Pinckneyville Community Hospital

leading the way to a healthier tomorrow

RECEIVED

JUN 14 2012

HEALTH FACILITIES & SERVICES REVIEW BOARD

June 13, 2012

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

Re: Alteration Permit
Project #09-068

Dear Ms. Avery,

We are requesting State Agency approval to alter our replacement hospital project. Our Board of Directors authorized the development and submission of an Alteration Permit at its April 2, 2012 open session meeting. The original permit application anticipated HUD-242 financing which was denied necessitating the request for an alteration permit.

Access to capital for critical access hospitals has been constrained due to severe restrictions in the capital markets and the uncertainty underlying healthcare reform. Most recently, the USDA has indicated the potential to secure a Rural Development Facilities loan, albeit at a level below the originally anticipated HUD-242 financing. We are pursuing this financing option which has the support of Sen. Richard J. Durbin (see attached support letter). In addition, our March 26 Debt Capacity Study developed by Wipfli, LLP indicates our ability to support the required debt.

Given these circumstances, including changes in the use of health services in our local market, we are seeking an alteration. The major project changes are:

	Approved	Proposed	Change
Beds	25	17	(8)
New Construction GSF	104,522	82,946	(21,576)
New Construction Cost	$31,169,117	$23,289,892	($7,879,225)

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

Project Cost	$46,624,405	$31,187,575	($15,436,830)
Financing Source	HUD-242	USDA	--
Obligation Date	10/20/2012	04/20/2013*	6 months
Completion Date	6/30/2012	10/1/2014	27 months

* Requested in a letter dated May 29, 2012

Our check in the amount of $1,000.00 is enclosed for the required processing fee.

If you have any questions, I can be reached at thudgins@pvillehosp.org or by phone at 618-357-5901.

Sincerely,

Thomas J. Hudgins, FACHE
Chief Executive Officer

CC: Mike Constantino

Enclosure: Sen. Durbin support letter

RICHARD J. DURBIN
ILLINOIS
ASSISTANT MAJORITY LEADER

COMMITTEE ON APPROPRIATIONS
COMMITTEE ON FOREIGN RELATIONS
COMMITTEE ON THE JUDICIARY
COMMITTEE ON RULES AND ADMINISTRATION

United States Senate
Washington, DC 20510–1304

April 25, 2012

Marsha Gajewski
USDA Service Center
221 Withers Drive
Mount Vernon, IL 62864

To Whom It May Concern:

I am writing in support of Pinckneyville Community Hospital's application to the United States Department of Agriculture Rural Development Community Facilities Loan Program.

Pinckneyville Community Hospital is a local hospital located in Pinckneyville, Illinois providing healthcare services to a broad area of rural Southern Illinois. Since 2003, the hospital has been pursuing construction of a replacement hospital with which to serve the community.

Pinckneyville Community Hospital's current facilities are not adequate to serve their community. A number of infrastructure challenges have been found in buildings ranging from 35 to 45 years old and the cost of repairing the current site would be greater than the cost of constructing a new, updated hospital. Also, the construction of a new hospital would avoid disruption to their current services that would occur during renovations.

Presently, Pinckneyville Community Hospital is the second largest employer in the region, providing over 200 individuals with employment. Further, the construction of a new facility and the increase in use of the hospital would provide more employment opportunities for individuals. At a time when jobs are scarce, this would be greatly beneficial to the economy in Southern Illinois.

I strongly support Pinckneyville Community Hospital's application to the USDA Rural Development Community Facilities Loan Program and I urge the USDA to give their application the most serious consideration.

Sincerely,

Richard J. Durbin
United States Senator

RJD/ddw

711 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510–1304
(202) 224–2152
TTY (202) 224–9100

230 SOUTH DEARBORN, 38TH FLOOR
CHICAGO, IL 60604
(312) 353–4952

525 SOUTH EIGHTH STREET
SPRINGFIELD, IL 62703
(217) 492–4062

1504 THIRD AVENUE
SUITE 227
ROCK ISLAND, IL 61201
(309) 793–5179

PAUL SIMON FEDERAL BUILDING
250 W. CHERRY STREET
SUITE 119-D
CARBONDALE, IL 62901
(618) 351–1122

durbin.senate.gov

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

CERTIFICATE OF NEED PERMIT

APPLICATION

MAY 2010 EDITION

TABLE OF CONTENTS

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2nd FLOOR
SPRINGFIELD, ILLINOIS 62761
(217) 782-3516

INSTRUCTIONS
GENERAL

- The Application must be completed for all proposed projects that are subject to the permit requirements of the Illinois Health Facilities Planning Act, including those involving establishment, expansion, modernization or discontinuation of a service or facility.
- The person(s) preparing the application for permit are advised to refer to the Planning Act, as well as the rules promulgated there under (77 Ill. Adm. Codes 1100, 1110, 1120 and 1130).
- **This Application does not supersede any of the above-cited rules and requirements that are currently in effect.**
- The application form is organized into several sections, involving information requirements that coincide with the Review Criteria in 77 Ill. Codes 1110 (Processing, Classification Policies and Review Criteria) and 1120 (Financial and Economic Feasibility).
- Questions concerning completion of this form may be directed to the Health Facilities and Services Review Board staff at (217)782-3516.
- Copies of this application form are available on the Health Facilities and Services Review Board Website www.hfsrb.illinois.gov

SPECIFIC

- Use this form, as written and formatted.
- Complete and submit **ONLY** those Sections along with the required attachments that are applicable to the type of project proposed.
- **ALL APPLICABLE CRITERIA** for each applicable section must be addressed. **If a criterion is NOT APPLICABLE label as such and state the reason why.**
- For all applications that time and distance are required for a criterion submit copies of all Map-Quest Printouts that indicate the distance and time from the proposed facility or location to the facilities identified.
- **ALL PAGES ARE TO BE NUMBERED CONSECUTIVELY BEGINNING WITH PAGE 1 OF THE APPLICATION FOR PERMIT. DO NOT INCLUDE INSTRUCTIONS AS PART OF THE APPLICATION AND OR NUMBERING.**
- Attachments for each Section should be appended after the last page of the application for permit.
- Begin each Attachment on a separate 8 1/2" x 11" sheet of paper and print or type the attachment identification in the lower right-hand corner of each attached page.
- For those criteria that require MapQuest printouts, physician referral letters and attachments, impact letters and documentation of receipt, include as appendices after that last attachment submitted with the application for permit. Label as Appendices 1, 2 etc.
- For all applications that require physician referrals the following must be provided: a summary of the total number of patients by zip code and a summary (number of patients by zip code) for each facility the physician referred patients in the past 12 or 24 months whichever is applicable.
- Information to be considered must be included with the applicable Section attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
- The application must be signed by the authorized representative(s) of each applicant entity.
- Provide an original application and one copy both **unbound. Label one copy original** that contains the original signatures **(on the application for permit).**

Failure to follow these requirements WILL result in the application being declared incomplete. In addition, failure to provide certain required information (e.g., not providing a site for the proposed project or having an

invalid entity listed as the applicant) may result in the application being declared null and void. Applicants are advised to read Part 1130 with respect to completeness (113.620(d)

ADDITIONAL REQUIREMENTS

FLOOD PLAIN REQUIREMENTS

Before an application for permit involving construction will be deemed **COMPLETE** the applicant must **attest** that the project **is or is not in a flood plain,** and that the location of the proposed project complies with the Flood Plain Rule under **Illinois Executive Order #2005-5**.

HISTORIC PRESERVATION REQUIREMENTS

In accordance with the requirements of the Illinois Historic Resources Preservation Act (IHRP), the Health Facilities Planning Board is required to advise the Historic Preservation Agency of any projects that could affect historic resources. Specifically, the Preservation Act provides for a review by the IHRP Agency to determine if certain projects may impact upon historic resources. Such types of projects include:

1. Projects involving demolition of any structures; or
2. Construction of new buildings; or
3. Modernization of existing buildings.

The applicant must submit the following information to the Illinois Historic Preservation Agency so known or potential cultural resources within the project area can be identified and the project's effects on significant properties can be evaluated:

1. General project description and address;
2. Topographic or metropolitan map showing the general location of the project;
3. Photographs of any standing buildings/structure within the project area; and
4. Addresses for buildings/structures, if present.

The Historic Preservation Agency (HPA) will provide a determination letter concerning the applicability of the Preservation Act. Include the determination letter or comments from the HPA with the submission of the application for permit.

Information concerning the Historic Resources Preservation Act may be obtained by calling (217)782-4836 or writing Illinois Historic Preservation Agency Preservation Services Division, Old State Capitol, Springfield, Illinois 67201,

SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**. **SEE SECTION XI** OF THE APPLICATION FOR PERMIT.

CHARITY CARE INFORMATION

CHARITY CARE INFORMATION must be provided for **ALL** projects. **SEE SECTION XII** OF THE APPLICATION FOR PERMIT.

FEE

An application processing fee (refer to Part 1130.620(f) for the determination of the fee) must be submitted with most applications. If a fee is applicable, and initial fee of $2,500 MUST be submitted at the same time as submission of the application. **The application will not be declared complete and the review will not be initiated if the processing fee is not submitted.** HFSRB staff will inform applicants of the amount of the fee balance, if any, that must be submitted. **Payment may be by check or money order and must be made payable to the Illinois Department of Public Health.**

SUBMISSION OF APPLICATION

Submit an original and one copy of all Sections of the application, including all necessary attachments. **The original must contain original signatures in the certification portions of this form.** Submit all copies to:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	**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 /Co-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**

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive all correspondence or inquiries 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:	**800 Roosevelt Road, Building E, Suite 110, 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

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

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

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

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 /Co-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**

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive all correspondence or inquiries 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:	**800 Roosevelt Road, Building E, Suite 110, 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

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 (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**

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

Type of Ownership

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

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

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**

Post Permit Contact

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

Name:	**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**

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**

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

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

Operating Identity/Licensee

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

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

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

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

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

Organizational Relationships

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

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

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

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**

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**

☐ 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.

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)**.

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

Post Permit Contact

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

Name:	**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**

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**

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

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

Operating Identity/Licensee

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

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

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

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

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

Organizational Relationships

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

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

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

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**

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**

☐ 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.

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)**.

APPEND DOCUMENTATION AS ATTACHMENT 4, 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.hfsrb.illinois.gov)**.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	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

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					

* The proposed alteration bed complement is 17 not 25.

2. 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.

The greatest majority of the Replacement Hospital Permit Application, Project 09-068, remains the same as noted in the original Narrative Description. However, the Alteration Permit proposes to reduce the replacement hospital size due to financing constraints resulting from the various crises in the financial markets over the last several years and the uncertainty surrounding health reform legislation. These circumstances have severely constrained access to capital.

The overall strategy is to maximize clinical functions on the new site and to support the replacement hospital facility through retaining select non-clinical administrative functions on the existing campus. The existing Hospital building will be demolished and the rural health clinic building or Annex (medical office building) will be repurposed at no cost as administrative support space for the organization. In addition, the Hospital will retain the existing outpatient physical medicine facility which is a separate building located on the "town square" approximately 1 block from the current main Hospital building.

The proposed changes are:

	Original Permit	Alteration Permit
Beds	25	17
Project Costs		
Clinical	$29,007,351	$15,748,800
Non-Clinical	$17,617,054	$15,438,775
Total	$46,624,405	$31,187,575

		Original Permit	Alteration Permit	Variance
Space Allocations (GSF)				
Clinical	New Construction	62,204	35,068	(27,136)
	Retained (Therapy)	0	6,468	6,468
	Subtotal	62,204	41,536	(20,668)
Non-Clinical	New Construction	42,318	47,878	5,560
	Retained	0	24,422*	24,422
	Subtotal	42,318	72,300	29,982*
Subtotal New		104,522	82,946	(21,576)
Subtotal Retained		0	30,890	30,890
Total Facility GSF		104,522	113,836	9,314

* The altered project will retain 3-existing facilities ... Therapy Building, Annex Building, and 15 N. Main. The Annex Building will be repurposed for administrative space; 15N Main functions will remain and the Therapy Building will continue to house outpatient PT / OT functions. In addition, this space summary allocates physician office space to the non-clinical category per State Agency guidelines; the original permit allocated 13,233 GSF to clinical; the altered permit, 14,433 GSF to non-clinical.

The proposed majority funding is through a USDA Rural Development Facilities Loan.

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.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$95,880	$92,120	$188,000
Site Survey and Soil Investigation	24,000	23,087	47,087
Site Preparation	373,700	516,000	889,700
Off Site Work	40,700	39,050	79,750
New Construction Contracts	11,878,000	11,411,892	23,289,892
Modernization Contracts	0	0	0
Contingencies (Owner)	406,000	294,000	700,000
Architectural/Engineering Fees	1,160,000	805,187	1,965,187
Consulting and Other Fees	48,000	46,200	94,200
Movable or Other Equipment (not in construction contracts) (under $200,000)	603,000	121,000	724,000
Bond Issuance Expense (project related)	131,600	126,523	258,123
Net Interest Expense During Construction (project related)	413,100	396,900	810,000
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	1,100,000	687,365	1,787,365
Acquisition of Building or Other Property (includes land per USDA Format)	180,680	173,591	354,271
TOTAL USES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities (includes land costs)	$4,296,160	$3,846,415	$8,142,575
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)			0
Mortgages (USDA Rural Development loan)	11,976,500	10,723,500	22,700,000
Leases (fair market value)			0
Governmental Appropriations			0
Grants (Illinois Capital)	182,000	163,000	345,000
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

* Note, land cost of $354,271 is included to reconcile with USDA project cost / budget reconciliation requirements. The land was purchased in 2006.

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 Variance Analysis

	Original	Alteration	Difference
Clinical	$29,007,351	$16,454,660	$12,552,691
Non-Clinical	$17,617,054	$14,732,915	$2,884,139
Total	$46,624,405	$31,187,575	$15,436,830

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 $ *.

* To be provided when feasibility study is completed

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): October 1, 2014

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.

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

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

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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 **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Cost / Space Requirements							
	Project Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
Department		Existing	Proposed	New Construction	Remodeled	As Is *	Vacated Space**
Clinical							
Medical / Surgical	$ 3,896,400	5,990	9,177	9,177			5,990
Emergency	$ 1,837,800	550	4,195	4,195			550
Diagnostic Imaging	$ 3,282,400	2,840	6,034	6,034			2,840
Surgery	$ 1,697,500	1,800	2,722	2,722			1,800
Same Day Surgery / Prep/Recovery / PACU	$ 1,775,300	0	3,823	3,823			0
Central Sterile Processing	$ 456,600	310	1,147	1,147			310
Laboratory	$ 1,024,000	1,640	2,708	2,708			1,640
Pharmacy	$ 466,500	800	1,350	1,350			800
Oncology	$ 951,400	1,170	2,703	2,703			1,170
Outpatient Rehabilitation	$ -	6,468	6,468	0	0	6,468	0
Inpatient Rehabilitation	$ 360,900	0	1,209	1,209			0
Total Clinical	$ 15,748,800	21,568	41,536	35,068	0	6,468	15,100
Non-Clinical *							
Registration	$ 442,300	0	1,258	1,258			0
Lobby / Public Space	$ 2,030,100	860	5,564	5,564			860
Ambulance Vestibule	$ 161,500	0	566	566			0
Business Office / Billing	$ -	0	2,024	0	0	2,024	0
Administration	$ -	7,450	7,450	0	0	7,450	0
Information Technology	$ 121,500	0	426	426			0
Dietary	$ 1,515,600	4,460	4,008	4,008			4,460
General Store / Materials Management	$ 466,300	800	1,674	1,674			800
Housekeeping / Linen (Environmental Services)	$ 375,500	560	1,415	1,415			560
Maintenance	$ 282,600	600	1,065	1,065			600
Circulation / Building Gross	$ 3,576,300	24,872	13,477	13,477			24,872
Mechanical / Electrical	$ 1,046,875	3,750	2,256	2,256			3,750
Canopies	$ 345,500	0	1,736	1,736			0
Storage / Archives	$ -	2,520	2,520	0	0	2,520	0
Vacant Space	$ -	17,298	0	0			0
Specialty Clinics (MOB) **	$ 1,514,000	2,100	4,306	4,306			2,100
Family Health Clinic (MOB) **	$ 3,560,700	7,340	10,127	10,127			7,340
Miscellaneous Storage / Support	$ -	1,360	12,428	0	0	12,428	0
Total Non-Clinical	**$ 15,438,775**	**73,970**	**72,300**	**47,878**	**0**	**24,422**	**45,342**
Total Project	**$ 31,187,575**	**95,538**	**113,836**	**82,946**	**0**	**30,890**	**60,442**

* Retention of Therapy, Annex, and 15N Main buildings; Annex is repurposed as non-clinical support space in altered project.

** Moved to non-clinical in order to correct category in Alteration Permit; physician office space (MOB) is non-clinical

Note: There is an approximate 4,000 GSF difference in the toal amount of retained and vacated space when compared to existing space due to variations in space takeoffs.

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 (Draft AHQ Survey – 2011)

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Pinckneyville Community Hospital		CITY: Pinckneyville			
REPORTING PERIOD DATES: From: January 11, 2011 to: December 31, 2011					
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical [b]	25	418	1,382 [a]	0	25
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other Swing Beds [c]	0	80	713	0	0
TOTALS:	25	498	2,095	0	25

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

Observation Days	
Category of Bed	Days
Medical / Surgical	300

[b] Peak M / S census in 2011 was 11

[c] Peak swing bed census in 2011 was 6

Facility Bed Capacity and Utilization (2010)

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Pinckneyville Community Hospital		CITY: Pinckneyville			
REPORTING PERIOD DATES: From: January 1, 2010 to: December 31, 2010					
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days [a]**	**Bed Changes**	**Proposed Beds**
Medical/Surgical [b]	25	455	1,462		25
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other Swing Beds [c]		88	852		
TOTALS:	25	543	2,314		25

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

Observation Days	
Category of Bed	Days
Medical / Surgical	228

[b] Peak M / S census in 2010was 10

[c] Peak swing bed census in 2011 was 7

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

Notarization:
Subscribed and sworn to before me
this 8 day of June 2012

Signature of Notary

Seal

OFFICIAL SEAL
CHRISTIE L GAJEWSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/17/14

SIGNATURE

John Shotton
PRINTED NAME

Chairman of the Board
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of June 2012

Signature of Notary

Seal

OFFICIAL SEAL
CHRISTIE L GAJEWSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/17/14

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of Pinckneyville Community Hospital * **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application 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

Notarization:
Subscribed and sworn to before me
this 8 day of June 2012

Signature of Notary

Seal OFFICIAL SEAL
CHRISTIE L GAJEWSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:11/17/14

*Insert EXACT legal name of the applicant

SIGNATURE

John Shotton
PRINTED NAME

Chairman of the Board
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of June 2012

Signature of Notary

Seal OFFICIAL SEAL
CHRISTIE L GAJEWSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:11/17/14

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 December 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 December, 2009

Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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 – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

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

Criterion 1110.230 – Background, Purpose of the Project, 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, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest 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-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

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 **as appropriate**.

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

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report. APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

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.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

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

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. **This must be a narrative.**

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

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

   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 space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**

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

PROJECT SERVICES UTILIZATION:

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

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MET STANDARD?**
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, 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

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-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 - 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. 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
☒ **Medical/Surgical**	**25**	**17**
☐ **Obstetric**	**0**	**0**
☐ **Pediatric**	**0**	**0**
☐ **Intensive Care**	**0**	**0**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

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	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X
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	X

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

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$8,142,575	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discount d value, estimated time table of gross receip s and relat d fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$22,700,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
$345,000	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$31,187,575	**TOTAL FUNDS AVAILABLE**	

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. **All of the projects capital expenditures are completely funded through internal sources**
2. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2009	FY 2010	FY 2011	FY 2016
Current Ratio	6.8	7.1	7.0	TBD
Net Margin Percentage	0.9%	3.1%	-1.1%	TBD
Percent Debt to Total Capitalization	7.0%	5.6%	4.5%	TBD
Projected Debt Service Coverage	5.9	7.7	2.2	TBD
Days Cash on Hand	73.7	87.3	74.0	TBD
Cushion Ratio	44.9	44.2	37.8	TBD

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.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-44, 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

Attachments

Original Permit Application # 09-068	Alteration Permit (May 2010 Format)	
1	1	Included
2	2	No Change to Site Ownership
	3	Included (Updated)
3	4	Included (Updated)
4	5	No Change
5	6	No Change
7	7	Included
	8	Not Applicable
8	9	Included
9	10	Included
10	11	No Change
11	12	No Change
11 & 12	13	Included (Alternatives)
12	14	Included (Size of Project)
14	15	Included (Utilization)
	16 to 19	Not Applicable
19 – 20	20	Included
	21 to 38	Not Applicable
75 – 77	39	Included
75 – 77	40	Included but not applicable
75 – 77	41	Included
75 – 77	42	Included (study in process)
75 – 77	43	Included
75 – 77	44	Included

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

INDEX OF ATTACHMENTS

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Applicant /Co-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**

Applicant /Co-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**

Type of Ownership of Applicant/Co-Applicant

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

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

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

There are no changes from the original permit application.

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

[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**

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

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

There is no change from the original application

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

[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**

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

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

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

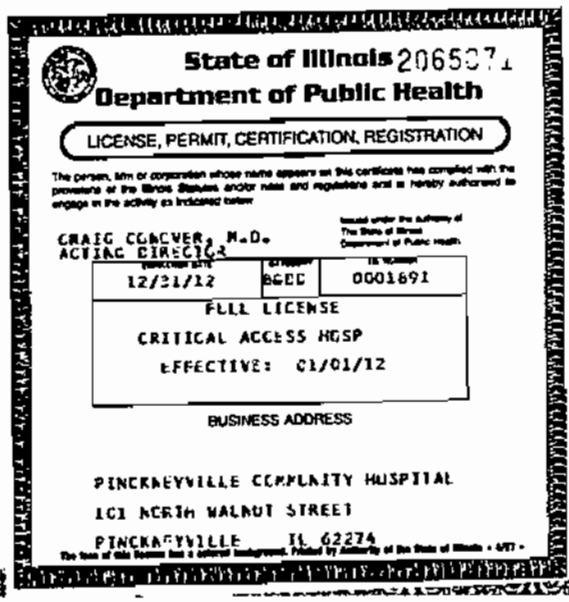
STATE OF ILLINOIS

LICENSE

Be it known that this facility is licensed to engage in the activities specified in the annual license certificate displayed below for the period designated in that certificate.

This Document is valid only so long as a current license certificate is displayed at right.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES



State of Illinois 2065071
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

CRAIG CONOVER, M.D.
ACTING DIRECTOR

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

Expiration Date	Category	ID Number
12/31/12	BGDC	0001691

FULL LICENSE
CRITICAL ACCESS HOSP
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET
PINCKNEYVILLE IL 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 Pincknayville Community Hospital District, and

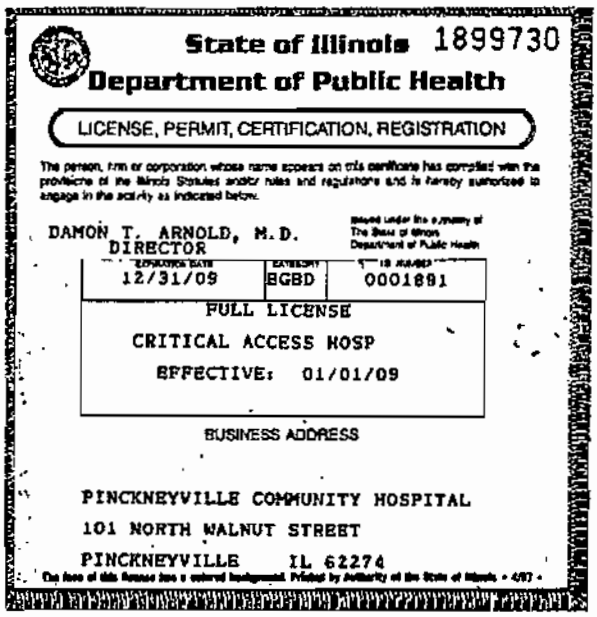
Whereas, said Order was entered and is dated the 18th day of December A. D. 19 50, and is certified to be a true and correct copy by the County Clerk of Perry County, Illinois, and

Whereas, it is found, by said Order, that those voting in favor of the establishment of the Pincknayville 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 Pincknayville 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 Pincknayville 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 fifthteenth 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

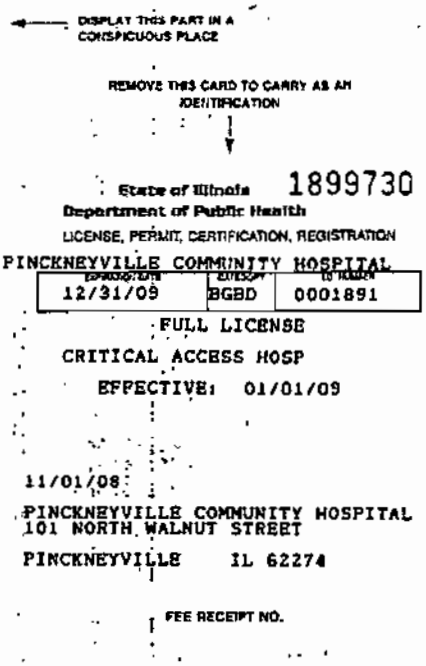
EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0001891

FULL LICENSE
CRITICAL ACCESS HOSP
EFFECTIVE: 01/01/09

BUSINESS ADDRESS

PINCKNEYVILLE COMMUNITY HOSPITAL
101 NORTH WALNUT STREET
PINCKNEYVILLE IL 62274

The 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.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Organizational Relationships

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

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

Pinckneyville Community Hospital – Organizational Structure Effective 04-17-12

Board of Directors – John Shotton, Chairman

Administrator/CEO - Thomas J. Hudgins, FACHE

Medical Staff President – Salva Bilal, MD

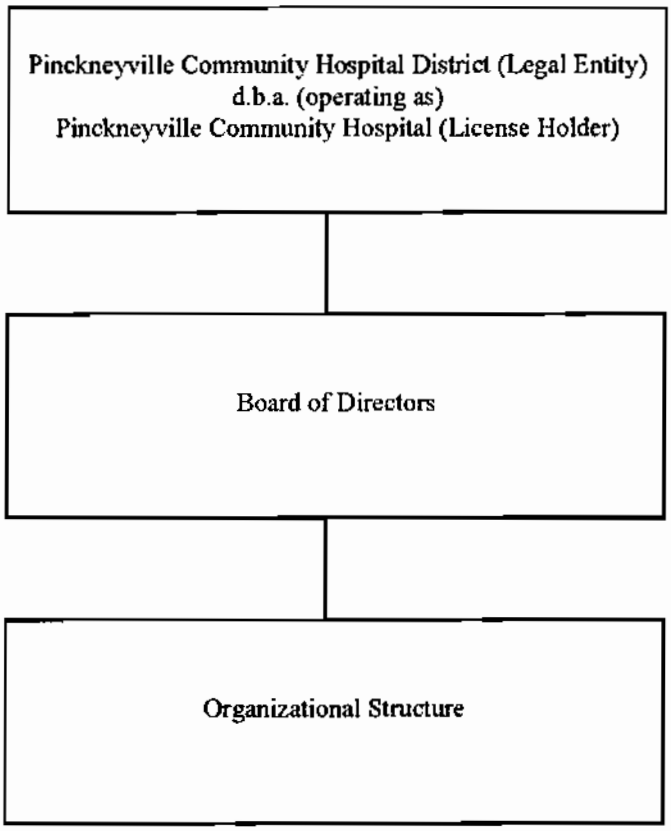
Billing Compliance – Debbie Engelman

Medical Staff Coordinator – Norma Gordon

Chief Financial Officer	*RHC Business Office Manager	Human Resources Director	Chief Nurse Exec	Maintenance Engineering	*RHC Med Dir	Rehabilitation Services	Risk Manager	Food Service	Information Systems	Environmental Services
Kara Carson	**Lisa Heisner**	**Christie Gajewski**	**Eva Hopp**	**Charles Herring**	**Dr. J. Gregg Fozard**	**Dan Northcutt**	**Carla Bruns**	**Martha Kellerman**	**Tina Grafton**	**Kevin Daugherty**
Accounts Payable	RHC Business Office	Human Resources	CAH Nursing	Bio-Med	RHC Physicians	Fitness/Wellness	Risk Management	Food Service	Information Systems Technology	Housekeeping
Accounts Receivable	Accounts Receivable	ICT Safety Liaison	Cardiopulmonary	Building & Grounds	Physician Assistants	Inpatient Therapies	QA/CQI	Cafeteria	HIPAA Information Security Officer	Laundry
Audits	Cashiering	Marketing Assistance	Case Mngt.	Construction	*Patient Care	Marketing II	IPT Liaison	Meals on Wheels		Linen
CAH Business Office	RHC Communication		Central Service	Communication Systems		Outpatient Therapies				
Compliance Officer	Reception		Education RLC:LPN/CNA	Engineering		Sports Medicine				
HIPPA Privacy Officer			Imaging	Maintenance		Work Hardening				
Materials Mngt			Infection Control							
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 & Triage Nurse.

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


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
Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$95,880	$92,120	$188,000
Site Survey and Soil Investigation	24,000	23,087	47,087
Site Preparation	373,700	516,000	889,700
Off Site Work	40,700	39,050	79,750
New Construction Contracts	11,878,000	11,411,892	23,289,892
Modernization Contracts	0	0	0
Contingencies (Owner)	406,000	294,000	700,000
Architectural/Engineering Fees	1,160,000	805,187	1,965,187
Consulting and Other Fees	48,000	46,200	94,200
Movable or Other Equipment (not in construction contracts) (under $200,000)	603,000	121,000	724,000
Bond Issuance Expense (project related)	131,600	126,523	258,123
Net Interest Expense During Construction (project related)	413,100	396,900	810,000
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	1,100,000	687,365	1,787,365
Acquisition of Building or Other Property (includes land per USDA Format)	180,680	173,591	354,271
TOTAL USES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities (includes land costs)	$4,296,160	$3,846,415	$8,142,575
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)			0
Mortgages (USDA Rural Development loan)	11,976,500	10,723,500	22,700,000
Leases (fair market value)			0
Governmental Appropriations			0
Grants (Illinois Capital)	182,000	163,000	345,000
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**

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

* Note, land cost of $354,271 is included to reconcile with USDA project cost / budget reconciliation requirements. The land was purchased in 2006.

Preplanning ($420,000)		
Preconstruction Services	$95,000	
Traffic Survey	5,000	
Legal (land acquisitions, project contracts, etc)	60,000	
Miscellaneous Studies	28,000	
Total		$188,000
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	
Total		$47,087
Site Preparation		
Site Excavation and Prep	$238,000	
Site Utilities	321,600	
Storm Drainage	319,400	
Fencing	10,700	
Total		$889,700
Off-site Work		
Utility Extension	$79,750	
		$79,750
Consulting and Other Fees		
Construction Testing / Inspection	$75,000	
Building Permit	3,200	
IDPH Plan Review	15,000	
Permit Alteration Fee	1,000	
Total		$94,200
Other Costs to be Capitalized		
Site Signage	$100,000	
Security System	72,000	
On-site Ancillary Structure (garage)	70,000	
Transformer	57,992	
Propane Tanks	100,000	
Cabling / IT Infrastructure / TV	426,800	
Paving, curbs, drives	954,311	
Miscellaneous Permits	6,262	
Total		$1,787,365

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	$35,630	$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.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Cost / Space Requirements								
	Project Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
Department		Existing	Proposed	New Construction	Remodeled	As Is *	Vacated Space**
Clinical							
Medical / Surgical	$ 3,896,400	5,990	9,177	9,177			5,990
Emergency	$ 1,837,800	550	4,195	4,195			550
Diagnostic Imaging	$ 3,282,400	2,840	6,034	6,034			2,840
Surgery	$ 1,697,500	1,800	2,722	2,722			1,800
Same Day Surgery / Prep/Recovery / PACU	$ 1,775,300	0	3,823	3,823			0
Central Sterile Processing	$ 456,600	310	1,147	1,147			310
Laboratory	$ 1,024,000	1,640	2,708	2,708			1,640
Pharmacy	$ 466,500	800	1,350	1,350			800
Oncology	$ 951,400	1,170	2,703	2,703			1,170
Outpatient Rehabilitation	$ -	6,468	6,468	0	0	6,468	0
Inpatient Rehabilitation	$ 360,900	0	1,209	1,209			0
Total Clinical	$ 15,748,800	21,568	41,536	35,068	0	6,468	15,100
Non-Clinical *							
Registration	$ 442,300	0	1,258	1,258			0
Lobby / Public Space	$ 2,030,100	860	5,564	5,564			860
Ambulance Vestibule	$ 161,500	0	566	566			0
Business Office / Billing	$ -	0	2,024	0	0	2,024	0
Administration	$ -	7,450	7,450	0	0	7,450	0
Information Technology	$ 121,500	0	426	426			0
Dietary	$ 1,515,600	4,460	4,008	4,008			4,460
General Store / Materials Management	$ 466,300	800	1,674	1,674			800
Housekeeping / Linen (Environmental Services)	$ 375,500	560	1,415	1,415			560
Maintenance	$ 282,600	600	1,065	1,065			600
Circulation / Building Gross	$ 3,576,300	24,872	13,477	13,477			24,872
Mechanical / Electrical	$ 1,046,875	3,750	2,256	2,256			3,750
Canopies	$ 345,500	0	1,736	1,736			0
Storage / Archives	$ -	2,520	2,520	0	0	2,520	0
Vacant Space	$ -	17,298	0	0			0
Specialty Clinics (MOB) **	$ 1,514,000	2,100	4,306	4,306			2,100
Family Health Clinic (MOB) **	$ 3,560,700	7,340	10,127	10,127			7,340
Miscellaneous Storage / Support	$ -	1,360	12,428	0	0	12,428	0
Total Non-Clinical	**$ 15,438,775**	**73,970**	**72,300**	**47,878**	**0**	**24,422**	**45,342**
Total Project	**$ 31,187,575**	**95,538**	**113,836**	**82,946**	**0**	**30,890**	**60,442**

* Retention of Therapy, Annex, and 15N Main buildings; Annex is repurposed as non-clinical support space in altered project.

** Moved to non-clinical in order to correct category in Alteration Permit; physician office space (MOB) is non-clinical

Note: There is an approimate 4,000 GSF difference in the toal amount of retained and vacated space when compared to existing space due to variations in space takeoffs.

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.

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.

Cost / Space Requirements Comparison

	Project 09-068	Alteration Permit	Difference
Project Cost			
Clinical	29,007,351	15,748,800	($13,258,551)
Non-Clinical	17,617,054	15,438,775	($2,178,279)
Total	46,624,405	31,187,575	($15,436,830)

				Alteration Total	
Project Gross Square Feet					
New Construction		New	As Is	Facility	Difference
Clinical	62,204	35,068	6,468	41,536	(20,668)
Non-Clinical	42,318	47,878	24,422	72,300	29,982
Total	104,522	82,946	30,890	113,836	9,314
Vacated / Demolished					
Gross Square Feet	95,538	64,648			30,890*

* The altered project will retain 3-existing facilities … Therapy Building, Annex Building, and 15 N. Main.

The Annex Building will be repurposed for administrative space; 15N Main functions will remain and the Therapy Building will continue to house outpatient PT / OT functions. In addition, this space summary allocates physician office space to the non-clinical category per State Agency guidelines; the original permit allocated 13,233 GSF to clinical; the altered permit, 14,433 GSF to non-clinical.

The proposed majority funding is through a USDA Rural Development Facilities Loan.

SECTION II. DISCONTINUATION

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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.

1110.130 Discontinuation

The discontinuation identified in the original permit application remains essentially the same with the following modifications;

1. The altered project will retain three-existing facilities (30,890 GSF)
    a. The Therapy building on the main Town Square will continue as an outpatient PT/OT and sports medicine facility.
    b. The Annex building which currently houses physicians offices and administrative space will be repurposed as administrative support space … all existing clinical functions will move to the replacement hospital site.
    c. The 15N Main building will be retained and continue its current archive / storage function.
2. The main hospital facility will be vacated and demolished (64,648 GSF).
3. The associated discontinuation date is expected to be on completion of the replacement hospital project which is currently estimated to be on or before October 1, 2014.

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

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

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

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

Criterion 1110.230 Alternatives

The alteration remains essentially the same as documented in the original permit application. However, the new project has been resized and made smaller. Certain select existing facilities will remain and be either retained for their existing use (Therapy building and 15 N. Main), or repurposed for non-clinical support space for the Hospital (Annex Building).

Also see Attachment 9

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. **This must be a narrative.**

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

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

    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 space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**

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

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;

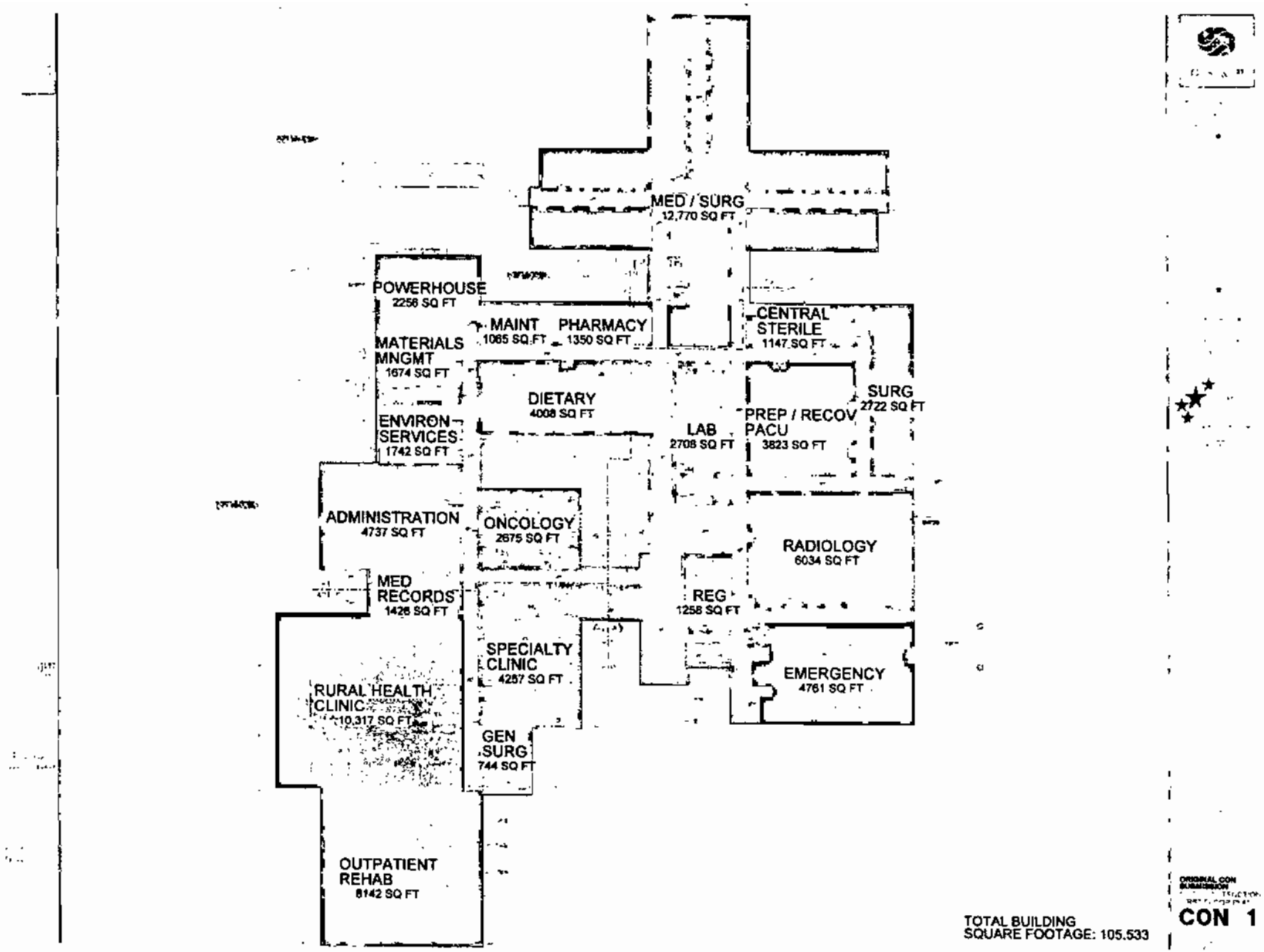
    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

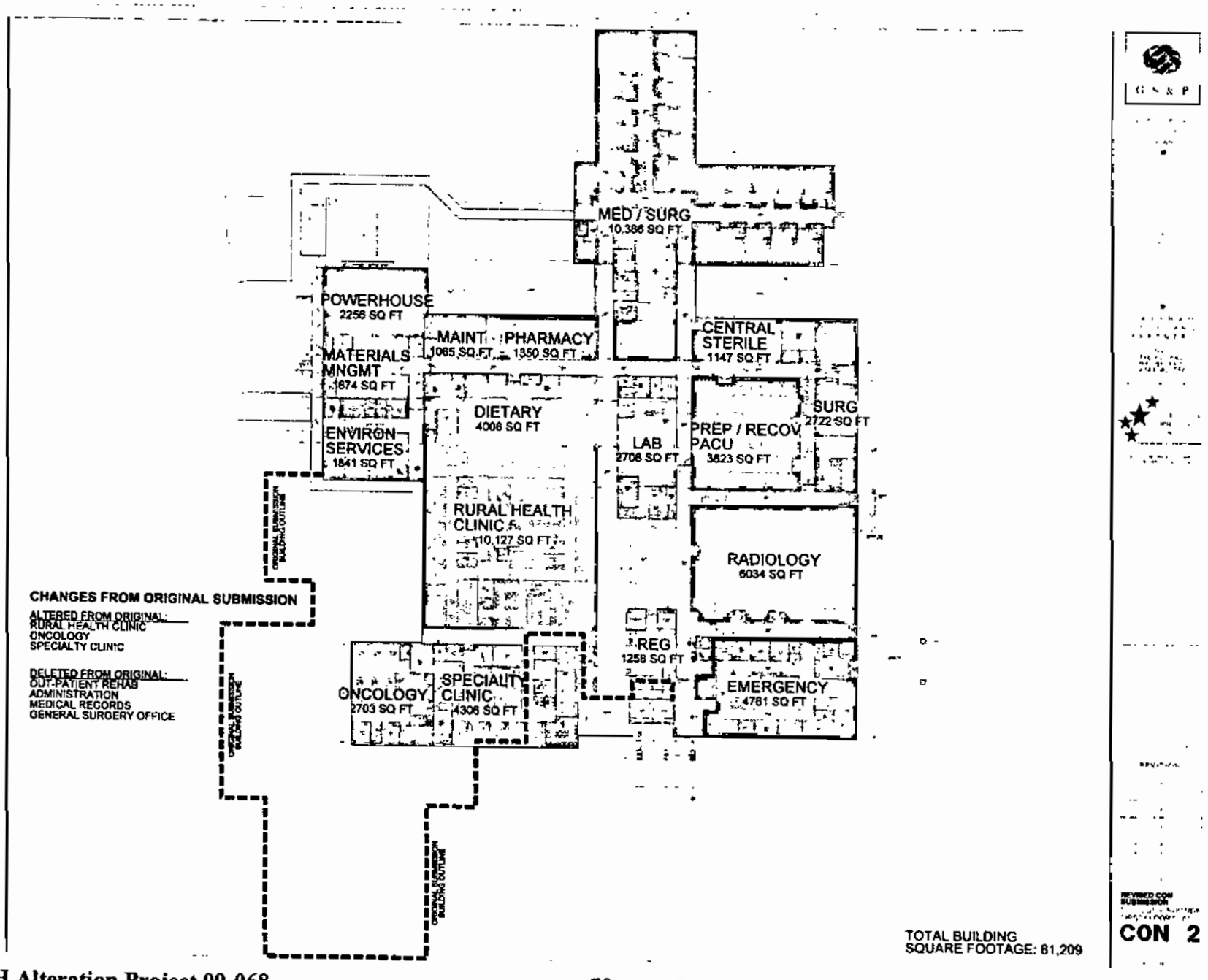
    c. The project involves the conversion of existing bed space that results in excess square footage.

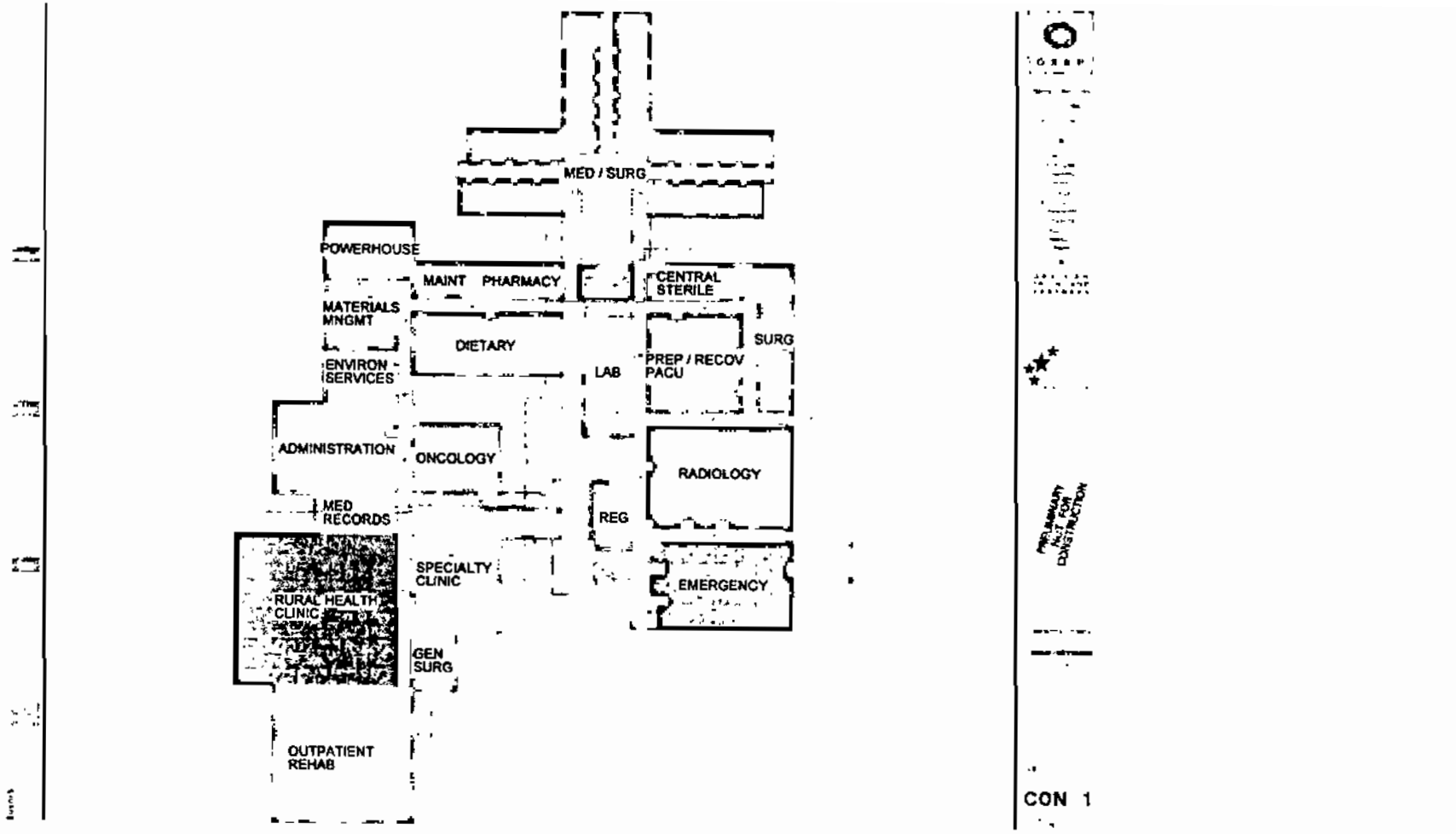
SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Medical / Surgical Beds (17)	8,500 to 11,200	9,177	677 to (2,023)	Yes
Diagnostic Radiology (Rooms)				
General (2)	--	2,600		
Mammography (1)	--	900		
Dexa (1)	--	900 *		
Ultrasound (1)	--	900		
Nuclear (1)	--	1600		
Total Space	6,034	6,900	(866)	Yes
* No State Agency Standard				
Emergency Services	4,195	4,500	(305)	Yes
(5 rooms to meet peak demand)				
(see original permit)				
Surgical Suite (Rooms)				
OR - 2	2,722	5,500	(2778)	
PACU I (3)	--	540	--	
PACU II (4)	--	1,600	--	
Subtotal PACU (7)	3,823	2,140	1,683	Yes
Surgical Space Subtotal	6,545	7,640	(1095)	Yes

The PACU space allocation provides support space for surgery rooms; Surgical Suite is below allowable space allocation State Standard.

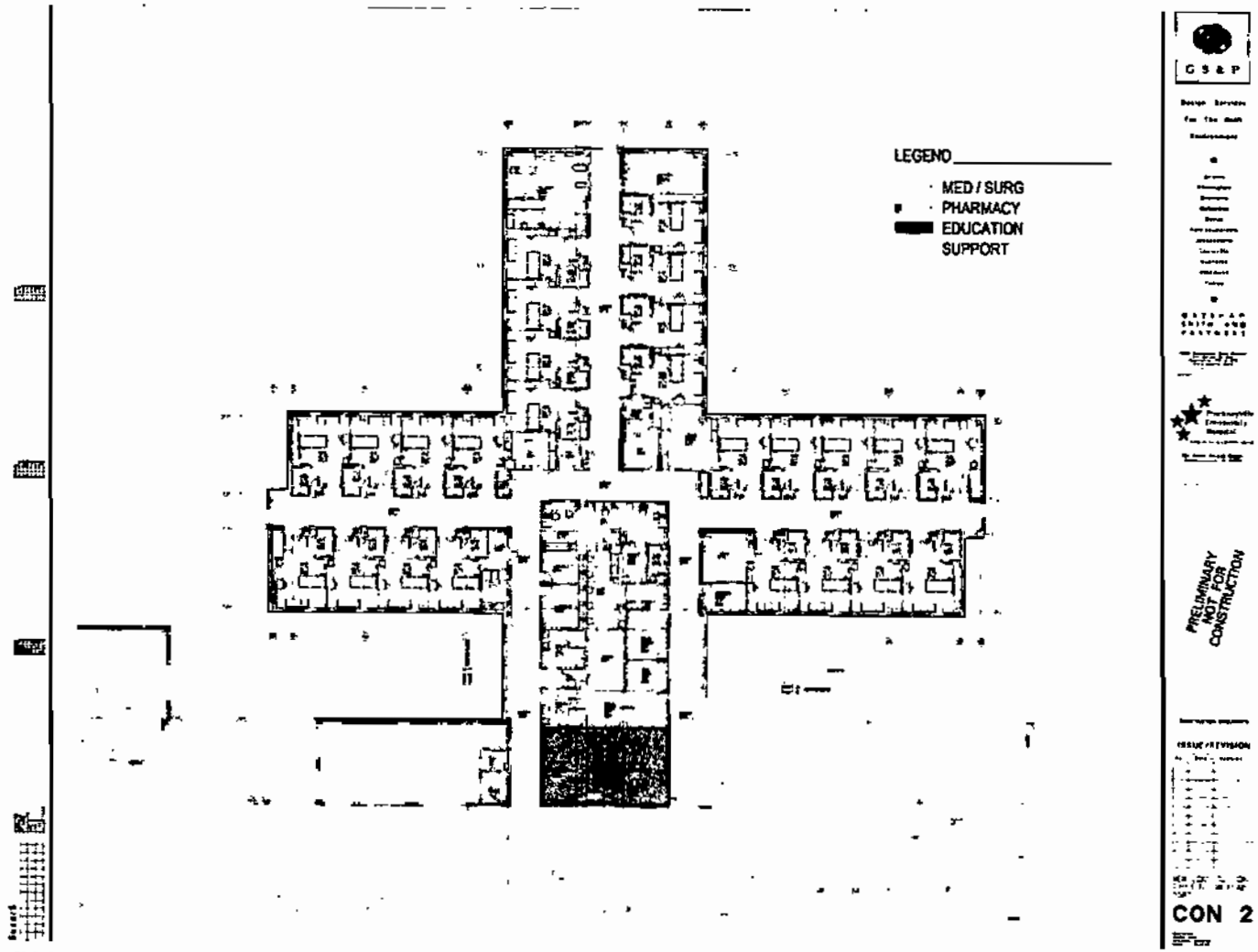
There are no other current State Standards for the remaining proposed replacement hospital clinical services based on Section 1110 Appendix B.


MED / SURG
12,770 SQ FT
POWERHOUSE
2256 SQ FT
MAINT
1085 SQ FT
PHARMACY
1350 SQ FT
CENTRAL
STERILE
1147 SQ FT
MATERIALS
MNGMT
1674 SQ FT
DIETARY
4008 SQ FT
SURG
2722 SQ FT
ENVIRON
SERVICES
1742 SQ FT
LAB
2708 SQ FT
PREP / RECOV
PACU
3823 SQ FT
ADMINISTRATION
4737 SQ FT
ONCOLOGY
2675 SQ FT
RADIOLOGY
6034 SQ FT
MED
RECORDS
1426 SQ FT
REG
1258 SQ FT
SPECIALTY
CLINIC
4257 SQ FT
EMERGENCY
4761 SQ FT
RURAL HEALTH
CLINIC
10,317 SQ FT
GEN
SURG
744 SQ FT
OUTPATIENT
REHAB
8142 SQ FT
TOTAL BUILDING
SQUARE FOOTAGE: 105,533
CON 1


MED / SURG
10,386 SQ FT
POWERHOUSE
2256 SQ FT
MAINT
1065 SQ FT
PHARMACY
1350 SQ FT
MATERIALS MNGMT
1674 SQ FT
CENTRAL STERILE
1147 SQ FT
DIETARY
4008 SQ FT
SURG
2722 SQ FT
ENVIRON SERVICES
1841 SQ FT
LAB
2708 SQ FT
PREP / RECOV PACU
3823 SQ FT
RURAL HEALTH CLINIC
10,127 SQ FT
RADIOLOGY
6034 SQ FT
REG
1258 SQ FT
ONCOLOGY
2703 SQ FT
SPECIALTY CLINIC
4306 SQ FT
EMERGENCY
4781 SQ FT
CHANGES FROM ORIGINAL SUBMISSION
ALTERED FROM ORIGINAL:
RURAL HEALTH CLINIC
ONCOLOGY
SPECIALTY CLINIC
DELETED FROM ORIGINAL:
OUT-PATIENT REHAB
ADMINISTRATION
MEDICAL RECORDS
GENERAL SURGERY OFFICE
ORIGINAL SUBMISSION BUILDING OUTLINE
TOTAL BUILDING SQUARE FOOTAGE: 81,209
REVISED CON SUBMISSION
CON 2

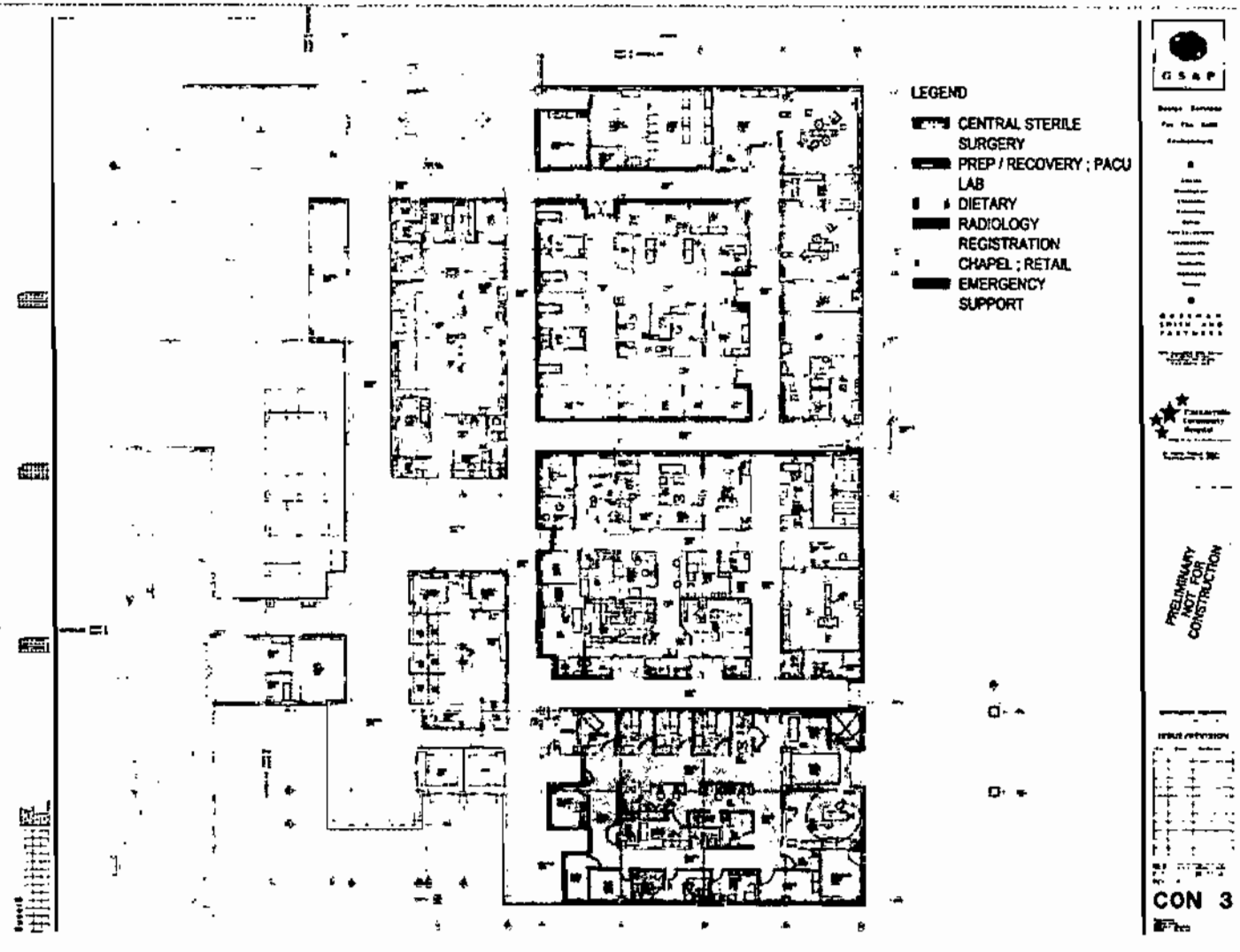


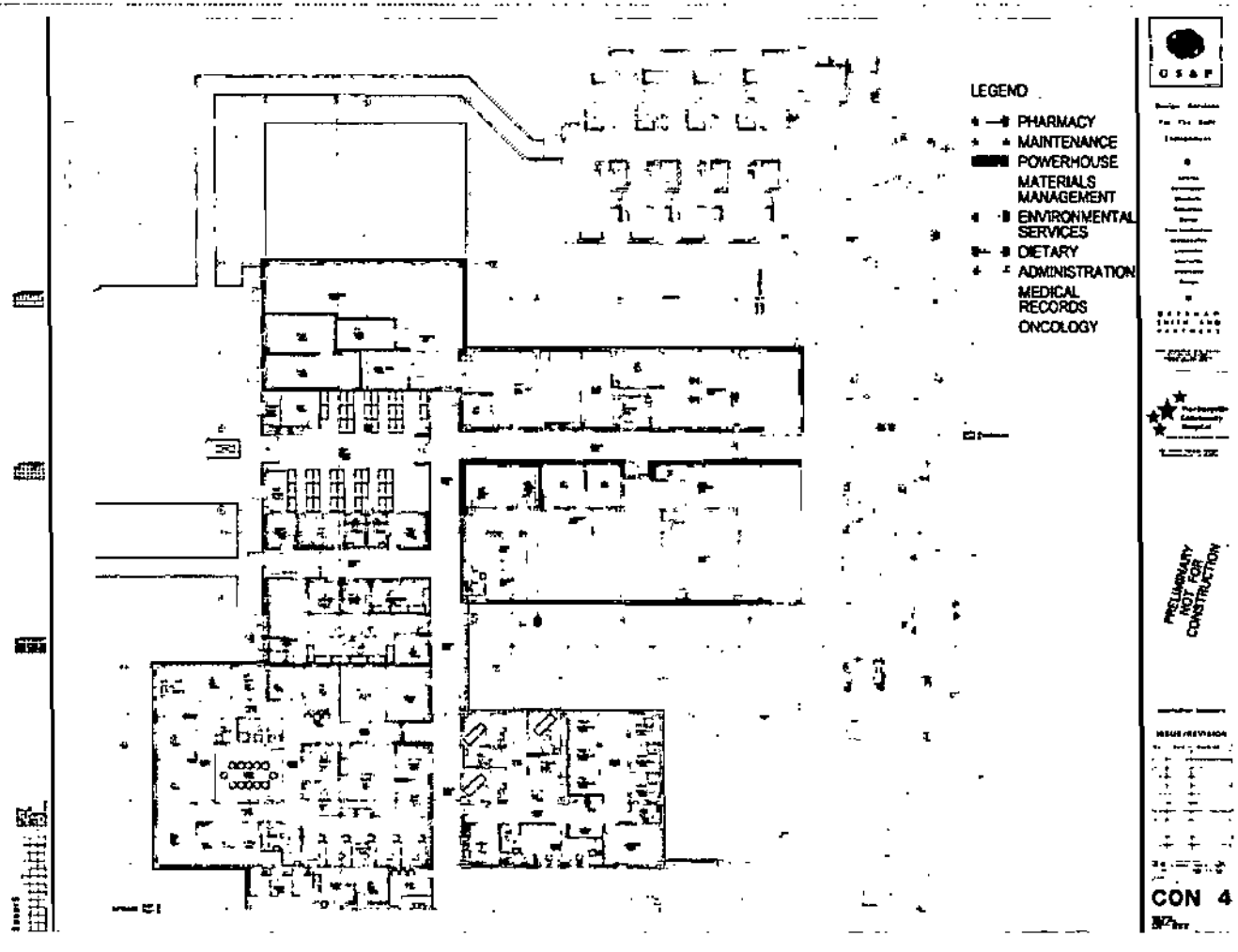
ATTACHMENT-13
PROJECT SCOPE - SIZE

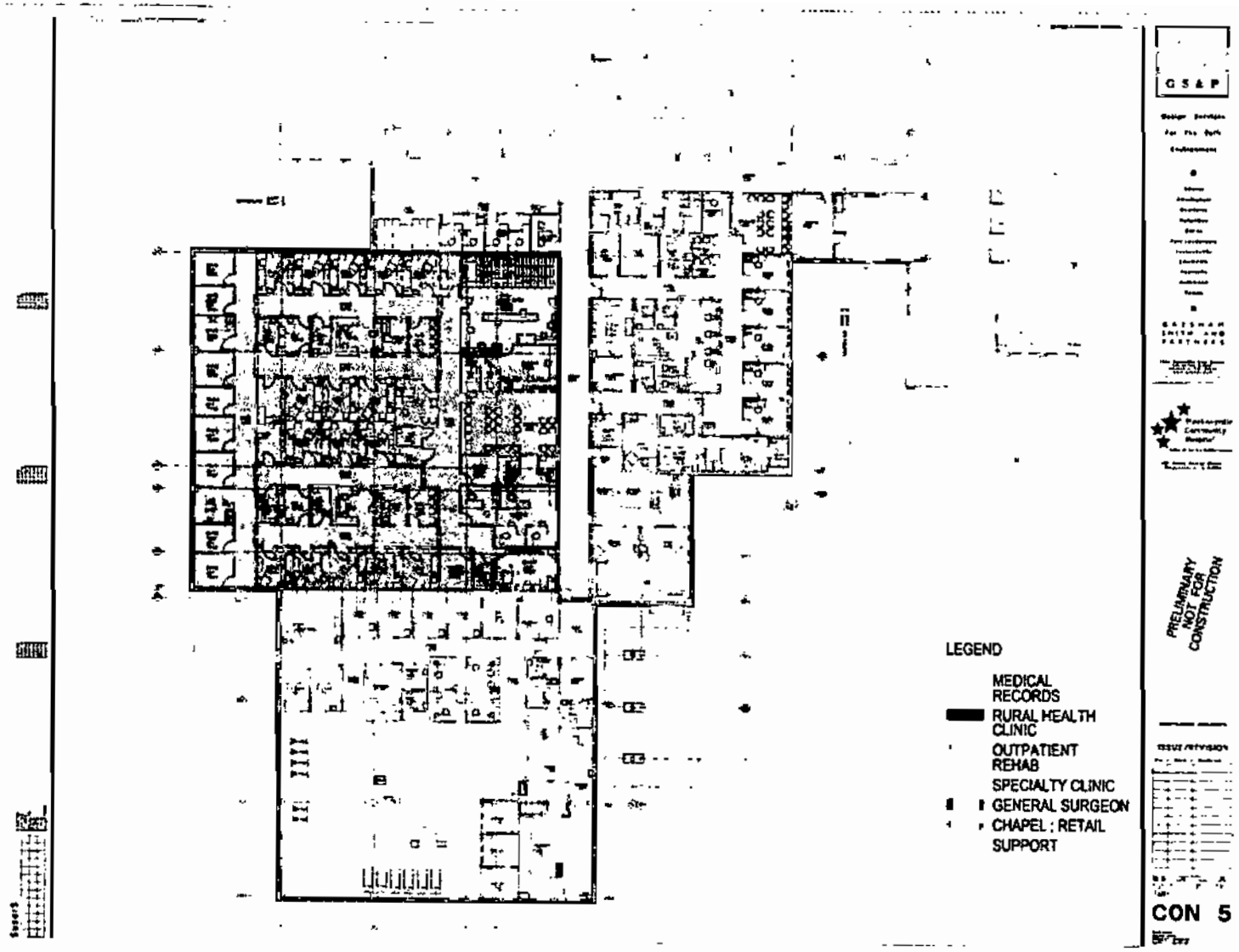


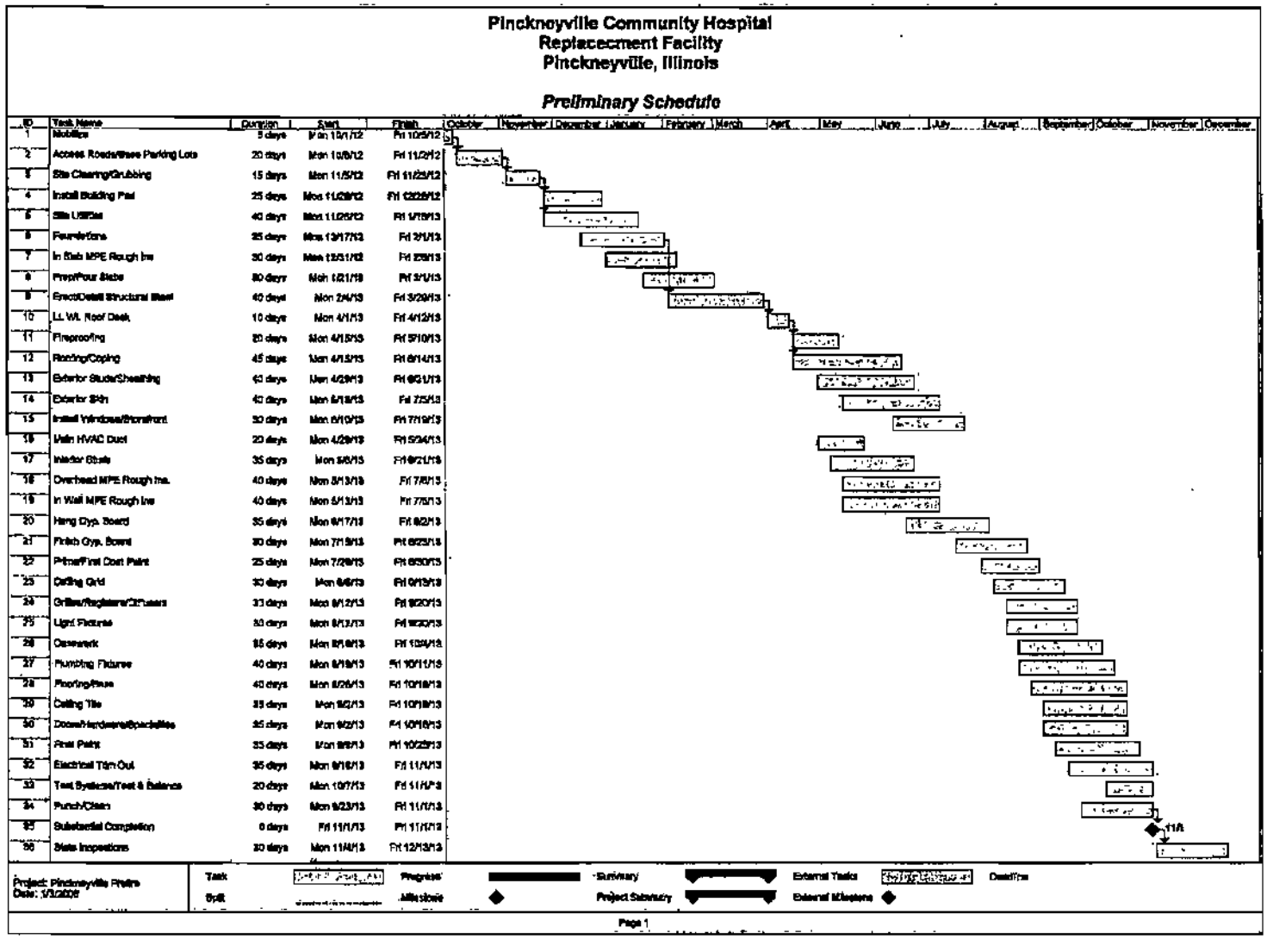
PCH 80C 11/19/2009 12:00:11 PM 123

ATTACHMENT-13
PROJECT SCOPE - SIZE


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


LEGEND
PHARMACY
MAINTENANCE
POWERHOUSE
MATERIALS MANAGEMENT
ENVIRONMENTAL SERVICES
DIETARY
ADMINISTRATION
MEDICAL RECORDS
ONCOLOGY
PRELIMINARY NOT FOR CONSTRUCTION
CON 4


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

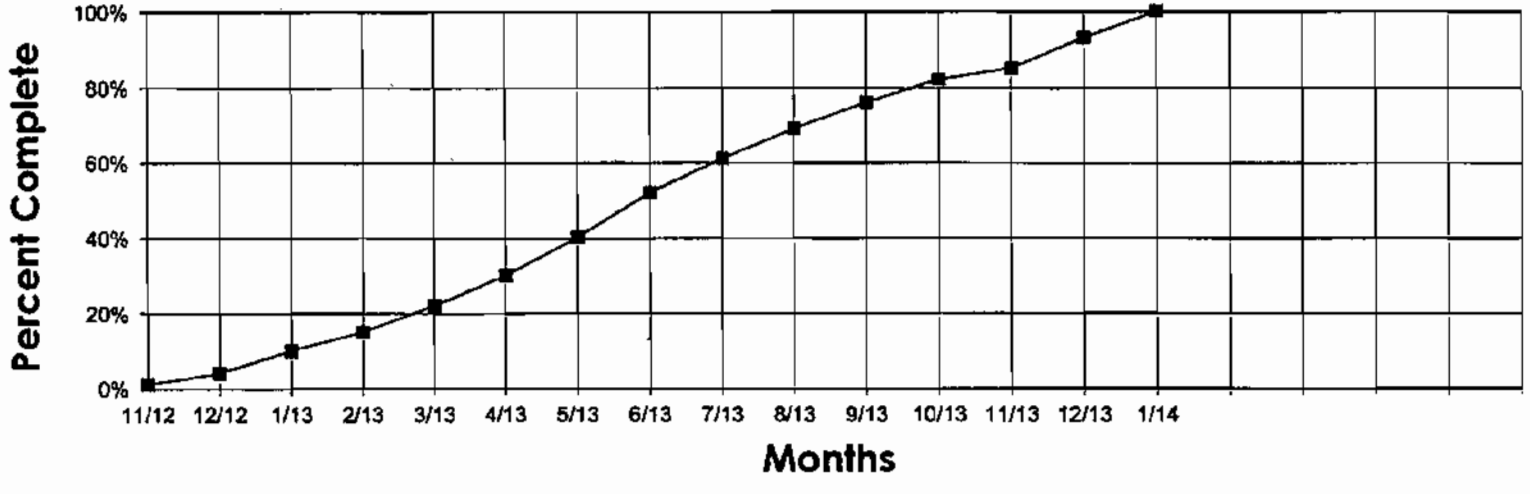

Pinckneyville Community Hospital
Replacement Facility
Pinckneyville, Illinois
Preliminary Schedule
Project: Pinckneyville Prelim
Date: 1/1/2009
Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline
Page 1

ROBINS & MORTON

PROJECTED CASH FLOW

PINCKNEYVILLE MEDICAL CENTER

Pinckneyville, Illinois



	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
Monthly Billing	$253,533.00	$760,600.00	$1,521,201.00	$1,267,667.00	$1,774,734.00	$2,028,268.00	$2,535,335.00	$3,042,401.00
Cumulative	$253,533.00	$1,014,133.00	$2,535,334.00	$3,803,001.00	$5,577,735.00	$7,606,003.00	$10,141,338.00	$13,183,739.00
Percent of Total	1%	4%	10%	15%	22%	30%	40%	52%

	7/13	8/13	9/13	10/13	11/13	12/13	1/14
Monthly Billing	$2,281,801.00	$2,028,268.00	$1,774,734.00	$1,521,201.00	$760,600.00	$2,028,268.00	$1,774,734.00
Cumulative	$15,465,540.00	$17,493,808.00	$19,268,542.00	$20,789,743.00	$21,550,343.00	$23,578,611.00	$25,353,345.00
Percent of Total	61%	69%	76%	82%	85%	93%	100%

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

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

PROJECT SERVICES UTILIZATION:

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

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

	UTILIZATION				
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, 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:

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.

Criterion 1110.234

Project Services Utilization

Attachment 15, Exhibit 1 profiles key clinical service utilization for the period 2006 through 2011. The financial feasibility study which is in development will document future projected utilization; that said, current utilization justifies the following replacement components.

Department / Service	Rooms / Units	Current Utilization		State Standard		Met Standard
M/S Beds	17	2,395	Patient Days	3,723		No [1]
General Radiology (R/F)	2	16,000	Procedures	4,469		No [2]
Mammography	1	505	Visits	5,000		Yes
Ultrasound	1	1,230	Visits	3,100		Yes
Nuclear	1	309	Visits	2,000		Yes
CT	1	1,443	Visits	7,000		Yes
MRI (Mobile)	1	451	Procedures	2,500		Yes
Emergency	5	2,000		3,541		No [3]
Surgical Rooms	2	436	Cases	--		
		392	Hours	1,500	hours	No [4]

Notes: [1.] The peak utilization (2011 ADC) justifies 19 beds @ 60 percent occupancy

[2.] Two rooms are needed for back-up if one is being serviced.

[3.] As noted in the original permit application, additional rooms are required for peak periods.

[4.] Two rooms are needed for peak / back-up.

See also Attachment 15, Exhibit 2 for Key Utilization Trends

Exhibit U.1
2006 Through 2011 CY Utilization Trends
Pinckneyville Community Hospital

Clinical Service	2006	2007	2008	2009	2010	2011	Change
Inpatient Admissions (excludes LTC)	1,059	873	691	581	543	498	(561)
Patient Days (including observation)	6,173	4,884	3,928	3,008	2,542	2,395	(3,778)
Average Daily Census	16.9	13.4	10.8	8.2	7.0	6.6	(10.3)
Peak M/S Census	14 (?)	15	14	12	10	11	(3)
Surgical Cases	490	466	416	472	443	436	(54)
Surgical Hours	316	602	488	572	521	392	76
ED Visits	3,688	3,649	3,494	3,637	3,431	3,541	(147)
Admissions from ED	515	458	411	340	323	323	(192)
Percent ED Admissions	48.6%	52.5%	59.5%	58.5%	59.5%	64.9%	--
Outpatient Visits	23,804	40,898	39,995	39,858	39,950	40,535	16,731
Imaging (Total)							
R/F	6,701	5,467	5,346	4,378	4,532	4,469	(2,232)
Nuclear	1,206	1,128	756	697	280	309	(897)
Mammography	774	839	747	605	522	505	(269)
Ultrasound	1,935	1,685	1,677	1,536	1,238	1,230	(705)
CT	1,869	1,948	1,680	1,911	2,033	1,443	(426)
MRI (Mobile)	61	433	448	431	456	451	390
Laboratory Studies	67,799	68,974	64,638	62,224	61,506	61,187	(6,612)

Source: IDPH Annual Hospital Questionnaires for years as noted; 2011 Data is from survey data

SECTION VII - 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. 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
☒ **Medical/Surgical**	**25**	**17**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

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	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X
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	X
APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.				

Section VIII Service Specific Review Criteria

Criterion 1110.530 Medical / Surgical (MS)

Pinckneyville Community Hospital has been designated an essential community provider and is categorized as a Critical Access Hospital (CAH). The original permit application contained a comprehensive market analysis which was reviewed as a basis for this Permit Alteration. The analysis findings and observations remain essentially the same and are being revised as one component of the forthcoming financial feasibility study. The following modifications pertain to this alteration permit:

1. The proposed number of beds has been reduced from 25 to 17 (Attachment 20, Exhibit 1) due to both capital financing considerations and recent utilization trends (see also Attachment 15, Exhibit 2). Current and expected utilization is more consistent with the need for 17 beds although the current peak census of 11 ADC justifies 18 to 19 MS beds @ 60 percent occupancy.
2. There remains an excess of M/S beds in Planning Area F-07. The original permit identified 108 excess M/S beds; the current calculated excess is 105 M/S beds (Attachment 20, Exhibit 2). As an essential community CAH provider, Pinckneyville continues to be essential to provide healthcare services to its market area as was documented in the original permit application.

3. Attachment 20, Exhibit 3 profiles the Hospital's patient origin trends for the period 2009 through 2011. The respective market area and discharges are consistent with the original permit application; albeit there has been a decrease in utilization over the period 2006 through 2011 (see also Attachment 15, Exhibit 2) due, in part, to the need to replace the current hospital facility. It should be noted outpatient visits have increased by 16,731 from 2006 to 2011 due, in part, to the shift to an ambulatory care delivery model.

4. Historically, the Hospital's market share in the combined PSA / SSA ranged from 22.9 percent in 2004 to 17.6 percent in 2008. Attachment 20, Exhibit 4 indicates the current market share ranges from 12.9 percent to 15.1 percent in the period 2009 through 2011. A new replacement facility is expected to reverse recent utilization declines as market share due to technological advancements, quality, comfort, and family-oriented care delivery in a contemporary hospital setting.

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

3. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☒ **Medical/Surgical**	**25**	**17**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

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	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X

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	**17**	**105 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

* The May 17, 2012 Addendum to Inventory of Health Care Facilities (IDPH) indicates an excess of 105 M/S beds in planning area F-07. Pinckneyville has been designated a critical access essential community provider. The Hospital's peak bed census in 2011 was 11 and at a 60 percent utilization rate can justify 19 beds … 17 beds are proposed.

Exhibit SA.1
Historic Patient Origin Discharges
Pinckneyville Community Hospital

Service Area	Zip Code	City	2009			2010			2011		
			PCH	Other	Total	PCH	Other	Total	PCH	Other	Total
Primary	62274	Pinckneyville	284	454	738	286	434	720	236	466	702
Secondary	62237	Coulterville	14	383	397	15	312	327	25	352	377
	62238	Cutler	18	86	104	12	74	86	10	75	85
	62268	Oakdale	5	41	46	10	48	58	4	44	48
	62832	DuQoin	47	1,138	1,185	29	1,212	1,241	46	1,219	1,265
	62888	Tamaroa	46	170	216	37	184	221	33	161	194
	62997	Willisville	3	81	84	6	65	71	1	71	72
Subtotal SSA			133	1,899	2,032	109	1,895	2,004	119	1,922	2,041
Subtotal PSA / SSA			417	2,353	2,770	395	2,329	2,724	355	2,388	2,743
Other		--	55	--	--	48	--	--	81	--	--
Total		--	472	--	--	443	--	--	436	--	--

Pinckneyville Discharges (Percent Distribution)	2009	2010	2011
Primary (PSA)	60.2%	64.6%	54.0%
Secondary (SSA)	28.2%	24.6%	27.4%
PSA / SSA Subtotal	88.4%	89.2%	81.4%
Other Zipcodes	11.6%	10.8%	18.6%
Total	100.0%	100.0%	100.0%

Source: CompData and IDPH Annual Questionnaire (AHQ)

* Resident discharges to other Illinois hospitals; measure of outmigration from respective zipcode

Exhibit SA.2
Market Share Based on Patient Origin / Discharge Analysis
Pinckneyville Community Hospital

Service Area	Zip Code	City	2009			2010			2011		
			PCH	Other	Total	PCH	Other	Total	PCH	Other	Total
Primary	62274	Pinckneyville	38.5%	61.5%	100.0%	39.7%	60.3%	100.0%	33.6%	66.4%	100.0%
Secondary	62237	Coulterville	3.6%	96.5%	100.0%	4.6%	95.4%	100.0%	6.6%	93.4%	100.0%
	62238	Cutler	17.3%	82.7%	100.0%	14.0%	86.0%	100.0%	11.8%	88.2%	100.0%
	62268	Oakdale	10.9%	89.1%	100.0%	17.2%	82.9%	100.0%	8.3%	91.7%	100.0%
	62832	DuQoin	4.0%	96.0%	100.0%	2.3%	97.7%	100.0%	3.6%	96.4%	100.0%
	62888	Tamaroa	21.3%	78.7%	100.0%	16.7%	83.3%	100.0%	17.0%	83.0%	100.0%
	62997	Willisville	3.6%	96.4%	100.0%	8.5%	91.5%	100.0%	1.4%	98.6%	100.0%
Subtotal SSA / Average			6.5%	93.5%	100.0%	5.4%	94.6%	100.0%	5.8%	94.2%	100.0%
Subtotal PSA / SSA			15.1%	84.9%	100.0%	14.5%	85.5%	100.0%	12.9%	87.1%	100.0%

Source: CompData and IDPH Annual Questionnaire (AHQ)
* Resident discharges to other Illinois hospitals; measure of outmigration from respective zipcode

Pinckneyville Community Hospital District d.b.a. Pinckneyville Community Hospital is a Critical Access Hospital (CAH) which is deemed a necessary provider of health services by IDPH.

Multiple analyses have demonstrated the market necessity, need, and feasibility of replacing the Hospital on a new campus 1.8 miles east of the existing site.

The original permit application financing was based on a HUD-242 mortgage commitment. At that time, the financial markets were stable, and HUD indicated a probable commitment to fund the replacement hospital development. In the meantime, the instability in the financial markets, the tightening of credit, and uncertainties associated with the various proposed health reform initiatives led HUD to deny their expected project financing. Hence, the need to secure another financing source for the replacement hospital project

Pinckneyville has explored several conventional financing options; but, given health reform uncertainty and the financial markets tightening of credit, financing has not occurred. Most recently, the USDA indicated the potential of a Rural Development Community Facilities loan. This potential has the support of Sen. Richard J. Durbin (Attachment 39, Exhibit 1). In addition, Wipfli, LLP, the Hospital's current auditors, prepared a Debt Capacity Study (Attachment 39, Exhibit 2) indicating Pinckneyville could support a minimum $22,700,000 of long-term debt. This level of debt is indicated in Attachments 7 and 39.

At present, Wipfli, LLP is completing a financial feasibility study / Financial Forecast. This analysis is expected to be completed in the near future and is required for both this Alteration Permit submission and a formal USDA loan application. Both a valid CON permit and USDA loan are necessary for a viable project. The Wipfli, LLP report will be forthcoming; hopefully before July 1, 2012.

In general, the USDA review schedule is as follows:

Task	Completion Date
Completion and submission of final feasibility study (Financial Forecast)	August 1, 2012
USDA Review	September 1, 2012
IHFSRB Alteration Permit Approval	September 11, 2012
Full USDA Application Invitation	September 15, 2012
Submit USDA Loan Application	October 1, 2012
USDA Field Office Review / Approval	November 1, 2012
National USDA Review / Approval	December 1, 2012
Funding and Interest Rate "lock"	December 1, 2012
Anticipated closing assuming project approval and federal financing	January 15 to February 1, 2013
Project Obligation (IHFSRB)	To follow

This situation poses a dilemma which must be resolved in the CON permitting process;

There are several issues.

1. The required financial feasibility study is not yet complete, but will be submitted to the State Agency, hopefully in draft form no later than July 1, 2012 with a final document submitted during the review process.

2. The current project obligation date expires prior to a potential USDA loan commitment. Thus, the extraordinary request before the State Agency to extend the current obligation date by 6-months to secure USDA funding and obligate the project.

3. The need for an approved Alteration Permit to fulfill USDA requirements.

Pinckneyville looks forward to working with the State Agency to resolve these schedule conflicts. If they cannot be resolved, the original permit will expire in that current obligation date is prior to a potential USDA loan commitment.

The original draft and final financial feasibility study developed by McGladry and Pullen (Attachment 75 in the original application) demonstrated the financial feasibility to successfully develop a $46,624,405 project. The revised project cost in this Alteration Permit is $31,187,575 and, given the respective sources and uses of funds, appears feasible based on Wipfli's more recent debt capacity analysis (Attachment 39, Exhibit 6). In addition, Wipfli reviewed McGladry's original Financial Forecast and agreed it was developed in compliance with AICPA standards (Attachment 42).

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$8,142,575	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$22,700,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
$345,000	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$31,187,575	**TOTAL FUNDS AVAILABLE**	

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

* Cash and securities include land purchase per USDA project format, depreciation, and earnings… See Financial feasibility and debt capacity analysis.

RICHARD J. DURBIN

ILLINOIS

ASSISTANT MAJORITY LEADER

United States Senate

Washington, DC 20510–1304

COMMITTEE ON APPROPRIATIONS

COMMITTEE ON FOREIGN RELATIONS

COMMITTEE ON THE JUDICIARY

COMMITTEE ON RULES AND ADMINISTRATION

April 25, 2012

Marsha Gajewski
USDA Service Center
221 Withers Drive
Mount Vernon, IL 62864

To Whom It May Concern:

I am writing in support of Pinckneyville Community Hospital's application to the United States Department of Agriculture Rural Development Community Facilities Loan Program.

Pinckneyville Community Hospital is a local hospital located in Pinckneyville, Illinois providing healthcare services to a broad area of rural Southern Illinois. Since 2003, the hospital has been pursuing construction of a replacement hospital with which to serve the community.

Pinckneyville Community Hospital's current facilities are not adequate to serve their community. A number of infrastructure challenges have been found in buildings ranging from 35 to 45 years old and the cost of repairing the current site would be greater than the cost of constructing a new, updated hospital. Also, the construction of a new hospital would avoid disruption to their current services that would occur during renovations.

Presently, Pinckneyville Community Hospital is the second largest employer in the region, providing over 200 individuals with employment. Further, the construction of a new facility and the increase in use of the hospital would provide more employment opportunities for individuals. At a time when jobs are scarce, this would be greatly beneficial to the economy in Southern Illinois.

I strongly support Pinckneyville Community Hospital's application to the USDA Rural Development Community Facilities Loan Program and I urge the USDA to give their application the most serious consideration.

Sincerely,

Richard J. Durbin
United States Senator

RJD/ddw

711 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510–1304
(202) 224–2152
TTY (202) 224–8180

230 SOUTH DEARBORN, 38TH FLOOR
CHICAGO, IL 60604
(312) 353–4952

525 SOUTH EIGHTH STREET
SPRINGFIELD, IL 62703
(217) 492–4062

1504 THIRD AVENUE
SUITE 227
ROCK ISLAND, IL 61201
(309) 786–5173

PAUL SIMON FEDERAL BUILDING
250 W. CHERRY STREET
SUITE 115–D
CARBONDALE, IL 62901
(618) 351–1122

durbin.senate.gov

Pinckneyville Community Hospital District

Pinckneyville, Illinois

Debt Capacity Study

March 26, 2012

WIPFLi
CPAs and Consultants

Wipfli LLP
10000 Innovation Drive
Suite 250
Milwaukee, WI 53226
414.431.9300
fax 414 431.9303
www.wipfli.com

March 26, 2012

Board of Directors
Pinckneyville Community Hospital District and
Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, Illinois

An analysis of the approximate amount of debt that Pinckneyville Community Hospital District (PCH) could reasonably support was conducted. The analysis was based on the historical results of PCH and certain assumptions made by management about future operating results, and was done for planning purposes only. There will be differences between this analysis and actual results, because events and circumstances do not occur as expected, and those differences could be significant.

Historical audited financial statements and the year to date internal financial statements for the nine-month period May 1, 2011 through January 31, 2012 were used to establish historical trends and baseline performance. The fiscal years 2013 and 2014 were assumed to include the construction and move-in period, with the new facility occupied by April 1, 2014. Accordingly, the first full year of debt service is assumed to occur in the fiscal year ending April 30, 2015. Financial assessments through the fiscal year ending April 30, 2019 were used to evaluate performance over time.

The following represent the specific key assumptions used by management to estimate the debt capacity of PCH:

<u>Revenue Assumptions:</u>

- The current payor mix, which has been relatively consistent over the past several years, was assumed to remain the same.
- Net revenues were assumed to increase at 3% annually to reflect inflationary rate increases from third-party payors. No volume growth was assumed.

- Bad debt and charity were assumed to remain at 2011 levels of 4.5% of gross revenue.
- Other operating revenue was assumed to decrease in 2013 to reflect the discontinuation of certain services, and then assumed to be flat over the period assessed.
- Assumed that PCH will continue to be reimbursed for capital expenditures as a Critical Access Hospital (CAH) under Medicare at the current rate of 46% of interest and depreciation.

Expense Assumptions:

- Salaries were assumed to increase at 3% annually except for a 4% increase in 2014 to account for overtime in planning and assisting with the move to the new facility.
- Employee benefits were assumed to remain at historical levels of between 29% and 30% of salaries.
- Supplies, purchased services, and professional fees were assumed to increase 4% annually.
- Repairs and maintenance, which includes certain service contracts, including IT services, were assumed to increase 5% annually.
- Rental and lease expense was assumed to increase at 1% annually.
- Utilities were assumed to increase over historical levels at 6% per year during the construction period to account for additional costs due to project, and then to increase 4% annually post-construction.

Project & Financing Assumptions:

- Assumed that PCH will first use internal funds, including an existing funded depreciation account and $500,000 from their short-term investments, then utilize a construction loan, to fund construction.
- During construction, PCH will draw the project funds from the construction loan as needed, thus only incurring interest on the outstanding balance of the draws. The construction loan interest rate is assumed to be 3.375% with the interest payments funded from hospital operations.
- After the new building opens, it is assumed that $100,000 annually will be set-aside to replenish the funded depreciation.
- It is assumed that PCH will receive an Illinois Capital Grant in the amount of $345,000 to partially fund the project.
- PCH will renew its existing property tax levy in the amount of $85,000 per year to partially fund debt service.
- The existing debt service reserve fund will be used to retire all existing debt prior to the start of fiscal 2015.

- The debt associated with the project will be financed with a loan under the USDA Rural Development Community Facilities Direct Loan program. It is assumed the current rate available under that program, which is a fixed rate of 3.375%, will be the interest rate on the loan. The debt is assumed to be amortized over 40 years.

Summary:

Based on management's assumptions detailed above, PCH could support $22,700,000 of long-term debt with a fixed interest rate of 3.375% and an amortization period of 40 years. This long-term debt, in addition to other sources of funds, including the existing funded depreciation, existing cash reserves, and an Illinois Capital Grant would allow PCH to support total project costs of up to $27,600,000.

This analysis was limited to evaluating the assumptions provided by management and did not include any evaluation of the support for those assumptions. Wipfli conducted this engagement in accordance with consulting standards established by the American Institute of Certified Public Accountants, accordingly, we do not express an opinion or any other assurance on the results of the analysis.

Sincerely,

Wipfli LLP

Wipfli LLP

From: Jones, Don F. [mailto:Don.Jones@Illinois.gov]
Sent: Wednesday, April 11, 2012 2:57 PM
To: Tom Hudgins
Subject: Grant Agreement

Dear Mr. Hudgins:
Attached is a signed grant agreement between your hospital and the Department in connection with the Hospital Capital Investment program. The next step is for the Department to voucher a payment to the Illinois Comptroller's Office in order for grant funds to be disbursed. I will notify you as soon as I receive confirmation from our accounting unit that this has been completed.
Please contact me should you have any questions.
Sincerely,
Donald Jones, Grants Administrator
Illinois Department of Public Health - Center for Rural Health
535 West Jefferson Street, Ground Floor
Springfield, Illinois 62761-0001
217-782-1624
217-782-2547 (fax)
don.jones@illinois.gov
www.idph.state.il.us

Illinois Department of PUBLIC HEALTH

Fiscal Year: 2012

Contract # 22580321
Appropriation# 971-48210-4400-0010
Federal Grant # N/A

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH

Grant Agreement

The Illinois Department of Public Health or its successor, hereinafter referred to as the "Department" and Pinckneyville Community Hospital hereinafter referred to as the "Grantee", hereby agree as follows:

1. **Authority**:

1.1 The Department is authorized to make this grant pursuant to Section 2310-640 of the Department of Public Health Powers and Duties Law, 20 ILCS 2310-640.

1.2 The sole purpose of this grant is to fund the Grantee's performance of the obligations described herein during the term of this grant. This Hospital Capital Investment Grant may be used only to fund capital projects including to satisfy any building code, safety standard or life safety code, maintain, improve, renovate, expand or construct buildings or structures, maintain, establish or improve medical equipment or health information technology or to maintain or improve patient safety, quality of care or access to care.

1.3 The Grantee represents and warrants that the grant application submitted by the Grantee is in all material aspects true and accurate; that it is authorized to undertake the obligations set forth in this Agreement and that it has obtained or will obtain all permits, licenses or other governmental approvals that may be necessary to perform the grant services.

2. **Services**:

2.1 The Grantee will perform the following obligations and agrees to act in compliance with all state and federal statutes and administrative rules applicable to the provision of this scope of work pursuant to this grant agreement. The grant application submitted by Grantee related to this grant agreement and on file with the Department is hereby incorporated and made a part of this agreement.

2.1.1 The Grantee agrees to undertake the following obligations that will encompass hospital-wide capital projects to address life safety code issues, improve and renovate patient care areas, establish and improve health information technology ("IT") and improve patient safety, quality of care and access to care. For this grant agreement, the scope of work includes the following projects or components thereof:

a. Installation of a new propane tank and
b. Replace roof on the 1976 hospital wing and on the rural health clinic building.

2.2 The Grantee will not use the services of a subcontractor or subgrantee to fulfill any obligations under this agreement without the prior written consent of the Department. All subgrantees shall have an application, including a budget and project deliverables, on file with the grantee and the Department prior to the issuance of any written consent. The Department reserves the right to review all subcontracts and subgrants.

2.3 In connection with the services described in Section 2.1 above, the Department will:

2.3.1 Compensate the Grantee as provided for in Section 4.3 of this agreement.

3. Term:

The period of this grant agreement is July 1, 2011 through June 30, 2013; however, it may be terminated at any time during this period by either party upon written notice to the other party thirty (30) calendar days prior to the actual termination date. Upon termination, the Grantee shall be paid for work satisfactorily completed prior to the date of termination.

4. Compensation:

4.1 The grant funds shall be for an amount of $345,040.00.

4.2 This grant is State funded.

4.3 Upon execution of this Agreement, the Department shall authorize an initial disbursement in the amount of fifty percent (50%) of the total grant award. The balance of the grant award will be paid no earlier than six months from the date the grant agreement is executed.

4.4 The Grantee will perform its obligations in accordance with the budget and scope of work submitted in the grant application and which is on file with the Department.

4.5 Grantee, through its agents, employees and contractors, will provide all equipment, supplies, services and other items of support which are necessary for the effective performance of the obligations, unless the agreement specifically set forth items of support to be provided by the Department.

4.6 Grantee and any subgrantees shall not, in accordance with P.A. 096-1456, expend any grant funds paid from the State of Illinois General Revenue Funds for the following promotional items: calendars, pens, buttons, pins, magnets, and any other similar promotional items. Promotional items also include but are not limited to: gift cards, posters, and stationery.

4.7 Expenditure of Grant Funds; Right to Refund

Payment of the grant amount specified in Section 4.1 shall be made to the Grantee as specified herein. Grant funds provided under this Agreement must be expended only to perform the tasks set forth in Section 2.1 of this agreement and the grant application on file with the Department. In addition to reasons set forth in other sections of this agreement, the Department will require a refund from Grantee if (i) the total grant expenditures are less than the amount vouchered to the Grantee from the Department pursuant to this agreement; or (ii) Grant funds have not been expended or legally obligated by a binding contractual obligation within the grant term. If the Department requires a refund under either of the above circumstances, the Grant funds must be returned to the Department within forty-five (45) days of the end of the grant term or the otherwise effective grant agreement termination date.

4.8 Grant Funds Recovery Act (30 ILCS 705/1, et seq.)

This Agreement is subject to all applicable provisions of the Illinois Grant Funds Recovery Act, including the requirement that any Grant Funds not expended or legally obligated at the expiration or termination of the Grant term must be returned to the Department within forty-five (45) days following said expiration or termination. Any interest earned on Grant Funds that is not expended or legally obligated during the Grant term must also be returned to the Department within forty-five (45) days following the expiration or termination of this Agreement. Grantee's failure to comply with any reporting requirements of the Department may result in the termination of this agreement or suspension of payments under this agreement.

5. Notices:

Notices and other communications provided for herein shall be given in writing by registered or certified mail, return receipt requested, by receipted hand delivery, by courier (UPS, Federal Express or other similar and reliable carrier), by e-mail, or by fax showing the date and time of successful receipt. Notices shall be sent to the individuals at the following respective addresses or to such other address as either party may from time to time designate by notice to the other party. Each such notice shall be deemed to have been provided at the time it was actually received. By giving notice, either Party may change the contact information.

to the Department: Illinois Department of Public Health
Center for Rural Health
535 West Jefferson Street, Ground Floor
Springfield, Illinois 62761
Attention: William Dart II

to the Grantee: Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, Illinois 62274
Attention: Thomas Hudgins

6. Public Information Requirements:

For the duration of the Agreement, the Grantee will prominently acknowledge the participation of the Department in the Project in all press releases, publications and promotional materials presented to the media or otherwise dissemination published concerning the Project. The Grantee must provide the Department with copies of any proposed press releases, publications and promotional materials not less than fifteen (15) days before these materials are disseminated. Grantee will submit copies of any press releases, publications and promotional materials to the Department's Project Manager. The Grantee shall not publish, disseminate or otherwise release any promotional materials without the express written approval by the Department.

The Grantee will provide adequate advance notice pursuant to Section 5 of promotional events such as open houses, dedications, or other planned publicity events; and will also coordinate in the planning of said events. Any materials or displays to be distributed in connection with the promotional event must be submitted to the Department in advance of publication or dissemination and must prominently acknowledge the Department's participation in the event.

7. Grant Fund Control Requirements:

7.1 Audits

A. Standard Audit: If the Grantee is required to obtain a Standard Audit and provide the Department with a copy of the audit report, the management letter, and the SAS 114 letter within thirty (30) days of the Grantee's receipt of such audit report, but in no event later than nine (9) months following the end of the period for which the audit was performed. The Audit Report is required to be provided to IDPH annually for the life of the grant.

B. Single Audit: If the Grantee is required to have a Single Audit performed in accordance with OMB Circular A-133, the Grantee is required to submit copies of the audit report, the data collection form, the management letter, and the SAS 114 letter, as provided for the in the Single Audit Act and OMB Circular A-133, to the Department within thirty (30) days of the Grantee's receipt of such audit report, but in event later than nine (9) months following the end of the period for which the audit was performed. If no Single Audit is required, the Grantee is to provide IDPH with an annual letter stating a Single Audit was not required.

C. Audit Requirements for State Grants Audited by the Illinois Office of the Auditor General (OAG): Grantees required by the Illinois OAG to obtain a financial audit, compliance examination, or performance audit will be notified by the OAG. The Grantee shall provide the Department with a copy of any financial audit, compliance examination, Single Audit or performance audit along with the accompanying management letter, letter of immaterial findings and the SAS 114 letter within thirty (30) days of the Grantee's receipt of such audit report, but in no event later than nine (9) months following the end of the period for which the audit or examination was performed. The Audit Report is required to be provided to IDPH any year an audit is performed over the life of the grant.

D. Discretionary Audit: The Department may, at any time, and its discretion, request a Grant-Specific Audit or other audit, Management Letter and SAS 114 letter to be delivered within thirty (30) days of the Grantee's receipt of such audit report, but in no event later than nine (9) months following the end of the period for which the audit was performed.

E. Audit Performance: All Audits shall be performed by an independent certified public accountant or accounting firm licensed by the appropriate licensing body in accordance with applicable auditing standards. The grantee will fully comply and cooperate with any and all audits.

7.2 Reporting Requirements

In addition to any other documents specified in this Agreement, the Grantee must submit the following reports and information in accordance with the provisions hereof.

A. At a minimum, the grantee shall file a quarterly report with the Department. The quarterly reports shall describe the progress of the program, project, or use and the expenditure of the grant funds provided to the grantee under this Agreement. The Department reserves the right to request revised quarterly reports or clarification to any statements made in such reports.

B. Expenditures and Project Activity Prior to Grant Execution. If the Agreement is executed more than ninety (90) days after the beginning date of the grant term provided in grant agreement, the Grantee must submit a Financial Status Report and a Project Status Report, in a format provided by the Department, accounting for expenditures and project activity incurred from the beginning of the grant term up to the end of the month preceding the date of the Department's execution. If these Reports are required, the Department will not disburse any Grant Funds until the report is submitted to and approved by the Department.

C. Final Financial Status Report The Final Financial Status Report is due within forty-five (45) days following the end date stated in the Notice of Grant Award. **The Grantee should refer to the Grant Instruction Package and the Reports Deliverable Schedule for the specific reporting requirements and due dates.** Grantee must submit the report in the format provided by the Department. This report must summarize expenditure of the Grant Funds and activities completed during the grant term. The Grantee's failure to comply with the this requirement will be considered a material breach of the performance required by this Agreement and may be the basis to initiate proceedings to recover all Grant Funds disbursed to the Grantee. Grantee's failure to comply with this Section shall be considered prima facie evidence of default, and may be admitted as such, without further proof, into evidence before the Department or in any other legal proceeding.

1. Additional Information: Upon request by the Department, the Grantee must, within the time directed by the Department, submit additional written reports regarding the Project, including, but not limited to materials sufficient to document information provided by the Grantee.

2. Submittal of Reports: Submittal of all reports and documentation required under this Agreement should be submitted to the individual as directed by the Department.

3. Failure to Submit Report: In the event Grantee fails to timely submit any reports required under this Agreement, the Department withhold or suspend the distribution of Grant Funds until said reports are filed and approved by the Department.

7.3 Grant Instructions

Upon execution of this Grant Agreement, the Grantee will receive a grant instruction package detailing reporting requirements and procedures relating to the Grant. The Grantee is obligated to comply with those requirements and any revisions thereto in accordance with Section 7.2(C) of this Grant Agreement.

7.4 Fiscal Recording Requirements

The Grantee's financial management system shall be structured to provide for accurate, current, and complete disclosure of the financial results of the Project funded under this grant program. The Grantee is accountable for all Grant Funds received under this Grant, including those expended for subgrantees. The Grantee shall maintain effective control and accountability over all Grant Funds, equipment, property, and other assets under the grant as required by the Department. The Grantee shall keep records sufficient to permit the tracing of Grant Funds to a level of expenditure adequate to insure that Grant Funds have not been inappropriately expended, and must have internal controls consistent with generally accepted accounting practices adopted by the American Institute of Certified Public Accountants.

7.5 Due Diligence in Expenditure of Grant Funds

Grantee shall ensure that Grant Funds are expended in accordance with the following principles: (i) grant expenditures should be made in accordance with generally accepted sound, business practices, arms-length bargaining, applicable federal and state laws and regulations; (ii) grant expenditures should conform to the terms and conditions of this Agreement; (iii) grant expenditures should not exceed the amount that would be incurred by a prudent person under the circumstances prevailing at the time the decision is made to incur the costs; and (iv) grant accounting should be consistent with generally accepted accounting principles.

7.6 Monitoring

The grant will be monitored for compliance in accordance with the terms and conditions of the Grant Agreement, together with appropriate programmatic rules, regulations, and/or guidelines that the Department promulgates or implements. The Grantee must permit any agent authorized by the Department, upon presentation of credentials, in accordance by all methods available by law, including full access to and the right to examine any documents, equipment, papers, or records either in hard copy or electronic, of the Grantee involving transactions relating to this grant.

8. General Provisions:

8.1 Availability of Appropriation/Sufficiency of Funds

This grant is contingent upon and subject to the availability of funds. The Department, at its sole option, may terminate or suspend this grant, in whole or in part, without penalty or further payment being required, if (1) the Illinois General Assembly fails to make an appropriation sufficient to pay such obligation, or if funds needed are insufficient for any reason, (2) the Governor decreases the Department's funding by reserving some or all of the Department's appropriation(s) pursuant to power delegated to the Governor by the Illinois General Assembly; or (3) the Department determines, in its sole discretion or as directed by the Office of the Governor, that a reduction is necessary or advisable based upon actual or projected budgetary

considerations. The Grantee will be notified in writing of the failure of appropriation or a reduction or decrease.

8.2 **Audit/Retention of Records (30 ILCS 500/20-65)**

Grantee and its subcontractors shall maintain books and records relating to the performance of the agreement or subcontract and necessary to support amounts charged to the State under the agreement or subcontract. Books and records, including information stored in databases or other computer systems, shall be maintained by the Grantee for a period of three (3) years from the later of the date of final payment under the agreement or completion of the agreement, and by the subcontractor for a period of three (3) years from the later of final payment under the term or completion of the subcontract. If federal funds are used to pay agreement costs, the Grantee and its subcontractors must retain its records for five (5) years. Books and records required to be maintained under this section shall be available for review or audit by representatives of: the granting Agency, the Auditor General, the Attorney General, the Executive Inspector General, the Chief Procurement Officer, State of Illinois internal auditors or other governmental entities with monitoring authority, upon reasonable notice and during normal business hours. Grantee and its subcontractors shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain books and records required by this section shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the agreement for which adequate books and records are not available to support the purported disbursement. The Grantee or subcontractors shall not impose a charge for audit or examination of the Grantee's books and records.

If any of the services to be performed under this Agreement are subcontracted and/or if subgrants are issued/awarded for the expenditure of Grant Funds provided under this Agreement, the Grantee shall include in all such subcontractors and subgrants, a provision that the Department, the Attorney General, the Office of Inspector General, and the Auditor General of the State of Illinois, or any of their duly authorized representatives, will have full access to and the right to examine any pertinent books, documents, papers and records of any such subcontractor or subgrantee involving transactions related to this Agreement for a period of three (3) years following the Department's final approval of all required close-outs (financial and/or programmatic), and any such subcontractor shall be governed by the same requirements to which the Grantee is subject under this Agreement.

8.3 **Time is of the Essence**

Time is of the essence with respect to Grantee's performance of this agreement. Grantee shall continue to perform its obligations while any dispute concerning the agreement is being resolved unless otherwise directed by the State.

8.4 **No Waiver of Rights**

Except as specifically waived in writing, failure by a Party to exercise or enforce a right does not waive that Party's right to exercise or enforce that or other rights in the future.

8.5 **Force Majeure**

Failure by either Party to perform its duties and obligations will be excused by unforeseeable circumstances beyond its reasonable control and not due to its negligence including acts of nature, acts of terrorism, riots, labor disputes, fire, flood, explosion, and governmental prohibition. The non-declaring Party may cancel the agreement without penalty if performance does not resume within thirty (30) days of the declaration.

8.6 **Confidential Information**

Each Party, including its agents and subgrantors, to this agreement may have or gain access to confidential data or information owned or maintained by the other Party in the course of carrying out its responsibilities under this agreement. Grantee shall presume all information received from the State or to which it gains access pursuant to this agreement is confidential. Grantee information, unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the agreement shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the period of the agreement or thereafter. The receiving Party must return any and all data collected, maintained, created or used in the course of the performance of the agreement, in whatever form it is maintained, promptly at the end of the agreement, or earlier at the request of the disclosing Party, or notify the disclosing Party in writing of its destruction. The foregoing obligations shall not apply to confidential data or information lawfully in the receiving Party's possession prior to its acquisition from the disclosing Party; received in good faith from a third-party not subject to any confidentiality obligation to the disclosing Party; now is or later becomes publicly known through no breach of confidentiality obligation by the receiving Party; or is independently developed by the receiving Party without the use or benefit of the disclosing Party's confidential information.

8.7 **Use and Ownership**

All work performed or supplies created by Grantee under this agreement, whether written documents or data, goods or deliverables of any kind, shall be deemed work for hire under copyright law and all intellectual property and other laws, and the State of Illinois is granted sole and exclusive ownership to all such work, unless otherwise agreed in writing. Grantee hereby assigns to the State all right, title, and interest in and to such work including any related intellectual property rights, and/or waives any and all claims that Grantee may have to such work including any so called "moral rights" in connection with the work. Grantee acknowledges the State may use the work product for any purpose. Confidential data or information contained in such work shall be subject to confidentiality provisions of this agreement.

Equipment and material authorized to be purchased with Grant Funds becomes the property of the Grantee. Grantee will maintain an inventory or property control record for all equipment and material purchased with Grant Funds. During the Grant term, the Grantee must: (1) use equipment and materials acquired with Grant Funds only for the approved Project purposes set forth in Section 2.1; and (2) provide sufficient maintenance on the equipment and materials to permit achievement of the approved Project purposes and maintain, at its own expense, insurance coverage on all equipment and material purchased with Grant Funds, for its full insurable value, against loss, damage and other risks ordinarily insured against by owners or users of similar equipment and material in similar businesses. The Grantee is prohibited from, and may not sell, transfer, encumber (other than original financing) or otherwise dispose of said equipment or material during the grant term without prior written approval of the Department. The Department reserves the right to inspect, at any time, such equipment and materials. All Grantee actions involving equipment and materials shall be in compliance with the applicable state and federal law.

8.8 **Indemnification and Liability**

The Grantee shall indemnify and hold harmless the State of Illinois, its agencies, officers, employees, agents and volunteers from any and all costs, demands, expenses, losses, claims, damages, liabilities, settlements and judgments, including in-house and contracted attorneys' fees and expenses, arising out of: (a) any breach or violation by Grantee of any of its certifications, representations, warranties, covenants or agreements; (b) any actual or alleged death or injury to any person, damage to any property or any other damage or loss claimed to result in whole or in part from Grantee's negligent performance; or (c) any act, activity or omission of Grantee or any of its employees, representatives, subcontractors or agents. Neither Party shall be liable for incidental, special, consequential or punitive damages.

8.9 **Independent Contractor**

Grantee shall act as an independent contractor and not an agent or employee of, or joint venturer with the State. All payments by the State shall be made on that basis.

8.10 **Solicitation and Employment**

Grantee shall not employ any person employed by the State during the term of this agreement to perform any work under this agreement. Grantee shall give notice immediately to the Agency's director if Grantee solicits or intends to solicit State employees to perform any work under this agreement.

8.11 **Compliance with the Law**

The Grantee, its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, orders, federal circulars and all license and permit requirements in the performance of this agreement. Grantee shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Grantee shall obtain at its own expense, all licenses and permissions necessary for the performance of this agreement.

8.12 **Background Check**

Whenever the State deems it reasonably necessary for security reasons, the State may conduct, at its expense, criminal and driver history background checks of Grantee's and subcontractors officers, employees or agents. Grantee or subagreementor shall reassign immediately any such individual who, in the opinion of the State, does not pass the background checks.

8.13 **Applicable Law**

This agreement shall be construed in accordance with and is subject to the laws and rules of the State of Illinois. The Department of Human Rights' Equal Opportunity requirements (44 Ill. Adm. Code 750) are incorporated by reference. Any claim against the State arising out of this agreement must be filed exclusively with the Illinois Court of Claims (705 ILCS 505/1). The State shall not enter into binding arbitration to resolve any agreement dispute. The State of Illinois does not waive sovereign immunity by entering into this agreement. The official text of cited statutes is incorporated by reference (an unofficial version can be viewed at http://www.ilga.gov/legislation/ilcs/ilcs.asp). In compliance with the Illinois and federal Constitutions, the Illinois Human Rights Act, the U. S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act and other applicable laws and rules the State does not unlawfully discriminate in employment, agreements, or any other activity.

8.14 **Contractual Authority**

The Agency that signs for the State of Illinois shall be the only State entity responsible for performance and payment under the agreement. When the Chief Procurement Officer or authorized designee signs in addition to an Agency, they do so as approving officer and shall have no liability to Grantee. When the Chief Procurement officer or authorized designee signs a master agreement on behalf of State agencies, only the Agency that places an order with the Grantee shall have any liability to Grantee for that order.

8.15 **Modifications and Survival**

Amendments, modifications and waivers must be in writing and signed by authorized representatives of the Parties. Any provision of this agreement officially declared void, unenforceable, or against public policy, shall be ignored and the remaining provisions shall be interpreted, as far as possible, to give effect to the Parties' intent. All provisions that by their nature would be expected to survive, shall survive termination. In the event of a conflict

between the State's and the Grantee's terms, conditions and attachments, the State's terms, conditions and attachments shall prevail.

8.16 **Performance Record/Suspension**

Upon request of the State, Grantee shall meet to discuss performance or provide agreement performance updates to help ensure proper performance of the agreement. The State may consider Grantee's performance under this agreement and compliance with law and rule to determine whether to continue the agreement, suspend Grantee from doing future business with the State for a specified period of time, or to assess whether Grantee can be considered responsible on specific future agreement opportunities. The Department may immediately suspend a grant agreement after due consideration of any issues affecting the Grantee's performance.

8.17 **Freedom of Information Act**

This agreement and all related public records maintained by, provided to or required to be provided to the State are subject to the Illinois Freedom of Information Act notwithstanding any provision to the contrary that may be found in this agreement.

8.18 **Amendments**

This Agreement may not be amended without prior written approval of both the Grantee and the Department. Any amendments must be executed by both parties no later than 30 days prior to the end of the grant term.

8.19 **Assignment**

The Grantee understands and agrees that this Agreement may not be sold, assigned, or transferred in any manner and that any actual or attempted sale, assignment, or transfer without the prior written approval of the Department shall render this Agreement null, void, and of no further effect.

8.20 **Termination for Cause**

The State may immediately terminate this agreement, in whole or in part, upon notice to the Grantee if: (a) the Grantee commits any illegal act; (b) the State determines that the actions or inactions of the Grantee, its agents, employees or subagreementors have caused, or reasonably could cause, jeopardy to health, safety, or property, (c) the Grantee has notified the State that it is unable or unwilling to perform the agreement or (d) the State has reasonable cause to believe that the Grantee cannot lawfully perform the grant agreement

If Grantee breaches any material term, condition, or provision of this agreement, is in violation of a material provision of this agreement, or the State determines that the Grantee lacks the financial resources to perform the agreement, the State may, upon 15 days prior written notice to the Grantee, cancel this agreement. For termination due to any of the causes contained in this Section, the State retains its rights to seek any available legal or equitable remedies and damages.

8.21 **Termination for Convenience**

The State may, for its convenience and with thirty (30) days prior written notice to Grantee, terminate this agreement in whole or in part and without payment of any penalty or incurring any further obligation to the Grantee. The Grantee shall be entitled to compensation upon submission of invoices and proof of claim for supplies and services provided in compliance with this agreement up to and including the date of termination.

8.22 **Health Insurance Portability and Accountability Act Compliance**

Grantee shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), including, but not limited to statute, 42 USC 132d, and applicable regulations, 45 CFR 160, 162, and 164, as may be promulgated or amended over time.

8.23 **Entire Agreement**

The Department and the Grantee understand and agree that this Agreement constitutes the entire Agreement between them and that no promises, terms, or conditions not recited or incorporated within this Agreement, including prior Agreements or oral discussions not incorporated within this Agreement, shall be binding upon either the Grantee or the Department.

9. **Taxpayer Status:**

I certify that:

a. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

b. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

c. I am a U.S. person (including a U.S. resident alien).

1. If you are an individual, enter your name and SSN as it appears on your Social Security Card.
2. If you are a sole proprietor, enter the owner's name on the name line followed by the name of the business and the owner's SSN or EIN.
3. If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's name on the name line and the d/b/a on the business name line and enter the owner's SSN or EIN.
4. If the LLC is a corporation or partnership, enter the entity's business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CPZ77).
5. For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.

Name: _____

Business Name: Pinckneyville Community Hospital

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number 37-6006755

Legal Status (*check one*):

____ Individual	✓ Governmental hospital district
____ Sole Proprietor	____ Nonresident alien
____ Partnership	____ Estate or trust
____ Legal Services Corporation	____ Pharmacy (Non-Corp.)
____ Tax-exempt	____ Pharmacy/Funeral Home/Cemetery (Corp.)
____ Corporation providing or billing medical and/or health care services	____ Limited Liability Company (select applicable tax classification) ____ D = disregarded entity ____ C = corporation ____ P = partnership
____ Corporation NOT providing or billing medical and/or health care services	

10. **Attestation:**

Grantee certifies under oath that Grantee has read, understands, and agrees to all provisions of this Agreement and that the information contained in the Agreement is true and correct to the best of his/her knowledge, information and belief, that the funds awarded under this grant shall be used only for the purposes described in this Agreement and that the Grantee shall be bound by the same. Grantee acknowledges that the award of Grant Funds under this Agreement is conditioned upon this certification/attestation.

For the Grantee:

Grantee Signature

Thomas Hodges
Typed Name

Administrator / CEO
Title

110162-00
Illinois Department of Human Rights Number (if applicable)

4/2/12
Date

For the Department:

Recommended By

Arthur R. Bohrman, M.D.
Acting Director of Public Health

4/9/12
Execution Date

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. **All of the projects capital expenditures are completely funded through internal sources**
2. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Not Applicable … Debt financing is expected through a USDA Rural Development loan and the Hospital is not A-rated.

IX. 1120.130 - Financial Viability

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2009	FY 2010	FY 2011	FY 2016
Current Ratio	6.8	7.1	7.0	TBD
Net Margin Percentage	0.9%	3.1%	-1.1%	TBD
Percent Debt to Total Capitalization	7.0%	5.6%	4.5%	TBD
Projected Debt Service Coverage	5.9	7.7	2.2	TBD
Days Cash on Hand	73.7	87.3	74.0	TBD
Cushion Ratio	44.9	44.2	37.8	TBD

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.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

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

* TBD … This information will be provided when the financial feasibility study is completed (Attachment 42)

The ratio calculation data is shown in Attachment 41, Exhibit 1; Exhibit 2 provides a comparison to State Agency guidelines.

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.

Financial Viability Ratio Data

Pinckneyville Community Hospital

	Description	Formulas	Historical				Projected				
			FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Current Ratio	Measures the dollars of current assets per dollar of current liabilities. For example, a current ratio of 2.5 indicates that there is $2.50 of current assets available to pay each dollar of current liabilities.	Current Assets + Current Liabilities	6.8	7.1	7.0	6.3	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Net Margin Percentage	Measures the number of days the organization could continue to pay its average daily cash obligations without new cash resources becoming available. High values imply higher liquidity and, hence, are viewed favorably by creditors.	(Total Revenue - Expenses) + Total Revenue	0.9%	3.1%	-1.1%	2.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Percent Debt to Total Capitalization	Measures the proportion of debt financing in a business's permanent financing mix.	Total Long-term Debt + (Net Assets + Long-term Debt)	7.0%	5.6%	4.5%	3.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Projected Debt Service Coverage	Measures the number of dollars of cash flow available to make debt payments per dollar of debt expense (including both principal repayments and interest expense).	(Net Income/Loss + Depreciation Expense + Interest Expense) + (Principal Payment + Interest Expense)	5.9	7.7	2.2	4.8	0.0	0.0	0.0	0.0	#DIV/0!
Days Cash on Hand	Measures the number of days the organization could continue to pay its average daily cash obligations without new cash resources becoming available	(Cash & Investments not restricted as to use) + ((Operating Expenses - Depreciation)/365)	73.7	87.3	74.0	97.7	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Cushion Ratio	Measures the ability of current cash and near-cash holdings to cover (meet) a business's debt obligations. A cushion ratio of 2 means that the organization has 2 times its debt payment obligations available in cash and near-cash to meet those obligations.	(Cash & Investments) + (Principal Payment + Interest Expense)	44.9	44.2	37.8	42.2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Current Ratio									
Current Assets	$ 6,288,234	$ 6,686,900	$ 6,840,096	$ 7,332,403					
Add in Assets Limited to Use: Cash	$ 1,210,929	$ 3,389,393	$ 3,970,021	$ 4,031,691					
Add in Assets Limited to Use: Investments	$ 3,054,878	$ 310,525	$ -	$ -					
Add in Assets Limited to Use: Restricted Cash & Investments	$ 152,516	$ 150,876	$ 139,451	$ 140,136					
Total Current Assets	$10,706,557	$10,537,694	$10,949,568	$11,504,230	$ -	$ -	$ -	$ -	$ -
Current Liabilities	$ 1,579,989	$ 1,484,742	$ 1,568,598	$ 1,812,191					
Net Margin Percentage									
Net Patient Revenue	$18,381,953	$17,774,109	$17,592,992	$18,279,259					
Other Operating Revenue	$ 251,638	$ 185,821	$ 147,422	$ 111,706					
Non-operating Revenue	$ 544,986	$ 421,190	$ 399,692	$ 408,677					
Interest Amortization Expense (Adjustment)			$ 39,965	$ 33,337					
Total Revenue	$19,178,577	$18,381,120	$18,180,071	$18,832,979	$ -	$ -	$ -	$ -	$ -
Expenses	$18,996,589	$17,810,754	$18,337,726	$18,378,319					
Interest Amortization Expense (Adjustment)			$ 39,965	$ 33,337	$ -	$ -	$ -	$ -	$ -
Total Expenses	$18,996,589	$17,810,754	$18,377,691	$18,411,656	$ -	$ -	$ -	$ -	$ -
Net Income (Loss) crosscheck	$ 181,988	$ 570,366	$ (197,620)	$ 421,323	$ -	$ -	$ -	$ -	$ -
Percent Debt to Total Capitalization									
Current Portion of LT Debt	$ 130,000	$ 160,000	$ 175,000	$ 166,000					
Long-term Debt	$ 943,000	$ 783,000	$ 608,000	$ 442,000					
Total Long-term Debt	$ 943,000	$ 783,000	$ 608,000	$ 442,000	$ -	$ -	$ -	$ -	$ -
Net Assets (Equity) - unrestricted	$12,611,124	$13,183,130	$12,996,933	$13,418,257					
Projected Debt Service Coverage									
Net Income (Loss)	$ 181,988	$ 570,366	$ (197,620)	$ 421,323	$ -	$ -	$ -	$ -	$ -
Depreciation Expense	$ 771,574	$ 734,286	$ 593,011	$ 542,059					
Interest Expense (excluding Amortization expense)	$ 51,096	$ 44,591	$ 38,613	$ 31,985					
Subtotal	$ 1,004,658	$ 1,349,243	$ 434,004	$ 995,367	$ -	$ -	$ -	$ -	$ -
Principal Payment	$ 120,000	$ 130,000	$ 160,000	$ 175,000	$166,000	$178,000	$181,000	$ 83,000	
Interest Expense (excluding Amortization expense)	$ 51,096	$ 44,591	$ 38,613	$ 31,985	$ -	$ -	$ -	$ -	$ -
Subtotal	$ 171,096	$ 174,591	$ 198,613	$ 206,985	$166,000	$178,000	$181,000	$ 83,000	$ -
Days Cash on Hand									
Total Cash (not restricted as to use)	$ 2,330,819	$ 1,298,372	$ 783,486	$ 2,955,420					
Total Investments (not restricted as to use)	$ 1,337,576	$ 2,772,971	$ 2,814,960	$ 1,805,745					
Subtotal Cash & Investments	$ 3,668,395	$ 4,071,343	$ 3,598,446	$ 4,761,165	$ -	$ -	$ -	$ -	$ -
Operating Expenses	$18,996,589	$17,810,754	$18,377,691	$18,411,656	$ -	$ -	$ -	$ -	$ -
Interest Expense (INCLUDING amorization expense)	$ 56,555	$ 45,943	$ 39,965	$ 33,337	$ -	$ -	$ -	$ -	$ -
Depreciation	$ 771,574	$ 734,286	$ 593,011	$ 542,059	$ -	$ -	$ -	$ -	$ -
Cash Outlay Subtotal (Oper Exp less interest & deprec)	$18,168,460	$17,030,526	$17,744,715	$17,836,260	$ -	$ -	$ -	$ -	$ -
Divided by 365 (366 in FY12 leap year)	$ 49,777	$ 46,659	$ 48,616	$ 48,733	$ -	$ -	$ -	$ -	$ -
Cushion Ratio									
Total Cash (Includes assets limited as to use since those are designated to make principal & interest pymts)	$ 3,541,748	$ 4,687,765	$ 4,753,507	$ 6,987,111					
Total Investments (Includes assets limited as to use since those are designated to make principal & interest pymts)	$ 4,392,454	$ 3,083,496	$ 2,814,960	$ 1,805,745					
Subtotal Cash & Investments	$ 7,934,202	$ 7,771,261	$ 7,568,467	$ 8,792,856					
Principal Payment	$ 120,000	$ 130,000	$ 160,000	$ 175,000	$166,000	$178,000	$181,000	$ 83,000	
Interest Expense	$ 56,555	$ 45,943	$ 39,965	$ 33,337					
Subtotal	$ 176,555	$ 175,943	$ 199,965	$ 208,337					

		Amortization Expense
2009	$	5,459
2010	$	1,352
2011	$	1,352
2012	$	1,352
2013	$	1,097
2014	$	1,097
2015	$	1,097
2016	$	1,097

PINCKNEYVILLE COMMUNITY HOSPITAL
BALANCE SHEET 07/30/10 10:04 AM
AS OF: 04/30/10

ASSETS	CURRENT YEAR FY10	PRIOR YEAR FY09	NET CHANGE
UNRESTRICTED FUNDS			
CURRENT ASSETS:			
CASH	1,298,372.19	2,330,818.89	(1,032,446.70)
INVESTMENTS	2,772,971.42	1,337,576.32	1,435,395.10
INVENTORY	194,210.15	196,225.81	(2,015.66)
PREPAID EXPENSES	127,790.58	155,124.34	(27,333.76)
OTHER CURRENT ASSETS	417,765.96	245,502.74	172,263.22
CURRENT ASSET SUBTOTAL	4,811,110.30	4,265,248.10	545,862.20
GROSS PATIENT ACCOUNTS RECEIVABLE	4,238,606.03	5,027,567.34	(788,961.31)
CONTRACTUAL & ALLOWANCE ADJUSTMENTS	(2,362,816.30)	(3,004,581.32)	641,765.02
NET ACCOUNTS RECEIVABLE	1,875,789.73	2,022,986.02	(147,196.29)
TOTAL CURRENT ASSETS.....	6,686,900.03	6,288,234.12	398,665.91
BOARD DESIGNATED FUNDS:			
CASH	3,389,393.15	1,210,928.78	2,178,464.37
INVESTMENTS	310,525.12	3,054,877.99	(2,744,352.87)
BOND ISSUE COSTS & GOODWILL	7,092.00	8,444.00	(1,352.00)
TOTAL BOARD DESIGNATED FUNDS	3,707,010.27	4,274,250.77	(567,240.50)
PROPERTY, BUILDINGS & EQUIPMENT:			
PROPERTY, BUILDINGS & EQUIPMENT	14,552,637.06	13,489,333.56	1,063,303.50
ACCUMULATED DEPRECIATION	(9,495,675.53)	(8,917,705.86)	(577,969.67)
NET PROPERTY, BUILDINGS & EQUIPMENT	5,056,961.53	4,571,627.70	485,333.83
TOTAL DESIGNATED FUNDS & PROPERTY.....	8,763,971.80	8,845,878.47	(81,906.67)
RESTRICTED FUNDS			
RESTRICTED CASH & INVESTMENTS.....	150,875.65	152,515.97	(1,640.32)
TOTAL ASSETS	15,601,747.48	15,286,628.56	315,118.92
LIABILITIES & EQUITY			
UNRESTRICTED FUNDS			
CURRENT LIABILITIES:			
CURRENT PORTION LONG TERM DEBT	160,000.00	130,000.00	30,000.00
ACCOUNTS PAYABLE & ACCRUED PAYROLL	764,567.34	734,826.29	29,741.05
OTHER LIABILITIES	560,174.83	715,162.79	(154,987.96)
TOTAL CURRENT LIABILITIES	1,484,742.17	1,579,989.08	(95,246.91)
LONG TERM DEBT	783,000.00	943,000.00	(160,000.00)
EQUITY	13,183,129.66	12,611,123.51	572,006.15
TOTAL UNRESTRICTED FUNDS.....	15,450,871.83	15,134,112.59	316,759.24
RESTRICTED FUNDS			
RESTRICTED EQUITY	150,875.65	152,515.97	(1,640.32)
TOTAL RESTRICTED FUNDS.....	150,875.65	152,515.97	(1,640.32)
TOTAL LIABILITIES & EQUITY	15,601,747.48	15,286,628.56	315,118.92

8

05/17/12 02:02 PM

PINCKNEYVILLE COMMUNITY HOSPITAL
BALANCE SHEET
FOR THE MONTH ENDING: 04/30/12

	Current Year FY12	Prior Year FY11	Net Change
ASSETS			
UNRESTRICTED FUNDS			
CURRENT ASSETS:			
CASH	2,955,419.74	783,485.69	2,171,934.05
INVESTMENTS	1,805,745.30	2,814,960.40	(1,009,215.10)
INVENTORY	210,094.44	189,881.35	20,213.09
PREPAID EXPENSES	140,765.68	157,846.68	(17,081.00)
OTHER CURRENT ASSETS	224,639.11	1,067,011.16	(842,372.05)
CURRENT ASSET SUBTOTAL	5,336,664.27	5,013,185.28	323,478.99
GROSS PATIENT ACCOUNTS RECEIVABLE	5,653,634.19	3,942,999.00	1,710,635.19
CONTRACTUAL & ALLOWANCE ADJUSTMENTS	(3,657,895.74)	(2,116,088.78)	(1,541,806.96)
NET ACCOUNTS RECEIVABLE	1,995,738.45	1,826,910.22	168,828.23
TOTAL CURRENT ASSETS.....	7,332,402.72	6,840,095.50	492,307.22
BOARD DESIGNATED FUNDS:			
CASH	4,031,691.46	3,970,021.27	61,670.19
BOND ISSUE COSTS & GOODWILL	4,388.00	5,740.00	(1,352.00)
TOTAL BOARD DESIGNATED FUNDS	4,036,079.46	3,975,761.27	60,318.19
PROPERTY, BUILDINGS & EQUIPMENT:			
PROPERTY, BUILDINGS & EQUIPMENT	14,516,664.83	14,192,728.40	323,936.43
ACCUMULATED DEPRECIATION	(10,213,384.41)	(9,835,053.56)	(378,330.85)
NET PROPERTY, BUILDINGS & EQUIPMENT	4,303,280.42	4,357,674.84	(54,394.42)
TOTAL DESIGNATED FUNDS & PROPERTY...	8,339,359.88	8,333,436.11	5,923.77
RESTRICTED FUNDS			
RESTRICTED CASH & INVESTMENTS.....	140,136.48	139,451.02	685.46
TOTAL ASSETS	15,811,899.08	15,312,982.63	498,916.45
LIABILITIES & EQUITY			
UNRESTRICTED FUNDS			
CURRENT LIABILITIES:			
CURRENT PORTION LONG TERM DEBT	166,000.00	175,000.00	(9,000.00)
ACCOUNTS PAYABLE & ACCRUED PAYROLL	1,023,955.37	859,447.58	164,507.79
OTHER LIABILITIES	622,235.42	534,150.62	88,084.80
TOTAL CURRENT LIABILITIES	1,812,190.79	1,568,598.20	243,592.59
LONG TERM DEBT	642,000.00	808,000.00	(166,000.00)
EQUITY	13,418,257.27	12,996,933.41	421,323.86
TOTAL UNRESTRICTED FUNDS.....	15,872,448.06	15,373,531.61	498,916.45
RESTRICTED FUNDS			
RESTRICTED EQUITY	139,451.02	139,451.02	.00
TOTAL RESTRICTED FUNDS.....	139,451.02	139,451.02	.00
TOTAL LIABILITIES & EQUITY	15,811,899.08	15,312,982.63	498,916.45

PINCKNEYVILLE COMMUNITY HOSPITAL
OPERATING STATEMENT 07/30/10 10:05 AM
FOR THE 12 MONTHS ENDING 04/30/10

	SINGLE MONTH			YEAR TO DATE		
	CURRENT	BUDGET	PRIOR YEAR	CURRENT YTD	BUDGET YTD	PRIOR YTD
				FY10		FY09
PATIENT SERVICE REVENUE:						
INPATIENT	154,677.17	404,341.00	432,581.60	3,963,163.45	4,852,319.00	4,878,418.32
OUTPATIENT	2,133,738.18	1,949,812.00	1,926,385.84	24,047,226.33	23,388,397.00	23,067,621.45
SKILLED CARE	.00	.00	.00	.00	.00	584,380.59
FAMILY MEDICAL CENTER	117,823.32	116,004.00	104,957.53	1,459,574.57	1,354,149.00	1,270,535.35
HOME MEDICAL EQUIPMENT	.00	.00	.00	.00	.00	114,013.71
GROSS PATIENT REV	2,406,238.67	2,469,357.00	2,463,924.17	29,469,964.35	29,594,865.00	29,914,969.42
BAD DEBTS NET OF RECOVERY	(28,767.29)	(49,468.00)	136,338.37	(498,816.15)	(593,550.00)	(530,236.29)
HOSPITAL FINANCIAL NEED	(37,628.28)	(17,163.00)	(62,046.78)	(367,659.62)	(206,000.00)	(183,407.40)
HOSPITAL DEDUCTIONS	(1,140,936.14)	(866,677.00)	(1,146,500.50)	(10,991,078.57)	(10,400,034.00)	(10,948,301.66)
SCU DEDUCTIONS	.00	.00	1,059.86	.00	.00	(37,217.93)
HOME HEALTH DEDUCTIONS	.00	.00	4,410.53	285.75	.00	(38,829.18)
HOSPICE DEDUCTIONS	.00	.00	30,546.33	.00	.00	28,771.11
FHC DEDUCTIONS	27,210.63	22,790.00	4,144.69	161,025.14	273,500.00	209,343.28
HMR DEDUCTIONS	(73.92)	.00	28,493.26	387.65	.00	(33,138.66)
NET PATIENT REVENUE	1,306,043.67	1,558,839.00	1,460,369.93	17,774,108.55	18,668,781.00	18,381,952.69
OTHER OPERATING REVENUE:						
NON-HOSPITAL PHARMACY	83.62	60.00	516.50	2,256.50	750.00	3,273.01
FITNESS CENTER	1,748.50	2,213.00	3,012.50	29,082.50	26,600.00	28,381.50
REBATES	3,507.31	8,837.00	(1,259.86)	28,255.30	106,000.00	103,118.78
OTHER OPERATING REV	32,889.62	6,069.00	16,980.68	126,227.10	72,800.00	116,864.41
TOTAL OTHER OPER.	38,229.05	17,179.00	19,249.82	185,821.40	206,150.00	251,637.70
TOTAL OPERATING REV	1,344,272.72	1,576,018.00	1,479,619.75	17,959,929.95	18,874,931.00	18,633,590.39

PINCKNEYVILLE COMMUNITY HOSPITAL
OPERATING STATEMENT 07/30/10 10:05 AM
FOR THE 12 MONTHS ENDING 04/30/10

	SINGLE MONTH			YEAR TO DATE		
	CURRENT	BUDGET	PRIOR YEAR	CURRENT YTD	BUDGET YTD	PRIOR YTD
				FY10		FY09
OPERATING EXPENSES:						
SALARIES	685,378.27	676,710.00	615,391.47	7,942,924.02	8,102,302.00	8,187,051.50
EMPLOYEE BENEFITS	220,490.37	203,026.00	77,030.33	2,324,295.53	2,438,287.00	2,557,924.24
SPECIALIST FEES	130,233.31	112,991.00	105,736.41	1,339,218.22	1,340,051.00	1,291,521.46
SUPPLIES	37,643.37	84,537.00	90,542.91	857,569.92	1,023,050.00	1,033,258.01
MINOR EQUIPMENT	1,379.93	3,110.00	3,661.55	54,494.87	68,872.00	73,136.00
REPAIRS/SERVICE AGRMNTS	42,976.65	45,291.00	28,725.52	509,280.64	499,818.00	605,011.06
UTILITIES	33,616.33	26,609.00	15,928.32	215,405.37	258,895.00	243,425.61
PHONE	4,377.17	4,803.00	3,734.22	51,615.59	57,700.00	56,403.01
DRUGS	226,573.79	165,150.00	309,986.19	1,976,554.65	1,981,800.00	2,053,771.03
PURCHASED SERVICE	73,449.41	68,899.00	59,610.38	780,875.44	828,661.00	902,382.34
TRAINING	4,886.39	11,372.00	7,304.80	68,446.52	136,800.00	103,957.23
DUES & SUBSCRIPTIONS	2,761.00	3,702.00	3,276.06	49,350.76	56,348.00	40,319.47
TRAVEL	3,815.73	2,009.00	1,378.92	25,607.00	23,975.00	19,110.80
MARKETING	6,607.85	6,250.00	514.50	58,654.60	75,000.00	84,596.73
PHYSICIAN RECRUITMENT	786.63	1,500.00	3,737.26	20,830.86	18,000.00	49,297.92
RENT/LEASES	8,614.26	11,427.50	14,958.82	145,543.90	147,438.00	153,109.98
OTHER EXPENSES	18,610.60	19,728.00	16,637.46	186,130.51	237,000.00	235,408.82
DEPRECIATION	82,653.63	61,397.00	61,092.25	734,285.82	736,764.00	771,573.86
INTEREST	3,828.00	3,828.00	(8,838.00)	45,942.50	45,943.00	56,555.42
INSURANCE	(78,456.09)	32,202.00	(8,777.31)	269,703.44	386,413.00	333,540.26
OTHER ADMIN & GENERAL EXPENSES	12,627.35	20,590.00	15,888.81	154,048.63	247,100.00	145,234.10
TOTAL OPERATING EXPENSES	1,503,853.95	1,565,139.50	1,418,520.07	17,810,753.79	18,690,217.00	18,996,588.85
OPERATING INC(LOSS)	(159,581.23)	18,878.50	61,099.68	149,176.16	186,714.00	(362,998.46)
NONOPERATING REVENUE:						
TAXES	53,577.78	18,290.00	8,841.63	254,787.78	219,500.00	217,841.63
CONTRIBUTIONS	(881.31)	87.00	6,627.35	20,457.38	2,141.00	9,142.54
INTEREST	8,433.10	18,000.00	15,828.62	155,263.51	216,000.00	264,888.43
OTHER	(24,919.00)	1,439.00	1,203.60	(9,319.00)	17,268.00	53,113.44
TOTAL NON-OPERATING REVENUE	36,210.57	31,816.00	32,501.20	421,189.67	454,909.00	544,986.04
NET INCOME (LOSS)	(123,370.66)	48,694.50	93,600.88	570,365.83	639,623.00	181,987.58

PINCKNEYVILLE COMMUNITY HOSPITAL
OPERATING STATEMENT 05/17/12 02:01 PM
FOR THE 12 MONTHS ENDING 04/30/12

	SINGLE MONTH			YEAR TO DATE		
	CURRENT	BUDGET	PRIOR YEAR	CURRENT YTD FY10	BUDGET YTD	PRIOR YTD FY09
PATIENT SERVICE REVENUE:						
INPATIENT	211,947.33	369,129.00	428,067.54	3,901,873.42	4,429,918.00	4,213,537.13
OUTPATIENT	1,925,442.30	2,103,431.00	1,817,115.87	26,114,078.15	25,241,126.00	23,244,150.34
FAMILY MEDICAL CENTER	124,622.65	159,198.00	128,382.28	1,759,377.43	1,910,321.00	1,598,019.64
GROSS PATIENT REV	2,262,012.28	2,631,758.00	2,373,565.69	31,775,329.00	31,581,365.00	29,056,307.11
BAD DEBTS NET OF RECOVERY	14,612.47	(52,301.00)	(30,765.36)	(899,765.65)	(627,700.00)	(532,536.55)
HOSPITAL FINANCIAL NEED	(30,013.19)	(45,138.00)	(73,286.19)	(402,448.54)	(541,700.00)	(537,020.81)
HOSPITAL DEDUCTIONS	(738,160.38)	(997,362.00)	(201,492.79)	(12,128,791.81)	(11,968,340.00)	(10,467,245.13)
FMC DEDUCTIONS	(27,854.98)	8,663.00	2,799.30	14,318.28	104,000.00	73,383.36
OTHER DEDUCTIONS	.00	.00	8.34	18.06	.00	103.67
NET PATIENT REVENUE	1,480,596.20	1,545,626.00	2,070,828.99	18,279,259.34	18,547,625.00	17,592,991.65
OTHER OPERATING REVENUE:						
NON-HOSPITAL PHARMACY	472.07	250.00	366.84	1,747.85	3,000.00	3,632.30
FITNESS CENTER	1,930.00	2,287.00	1,630.00	27,766.00	27,400.00	27,094.50
REBATES	241.49	954.00	1,256.08	19,215.66	11,414.00	12,586.38
OTHER OPERATING REV	8,159.99	4,713.00	5,451.58	62,976.47	56,620.00	104,108.72
TOTAL OTHER OPER.	10,803.55	8,204.00	8,704.50	111,705.98	98,434.00	147,421.70
TOTAL OPERATING REV	1,491,399.75	1,553,824.00	2,079,533.49	18,390,965.32	18,646,059.00	17,740,413.35

PINCKNEYVILLE COMMUNITY HOSPITAL
OPERATING STATEMENT
FOR THE 12 MONTHS ENDING 04/30/12

05/13/12 02:01 PM

	SINGLE MONTH			YEAR TO DATE		
	CURRENT	BUDGET	PRIOR YEAR	CURRENT YTD	BUDGET YTD	PRIOR YTD
				FY10		FY09
OPERATING EXPENSES:						
SALARIES	693,622.04	690,499.00	712,055.08	8,325,457.60	8,295,393.00	8,099,679.09
EMPLOYEE BENEFITS	206,352.90	183,260.00	93,613.77	2,428,039.05	2,525,372.00	2,371,532.58
SPECIALIST FEES	129,834.32	119,512.00	720,199.12	1,401,452.32	1,434,150.00	1,925,338.42
SUPPLIES	67,770.45	75,431.00	211,555.25	827,728.31	886,420.00	959,746.09
MINOR EQUIPMENT	10,213.72	3,680.00	6,378.34	74,662.04	68,081.00	37,664.50
REPAIRS/SERVICE AGRMNTS	50,558.18	47,230.00	42,260.30	564,693.55	558,239.00	494,349.30
UTILITIES	15,670.82	14,066.00	17,012.18	203,657.80	218,551.00	211,801.80
PHONE	3,007.99	6,375.00	2,613.55	33,298.17	65,500.00	38,540.76
DRUGS	146,628.64	160,674.00	169,248.63	2,164,952.91	1,928,000.00	1,779,777.54
PURCHASED SERVICE	87,593.39	73,910.00	38,725.10	988,364.00	889,190.00	832,738.63
TRAINING	12,365.04	11,285.00	8,755.47	85,100.81	107,300.00	136,352.98
DUES & SUBSCRIPTIONS	2,614.75	5,090.00	4,709.48	51,906.25	59,881.00	43,343.43
TRAVEL	2,687.20	1,483.00	1,285.98	18,437.33	17,698.00	20,071.03
MARKETING	3,810.43	5,500.00	3,775.55	56,708.35	66,000.00	63,173.30
PHYSICIAN RECRUITMENT	8,132.43	2,500.00	950.00	28,554.49	31,900.00	74,240.35
RENT/LEASES	10,115.68	12,407.00	14,330.36	125,796.63	151,933.00	128,192.95
OTHER EXPENSES	15,831.37	16,357.00	11,983.52	185,362.23	196,270.00	204,313.58
DEPRECIATION	41,229.28	50,360.00	54,971.60	542,059.17	604,320.00	593,010.81
INSURANCE	38,204.13	(10,950.00)	23,852.07	185,587.39	267,866.00	210,903.76
OTHER ADMIN & GENERAL EXPENSES	6,267.70	9,390.00	7,278.84	106,508.47	111,600.00	102,955.56
TOTAL OPERATING EXPENSES	1,552,510.44	1,477,969.00	2,185,554.23	18,378,318.87	18,483,664.00	18,337,726.46
OPERATING INC(LOSS)	(61,110.69)	75,855.00	(106,020.74)	12,646.45	162,395.00	(597,313.11)
NONOPERATING ITEMS:						
TAX REVENUE	36,658.74	23,527.00	30,475.31	295,466.74	282,335.00	286,126.31
CONTRIBUTION & GRANT REVENUE	11,286.62	2,775.00	14,871.52	66,821.85	34,441.00	46,846.52
INTEREST REVENUE	6,669.68	7,000.00	5,953.92	70,200.58	84,000.00	87,974.39
INTEREST & AMORT EXPENSE	(2,777.01)	(2,777.00)	(3,330.00)	(33,336.76)	(33,337.00)	(39,965.00)
OTHER	1,335.00	666.00	2,510.01	9,525.00	7,992.00	18,710.01
TOTAL NON-OPERATING ITEMS	53,173.03	31,191.00	50,480.76	408,677.41	375,431.00	399,692.23
NET INCOME (LOSS)	(7,937.66)	107,046.00	(55,539.98)	421,323.86	537,826.00	(197,620.88)

Ratio Comparison

	State Standard	FY 2011	FY 2012	Projected	Current Operations Meets Standards
Current Ratio	2.0	4.7	4.3	TBD	Yes
Net Margin %	3.0%	(1.1%)	2.2%	TBD	No
Percent Debt to Capitalization	<50%	2.2%	3.2%	TBD	Yes
Debt Service Coverage	2.5>	2.2	4.8	TBD	Yes
Days Cash on Hand	75.0+	147.3	173.5	TBD	Yes
Cushion Ratio	7.0+	37.8	42.2	TBD	Yes

* TBD … This information will be provided when the financial feasibility study is completed (Attachment 42)

The Hospital District shall assume legal responsibility to meet debt obligation consistent with proposed USDA loan obligation requirements.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

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

* Include the percentage (%) of space for circulation

Section 1120.140 Responses

A Attached is the required alteration letter regarding financing and conditions; (Attachment 42, Exhibit 1)

B. Reasonableness of Project and Related Costs; Attachment 42, Exhibits 2 and 3.

C. Cost and GSF; Attachment 42, Exhibit 4.

D. Projected Operating Costs (to be provided)

E. Financial Feasibility Analysis (in process)

Attachment 75 (now Attachment 42) in the original permit application demonstrated the feasibility of a larger project than currently being proposed in the alteration permit. Wipfli has developed a debt capacity analysis (Attachment 39) including the potential to fund a smaller project as defined in this Alteration Permit. The Feasibility Analysis / Financial Forecast is in development and will be submitted when complete (see Attachment 42, Exhibit 6). Wipfli has stated the original feasibility study (Financial Forecast) was completed in accordance with AICPA standards.

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

leading the way to a healthier tomorrow

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

Re: Alteration Permit
Project #09-068
1120.140 Economic Feasibility
Attachment 42

Dear Ms. Avery,

This letter attests to the facts that:

1) The total estimated project costs will be funded in part by borrowing in that the Hospital does not have sufficient assets to fund the proposed hospital project; and,

2) The proposed USDA Rural Development loan will be at the lowest net cost available.

We have enclosed our debit capacity analysis dated March 26, 2012 in the Permit Application. It indicates the Hospital's capability to borrow a minimum of $22,700,000. We are also in the process of completing a financial feasibility study as will be required for submitting the USDA loan application. The feasibility study will be submitted to the State Agency when complete.

Sincerely,

Thomas J. Hudgins, FACHE
Chief Executive Officer
June 11, 2012

Notarization:
Subscribed and sworn to before me
this 11 day of June 2012

OFFICIAL SEAL
CHRISTIE L GAJEWSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 1/17/16

Signature of Notary
Seal Christie L Gajewski

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$95,880	$92,120	$188,000
Site Survey and Soil Investigation	24,000	23,087	47,087
Site Preparation	373,700	516,000	889,700
Off Site Work	40,700	39,050	79,750
New Construction Contracts	11,878,000	11,411,892	23,289,892
Modernization Contracts	0	0	0
Contingencies (Owner)	406,000	294,000	700,000
Architectural/Engineering Fees	1,160,000	805,187	1,965,187
Consulting and Other Fees	48,000	46,200	94,200
Movable or Other Equipment (not in construction contracts) (under $200,000)	603,000	121,000	724,000
Bond Issuance Expense (project related)	131,600	126,523	258,123
Net Interest Expense During Construction (project related)	413,100	396,900	810,000
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	1,100,000	687,365	1,787,365
Acquisition of Building or Other Property (includes land per USDA Format)	180,680	173,591	354,271
TOTAL USES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities (includes land costs)	$4,296,160	$3,846,415	$8,142,575
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)			0
Mortgages (USDA Rural Development loan)	11,976,500	10,723,500	22,700,000
Leases (fair market value)			0
Governmental Appropriations			0
Grants (Illinois Capital)	182,000	163,000	345,000
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS	**$ 16,454,660**	**$ 14,732,915**	**$ 31,187,575**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

* Note, land cost of $354,271 is included to reconcile with USDA project cost / budget reconciliation requirements. The land was purchased in 2006.

Preplanning ($420,000)		
Preconstruction Services	$95,000	
Traffic Survey	5,000	
Legal (land acquisitions, project contracts, etc)	60,000	
Miscellaneous Studies	28,000	
Total		$188,000
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	
Total		$47,087
Site Preparation		
Site Excavation and Prep	$238,000	
Site Utilities	321,600	
Storm Drainage	319,400	
Fencing	10,700	
Total		$889,700
Off-site Work		
Utility Extension	$79,750	
		$79,750
Consulting and Other Fees		
Construction Testing / Inspection	$75,000	
Building Permit	3,200	
IDPH Plan Review	15,000	
Permit Alteration Fee	1,000	
Total		$94,200
Other Costs to be Capitalized		
Site Signage	$100,000	
Security System	72,000	
On-site Ancillary Structure (garage)	70,000	
Transformer	57,992	
Propane Tanks	100,000	
Cabling / IT Infrastructure / TV	426,800	
Paving, curbs, drives	954,311	
Miscellaneous Permits	6,262	
Total		$1,787,365

	Cost and Gross Square Feet by Department or Service								
	A	B	C	D	E	F	G	H	Total Cost
	Cost / Square Foot		Gross Square Feet		Gross Square Feet		Const. Cost	Mod. Cost	
Department	New	Mod.	New	Circ. %	Mod.	Circ.	(AxC)	(BxE)	(G+H)
Clinical									
Medical / Surgical	$320	--	9,177	19%	0	--	2,936,640	0	2,936,640
Emergency	330	--	4,195	28%	0	--	1,384,350	0	1,384,350
Diagnostic Imaging	410	--	6,034	28%	0	--	2,473,940	0	2,473,940
Surgery	470	--	2,722	28%	0	--	1,279,340	0	1,279,340
Same Day Surgery / Prep/Recovery / PACU	350	--	3,823	28%	0	--	1,338,050	0	1,338,050
Central Sterile Processing	300	--	1,147	10%	0	--	344,100	0	344,100
Laboratory	285	--	2,708	13%	0	--	771,780	0	771,780
Pharmacy	260	--	1,350	13%	0	--	351,608	0	351,608
Oncology	265	--	2,703	17%	0	--	715,064	0	715,064
Outpatient Rehabilitation	--	$0	0	--	6,468	--	0	0	0
Inpatient Rehabilitation	225	--	1,209	10%	0	--	272,025	0	272,025
Total Clinical / Average Cost / Sq. Ft.	**$338.40**	**$0**	**35,068**	--	**6,468**	**0**	**11,866,897**	**0**	**11,866,897**
Non-Clinical									
Registration	$265	--	1,258	10%	0	--	$333,370	0	333,370
Lobby / Public Space	275	--	5,564	13%	0	--	1,530,100	0	1,530,100
Ambulance Vestibule	215	--	566	90%	0	--	121,690	0	121,690
Business Office / Billing	--	0	0	--	2,024	--	0	0	0
Administration	--	0	0	--	7,450	--	0	0	0
Information Technology	215	--	426	13%	0	--	91,590	0	91,590
Dietary	285	--	4,008	10%	0	--	1,142,280	0	1,142,280
General Store / Materials Management	210	--	1,674	10%	0	--	351,540	0	351,540
Housekeeping / Linen (Environmental Services)	200	--	1,415	10%	0	--	283,000	0	283,000
Maintenance	200	--	1,065	10%	0	--	213,000	0	213,000
Circulation / Building Gross	184	--	13,477	16%	0	--	0	0	0
Mechanical / Electrical	350	--	2,256	5%	0	--	789,600	0	789,600
Canopies	150	--	1,736	90%	0	--	260,400	0	260,400
Storage / Archives	--	0	0	--	2,520	--	0	0	0
Specialty Clinics (MOB)	265	--	4,306	17%	0	--	1,141,090	0	1,141,090
Family Health Clinic (MOB)	265	--	10,127	17%	0	--	2,683,655	0	2,683,655
Miscellaneous Storage / Support	--	0	0	--	12,428	--	0	0	0
Total Non-Clinical / Average Cost / Sq. Ft.	**$238.59**	**0**	**47,878**	--	**24,422**	--	**11,422,995**	**0**	**11,422,995**
Subtotal / Average Cost / Sq. Ft.	**$280.78**	**0**	**82,946**	--	**30,890**	--	**23,289,892**	**0**	**23,289,892**
Contingency	**8.44**	0	--	--	--	--	**700,000**	**0**	**700,000**
Total with contingency / Average Cost / Sq. Ft.	**$289.22**	**0**	**82,946**	--	**30,890**	**0**	**23,989,892**	**0**	**23,989,892**

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

To be submitted when the financial feasibility study is completed.

WIPFLI
CPAs and Consultants

Wipfli LLP
10000 Innovation Drive
Suite 250
Milwaukee, WI 53226
414.431.9300
fax 414.431.9303
www.wipfli.com

May 22, 2012

Board of Directors
Pinckneyville Community Hospital District and
Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, Illinois

We have read the "Financial Forecast Related to the Proposed Hospital Construction and Replacement Program" and McGladrey & Pullen's Independent Accountant's Report, dated November 18, 2009, on the forecasted financial statements, including the summary of significant accounting policies and forecast assumptions, as of and for the years ending April 30, 2010 through April 30, 2015.

The Independent Accountant's Report noted above indicated that McGladrey & Pullen completed an examination. An examination involves corroborative procedures resulting in positive assurance about the presentation and the underlying assumptions related to the forecast. An examination is the highest level of assurance Certified Public Accountants can provide on prospective financial statements. Based on our reading of that report and the accompanying forecasted financial statements and summary of significant accounting policies and forecast assumptions, we believe the financial forecast was presented in accordance with attestation standards established by the American Institute of Certified Public Accountants.

Sincerely,

Wipfli LLP

Wipfli LLP

Pinckneyville Community Hospital District

Pinckneyville, Illinois

Debt Capacity Study

March 26, 2012

WIPFLI
CPAs and Consultants

Wipfli LLP
10000 Innovation Drive
Suite 250
Milwaukee, WI 53226
414.431.9300
fax 414.431.9303
www.wipfli.com

March 26, 2012

Board of Directors
Pinckneyville Community Hospital District and
Pinckneyville Community Hospital
101 North Walnut Street
Pinckneyville, Illinois

An analysis of the approximate amount of debt that Pinckneyville Community Hospital District (PCH) could reasonably support was conducted. The analysis was based on the historical results of PCH and certain assumptions made by management about future operating results, and was done for planning purposes only. There will be differences between this analysis and actual results, because events and circumstances do not occur as expected, and those differences could be significant.

Historical audited financial statements and the year to date internal financial statements for the nine-month period May 1, 2011 through January 31, 2012 were used to establish historical trends and baseline performance. The fiscal years 2013 and 2014 were assumed to include the construction and move-in period, with the new facility occupied by April 1, 2014. Accordingly, the first full year of debt service is assumed to occur in the fiscal year ending April 30, 2015. Financial assessments through the fiscal year ending April 30, 2019 were used to evaluate performance over time.

The following represent the specific key assumptions used by management to estimate the debt capacity of PCH:

Revenue Assumptions:

- The current payor mix, which has been relatively consistent over the past several years, was assumed to remain the same.
- Net revenues were assumed to increase at 3% annually to reflect inflationary rate increases from third-party payors. No volume growth was assumed.

- Bad debt and charity were assumed to remain at 2011 levels of 4.5% of gross revenue.
- Other operating revenue was assumed to decrease in 2013 to reflect the discontinuation of certain services, and then assumed to be flat over the period assessed.
- Assumed that PCH will continue to be reimbursed for capital expenditures as a Critical Access Hospital (CAH) under Medicare at the current rate of 46% of interest and depreciation.

Expense Assumptions:

- Salaries were assumed to increase at 3% annually except for a 4% increase in 2014 to account for overtime in planning and assisting with the move to the new facility.
- Employee benefits were assumed to remain at historical levels of between 29% and 30% of salaries.
- Supplies, purchased services, and professional fees were assumed to increase 4% annually.
- Repairs and maintenance, which includes certain service contracts, including IT services, were assumed to increase 5% annually.
- Rental and lease expense was assumed to increase at 1% annually.
- Utilities were assumed to increase over historical levels at 6% per year during the construction period to account for additional costs due to project, and then to increase 4% annually post-construction.

Project & Financing Assumptions:

- Assumed that PCH will first use internal funds, including an existing funded depreciation account and $500,000 from their short-term investments, then utilize a construction loan, to fund construction.
- During construction, PCH will draw the project funds from the construction loan as needed, thus only incurring interest on the outstanding balance of the draws. The construction loan interest rate is assumed to be 3.375% with the interest payments funded from hospital operations.
- After the new building opens, it is assumed that $100,000 annually will be set-aside to replenish the funded depreciation.
- It is assumed that PCH will receive an Illinois Capital Grant in the amount of $345,000 to partially fund the project.
- PCH will renew its existing property tax levy in the amount of $85,000 per year to partially fund debt service.
- The existing debt service reserve fund will be used to retire all existing debt prior to the start of fiscal 2015.

- The debt associated with the project will be financed with a loan under the USDA Rural Development Community Facilities Direct Loan program. It is assumed the current rate available under that program, which is a fixed rate of 3.375%, will be the interest rate on the loan. The debt is assumed to be amortized over 40 years.

Summary:

Based on management's assumptions detailed above, PCH could support $22,700,000 of long-term debt with a fixed interest rate of 3.375% and an amortization period of 40 years. This long-term debt, in addition to other sources of funds, including the existing funded depreciation, existing cash reserves, and an Illinois Capital Grant would allow PCH to support total project costs of up to $27,600,000.

This analysis was limited to evaluating the assumptions provided by management and did not include any evaluation of the support for those assumptions. Wipfli conducted this engagement in accordance with consulting standards established by the American Institute of Certified Public Accountants, accordingly, we do not express an opinion or any other assurance on the results of the analysis.

Sincerely,

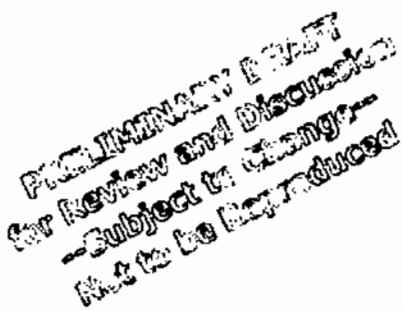
Wipfli LLP

Wipfli LLP

McGladrey & Pullen
Certified Public Accountants

Pinckneyville Community Hospital District

Financial Forecast Related to the Proposed Hospital Construction and Replacement Program



XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2009**	**Year 2010**	**Year 2011**
Inpatient	22	28	28
Outpatient	457	646	697
Total	479	674	725
Charity (cost In dollars)			
Inpatient	$26,221	$27,854	$51,438.88
Outpatient	86,336	193,110	273,995.73
Total	$112,557	$220,964	$325,434.61
MEDICAID			
Medicaid (# of patients)	**Year 2009**	**Year 2010**	**Year 2011**
Inpatient	25	36	22
Outpatient	2,464	2,431	2,439
Total	2,489	2,467	2,461
Medicaid (revenue)			
Inpatient	$247,290	$35,192	$83,673
Outpatient	2,722,512	955,861	1,448,455
Total	$2,969,802	$991,053	$1,532,128

Source: Published and Draft AHQ Data; IDPH

XII. Charity Care Information

Charity Care Information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

CHARITY CARE			
	Year 2009	Year 2010	Year 2011
Net Patient Revenue	$27,946,042	$17,771,587	$17,592,888
Amount of Charity Care (charges)	$183,407	$367,660	$537,021
Cost of Charity Care	$112,557	$220,764	$325,435

Source: Hospital Records and Published / Draft AHQ Data; IDPH

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT * 101 NORTH WALNUT * PINCKNEYVILLE, ILLINOIS 62274

					NET PAYABLE
2012 PERMIT FEE ALTERATION OF PERMIT FEE	06/08/12	1,000.00			1,000.00
CHECK NO. 76468		1,000.00			1,000.00

WARNING – THIS CHECK IS PROTECTED BY SPECIAL SECURITY GUARD PROGRAM℠ FEATURES

PINCKNEYVILLE COMMUNITY HOSPITAL DISTRICT
101 NORTH WALNUT
PINCKNEYVILLE, ILLINOIS 62274
GENERAL CASH ACCOUNT

FIRST NATIONAL BANK IN PINCKNEYVILLE
PINCKNEYVILLE, ILLINOIS

70-534
819

76468

01223

DATE 06/08/12 AMOUNT $1,000.00

One Thousand Dollars and No Cents

VOID AFTER 60 DAYS.

PAY TO THE ORDER OF
ILLINOIS DEPT OF PUBLIC HEALTH
535 WEST JEFFERSON STREET
SPRINGFIELD, IL 62761-0001

HEAT SENSITIVE RUB AREA TO VERIFY

09-068 Alteration

John Shelton

THIS CHECK CONTAINS MULTIPLE SECURITY FEATURES – SEE BACK FOR DETAILS

⑈076468⑈ ⑆081905344⑆ 400 854 6⑈