% for the years ended April 30, 2008 and 2007, respectively. Contributions made by the Hospital totaled $204,158 and $193,411 during 2008 and 2007, respectively.

Hospital Uninsured Patient Discount Act: On May 30, 2008, the Illinois legislature passed a bill titled the "Hospital Uninsured Patient Discount Act", (the Act). Once signed by the Governor of Illinois, this Act will require hospitals to provide certain mandated discounts from charges to the uninsured in Illinois. Charges are to be discounted to 135% of cost. Furthermore, a hospital may not collect more than 25% of an insured family's gross income in any one year. Once the Governor signs the bill, hospitals will have 180 days to prepare for implementation to accommodate the provisions of the Act. The Hospital is in the process of determining the impact of this Act and is developing procedures in order to implement the Act.

Compensated absences: Activity in the Hospital's accrued vacation liability is as follows:

	Years Ended April 30,	
	2008	2007
Balance, beginning of year	$ 449,477	$ 393,542
Earned	449,122	423,283
Used or cashed-out	(463,944)	(367,348)
Balance, ending of year	$ 434,655	$ 449,477

Note 8. Restricted and Designated Net Assets

At April 30, 2008 and 2007, restricted expendable net assets were available for the following purposes:

	2008	2007
Debt service	$ 373,483	$ 712,644
Specific operating activities	146,234	125,528
Total restricted expendable net assets	$ 519,717	$ 838,172

At April 30, 2008 and 2007, $4,647,564 and $4,716,895, respectively, of unrestricted net assets has been designated by the Hospital's Board of Directors for capital acquisitions. Designated net assets remain under the control of the Board of Directors which may, at its discretion, later use these net assets for other purposes.

Note 9. Labor Force

Approximately 19% of the Hospital's labor force was covered under a collective bargaining agreement in effect through April 30, 2008.

Note 10. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of patient receivables from patients and third-party payors at April 30, 2008 and 2007 was as follows:

	2008	2007
Medicare	43%	41%
Commercial insurance and other	22%	26%
Private pay	12%	20%
Medicaid	23%	13%
	100%	100%

Note 11. Discontinued Operations

On March 17, 2008, the Hospital entered into an asset purchase agreement with an unrelated third-party to sell the Hospital's Home Health and Hospice services (servicing lines) for $100,000. Assets sold in conjunction with this asset purchase agreement include various office equipment, the servicing lines' training materials, policy and procedural manuals, and office supply inventory, and the medical records for active patients. Patient receivables for the servicing lines for services performed up to the date of the sale were retained by the Hospital in accordance with the asset purchase agreement. The patient receivable balances for the servicing lines are included in the accompanying Balance Sheet in the amount of $80,045 and $78,310 at April 30, 2008 and 2007, respectively. No liabilities or other obligations were assumed by the third-party. The results of the servicing lines' operations have been reported separately as discontinued operations in the Statements of Revenue, Expenses, and Changes in Net Assets.

Note 11. Discontinued Operations (Continued)

Gain on the disposal of the servicing lines' capital assets is computed as follows:

	Amount
Net proceeds	$ 100,000
Book value of equipment sold	6,915
Gain on disposal of capital assets	$ 93,085

Comparative Statements of Revenue, Expenses, and Changes in Net Assets for the discontinued servicing lines are as follows:

	2008	2007
Net patient service revenue	$ 998,229	$ 1,068,203
Less operating expenses:		
Nursing services	711,240	771,273
	286,989	296,930
Gain on disposal of capital assets	93,085	-
Gain on discontinued operations	$ 380,074	$ 296,930

Note 12. New and Pending Pronouncements

As of April 30, 2008, the Governmental Accounting Standards Board (GASB) had issued the following statements not yet implemented by the Hospital. The statements which might impact the Hospital are as follows:

- GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postretirement Benefits Other Than Pensions*, issued June 2004, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement establishes standards for the measurement, recognition and display of other postemployment benefits expenses and related liabilities or assets, note disclosures and, if applicable, required supplementary information in the financial reports.

- GASB Statement No. 49, *Accounting and Financial Reporting for Pollution Remediation obligations*, issued November 2006, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement addresses accounting and financial reporting standards for pollution (including contamination) remediation obligations, which are obligations to address the current or potential detrimental effects of existing pollution by participating in pollution remediation activities, such as site assessments and cleanups. This standard requires the government to estimate the components of expected pollution remediation outlays and determine whether the outlays for those components should be accrued as a liability or, if appropriate, capitalized when goods and services are acquired.

- GASB Statement No. 50, *Pension Disclosures*, an amendment of GASB Statement Nos. 25 and 27, issued May 2007, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement more closely aligns the financial reporting requirements for pensions with those for other postemployment benefits (OPEB) and, in doing so, enhances information disclosed in notes to the financial statements or presented as required supplementary information (RSI) by pension plans and by employers that provide pension benefits.

Note 12. New and Pending Pronouncements (Continued)

- GASB Statement No. 51, *Accounting and Financial Reporting for Intangible Assets*, issued June 2007, will be effective for the Hospital beginning with its year ending April 30, 2011. This Statement establishes accounting and financial reporting requirements for intangible assets. All intangible assets not specifically excluded by the scope of this statement should be classified as capital assets. All existing authoritative guidance for capital assets should be applied to these intangible assets, as appreciable.

The Hospital management has not yet determined the effect these Statements will have on the Hospital's financial statements.

Note 13. Subsequent Event

In July 2008, the Hospital's Certificate of Need for the discontinuance of its long-term care unit was approved by the State of Illinois Health Facilities Planning Board. Subsequent to this approval, the Hospital's Board passed a motion to proceed with the closure of the long-term care unit.

Pinckneyville Community Hospital District

Net Patient Service Revenue
Years Ended April 30, 2008 and 2007

	2008			2007		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Daily Patient Services:						
Acute Care	$ 1,289,480	$ 14,254	$ 1,303,734	$ 1,663,829	$ 26,492	$ 1,690,321
Swing bed	380,919	-	380,919	437,340	-	437,340
Skilled nursing care	1,841,936	-	1,841,936	1,785,373	-	1,785,373
	3,512,335	14,254	3,526,589	3,886,542	26,492	3,913,034
Other Nursing Services:						
Operating and recovery	213,220	900,344	1,113,564	246,183	805,440	1,051,623
Central services and supply	273,978	24,369	298,347	379,146	331,901	711,047
Emergency services	62,035	1,898,640	1,960,675	76,256	1,575,880	1,652,136
	549,233	2,823,353	3,372,586	701,585	2,713,221	3,414,808
Other Professional Services:						
Laboratory	609,872	3,950,898	4,560,770	826,842	3,468,834	4,295,676
Radiology	381,518	4,293,652	4,675,170	559,603	4,445,855	5,005,458
Nuclear medicine	16,254	747,243	763,497	30,784	899,578	930,362
Oncology	2,923	398,452	401,375	2,975	332,834	335,809
Respiratory therapy	259,585	632,317	891,902	343,353	654,746	998,099
Cardiac rehabilitation	-	3,076	3,076	-	6,343	6,343
Pharmacy	1,591,073	6,884,589	8,475,662	1,815,826	7,181,037	8,996,863
Anesthesiology	50,039	314,431	364,470	66,515	296,226	362,741
Physical therapy	546,440	1,320,910	1,867,350	600,089	1,294,779	1,894,868
Durable medical equipment	-	330,869	330,869	-	379,796	379,796
Clinic	-	1,179,440	1,179,440	-	1,181,628	1,181,628
	3,457,704	20,055,877	23,513,581	4,245,987	20,141,656	24,387,643
Gross patient service revenue	$ 7,519,272	$ 22,893,484	$ 30,412,756	$ 8,834,114	$ 22,881,369	$ 31,715,483
Less discounts, allowances, and estimated contractual adjustments, third-party reimbursement programs			10,213,235			11,846,325
Provision for uncollectible accounts			947,178			220,154
Net patient service revenue			$ 19,252,343			$ 19,649,004

Pinckneyville Community Hospital District

Operating Expenses
Years Ended April 30, 2008 and 2007

	2008			2007		
	Salaries and Wages	Supplies and Expense	Total	Salaries and Wages	Supplies and Expense	Total
Nursing Services:						
Nursing administration	$ 323,641	$ 34,345	$ 357,986	$ 297,807	$ 33,818	$ 331,625
Acute care	1,053,955	121,753	1,175,708	982,350	185,602	1,167,952
Skilled nursing care	1,120,283	254,746	1,375,029	1,136,998	141,145	1,278,143
Operating and recovery	172,686	72,168	244,854	178,493	86,232	264,725
Central services and supply	18,799	2,903	21,702	20,645	144,559	165,204
Emergency services	315,958	800,569	1,116,527	344,752	690,297	1,035,049
	3,005,322	1,286,484	4,291,806	2,961,045	1,281,653	4,242,698
Other Professional Services:						
Laboratory	400,758	508,201	908,959	390,407	436,752	827,159
Radiology	451,224	393,024	844,248	430,150	416,533	846,683
Nuclear medicine	16,511	129,201	145,712	34,721	155,344	190,065
Respiratory therapy	246,894	95,391	342,285	242,104	79,079	321,183
Cardiac rehabilitation	-	-	-	93	-	93
Pharmacy	289,835	2,165,901	2,455,736	288,015	2,259,247	2,547,262
Anesthesiology	-	263,667	263,667	-	253,872	253,872
Physical therapy	551,895	31,319	583,214	603,578	34,510	638,088
Medical records	273,159	50,635	323,794	261,398	42,361	303,759
Durable medical equipment	142,304	97,015	239,319	133,347	92,092	225,439
Social services	66,479	1,691	68,170	64,720	1,090	65,810
Clinic	1,235,401	67,081	1,302,482	1,161,940	72,214	1,234,154
Oncology	198,693	284,004	482,697	166,362	211,532	377,894
Retail pharmacy	2,674	6,010	8,684	2,403	3,396	5,799
	3,875,827	4,093,140	7,968,967	3,779,238	4,058,022	7,837,260
General Services:						
Dietary	381,842	224,727	606,569	328,428	203,742	532,170
Operation and maint. of plant	172,935	379,404	552,339	164,839	384,564	549,403
Housekeeping	254,877	64,419	319,296	228,599	58,114	286,713
Laundry and linen	89,647	18,175	107,822	84,559	21,114	105,673
	899,301	686,725	1,586,026	806,425	667,534	1,473,959
Administrative Services:						
Administrative	949,862	1,206,341	2,156,203	896,629	1,246,239	2,142,868
Employee benefits	-	2,581,815	2,581,815	-	2,668,872	2,668,872
	949,862	3,788,156	4,738,018	896,629	3,915,111	4,811,740
Other administrative expenses	-	139,650	139,650	-	129,746	129,746
Depreciation	-	858,327	858,327	-	837,478	837,478
Interest and amortization	-	75,250	75,250	-	88,067	88,067
	-	1,073,227	1,073,227	-	1,055,291	1,055,291
	$ 8,730,312	$ 10,927,732	$ 19,658,044	$ 8,443,337	$ 10,977,611	$ 19,420,948

Pinckneyville Community Hospital District

Service Statistics (Unaudited)
Years Ended April 30, 2008, 2007, 2006, 2005 and 2004

	2008	2007	2006	2005	2004
Hospital:					
Medical and surgical patient days	1,930	2,486	2,728	2,607	2,806
Medicare patient days	1,500	1,856	2,040	1,946	2,004
Medicare utilization	77.7%	74.7%	74.8%	74.6%	71.4%
Discharges	563	796	819	767	812
Average length-of-stay (days):					
Non-Medicare patients	3.09	2.89	3.03	3.10	3.07
Medicare patients	3.54	3.21	3.44	3.51	3.64
All acute patients	3.43	3.12	3.33	3.40	3.46
Skilled-Nursing Facility:					
Licensed available beds	50	50	50	50	50
Medicare certified area patient days	791	1,005	1,817	2,498	2,663
Noncertified area patient days	15,240	14,731	13,848	13,333	13,156
Total patient days	16,031	15,736	15,665	15,831	15,819
Medicare patient days	774	851	1,399	2,003	2,045
Medicare utilization	4.8%	5.4%	8.9%	12.7%	12.9%

McGladrey & Pullen
Certified Public Accountants

Pinckneyville Community Hospital District

Financial Report
04.30.2007

Contents

McGladrey & Pullen

Certified Public Accountants

Independent Auditor's Report

To the Board of Directors
Pinckneyville Community Hospital District
Pinckneyville, Illinois

We have audited the accompanying basic financial statements of Pinckneyville Community Hospital District (Hospital) as of and for the years ended April 30, 2007 and 2006, as listed in the table of contents. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinions.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Pinckneyville Community Hospital District as of April 30, 2007 and 2006, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated August 15, 2007, on our consideration of Pinckneyville Community Hospital District's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

The management's discussion and analysis on pages 3 through 8 is not a required part of the basic financial statements, but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures which consisted principally of inquiries of management regarding the methods of measurement and representation of the required 2007 and 2006 supplementary information. However, we did not audit the information and express no opinion on it.

Our audits were conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Hospital's basic financial statements. The supplementary information on pages 28 through 30 is presented for purposes of additional analysis and is not a required part of the basic financial statements. The supplementary information on pages 28 and 29 for the years ended April 30, 2007 and 2006 has been subjected to the auditing procedures applied in the audits of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole. The supplementary information on page 30 marked "unaudited" has not been subjected to the auditing procedures applied in the audits of the basic financial statements and, accordingly, we express no opinion on it.

McGladrey & Pullen, LLP

Springfield, Illinois
August 15, 2007

Management's discussion and analysis of the Pinckneyville Community Hospital District's (Hospital) financial performance provides an overall review of the Hospital's financial activities for the fiscal years ended April 30, 2007, 2006 and 2005. The intent of this discussion is to provide an overview of the Hospital's performance for the years and should be read in conjunction with the accompanying financial statements and notes thereto.

Pinckneyville Community Hospital District operates a critical access hospital with 25 acute care beds and 50 long-term care beds as well as a physician clinic in Pinckneyville, Illinois. Pinckneyville Community Hospital District serves the citizens of the Perry County area and particularly the residents of Pinckneyville, Illinois.

Financial Highlights

During 2007, Hospital's assets exceeded its liabilities by $11,772,775 or approximately 12% from April 30, 2006 and the Hospital's assets exceeded its liabilities by $10,537,908 or approximately 8% from April 30, 2005 to April 30, 2006.

During 2007, Hospital's total assets increased by $1,274,606 or approximately 9% from April 30, 2006 and increased $529,561 or approximately 4% from April 30, 2005 to April 30, 2006.

During 2007, Hospital's total liabilities increased by $39,739 or approximately 1% from April 30, 2006 and decreased by $289,020 or approximately 9% from April 30, 2005 to April 30, 2006.

Overview of Financial Statements

The audited financial statements include: Balance Sheets, Statements of Revenue, Expenses and Changes in Net Assets, and Statements of Cash Flows plus the Notes to the Basic Financial Statements.

Our financial position is measured in terms of resources (assets) we own and obligations (liabilities) we owe at a given date. This information is reported in the Balance Sheets, which reflect the Hospital's assets in relation to its debts to bondholders, suppliers, employees, and other creditors. The excess of our assets over our liabilities is reported as Net Assets.

Information regarding the results from operations during the year is reported in the Statements of Revenue, Expenses and Changes in Net Assets. This statement shows how much our net assets increased during the year as a result of our operations, nonoperating activities, and other changes.

The Statements of Cash Flows disclose the flow of cash resources into and out of the Hospital during the year. It identifies all cash received during the year from operating activities, contributions and other sources, and how we applied those funds (for example, payment of expenses, repayment of debt, purchases of new property and equipment, and additions and sales to the investment accounts).

The Notes to Basic Financial Statements provide additional information that is essential to a full understanding of the data provided in the financial statements.

Condensed Balance Sheets

Condensed versions of the Balance Sheets as of April 30, 2007, 2006, and 2005 follow.

	April 30,		
	2007	2006	2005
Assets			
Cash and short-term investments	$ 2,452,937	$ 2,026,251	$ 1,854,248
Restricted cash and investments	838,172	753,388	684,815
Board designated instruments	4,716,895	4,407,885	4,091,878
Total cash and investments	8,008,004	7,187,524	6,630,941
Patient accounts receivable, net	2,648,402	2,541,046	2,465,675
Other current assets	629,051	429,777	390,135
Capital assets, net	3,577,429	3,429,933	3,571,968
Total assets	$ 14,862,886	$ 13,588,280	$ 13,058,719
Liabilities:			
Current liabilities	$ 1,906,111	$ 1,660,343	$ 1,614,043
Long-term debt	1,184,000	1,390,029	1,725,349
Total liabilities	3,090,111	3,050,372	3,339,392
Net Assets			
Invested in capital assets, net of related debt	2,187,400	1,704,584	1,454,767
Restricted	838,172	753,388	684,815
Unrestricted	8,747,203	8,079,936	7,579,745
Total net assets	11,772,775	10,537,908	9,719,327
Total liabilities and net assets	$ 14,862,886	$ 13,588,280	$ 13,058,719

Year ended April 30, 2007: Total assets increased in 2007 due to the increases discussed below.

The Hospital experienced an increase in cash and investments of $820,480 or 11% from April 30, 2006. The build-up of cash and investments is primarily due to an increase of $3,175,799, or 15%, in hospital outpatient revenues (primarily Oncology) and an increase of $86,158 or 33%, in investment earnings due to higher interest rates achieved when the checking accounts were bid out around February/March of 2006 and due to growth in cash and investment balances. Net patient receivables increased by $107,356 (gross receivables decreased by $437,131, or 8%), in 2007, compared to an increase of approximately $75,000 experienced in 2006. In 2007, gross receivables decreased while net receivables increased due to a change in the methodology surrounding the calculation in the allowance for uncollectible accounts. Receivables, without factoring in the change in methodology previously described, have decreased due to activity drops in inpatient, swing bed and skilled care service areas and the consistent collection efforts on the increased outpatient account balances. A temporary improvement in Medicaid claim payments at our rural health clinic helped decrease their receivables from the prior year.

Year ended April 30, 2006: Total assets increased in 2006 due to the increases discussed below.

The Hospital experienced an increase in cash and investments of $556,583 or 8% from April 30, 2005. The build-up of cash and investments is primarily due to an increase of $97,354 in investment earnings, an increase in swingbed utilization and an increase in outpatient revenue of approximately $540,000. Patient receivables increased by approximately $75,000 in 2006, compared to an increase of approximately $265,000 experienced in 2005. This increase is mainly due to the effects of a charge increase and greater average daily gross charges.

Long-Term Debt

Long-term debt includes revenue bonds issued in 1976, 1982, and 1995 and general obligation bonds issued in 1995 as well as capital lease obligations that are detailed in Note 6 to the basic financial statements. The Hospital did not issue any new debt in 2007 or 2006

Capital Assets

Year Ended April 30, 2007: At April 30, 2007, the Hospital had $3,577,429 invested in capital assets. This represents an increase of $147,496 in comparison to April 30, 2006 due to approximately $908,000 in equipment purchases for expansion of the CPSI system (including nursing Point-of-care, Electronic Forms, Physician Chartlink and Imagelink); the purchase of a CR Reader in the imaging department and Omnicell automated medication dispensing units for our Acute Care and Emergency Room departments, less applicable depreciation. Approximately $187,000 worth of assets were retired during the year and the CT scanner became fully depreciated in 2007. Furthermore, several other items of imaging equipment that were leased approximately 4 years ago will be nearing their fully depreciated life in the upcoming year.

Year Ended April 30, 2006: At April 30, 2006, the Hospital had $3,429,933 invested in capital assets. This represents a decrease in comparison to April 30, 2005 due to more of the assets of the Hospital becoming fully depreciated causing net capital assets to decrease.

Condensed Statements of Revenue, Expenses and Changes in Net Assets

A summary version of the Statements of Revenue, Expenses and Changes in Net Assets for the years ended April 30, 2007, 2006, and 2005 follows:

	2007	2006	2005
Net patient service revenue	$ 20,587,461	$ 18,698,651	$ 18,338,194
Other operating revenue	97,638	104,793	110,402
Total operating revenue	20,685,099	18,803,444	18,448,596
Total nonoperating revenue, net	612,243	549,046	436,614
Total revenue	21,297,342	19,352,490	18,885,210
Expenses:			
Salaries and wages and employee benefits	11,687,900	11,066,398	10,196,675
Purchased services and professional fees	1,928,942	1,633,422	1,822,138
Depreciation	837,478	807,848	783,051
Other operating expenses	5,520,088	4,919,647	5,037,311
Interest and amortization	88,067	106,594	124,299
Total operating expenses	20,062,475	18,533,909	17,963,474
Change in net assets	1,234,867	818,581	921,736
Net assets:			
Beginning	10,537,908	9,719,327	8,797,591
Ending	$ 11,772,775	$ 10,537,908	$ 9,719,327

Operations

Year Ended April 30, 2007: 2007 income from operations showed an increase compared to the prior year. Net operating revenue increased $1,881,655 to $20,685,099 in 2007 from $18,803,444 in 2006, approximately 10% increase. The increase in net operating revenue was primarily due to an increase in Oncology services and related outpatient pharmacy revenues which grew by $2,039,626 in gross revenues. This was likely driven by an increase in cancer-related illnesses in our area and increased preference for area patients to utilize our facilities instead of traveling to metropolitan hospitals. Additionally, a portion of the increase in net revenues can be attributed to favorable cost report settlements during 2007, which also was a significant portion of the $416,286 increase in the change in net assets over prior years. Overall, outpatient gross revenues increased by $3,175,799, or 15%, helping compensate for the $1,339,280, or 13%, drop in inpatient and swing bed related services. The increase in operating expenses of $1,528,566 was primarily driven by a $434,194 increase in drug expenses related to the Oncology services.

Salaries were up $458,960 over prior year, an increase of 5.36%. Average annual merits account for 3 to 3.5% of the adjustments and market adjustments were implemented for nursing throughout the year, accounting for a portion of the remaining difference. Employee benefits were $162,542 over prior year. The primary increase in benefits from prior year was related to an $80,068 increase in worker's compensation premiums. With the annual increase in wages to account for merit and market adjustments, FICA taxes rose by $34,117 over prior year. Although health insurance claim experience was down by $43,065, prescription costs were up by $68,941, thereby creating an increase of $25,876 over prior year. We also spent $18,913 more on our employee wellness program with the implementation of the "Healthier Me" program.

Purchased services and professional fees were up $295,520 over prior year, driven by $84,269 in extra temp agency nursing staff in Acute Care and Skilled Care and $45,210 for a temporary contracted physical therapist. Professional fees were $193,733 over prior year, primarily driven by ER professional and Oncologist fees. Additional ER coverage was required while our ER physician assistant covered at the rural health clinic with the absence of one physician. Oncology physician fees were up due to negotiated fee increases, additional clinic days and added coverage by a physician assistant.

Year Ended April 30, 2006: 2006 income from operations showed a decrease compared to the prior year. Operating revenue increased $354,848 to $18,803,444 in 2006 from $18,448,596 in 2005, a 2% increase. The decrease in income from operations was primarily due to an increase in salaries, wages, and benefits of $869,724 or 9%. This increase is in connection with the Hospital's retention and recruitment efforts, in addition to merit increases of 3%. Net patient revenue increased by $360,457 or 2% over 2005. This increase is mainly due to significant growth in swingbed inpatient utilization. Operating expenses, purchased services and professional fees decreased by $306,380 or 4% from 2005.

Non-operating income, which consists of investment earnings, tax revenue, and contributions income, was up $112,432 or 26% from 2005.

Condensed Statements of Cash Flows

	Year ended April 30		
	2007	2006	2005
Cash provided by operating activities	$ 1,608,493	$ 1,168,870	$ 1,073,619
Cash provided by non-capital financing activities	275,279	283,061	294,641
Cash (used in) capital and related financing activities	(1,408,361)	(1,164,260)	(885,036)
Cash provided by (used in) investing activities	793,818	(853,867)	217,686
Net increase (decrease) in cash	1,269,229	(556,196)	700,910
Cash:			
Beginning	1,298,564	1,854,760	1,153,850
Ending	$ 2,567,793	$ 1,298,564	$ 1,854,760

Years ended April 30, 2007 and 2006: Changes in the Hospitals cash flows are consistent with changes in operating income and nonoperating revenues and expense.

Economic Factors

Year Ended April 30, 2007: The Hospital is continuing its physician recruitment efforts to replace a family practice physician who left the rural health clinic in fiscal year 2007 and another internal medicine/pulmonologist who will be leaving the clinic in fiscal year 2008. The Hospital also continues to work with SSM Healthcare and Washington County Hospital regarding surgeon recruitment efforts.

Sleep studies declined with the opening of additional sleep labs in the area. A Nephrology clinic was added to the Specialty Clinic in February 2007 which has created additional service referrals to our laboratory and imaging departments.

The Technicolor plant located just east of Pinckneyville closed at the end of March 2007. The majority of the employees lived outside the Hospital's service area but the annual impact on cash receipts was estimated to be approximately $189,000.

In July 2007, management initiated the process toward a Certificate of Need application for a replacement hospital without the Skilled Care Unit as part of that project. Management also created a 501(c)3 not-for-profit corporation with the intent that that entity could look at options that might be available to sustain the skilled care unit either in the present building or to determine if there are other options available.

Year Ended April 30, 2006: Physician recruitment was ongoing during fiscal year 2007 for a replacement physician at the physician clinic. The Hospital has continued to work with SSM Healthcare and Washington County Hospital regarding surgeon recruitment efforts.

Specialty clinics continued to operate as in prior years. The largest clinics, Cardiology, Podiatry and Orthopedics all experienced declines in patient visits. This decline was primarily due to heart patients who are opting to see physicians who do not hold clinics at the Hospital. In addition, the orthopedist reduced his clinic to two half days per week from two full days because of commitments in other locales. Lastly, the podiatrist introduced a new partner to staff the clinic. This negatively impacted visits during the transition.

Increased education support contributed to a decrease in operating income. Education support increased due to five registered nurses completing a bachelor of nursing degree, attendance at LPN and RN nursing programs, and various other education and certification pursuits of hospital employees.

Ongoing analysis and discussions have continued during fiscal year 2006 regarding a replacement facility. As a part of these discussions, non-cost reimbursed areas are being reviewed. It is anticipated that a decision will be reached during fiscal year 2007.

Contacting the Hospital's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the Hospital's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Hospital Administrator at Pinckneyville Community Hospital District, 101 N. Walnut Street, Pinckneyville, Illinois 62274-1099.

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Pinckneyville Community Hospital District

Balance Sheets
April 30, 2007 and 2006

Assets	2007	2006
Current Assets:		
Cash	$ 930,810	$ 593,613
Short-term cash and investments - current	1,522,127	1,432,638
Restricted by donor for specific operating activities - investments	125,528	107,575
Held by trustee for debt service - investments	712,644	645,813
Patient accounts receivable, less allowances for contractual adjustments and doubtful accounts: 2007 $2,832,180; 2006 $3,176,667	2,648,402	2,541,046
Estimated third party payor settlements, net	200,000	-
Inventories	256,952	277,061
Prepaid expenses and other	172,099	152,716
Total current assets	6,568,562	5,750,462
Board designated instruments	4,716,895	4,407,885
Capital assets, not being depreciated	274,036	267,389
Capital assets, being depreciated, net	3,303,393	3,162,544
	3,577,429	3,429,933
Total assets	$ 14,862,886	$ 13,588,280

See Notes to Basic Financial Statements.

Liabilities and Net Assets	2007	2006
Current Liabilities:		
Current maturities of long-term debt	$ 206,029	$ 335,320
Accounts payable	229,533	232,490
Accrued payroll and related expenses	920,606	806,870
Estimated amounts due to third-party payors, net	-	20,000
Other	549,943	265,663
Total current liabilities	1,906,111	1,660,343
Long-term debt, less current maturities	1,184,000	1,390,029
Total liabilities	3,090,111	3,050,372
Commitments and contingencies (Note 7)		
Net Assets:		
Invested in capital assets, net of related debt	2,187,400	1,704,584
Restricted:		
Under bond indenture	712,644	645,813
Specific operating activities	125,528	107,575
Unrestricted	8,747,203	8,079,936
	11,772,775	10,537,908
Total liabilities and net assets	$ 14,862,886	$ 13,588,280

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Pinckneyville Community Hospital District

Statements of Revenue, Expenses, and Changes in Net Assets
Years ended April 30, 2007 and 2006

	2007	2006
Operating revenue:		
Net patient service revenue	$ 20,587,461	$ 18,698,651
Other operating revenue	97,638	104,793
Total operating revenue	20,685,099	18,803,444
Operating expenses:		
Nursing services	5,013,971	4,669,606
Other professional services	7,837,260	7,089,910
General services and administration	6,285,699	5,859,951
Interest and amortization	88,067	106,594
Depreciation	837,478	807,848
Total operating expenses	20,062,475	18,533,909
Income from operations	622,624	269,535
Nonoperating revenue (expense):		
Interest earnings	345,069	258,911
Tax revenue	217,334	206,703
Gifts, donations, other	57,945	86,358
Loss on disposal of capital assets	(8,105)	(2,926)
	612,243	549,046
Change in net assets	1,234,867	818,581
Net assets:		
Beginning	10,537,908	9,719,327
Ending	$ 11,772,775	$ 10,537,908

See Notes to Basic Financial Statements.

Pinckneyville Community Hospital District

Statements of Cash Flows
Years ended April 30, 2007 and 2006

	2007	2006
Cash Flows from Operating Activities:		
Receipts from and on behalf of patients	$ 21,598,064	$ 19,740,429
Payments to suppliers and contractors	(8,507,887)	(7,662,045)
Payments to employees	(11,571,217)	(11,011,381)
Other receipts, net	89,533	101,867
Net cash provided by operating activities	1,608,493	1,168,870
Cash Flows from Non-Capital Financing Activities:		
Property taxes supporting operations	217,334	206,703
Capital grants and gifts	57,945	86,358
Net cash provided by non-capital financing activities	275,279	293,061
Cash flows from Capital and Related Financing Activities:		
Principal paid on long-term debt	(335,320)	(391,853)
Interest paid	(88,067)	(106,594)
Loss on disposal of capital assets	8,105	2,926
Purchase of capital assets	(993,079)	(668,739)
Net cash (used in) capital and related financing activities	(1,408,361)	(1,164,260)
Cash Flows from Investing Activities		
Interest on investments	345,069	258,911
Purchase of investments	(5,326,500)	(5,968,718)
Proceeds from disposition of investments	5,775,249	4,855,940
Net cash (used in) investing activities	793,818	(853,867)
Increase (decrease) in cash	1,269,229	(556,196)
Cash:		
Beginning	1,298,564	1,854,760
Ending, including cash included in current investments: 2007 $1,636,983; 2006 $704,951	$ 2,567,793	$ 1,298,564

- Continued -

Pinckneyville Community Hospital District

Statements of Cash Flows (Continued)
Years ended April 30, 2007 and 2006

	2007	2006
Reconciliation of operating income to net cash provided by operating activities:		
Operating income	$ 614,519	$ 266,609
Depreciation	837,478	807,848
Bad debts	220,154	933,830
Interest and amortization	88,067	106,594
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(327,510)	(1,009,201)
Estimated amounts due to and from third-party payors	(220,000)	5,000
Accounts payable, accrued expenses, and other liabilities	395,059	97,832
Other assets	726	(39,642)
Net cash provided by operating activities	$ 1,608,493	$ 1,168,870

See Notes to Basic Financial Statements.

Note 1. Nature of Business and Summary of Significant Accounting Policies

Nature of business

Pinckneyville Community Hospital District (Hospital) operates a critical access hospital with 25 acute care beds and 50 long-term care beds as well as a physician clinic in Pinckneyville, Illinois. The Hospital is established in accordance with provisions of the Illinois Hospital District Law and is located in Pinckneyville, Illinois.

The Hospital primarily earns revenue by providing inpatient, outpatient, skilled nursing, physician clinic and home health care services to area residents.

The Hospital is exempt from income taxes under provisions of the Internal Revenue Code as a political subdivision of the State of Illinois.

Significant accounting policies

Basis of accounting: The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenue is recognized when earned and expenses are recorded when the liability is incurred.

Accounting pronouncements: The Hospital prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB). Pursuant to GASB Statement No. 20, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB) that were issued on or before November 30, 1989, and do not conflict with or contradict GASB pronouncements.

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

Cash and cash equivalents: Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months of less, excluding amounts whose use is limited by board designation or other arrangements under trust agreements, with third-party payors or donors.

Patient receivables: Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by identifying troubled accounts, by historical experience applied to an aging of accounts, and by considering the patient's financial history, credit history and current economic conditions. The Hospital does not charge interest on patient receivables. Patient receivables are written off as bad debt expense when deemed uncollectible and when transferred to outside collection agencies and attorneys. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received. The provision for doubtful accounts was $220,154 and $933,830 for the years ended April 30, 2007 and 2006, respectively.

Inventories: Inventories are valued at the lower of cost (first-in, first-out method) or market.

Note 1. Nature of Business and Summary of Significant Accounting Policies (Continued)

Assets limited as to use or restricted: Assets limited as to use or restricted include assets restricted by revenue bond ordinance, donor-restricted assets and assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes.

Investments: Investments in certificates of deposit are carried at amortized cost, which approximates market value. Investment income consists of interest income.

Capital assets: Capital assets are recorded at cost or fair value if donated. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives. Amortization of assets under capital leases is included with depreciation expense on owned capital assets. Depreciation is computed by the straight-line method over estimated useful lives as follows.

Land improvements	8 – 20 years
Buildings and building improvements	5 – 40 years
Equipment	3 – 20 years

Donations of capital assets are reported at fair value as an increase in unrestricted net assets unless use of the asset is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted net assets. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

Net patient service revenue: Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Net patient service revenue is reported net of provision for uncollectible accounts.

Operating income: The Hospital distinguishes operating revenue and expenses from nonoperating items. Operating revenue and expenses generally result from the primary purpose of the Hospital, which is to provide medical services to the region. Operating expenses consist of salaries and wages, employee benefits, purchased services and professional fees, depreciation, interest and supplies and other. All revenue and expenses not meeting these criteria are considered nonoperating.

Tax revenue: Property taxes are recognized as assets in the period an enforceable legal claim to the assets arises and are recognized as revenue in the period for which the taxes are levied. Property taxes are collected by the county and are primarily received by the Hospital in October, November and December. Other state property tax revenue is recognized as revenue when received by the Hospital. Property taxes that are not available for current year operations, if any, are shown as deferred revenue.

Net assets: Net assets of the Hospital are defined as follows:

Invested in capital assets, net of related debt – This component of net assets consists of capital assets, including any restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. If there are significant unspent related debt proceeds at year-end, the portion of the debt attributable to the unspent proceeds is not included in the calculation of invested in capital assets component as the unspent proceeds.

Note 1. Nature of Operations and Summary of Significant Accounting Policies (Continued)

Restricted – This component of net assets consists of constraints placed on net assets through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted net assets – This component of net assets consists of net assets that do not meet the definition of "restricted" or "invested in capital assets, net of related debt," above.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care for the years ended April 30, 2007 and 2006 was approximately $170,000 and $39,200, respectively, based on prevailing charges.

Reclassifications: Certain 2006 data has been reclassified to conform to the 2007 presentation, with no effect on previously-reported net assets or change in net assets.

Note 2. Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare: The Hospital is designated as a critical access hospital. This designation provides for inpatient and outpatient services to be reimbursed on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. Inpatient nonacute services related to Medicare beneficiaries are paid at prospectively determined rates per day. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors.

The Hospital's Medicare cost reports have been audited and finalized by the Medicare fiscal intermediary through April 30, 2006.

Medicaid: Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under prospectively determined fee schedules.

Approximately 41% and 35% of net patient service revenue is from participation in the Medicare and state-sponsored Medicaid programs for the years ended April 30, 2007 and 2006, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

On November 21, 2006, the Federal Centers for Medicare and Medicaid Services (CMS) approved State of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program) relating to the period June 30, 2006 to June 30, 2008. Under the Program, the Hospital receives additional Medicaid reimbursement from the State. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $174,848 during the Hospital's year ended April 30, 2007, and is included in net patient service revenue on the statements of revenue, expenses, and changes in net assets. As a governmental entity, the Hospital did not incur any assessments related to this Program. The laws and regulations authorizing this Program expire on June 30, 2008.

Note 2. Net Patient Service Revenue (Continued)

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

	2007	2006
Gross patient service revenue	$ 32,822,662	$ 30,986,143
Less discounts, allowances and estimated contractual adjustments under third-party reimbursement programs	12,015,047	11,353,662
Less provision for doubtful accounts	220,154	933,830
Net patient service revenue	$ 20,587,461	$ 18,698,651

Note 3. Deposits and Investments

Authorized investments: Illinois state statues authorize the Hospital to make deposits and investments in interest-bearing depository accounts in federally insured and/or state chartered banks and savings and loan associations, or other financial institutions as designated by ordinances, and to invest available funds in direct obligations of, or obligations guaranteed by, the U.S. Treasury or agencies of the United States, money market mutual funds whose portfolios consist of government securities, and the Illinois Public Treasury's Investment Pool The Hospital's investments consist entirely of certificates of deposit. The Hospital has not adopted a formal investment policy.

Custodial credit risk: Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to the Hospital. State law allows collateralization of deposits in excess of federal depository insurance. The Hospital's deposit policy for custodial credit risk is to obtain a pledge of collateral for deposits substantially in excess of federal depository insurance.

At April 30, 2007 and 2006, respectively, the Hospital's deposit bank balances of $8,093,818 and $8,561,486, respectively, were exposed to custodial credit risk as follows:

	2007	2006
Uninsured, collateral held by pledging financial institution's trust department or agent in other than the Hospital's name	$ 8,008,004	$ 7,187,524

The Hospital maintains a substantial portion of its deposits in two financial institutions. The Hospital has not experienced any losses in such amounts and believes it is not exposed to any significant credit risk on its deposits.

The deposits shown above are included in the balance sheets as follows:

	2007	2006
Included in the following balance sheet captions:		
Cash	$ 930,810	$ 593,613
Short-term cash and investments	1,522,127	1,432,638
Board designated instruments	4,716,895	4,407,885
Restricted by donor for specific operating activities	125,528	107,575
Held by trustee for debt service	712,644	645,813
	$ 8,008,004	$ 7,187,524

Note 4. Accounts Receivable

The Hospital grants credit without collateral to its patients, most of who are area residents and are insured under third-party payor agreements. Patient accounts receivable, at April 30, 2007 and 2006, are as follows:

Patient Accounts Receivable

	2007	2006
Medicare	$ 992,434	$ 1,277,777
Medicaid	219,520	443,429
Other third-party payors	1,070,024	1,005,219
Patients	1,129,463	1,232,579
	3,411,441	3,959,004
Less allowance for uncollectible accounts	763,039	1,417,958
Patient accounts receivable, net	$ 2,648,402	$ 2,541,046

Note 5. Capital Assets

Capital assets activity for the years ended April 30, 2007 and 2006 is as follows:

	2007				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 236,114	$ -	$ -	$ -	$ 236,114
Construction in progress	31,275	37,922	(31,275)	-	37,922
Total capital assets, not being depreciated	267,389	37,922	(31,275)	-	274,036
Capital assets, being depreciated:					
Land improvements	246,028	-	-	-	246,028
Buildings and building improvements	5,390,016	78,505	-	9,414	5,459,107
Equipment	4,830,406	876,652	31,275	177,888	5,560,445
Total capital assets, being depreciated	10,466,450	955,157	31,275	187,302	11,265,580
Less accumulated depreciation for:					
Land improvements	192,830	6,417	-	-	199,247
Buildings and building improvements	4,149,875	149,513	-	5,813	4,293,575
Equipment	2,961,201	681,548	-	173,384	3,469,365
Total accumulated depreciation	7,303,906	837,478	-	179,197	7,962,187
Total capital assets, being depreciated, net	3,162,544	117,679	31,275	8,105	3,303,393
Capital Assets, Net	$ 3,429,933	$ 155,601	$ -	$ 8,105	$ 3,577,429

	2006				
	Beginning Balance	Additions	Transfers	Disposals	Ending Balance
Capital assets, not being depreciated:					
Land	$ 236,114	$ -	$ -	$ -	$ 236,114
Construction in progress	16,646	31,275	(16,646)	-	31,275
Total capital assets, not being depreciated	252,760	31,275	(16,646)	-	267,389
Capital assets, being depreciated:					
Land improvements	227,672	18,356	-	-	246,028
Buildings and building improvements	5,431,006	-	-	40,990	5,390,016
Equipment	4,303,585	619,108	16,646	108,933	4,830,406
Total capital assets, being depreciated	9,962,263	637,464	16,646	149,923	10,466,450
Less accumulated depreciation for:					
Land improvements	186,495	6,335	-	-	192,830
Buildings and building improvements	4,034,341	155,691	-	40,157	4,149,875
Equipment	2,422,219	645,822	-	106,840	2,961,201
Total accumulated depreciation	6,643,055	807,848	-	146,997	7,303,906
Total capital assets, being depreciated, net	3,319,208	(170,384)	16,646	2,926	3,162,544
Capital Assets, Net	$ 3,571,968	$ (139,109)	$ -	$ 2,926	$ 3,429,933

Note 6. Notes Payable

The following is a summary of long-term obligation transactions for the Hospital for the years ended April 30, 2007 and 2006:

	2007				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 760,000	$ -	$ 70,000	$ 690,000	$ 70,000
1982 Revenue bonds	54,000	-	7,000	47,000	8,000
1995 Revenue bonds	140,000	-	55,000	85,000	60,000
1995 General obligation bonds	500,000	-	-	500,000	-
Capital lease obligations	271,349	-	203,320	68,029	68,029
Total long-term obligations	$ 1,725,349	$ -	$ 335,320	$ 1,390,029	$ 206,029

	2006				
	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
Long-term debt					
1976 Revenue bonds	$ 830,000	$ -	$ 70,000	$ 760,000	$ 70,000
1982 Revenue bonds	61,000	-	7,000	54,000	7,000
1995 Revenue bonds	190,000	-	50,000	140,000	55,000
1995 General obligation bonds	500,000	-	-	500,000	-
Capital lease obligations	536,202	-	264,853	271,349	203,320
Total long-term obligations	$ 2,117,202	$ -	$ 391,853	$ 1,725,349	$ 335,320

Revenue Bonds Payable

The 1978 revenue bonds bear interest at 5% payable semi-annually; maturing through April 2015.
The 1982 revenue bonds bear interest at 5% payable semi-annually; maturing through August 2012.
The 1995 revenue bonds bear interest at 5.6% to 6.05% payable semi-annually; maturing through May 2009.

The revenue bonds are payable solely from the revenues of the facility and are not secured by the Hospital's taxing authority. The rights of the 1995 revenue bond holders are subordinated to the rights of the holders of the 1976 and 1982 revenue bonds. The 1976 and 1982 revenue bonds can be paid prior to scheduled maturity at par. The 1995 revenue bonds can be paid prior to scheduled maturity at par on any interest payment date beginning November 1, 2006.

The 1995 general obligation bonds bear interest at 6.05% to 6.35% payable semi-annually maturing from November 2009 through November 2015. These bonds are secured by the Hospital's full faith and credit and taxing authority, and can be paid prior to maturity at par on any interest payment date beginning November 1, 2006.

Note 6. Notes Payable (Continued)

The bonds place limits on the incurrence of additional borrowings and requires the Hospital to satisfy certain earnings performance measures, prior to early extinguishment. There was no additional borrowing or early extinguishment for the years ended April 30, 2007 and 2006, respectively.

Under the terms of the revenue bond indentures, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets held by trustee for debt service.

The debt service requirements as of April 30, 2007, are as follows:

Year Ending April 30,	Total to be Paid	Principal	Interest
2008	$ 211,080	$ 138,000	$ 73,080
2009	178,570	113,000	65,570
2010	183,599	124,000	59,599
2011	206,108	155,000	51,108
2012	214,473	172,000	42,473
2013 - 2017	692,715	620,000	72,715
	$ 1,686,545	$ 1,322,000	$ 364,545

Capital Lease Obligations

The Hospital is obligated under leases for equipment that are accounted for as capital leases. Assets under capital leases at April 30, 2007 and 2006, totaled $1,200,506 and $1,268,299, respectively, net of accumulated depreciation of $1,140,880 and $1,019,505, respectively. The following is a schedule by year of future minimum lease payments under the capital lease including interest at rates of 3.69% to 4.40% together with the present value of the future minimum lease payments as of April 30, 2007:

Year Ending April 30, 2008	$ 68,770
Less amount representing interest	741
Present value of future minimum lease payments	$ 68,029

Note 7. Self Insurance and Contingent Liabilities

The Hospital is a party to certain claims and legal proceedings arising in the ordinary course of its business. It is the opinion of management that any liability of the Hospital with respect to these actions will not materially affect its financial position. The Hospital is also a defendant in various lawsuits which, in the opinion of management, are covered by insurance.

Note 7. Self Insurance and Contingent Liabilities (Continued)

Laws and regulations:

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not limited to, accreditation, licensure, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in exclusion from government health care program participation, together with the imposition of significant fines and penalties, as well as significant repayment for past reimbursement for patient services received. While the Hospital is subject to similar regulatory reviews, management believes the outcome of any such regulatory review will not have a material adverse effect on the Hospital's financial position.

Medical Malpractice and General Liability Insurance:

Pinckneyville Community Hospital District purchases general and professional liability insurance coverage from the Illinois Provider Trust (IPT). IPT is a pooled self-insurance trust program organized under Illinois Statutes for the purpose of providing general and professional liability insurance to member hospitals on a claims-made basis (IPT was on the occurrence-basis until January 1, 2005). Premium rates have been established based on the loss experiences of the insured hospitals and includes a provision for retrospective premium adjusted based on incurred losses, which management has determined to be approximately $100,000 at April 30, 2007.

The Hospital also purchases claims-made medical malpractice insurance coverage for all employee physicians. These policies contain loss limits of $1,000,000 per claim and an annual limit of $3,000,000, with no deductible.

The medical malpractice insurance costs of the Hospital totaled approximately $100,000 and $60,000 for the years ended June 30, 2007 and 2006, respectively. Settled claims from these risks have not exceeded insurance coverage in any of the past three fiscal years.

Workers Compensation:

The Hospital is self-insured for a portion of its exposure to risk of loss from employee health claims. Annual estimated provisions are accrued for the self-insured portion of employee health claims and include an estimate of the ultimate costs for both reported claims and claims incurred but not yet reported.

Employee Health Claims:

Substantially all of the Hospital's employees and their dependents are eligible to participate in the Hospital's self-insurance program for health insurance. Self-insurance is in effect up to an individual stop/loss amount of $60,000 and aggregate stop/loss amount of $2,000,000 with coverage from a private insurance company maintained for all claims in excess of the stop/loss amounts. All claim handling procedures are performed by an independent claims administrator.

Note 7. Self Insurance and Contingent Liabilities (Continued)

A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Hospital's estimate will change by a material amount in the near term.

Activity in the Hospital's accrued employee health claims liability during the years ended April 30, 2007 and 2006 is summarized as follows:

	2007	2006
Balance, beginning of year	$ 211,000	$ 195,000
Current year claims incurred and changes in estimates for claims incurred in prior years	1,234,380	1,277,445
Claims and expenses paid	(1,221,190)	(1,261,445)
Balance, end of year	$ 224,190	$ 211,000

Pension Plan:

The Hospital contributes to a defined contribution pension plan covering substantially all employees. Pension expense is recorded for the amount of the Hospital's required contributions, determined in accordance with the terms of the plan. The plan is administered by the Hospital. The plan provides retirement and death benefits to plan members and their beneficiaries. Benefit provisions are contained in the plan document and were established and can be amended by action of the Hospital's governing body. Contribution rates for the Hospital were 3.5% for the years ended April 30, 2007 and 2006, respectively. Contributions made by the Hospital totaled $193,411 and $183,632 during 2007 and 2006, respectively.

Note 8. Restricted and Designated Net Assets

At April 30, 2007 and 2006, restricted expendable net assets were available for the following purposes:

	2007	2006
Debt service	$ 712,644	$ 645,813
Specific operating activities	125,528	107,575
Total restricted expendable net assets	$ 838,172	$ 753,388

At April 30, 2007 and 2006, $4,716,895 and $4,407,885, respectively, of unrestricted net assets has been designated by the Hospital's Board of Directors for capital acquisitions. Designated net assets remain under the control of the Board of Directors which may, at its discretion, later use these net assets for other purposes.

Note 9. Labor Force

Approximately 17% of the Hospital's labor force was covered under a collective bargaining agreement in effect through April 30, 2008.

Note 10. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of patient receivables from patients and third-party payors at April 30, 2007 and 2006 was as follows:

	2007	2006
Medicare	41%	44%
Commercial insurance and other	26%	19%
Private pay	20%	22%
Medicaid	13%	15%
	100%	100%

Note 11. New and Pending Pronouncements

As of April 30, 2007, the Governmental Accounting Standards Board (GASB) had issued the following statements not yet implemented by the Hospital. The statements which might impact the Hospital are as follows:

- GASB Statement No. 43, *Financial Reporting For Postemployment Benefit Plans Other Than Pension Plans*, issued April 2004, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement establishes uniform financial reporting standards for other postemployment benefit plans (OPEB plans) and supersedes existing guidance.

- GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postretirement Benefits Other Than Pensions*, issued June 2004, will be effective for the Hospital beginning with its year ending April 30, 2010. This Statement establishes standards for the measurement, recognition and display of other postemployment benefits expenses and related liabilities or assets, note disclosures and, if applicable, required supplementary information in the financial reports.

- GASB Statement No. 48, *Sales and Pledges of Receivables and Future Revenues and Intra-Entity Transfers of Assets and Future Revenues*, issued September 2006, will be effective for the Hospital beginning with its year ending April 30, 2008. This Statement establishes accounting and financial reporting standards for transactions in which a government receives, or is entitled to, resources in exchange for future cash flows generated by collecting specific receivables or specific future revenues. It also provides disclosure requirements for a government that pledges or commits future cash flows from a specific revenue source. In addition this Statement establishes accounting and financial reporting standards for intra-entity transfers of assets and future revenues.

- GASB Statement No. 49, *Accounting and Financial Reporting for Pollution Remediation obligations*, issued November 2006, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement addresses accounting and financial reporting standards for pollution (including contamination) remediation obligations, which are obligations to address the current or potential detrimental effects of existing pollution by participating in pollution remediation activities, such as site assessments end cleanups. This standard requires the government to estimate the components of expected pollution remediation outlays and determine whether the outlays for those components should be accrued as a liability or, if appropriate, capitalized when goods and services are acquired.

Note 11. New and Pending Pronouncements (Continued)

- GASB Statement No. 50, *Pension Disclosures*, an amendment of GASB Statement Nos. 25 and 27, issued May 2007, will be effective for the Hospital beginning with its year ending April 30, 2009. This Statement more closely aligns the financial reporting requirements for pensions with those for other postemployment benefits (OPEB) and, in doing so, enhances information disclosed in notes to the financial statements or presented as required supplementary information (RSI) by pension plans and by employers that provide pension benefits.

The Hospital management has not yet determined the effect these Statements will have on the Hospital's financial statements.

Note 12. Subsequent Event

On July 2, 2007, the Board passed a motion to effectively proceed with pursing the construction of a new stand-alone hospital facility, without a long-term care unit as part of the new facility. Further, they voted to establish a separate 501 (c)(3) organization to look at the possibility of establishing a free-standing nursing home.

Pinckneyville Community Hospital District

Net Patient Service Revenue Supplementary Information
Years ended April 30, 2007 and 2006

	2007			2006		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Daily Patient Services						
Acute Care	$ 1,690,321	$ -	$ 1,690,321	$ 1,827,627	$ -	$ 1,827,627
Swing bed	437,340	-	437,340	523,536	-	523,536
Skilled nursing care	1,785,373	-	1,785,373	1,782,064	-	1,782,064
	3,913,034	-	3,913,034	4,133,227	-	4,133,227
Other Nursing Services						
Operating and recovery	246,183	805,440	1,051,623	382,053	786,742	1,168,795
Central services and supply	379,146	331,901	711,047	487,727	442,483	930,210
Emergency services	76,256	1,575,880	1,652,136	77,004	1,460,074	1,537,078
Home health services	-	836,836	836,836	-	835,272	835,272
Hospice	-	270,343	270,343	-	166,684	166,684
	701,585	3,820,400	4,521,985	946,784	3,691,255	4,638,039
Other Professional Services						
Laboratory	826,842	3,468,834	4,295,676	965,078	3,045,614	4,010,692
Radiology	559,603	4,445,855	5,005,458	626,417	3,947,452	4,573,869
Nuclear medicine	30,784	899,578	930,362	42,657	910,071	952,728
Oncology	2,975	332,834	335,809	1,694	216,916	218,610
Respiratory therapy	343,353	654,746	998,099	404,417	768,695	1,173,112
Cardiac rehabilitation	-	6,343	6,343	-	4,852	4,852
Pharmacy	1,815,826	7,181,037	8,996,863	2,297,286	5,257,329	7,554,615
Anesthesiology	66,515	296,226	362,741	117,006	278,254	395,260
Physical therapy	600,089	1,294,779	1,894,868	665,320	1,044,239	1,709,559
Durable medical equipment	-	379,796	379,796	-	390,887	390,887
Clinic	-	1,181,628	1,181,628	-	1,230,693	1,230,693
	4,245,987	20,141,656	24,387,643	5,119,875	17,095,002	22,214,877
Gross patient service revenue	$ 8,860,606	$ 23,962,056	32,822,662	$ 10,199,886	$ 20,786,257	30,986,143
Less discounts, allowances, and estimated contractual adjustments, third-party reimbursement programs			12,015,047			11,353,662
Provision for uncollectible accounts			220,154			933,830
Net Patient Service Revenue			$ 20,587,461			$ 18,698,651

Pinckneyville Community Hospital District

Operating Expenses Supplementary Information
Years ended April 30, 2007 and 2006

	2007			2006		
	Salaries and Wages	Supplies and Expense	Total	Salaries and Wages	Supplies and Expense	Total
Nursing Services						
Nursing administration	$ 297,807	$ 33,818	$ 331,625	$ 259,457	$ 32,286	$ 291,743
Acute care	982,350	185,602	1,167,952	931,428	170,845	1,102,273
Skilled nursing care	1,136,998	141,145	1,278,143	1,180,608	77,083	1,257,691
Operating and recovery	178,493	86,232	264,725	184,054	118,577	302,631
Central services and supply	20,645	144,559	165,204	21,490	166,108	187,598
Emergency services	344,752	690,297	1,035,049	338,998	532,870	871,868
Home health services	472,185	139,029	611,214	448,821	96,761	545,582
Hospice	103,506	56,553	160,059	73,077	37,143	110,220
	3,536,736	1,477,235	5,013,971	3,437,933	1,231,673	4,669,606
Other Professional Services						
Laboratory	390,407	436,752	827,159	403,792	383,156	786,948
Radiology	430,150	416,533	846,683	376,413	417,469	793,882
Nuclear medicine	34,721	155,344	190,065	31,501	161,802	193,303
Respiratory therapy	242,104	79,079	321,183	230,881	103,040	333,921
Cardiac rehabilitation	93	-	93	1,029	-	1,029
Pharmacy	288,015	2,259,247	2,547,262	267,933	1,800,166	2,068,099
Anesthesiology	-	253,872	253,872	-	261,176	261,176
Physical therapy	603,578	34,510	638,088	561,401	31,490	592,891
Medical records	261,398	42,361	303,759	256,001	35,979	291,980
Durable medical equipment	133,347	92,092	225,439	135,699	99,569	235,268
Social services	64,720	1,090	65,810	62,064	1,371	63,435
Clinic	1,161,940	72,214	1,234,154	1,110,514	61,560	1,172,074
Oncology	166,362	211,532	377,894	117,452	150,265	267,717
Retail pharmacy	2,403	3,396	5,799	2,622	25,565	28,187
	3,779,238	4,058,022	7,837,260	3,557,302	3,532,608	7,089,910
General Services						
Dietary	328,428	203,742	532,170	315,749	209,228	524,977
Operation and maint. of plant	164,839	384,564	549,403	149,460	422,974	572,434
Housekeeping	228,589	58,114	286,713	223,476	51,011	274,487
Laundry and linen	84,559	21,114	105,673	74,441	17,466	91,907
	806,425	667,534	1,473,959	763,126	700,679	1,463,805
Administrative Services						
Administrative	896,629	1,246,239	2,142,868	801,707	1,088,109	1,889,816
Employee benefits	-	2,668,872	2,668,872	-	2,506,330	2,506,330
	896,629	3,915,111	4,811,740	801,707	3,594,439	4,396,146
Depreciation	-	837,478	837,478	-	807,848	807,848
Interest and amortization	-	88,067	88,067	-	106,594	106,594
	$ 9,019,028	$ 11,043,447	$ 20,062,475	$ 8,560,068	$ 9,973,841	$ 18,533,909

Pinckneyville Community Hospital District

Service Statistics (Unaudited)
Years ended April 30, 2007, 2006, 2005, 2004, and 2003

	2007	2006	2005	2004	2003
Hospital					
Medical and surgical patient days	2,486	2,728	2,607	2,806	2,595
Medicare patient days	1,856	2,040	1,946	2,004	1,899
Medicare utilization	74.7%	74.8%	74.6%	71.4%	73.2%
Discharges	796	819	767	812	788
Average length-of-stay (days)					
Non-Medicare patients	2.89	3.03	3.10	3.07	3.01
Medicare patients	3.21	3.44	3.51	3.64	3.41
All acute patients	3.12	3.33	3.40	3.46	3.29
Skilled-Nursing Facility					
Licensed available beds	50	50	50	50	50
Medicare certified area patient days	1,005	1,817	2,498	2,663	3,262
Noncertified area patient days	14,731	13,848	13,333	13,156	12,720
Total patient days	15,736	15,665	15,831	15,819	15,982
Medicare patient days	851	1,399	2,003	2,045	2,730
Medicare utilization	5.4%	8.9%	12.7%	12.9%	17.1%

McGladrey & Pullen

Certified Public Accountants

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with Government Auditing Standards

To the Board of Trustees
Pinckneyville Community Hospital District
Pinckneyville, Illinois

We have audited the financial statements of Pinckneyville Community Hospital District (Hospital), as of and for the year ended April 30, 2007, and have issued our report thereon dated August 15, 2007. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Hospital's internal control over financial reporting as a basis for designing auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses. However, as discussed below, we identified certain deficiencies in internal control over financial reporting that we consider to be significant deficiencies.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential, will not be prevented or detected by the entity's internal control. We consider the deficiencies described in the accompanying schedule of findings and responses to be significant deficiencies in internal control over financial reporting. (Findings 07-01 and 07-02)

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the entity's internal control.

Our consideration of the internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in the internal control that might be significant deficiencies and, accordingly, would not necessarily disclose all significant deficiencies that are also considered to be material weaknesses. However, we believe that none of the significant deficiencies described above is a material weakness.

Compliance and Other Matters

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

This report is intended solely for the information and use of Pinckneyville Community Hospital District and the Office of the Comptroller, State of Illinois, and is not intended and should not be used by anyone other than those specified parties.

McGladrey & Pullen, LLP

Springfield, Illinois
August 15, 2007

Financial Statement Findings

Finding:	The Organization has a lack of segregation of duties. (Finding 07-01) (Significant Deficiency in Internal Control)
Condition:	A small number of persons have the primary responsibility for performing most of the accounting and financial duties. As a result, some of the aspects of internal accounting control which rely upon adequate segregation of duties are missing in your Hospital.
Criteria:	To minimize the potential of material misstatements in financial statements, an adequate segregation of duties should be in place and functioning.
Effect of Condition:	Misstatements in the financial statements or an irregularity could occur.
Cause of the Condition:	The Organization has a small number of employees, thus duties are not adequately segregated.
Recommendation:	We recommend that checks should be prepared for mailing and mailed by an employee independent of the accounts payable processing and/or cash disbursing functions. The Purchasing Agent's current responsibilities of approving purchase orders, receiving goods, and receiving invoices should be segregated. We also recommend that management receive bank statements unopened and review statements and checks for any unauthorized transactions.
Management's Response:	Segregating the check mailing process would require several individuals outside the department to be assigned these responsibilities. Limited staff availability, cost control concerns over hiring additional staff and the desire to limit access to confidential payroll data have restricted prior action in this area. Since the audit testing did not uncover any unfavorable findings and independent check reviews are performed by the Administrator and Internal Auditor, Administration feels that sufficient mitigating controls are in place. However, management will examine these opportunities further and will try to implement what can be done without hiring additional staff. Currently, there is no available staff to separate out the duties of approving purchase orders, receiving goods and receiving invoices and there is insufficient volume to warrant hiring additional staffing at this time. Since the audit testing did not uncover any unfavorable findings, Administration feels that the mitigating controls currently in place are sufficient to control the risk. Assigning someone outside the department to receive and review bank statements would not do much good unless they were extensively trained to complete the full bank reconciliation process. The Payroll Clerk is currently being trained on the bank reconciliation process since she does not have access to the general ledger for posting entries. Since the audit testing did not uncover any unfavorable findings, the hiring of additional staff to cover in her absence is not warranted and the Accounting Department staff will serve as backup in this capacity. Given other mitigating controls in place, for example, with the internal Auditor and Administrator verifying check sequence before checks are distributed, Administration feels that sufficient controls are now in place.

Financial Statement Findings

Finding:	The Organization has a lack of segregation of duties in its information technology department. (Finding 07-02) (Significant Deficiency in Internal control)
Condition:	There is no review of network file edit reports and the computer servers are not secured from unauthorized use.
Criteria:	To minimize the errors that may result from not checking network file edit reports and unauthorized access to the computer network adequate procedures should be in place and functioning.
Effect of Condition:	Misstatements in the financial statements, breach of security over information, or an irregularity could occur.
Cause of the Condition:	The Organization has not devoted the resources to address these issues.
Recommendation:	We recommend that a person with the proper authority be assigned the task of printing and reviewing network file edit reports. In regards to the unsecured network without proper access controls, we recommend that Hospital should use a computer room, keep the computer room locked, and control access to it. Also, network usage is not monitored. Network usage should be monitored to ensure security of data and proper use by employees.
Management's Response:	Access logs are reviewed for particular investigations but are quite lengthy and detailed, therefore, monthly reviews would require additional staff resources that are currently not available. All employees are educated on the HIPAA regulations upon hire and throughout the year which includes the requirement to report any observed wrongdoing. However, Administration and the Compliance Committee will continue to look at opportunities to improve upon this review and audit process. The network servers maintained in an open area are password protected and changes are currently in progress in order to centralize the Hospital's various network systems into the IT office. If a new facility is constructed, building plans will incorporate a computer room with all the necessary requirements. Our current networks have limited capabilities of logging all network access attempts and sophisticated software to enable detailed logs would be cost prohibitive. The IT department does perform random audits of network systems and of PCs. Random audits of PCs have not uncovered any compromise of facility data. Furthermore, external audits completed by a contracted agent on a regular basis to test the vulnerability of networks to unauthorized external access, have not uncovered any deficiencies.

Pinckneyville Community Hospital

Summary Schedule of Prior Audit Findings
Year ended April 30, 2006

Audit Finding:	The Organization has a lack of segregation of duties. A small number of persons have the primary responsibility for performing most of the accounting and financial duties. As a result, some of the aspects of internal accounting control which rely upon adequate segregation of duties are missing. (Finding 06-01)
Corrective Action Taken:	Management has added personnel, changed procedures and increased documentation in order to address the lack of segregation of duties. Checks cannot be issued unless a password is entered by the Administrator or Internal Auditor, who is outside the accounting department. Any signature stamps used are also controlled by the Administrator. All checks are then reviewed by the Administrator or Internal Auditor prior to distribution/mailing, documented by signing off on the printed check registers which verify sequential check number sequence. The Internal Auditor reviews all bank statements and reconciliation to the general ledger and the general ledger entries as part of each month-end closing process. New Accounts Payable vendors are not entered in the system until authorization is received from the Administrator or Internal Auditor. An Accounts Payable Master File Change Report is also reviewed by the CFO and the Internal Auditor or Administrator for each month to verify that all changes were properly authorized. Similar reviews of payroll registers and master employee file change reports are also performed by the CFO and Administrator for additional mitigating controls. All the mentioned reports are stamped with an authorization stamp in order to document the initials of the staff outside the accounting and payroll departments who perform the reviews. Although significant steps have been made to address the segregation issues some instances still exists, see finding 07-01.

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ☒ No ☐. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes _ No ☒. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☒ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. 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. Criterion 1120.310(b), Conditions of Debt Financing (Attachment 76, Exhibit 1)

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

C. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	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									

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

November 13, 2009

Ms. Courtney Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Conditions of Debt Financing – Attachment 76

Dear Ms. Avery:

Pinckneyville Community Hospital and Pinckneyville Community Hospital District intend to secure debt financing to partially fund the project described in this specific Certificate of Need application which proposes to establish a new replacement hospital. The proposed $40,950,000 bond issue used to finance the project will be the lowest net cost available to Pinckneyville Community Hospital and Pinckneyville Community Hospital District

Equipment for this project will be purchased and not leased.

By signing this letter, we attest to the above.

Sincerely,

John Shotton
Chairman of the Board

Subscribed and Sworn to before me
this 13th day of November, 2009
Phyllis M. Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

Thomas J. Hudgins, FACHE
Administrator / CEO

Subscribed and Sworn to before me
this 13th day of November, 2009
Phyllis M. Keller
Notary

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

November 13, 2009

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Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

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Sincerely,

John Shotton
Chairman of the Board

Subscribed and Sworn to before me
this 13th day of November, 2009

Notary

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MY COMMISSION EXPIRES:02/13/13

Thomas J. Hudgins, FACHE
Administrator / CEO

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this 13th day of November, 2009

Notary

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101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided. **(See financial forecast, Attachment 75)**

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☒ No ☐ If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided. **(See financial forecast, Attachment 75)**

F. Criterion 1120.310(f), Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes ☐ No ☒. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

C. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

   See the attached detail, Attachment 76, Exhibit 2.

Cost and Gross Square Feet by Department or Service

	A	B	C	D	E	F	G	H	Total
	Cost / Square Feet		Gross Square Feet		Gross Square Feet		Const. Cost	Mod. Cost	Cost
Department	New	Mod.	New	Circ.	Mod.	Circ.	(AxC)	(BxE)	(G+H)
Clinical									
Medical / Surgical	$ 320.00		13,671				$ 4,374,643	0	$ 4,374,643
Emergency	$ 335.00		3,674				$ 1,230,679	0	$ 1,230,679
Diagnostic Imaging	$ 420.00		6,098				$ 2,560,950	0	$ 2,560,950
Surgery	$ 475.00		3,654				$ 1,735,793	0	$ 1,735,793
Same Day Surgery / Prep/Recovery / PACU	$ 360.08		3,007				$ 1,082,869	0	$ 1,082,869
Central Sterile Processing	$ 300.00		931				$ 279,375	0	$ 279,375
Laboratory	$ 320.00		2,173				$ 695,200	0	$ 695,200
Pharmacy	$ 265.00		1,351				$ 357,962	0	$ 357,962
Oncology	$ 275.00		2,683				$ 737,737	0	$ 737,737
Specialty Clinics	$ 265.00		2,985				$ 791,057	0	$ 791,057
Rural Health Clinic	$ 265.00		10,248				$ 2,715,688	0	$ 2,715,688
Outpatient Rehabilitation	$ 265.25		8,189				$ 2,172,161	0	$ 2,172,161
Sleep Lab	$ 320.25		435				$ 139,309	0	$ 139,309
Cardio-Pulmonary	$ 265.24		668				$ 177,300	0	$ 177,300
Pre-Admission Testing	$ 265.25		500				$ 132,691	0	$ 132,691
Inpatient Rehabilitation	$ 270.25		1,209				$ 326,775	0	$ 326,775
General Surgeon Suite	$ 264.50		728				$ 192,556	0	$ 192,556
Total Clinical	$ 313.65	0	62,204	0	0	0	$ 19,510,189	0	$ 19,510,189
Nonclinical									
Registration	$ 265.00		1,284				$ 340,292	0	$ 340,292
Lobby / Public Space	$ 285.00		5,564				$ 1,585,649	0	$ 1,585,649
Ambulance Vestibule	$ 250.00		566				$ 141,570	0	$ 141,570
Business Office	$ 250.00		779				$ 194,750	0	$ 194,750
Health Information Management	$ 250.00		1,422				$ 355,600	0	$ 355,600
Administration	$ 250.00		4,841				$ 1,210,300	0	$ 1,210,300
Information Technology	$ 285.00		426				$ 121,268	0	$ 121,268
Dietary	$ 300.00		4,900				$ 1,469,880	0	$ 1,469,880
Materials Management	$ 250.00		1,965				$ 491,338	0	$ 491,338
Environmental Services	$ 250.00		1,894				$ 473,438	0	$ 473,438
Maintenance	$ 250.00		838				$ 209,550	0	$ 209,550
Circulation	$ 285.00		12,764				$ 3,637,832	0	$ 3,637,832
Mechanical	$ 399.50		2,075				$ 828,963	0	$ 828,963
Canopies @ 50%	$ 199.50		3,000				$ 598,500	0	$ 598,500
Total Non-Clinical	$ 275.50	0	42,318	0	0	0	$ 11,658,927	0	$ 11,658,928
Subtotal	$ 298.21		104,522				$ 31,169,117		$ 31,169,117
Contingency	$ 16.12		104,522				$ 1,684,851		$ 1,684,851
Total	$ 314.33	0	104,522	0	0	0	$ 32,853,968	0	$ 32,853,968

C. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

   See the attached detail, Attachment 76, Exhibit 3.

Reasonableness of Project and Related Costs

Category of Capitalized Cost	Total
Preplanning	
Preconstruction Services	$ 95,000
	$ 95,000
Site Survey	
Survey / Topo	$ 5,500
Boundary	$ 2,468
Soil Borings	$ 6,831
Phase I Environmental Analysis	$ 8,003
Soils Testing and Analysis	$ 24,285
	$ 47,087
Site Preparation	
Earthwork	$ 1,123,255
	$ 1,123,255
Off Site Work	
Extension of Off Site Utilities	$ 79,750
	$ 79,750
Architectural and Engineering Fees	
Basic	$ 1,987,700
MEP	included in Basic
	$ 1,987,700
Consulting and Other Fees	
Traffic Survey	$ 5,000
CON Consultant	$ 53,000
Equipment Planner	$ 139,365
Dietary Consultant	$ 28,380
Legal Fees Related to HUD	$ 100,000
Construction Testing	$ 40,000
Building Permit	$ 3,200
Feasibility Study	$ 80,000
	$ 448,945
Moveable and Other Equipment	
New Equipment >$250k	$ -
New Equipment <$250k	$ 1,537,341
Furniture and Furnishings	$ 1,145,309
Miscellaneous / Other	$ 602,441
	$ 3,285,091
Other Costs to be Capitalized	
Site Signage	$ 150,000
CON Filing Fee	$ 100,000
Project Related Reimbursable Expenses	$ 85,468
On-Site Ancillary Structure	$ 65,000
Paving, Curbs, Walks, and Drives	$ 1,249,656
Landscaping	$ 155,000
Builder's Risk Insurance	$ 26,000
Miscellaneous / Other Fees	$ 246,800
	$ 2,077,924

SECTION XI. SAFETY NET IMPACT STATEMENT

20 ILSC 3960 Sec. 5.4 requires that certificate of need applicants provide a Safety Net Impact Statement.

As developed by the applicant, a Safety Net Impact Statement shall describe all of the following:

1. The project's material impact, if any, on essentially safety net services in the community, to the extent that it is feasible for the 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 by 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.

4. Safety Net Impact Statement shall also include all of the following:

    a. 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.

    b. 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 Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

APPEND DOCUMENTATION AS ATTACHMENT-77, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. SAFETY NET IMPACT STATEMENT

Pinckneyville Community Hospital District (Legal Entity) d.b.a. Pinckneyville Community Hospital (License holder) proposes to discontinue a medical / surgical category of service (i.e., close and vacate the hospital related facilities on its current site) and establish a medical / surgical category of service 1.8 mils east of its current site (i.e. develop and open a replacement hospital facility). The Hospital is a 25-bed critical access hospital deemed a necessary provider of health services by IDPH. If "establishment" is not granted, "discontinuation" will not occur; i.e. the Hospital seeks to replace it current programs and services in a replacement hospital on a new site within Pinckneyville, and, if replacement is not approved, will continue to operate its existing facilities in order to retain community based healthcare services.

The Hospital currently provides essential community services and programs to patients and families within its service area. As such, it is the "community safety net" for hospital-based healthcare services. Pinckneyville Community Hospital provides benefits in, but not exclusively, the following areas:

- Charity care
- Other uncompensated care costs
- Volunteer services
- Hospital-based community education
- Outreach health education programs

Attachment 77, Exhibit 1 attests to the Hospital's commitment to provide care regardless of a patient's ability to pay; Attachment 77, Exhibit 2 delineates the organizations charity care policy.

The following narrative responds directly to the State Agency criterion.

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.**

   If the medical / surgical category of service is discontinued and not reestablished it would climinate locally available safety net services in Pinckneyville and the surrounding market and thereby burden other regional hospital providers. However, there is no intent to actually discontinue these services. By State Agency rules, policies, and procedures, both a service discontinuation and service establishment must occur simultaneously if a hospital proposes to relocate to a new site. If establishment is not approved, discontinuation will not occur so there is no expected impact on essential safety net services in the community.

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.**

   The applicants understand this question as asking whether the discontinuation of Pinckneyville Community Hospital's medical / surgical bed category of service will burden other regional providers. As discussed herein, there is no intention of actually discontinuing this service category. Hence, there is no expected impact on other provides. Discontinuation of a service and establishment on a new site is a State Agency rules requirement. If establishment is not approved, discontinuation will not occur.

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.**

   As previously stated, the project proposes to replace the existing 25-bed CAH hospital on a new site with the same category of service with associated clinical services / ancillary support capabilities. Hence, there is no expected impact on other providers. There will be no change in the Hospital's services.

SECTION XI. SAFETY NET IMPACT STATEMENT

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

4a.. 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.

Pinckneyville Community Hospital
Charity Care Patients Served

	2006	2007	2008
Inpatient	14	12	6
Outpatient	128	273	276
Total	142	285	282

Pinckneyville Community Hospital
Charity Care Expense

	2006	2007	2008
Inpatient	$ 25,603	$ 41,435	$ 12,670
Outpatient	$ 8,672	$ 57,926	$ 250,209
Total	$ 34,275	$ 99,361	$262,879

Source: IDPH Hospital Profiles; Hospital Data

4b.. 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.

Pinckneyville Community Hospital
Medicaid Patients Served

	2006 Medicaid Patients Served	2007 Medicaid Patients Served	2008 Medicaid Patients Served
Inpatient	44	51	27
Outpatient	1,811	2,088	2,552
Total	1,855	2,139	2,579

Pinckneyville Community Hospital
Total Medicaid (Gross Revenue)

	2006 Medicaid Revenue	2007 Medicaid Revenue	2008 Medicaid Revenue
Inpatient	$ 383,414	$ 403,098	$ 200,705
Outpatient	$ 783,860	$ 779,688	$ 2,358,622
Total	$ 1,167,274	$1,882,786	$ 2,559,327

Source: IDPH Hospital Profiles; Hospital Data

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

Attached additional information pertaining to commitment to care and charity care policy.

Pinckneyville Community Hospital

leading the way to a healthier tomorrow

November 13, 2009

Ms. Courtney Avery
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Avery,

This letter shall serve as certification that Pinckneyville Community Hospital and Pinckneyville Community Hospital District will maintain a commitment to providing accessible, high-quality care to all patients regardless of their ability to pay, and will continue its charity care policy.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator / CEO
Pinckneyville Community Hospital
Pinckneyville Community Hospital District

Subscribed and sworn to before me
this 13th day of November 2009

Notary Public

OFFICIAL SEAL
PHYLLIS M KELLER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/13/13

101 N. Walnut St., Pinckneyville, Illinois 62274
(618) 357-2187 · fax: (618) 357-6740

Pinckneyville
Community
Hospital

leading the way to a healthier tomorrow

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PINCKNEYVILLE COMMUNITY HOSPITAL POLICY AND PROCEDURE

Title: PATIENT FINANCIAL ASSISTANCE POLICY		Page 1 of 6	
Originator: Kara Jo Carson	Applies to: Patient Accounting Hospital Inpatient & Outpatient only	Category:	
Issuing Department: Patient Accounting		Reference #: BUS0024	
Approved by: Thomas Hudgins, Administrator Date		Originating Date: 03/10/00 Effective Date: 01/01/09	
		Reviewed: 06/27/08	Revised: 03/01/01 12/01/03 09/23/04 12/07/04 11/07/05 01/01/09

POLICY:

1. Patients requiring financial assistance are those who qualify for discounts under the Illinois Uninsured Patient Discount Act and those who demonstrate the inability to pay (financial need), versus the unwillingness to pay (bad debt). The financial status of each patient should be determined so that an appropriate determination as to the eligibility of financial assistance can be made.

2. Financial assistance includes services provided to:
   - Uninsured patients who qualify for discounts under the Illinois Uninsured Patient Discount Act.
   - Financial Need Discount Program:
     - Uninsured patients who do not meet the qualifications or deadlines required by the Illinois Uninsured Patient Discount Act.
     - Medically Indigent =
       - No significant assets owned by household members
       - Patient portion of medical expenses exceed 40% of the applicant's annual household income
       - Subtracting the patient portion of medical expenses from the applicant's annual household income would cause the applicant to be less than 200% of the Federal Poverty Level.
     - Persons whose income is sufficient to pay for basic living costs but not medical care because income is assigned to a licensed nursing home or an assisted/supportive living facility.
   - Deceased patients with no estate and those who are homeless.

3. The Financial Assistance Program is intended solely for the benefit of the patient and his or her family living within the same household as dependents and does not relieve third parties of liability for payment.

4. No refunds will be paid to a patient or guarantor approved for financial assistance on prior payments paid towards account balances.

5. Uninsured Patients - Illinois Uninsured Patient Discount Act
   - Notwithstanding the requirements under EMTALA, nothing in this Act shall be construed to require a hospital to provide an uninsured patient with a particular type of health care service.
   - Illinois resident not covered by any third-party insurance plan, including high deductible plans, workers' compensation, accident liability insurance.
   - Proof of Illinois residence must be provided through ONE of the following:
     - A valid state-issued ID
     - A recent residential utility bill
     - Lease agreement
     - Vehicle registration card
     - Voter registration card
     - Mail address to patient at an Illinois address (not a P.O. Box) from a government or other credible source.
     - A statement from a family member of the patient who resides at the same address and presents verification of Illinois residency
     - A letter from a homeless shelter, transitional house or other similar facility verifying that the patient resides at the facility.
   - Patients who may be eligible for coverage under public programs such as Medicaid may be required to first apply to those programs prior to being considered for discounted services under the Uninsured Patient Discount Act. Pinckneyville Community Hospital shall require patients to apply for Medicaid coverage to be eligible for the uninsured patient discount.
   - If a patient is not fully truthful on the application, the patient forfeits the discount and may be held responsible for full billed charges.
   - All billing statements, letters and brochures shall include the following, or similar, statement "Uninsured patients meeting certain income requirements may be eligible for discounted services upon completion of an application with the Hospital's Collection Department. Contact 618-357-5906 for information."
   - Eligible Illinois uninsured residents include those with family (household) income of 300% or lower of the federal poverty level (FPL).
     - Annual earnings and cash benefits
     - Includes distributions from pensions and retirement.
     - Excludes child support payments
   - Proof of income eligibility shall require ONE of the following acceptable forms of documentation for each source of household income. Pinckneyville Community Hospital shall prefer to collect copies of the two most recent pay stubs:
     - Copy of the most recent W-2 and 1099 forms
     - Copies of the two most recent pay stubs
     - Written income verification from an employer if paid in cash
     - Other reasonable form of third party income verification as deemed acceptable by the hospital.
   - The Illinois Uninsured Patient Discount Act requires that charges in excess of $300 for any one inpatient admission or outpatient encounter shall be discounted to 135% of cost as determined by Worksheet C Part I of the Medicare Cost Report.
     - The Hospital shall use all combined charges in excess of $300 and will not exclude from the discounted services calculation individual accounts that may be less than $300.
     - Individual accounts $300 or less shall not be eligible for the uninsured patient discount; however, may still qualify for the Hospital's Financial Need Discount Program described later in this policy.
   - Once eligibility under the Uninsured Patient Discount Act is determined, any further discounts beyond that to arrive at 135% of cost will be determined utilized the Hospital's Financial Need Program.
   - Physician fees and charges for non-covered services under a third-party insurance plan are not subject to the discount.
     - If a patient has physician related fees on hospital accounts (e.g. Oncology, ER), such fees will be eligible for the uninsured patient discount since they are associated with other hospital services.

- Physician fees and services provided at the Hospital's Family Medical Center shall not be eligible for the uninsured patient discount, but may be eligible for a financial need discount.
- Non-covered services are not eligible for the uninsured patient discount but may be eligible for a financial need discount.

- Each individual hospital can collect up to a maximum of 25% of the family's annual gross income in the 12-month period which begins on the date of service for which eligibility is first determined.
  - Those with substantial assets are excluded from the 25% limit.
  - Excluded assets are primary residence, amounts in retirement and pension funds and personal property exempt from collections as determine by Section 5/12-1001 of the Illinois Code of Civil Procedure.
    - Primary residence, pension and retirement plan funds (but not distributions from such funds)& certain protected personal property.
- The Illinois Uninsured Patient Discount Act requires Hospitals to provide the patient the ability to apply for discounted services for up to 60 days from the date of service. Patients not applying within 60 days shall forfeit the uninsured patient discount and may apply for eligibility under Pinckneyville Community Hospital's Financial Need Discount program.
- The Illinois Uninsured Patient Discount Act requires the patient to supply third party verification of income and assets within 30 days of request, or else risk forfeiture of the discount. Patients not supplying the required information within 30 days shall forfeit the uninsured patient discount and may apply for eligibility under Pinckneyville Community Hospital's medically indigent financial need discounts.
- The Hospital must annually file of copy of Worksheet C with the Attorney General's Office within 30 days of filing its Medicare Cost report, with the first filing due by February 20, 2009.

6. Financial Need Discount Program
   - Uninsured patients who do not meet the qualifications or deadlines required by the Illinois Uninsured Patient Discount Act.
   - Persons whose income is sufficient to pay for basic living costs but not medical care because income is assigned to a licensed nursing home or an assisted/supportive living facility and there are no significant disposable assets.
   - Medically Indigent =
     - No significant disposable assets owned by household members
     - Patient portion of medical expenses exceed 40% of the applicant's annual household income
     - Subtracting the patient portion of medical expenses from the applicant's annual household income and disposable assets would ceuse the applicant to be less than 200% of the Federal Poverty Level.
   - The formula applied for determining eligibility under the Financial Need Discount Program is as follows:

     Applicant's annual household income (includes distributions from pension & retirement)
     Less payments for child support
     Less assigned income (to a licensed nursing home or assisted/supportive living facility)
     Adjusted Annual Household Income Subtotal (a)
     Plus value of disposable assets:
     Value of checking accounts, savings, certificates of deposit (excluding pension/retirement funds)
     Value of property other than primary residence or for primary source of income
     Value of vehicles other than the primary vehicle used for transportation to/from work
     Value of recreational items (motorcycles, boats, ATVs, RVs, trailers, etc.)
     Total Disposable Assets
     Adjusted Annual Household Income & Assets for Financial Need Discount Determination (b)
     Patient portion of Medical Bills
     % of patient portion of medical bills as compared to Adjusted Annual Household Income Subtotal (a)
     Is the patient portion of medical bills > 40%?
     If yes, subtract from Adjusted Annual Household Income & Assets (b). If no, patient is not medically indigent.
     Medically Indigent Adjusted Gross Income used for poverty level determination

- Such patients qualifying for the Financial Need Discount Program shall be eligible for discounts according to the following scale:
  - < 100% of poverty level — Full financial need write-off
  - 101% to 125% of poverty level — 75% financial need write-off w/ 25% of balance due from patient
  - 126% to 150% of poverty level — 50% financial need write-off w/ 50% of balance due from patient
  - 151% to 200% of poverty level — 25% financial need write-off w/ 75% of balance due from patient
  - > 200% of poverty level — No financial need write-off w/ 100% of balance due from patient

- Patients with balances at the Hospital's Family Medical Center can apply for assistance under the Financial Need Discount Program. Balances at the Family Medical Center are not eligible for discount under the Illinois Uninsured Patient Discount Act.

7. A single application form is used for the Uninsured Patient Discount and Financial Need Programs. Separate determination forms will be utilize to examine the applicant's eligibility under each program.

8. Pinckneyville Community Hospital shall request a copy of the most recent W-2 form as proof of dependents in determining the patient's applicable federal poverty level.

9. Determination of eligibility for financial assistance will occur with each incident of service and new application. If an application is approved, such financial assistance will be valid for any services provided within the six (6) months following the financial assistance approval date. Upon expiration of the six (6) month period, the patient shall be required to submit the following documents to continue the financial assistance for each subsequent six (6) month period:
   - Current pay stub.
   - Current bank statement (checking, savings, investments, pension, etc.)
   - Current tax return (if a new return has been filed within the past six months) in order to support number of claimed household dependents
   - Copies of any medical bills that have changed significantly since the initial financial assistance application was submitted.
   - Signed attestation form (copy attached to this policy) that no financial circumstances have changed since the initial financial assistance application was approved.

10. Communication on the Hospital's Billing Policies (including financial assistance applications) will be communicated to patients through brochures.

11. Upon request by the patient/guarantor, Pinckneyville Community Hospital will review the account(s) of patients who demonstrate eligibility for financial assistance for services that are medically necessary; however, this review does not mean that the patient/guarantor is no longer responsible for payment of the bill.

12. The Office Manager oversees all financing procedures, and directs the authorized personnel who enforce the policies.

13. The Business Office will use the poverty guidelines established by the Department of Health and Human Services in effect at the time of application when reviewing the financial need of patients. The guidelines are used as an eligibility criterion in federal programs and are updated frequently by the federal government. Existing guidelines are updated annually.

PROCEDURE:

1. The Patient Financial Counselor shall determine whether the patient qualifies for the Illinois Uninsured Patient Discount Act or the Hospital's Financial Need Discount Program. The Patient Financial Counselor shall assist the patient in completing an Uninsured Patient Discount Application or Financial Need Determination Worksheet for patients who express an inability to pay for medically necessary services and the following conditions have been met:
   - Patients who demonstrate financial need and whose gross income falls within federal standards for determination of poverty level with consideration to family size, geographic area and other pertinent factors.
   - Have exhausted other sources of assistance including all third-party payers, victims of crime programs and Medicaid.
   - Have been denied by Illinois Department of Public Aid. Patients must show that they have applied for public aid assistance and have been denied by bringing in a copy of the denial.
   - Patients who would possibly qualify for medically indigent status.

2. Patients must demonstrate financial need by providing:
   - Most recent tax return that documents the number of household dependents.
   - Current pay stubs (or) written verification of wages from employer or other third party for each source of household income (or) unemployment letter
   - Pension, Social security or disability check (whichever is applicable)
   - Bank statement (e.g. checking, savings, investments)
   - Evidence of any assets owned (e.g. vehicles, property)
   - Copies of other medical expenses
   - Estimated monthly food expenses

3. Upon completion of the Uninsured Patient Discount Application or Financial Need Determination Worksheet, the Office Manager should review all the supporting documentation and submit the request to the CFO for review and recommendation to the Administrator. Based upon the patient's qualifications, the Administrator will determine the appropriate amount of financial assistance discount in relation to the amounts due after applying all other resources. The federal poverty guidelines will be utilized in determining the level of financial assistance. A patient who can afford to pay for a portion of the services will be expected to do so. If the patient does not pay the amount deemed to be his/her responsibility, this amount would become bad debt.

4. If the financial assistance application is for a patient/guarantor who is deceased, approval of any financial need will be held pending settlement of the estate. If the estate is settled through probate or unsupervised distribution, then a lien should be filed with the estate for the balance of any outstanding bills.
   - The Patient Financial Counselor, or designee, shall review the obituary section of local newspapers and when applicable, note the date of the patient's death in the patient's account(s).
   - The executor has 30 days from the individual's death in order to file the will but there is no deadline for filing a probate of the estate when applicable.
   - The Patient Financial Counselor, or designee, shall review the local newspapers for any filed probates.
   - If a probate is filed on a patient, a lien against the estate must be filed within six (6) months from the date of the probate notice.
   - If after 90 days from the patient's death, no probate notice has been noticed in the local newspapers, the Patient Financial Counselor, or designee, shall contact the Circuit Clerk's office in the county of the patient's residence to verify that no probate has been filed. Such contact with the Circuit Clerk's office shall be noted in the patient's account(s).
   - Once it is confirmed that the patient had no estate for probate, the account can be written-off as a financial need adjustment once approved by the Administrator.

5. Medically Indigent: If the patient is completing the financial assistance application in order to receive consideration for medically indigent status, the following review shall be performed:

   - According to the Centers for Medicare & Medicaid Services (CMS), medically indigent is defined as patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.
   - Medical expenses utilized to calculate medically indigent status shall include the patient's portion of account balances of Pinckneyville Community Hospital as well as those of other healthcare providers based on current copies of statements submitted by the patient.
   - The value of disposable assets and optional expenses will be considered in determining the medically indigent status of the patient. Disposable assets including balances in checking, savings, certificates of deposit, extra property not used as the primary source of income, extra vehicles used for primarily for recreation purposes and similar assets that can be accessed or sold to help cover the medical expenses.
   - To qualify for medically indigent status, the following calculation must be performed:

   Adjusted Annual Household Income & Assets for Financial Need Discount Determination

   Patient portion of Medical Bills
   % of patient portion of medical bills as compared to Adjusted Annual Household Income Subtotal
   Is the patient portion of medical bills > 40%?
   If yes, subtract from Adjusted Annual Household Income & Assets. If no, patient is not medically indigent.
   Medically Indigent Adjusted Gross Income used for poverty level determination

6. The Patient Financial Counselor notifies the patient with a letter within 30 days, informing the patient of the decision, the amount of any discount provided, and the terms for which any remaining balance is to be repaid. Denials may be appealed within thirty (30) days of receipt of the determination but must be accompanied by supporting documents that prove inability to pay that were not part of the initial consideration.

7. The Office Manager should then forward to Posting the necessary information to post a Patient Pay adjustment code on the patient account in the amount of the discount approved.

8. The Patient Financial Counselor should then set up the payment plan for any remaining balance owed.

9. Financial need applications can be re-evaluated and revoked if it is found that the recipient misrepresented their income, assets or other information on the financial need application.

☐ ORIGINAL

HEALTH FACILITIES SERVICES AND REVIEW BOARD

PERMIT APPLICATION TO:

- DISCONTINUE MEDICAL / SURGICAL CATEGORY OF SERVICE (EXISTING HEALTHCARE FACILITY)
- ESTABLISH MEDICAL / SURGICAL CATEGORY OF SERVICE (NEW HEALTHCARE FACILITY)

PINCKNEYVILLE COMMUNITY HOSPITAL REPLACEMENT PROJECT

Pinckneyville Community Hospital District,
Perry County, IL,
d/b/a,
Pinckneyville Community Hospital

November, 2009

Pinckneyville Community Hospital

Replacement Project

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