- Original -

10-087

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

DEC 28 2010

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	FRANKLIN HOSPITAL DISTRICT		
Street Address:	201 BAILEY LANE		
City and Zip Code:	BENTON, IL 62812		
County: Franklin	Health Service Area: 5	Health Planning Area:	F-06

Applicant /Co-Applicant Identification

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

Exact Legal Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Name of Registered Agent:	
Name of Chief Executive Officer:	HERVEY DAVIS
CEO Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301

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:	HERVEY DAVIS
Title:	CEO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301
E-mail Address:	hervey.davis@franklinhospital.net
Fax Number:	(618) 439-7285

Additional Contact

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

Name:	TERRI HERMANN
Title:	CNO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 303
E-mail Address:	terri.hermann@franklinhospital.net
Fax Number:	(618) 439-7285

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:	HERVEY DAVIS
Title:	CEO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301
E-mail Address:	hervey.davis@franklinhospital.net
Fax Number:	(618) 439-7285

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	FRANKLIN HOSPITAL DISTRICT
Address of Site Owner:	201 BAILEY LANE, BENTON, IL 62812

Street Address or Legal Description of Site:

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

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

Operating Identity/Licensee

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

Exact Legal Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812

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

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

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

Organizational Relationships

Provide (for each 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.

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

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.

This application is to seek approval to discontinue the use of 4 "intensive care" beds at Franklin Hospital District. This change is the result of Franklin Hospital District no longer providing a level of care to the inpatients that would be described as "intensive care." Patients requiring such a level of care are now transferred to tertiary level hospitals in Mt. Vernon, IL, Carbondale, IL, St. Louis, MO, and Evansville, IN.

Our plan is to take the 1,603 sq. ft. area that was formerly the intensive care unit and utilize as an expanded area of out patient services as needed. The 1,603 sq. ft. will be utilized for select outpatient services (blood transfusions, IV antibiotic therapy, injections, etc.) to be provided to outpatients as well as pre-op and post-op staging area for outpatient surgery. This improvement will allow enhanced functionality in caring for patients.

There will be no remodeling or redecorating required as a result of this change.

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			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$0**	**$0**	**$0**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$0**	**$0**	**$0**

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

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): _____

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.

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		1,603	0			0	
Diagnostic Radiology							
MRI							
Total Clinical		1,603	0			0	
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical		0	0			0	
TOTAL		**1,603**	**0**				

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert 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: FRANKLIN HOSPITAL DISTRICT		CITY: BENTON, IL 62812			
REPORTING PERIOD DATES:		From: 01-01-09		to: 12-31-09	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	25	351	1,206	0	25
Obstetrics					
Pediatrics					
Intensive Care	4	0	0	-4	0
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	29	351	1,206	-4	25

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 FRANKLIN 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.

Derek S. Johnson, Sr.
SIGNATURE

Derek S. Johnson, Sr.
PRINTED NAME

President, Board of Directors
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 23 day of December, 2010

Jamie J. Voorhees
Signature of Notary

Seal

OFFICIAL SEAL
JAMIE J VOORHEES
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/30/13

Hervey Davis
SIGNATURE

Hervey Davis
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 23 day of December, 2010

Jamie J. Voorhees
Signature of Notary

Seal

OFFICIAL SEAL
JAMIE J VOORHEES
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/30/13

*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.

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	**See Attachment**		
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient	**See Attachment**		
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)	**See Attachment**		
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

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Identification

Facility Name:	FRANKLIN HOSPITAL DISTRICT			
Street Address:	201 BAILEY LANE			
City and Zip Code:	BENTON, IL 62812			
County: Franklin	Health Service Area:	5	Health Planning Area:	F-06

Applicant /Co-Applicant Identification

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

Exact Legal Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Name of Registered Agent:	
Name of Chief Executive Officer:	HERVEY DAVIS
CEO Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301

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.

ATTACHMENT 1
Applicant/Co-Applicant Identification
Including Certificate of Good Standing

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Primary Contact

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

Name:	HERVEY DAVIS
Title:	CEO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301
E-mail Address:	hervey.davis@franklinhospital.net
Fax Number:	(618) 439-7285

Additional Contact

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

Name:	TERRI HERMANN
Title:	CNO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 303
E-mail Address:	terri.hermann@franklinhospital.net
Fax Number:	(618) 439-7285

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:	HERVEY DAVIS
Title:	CEO
Company Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812
Telephone Number:	(618) 439-3161 EXT. 301
E-mail Address:	hervey.davis@franklinhospital.net
Fax Number:	(618) 439-7285

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	FRANKLIN HOSPITAL DISTRICT
Address of Site Owner:	201 BAILEY LANE, BENTON, IL 62812
Street Address or Legal Description of Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**	

ATTACHMENT 2
Site Ownership

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Operating Identity/Licensee

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

Exact Legal Name:	FRANKLIN HOSPITAL DISTRICT
Address:	201 BAILEY LANE, BENTON, IL 62812

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

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

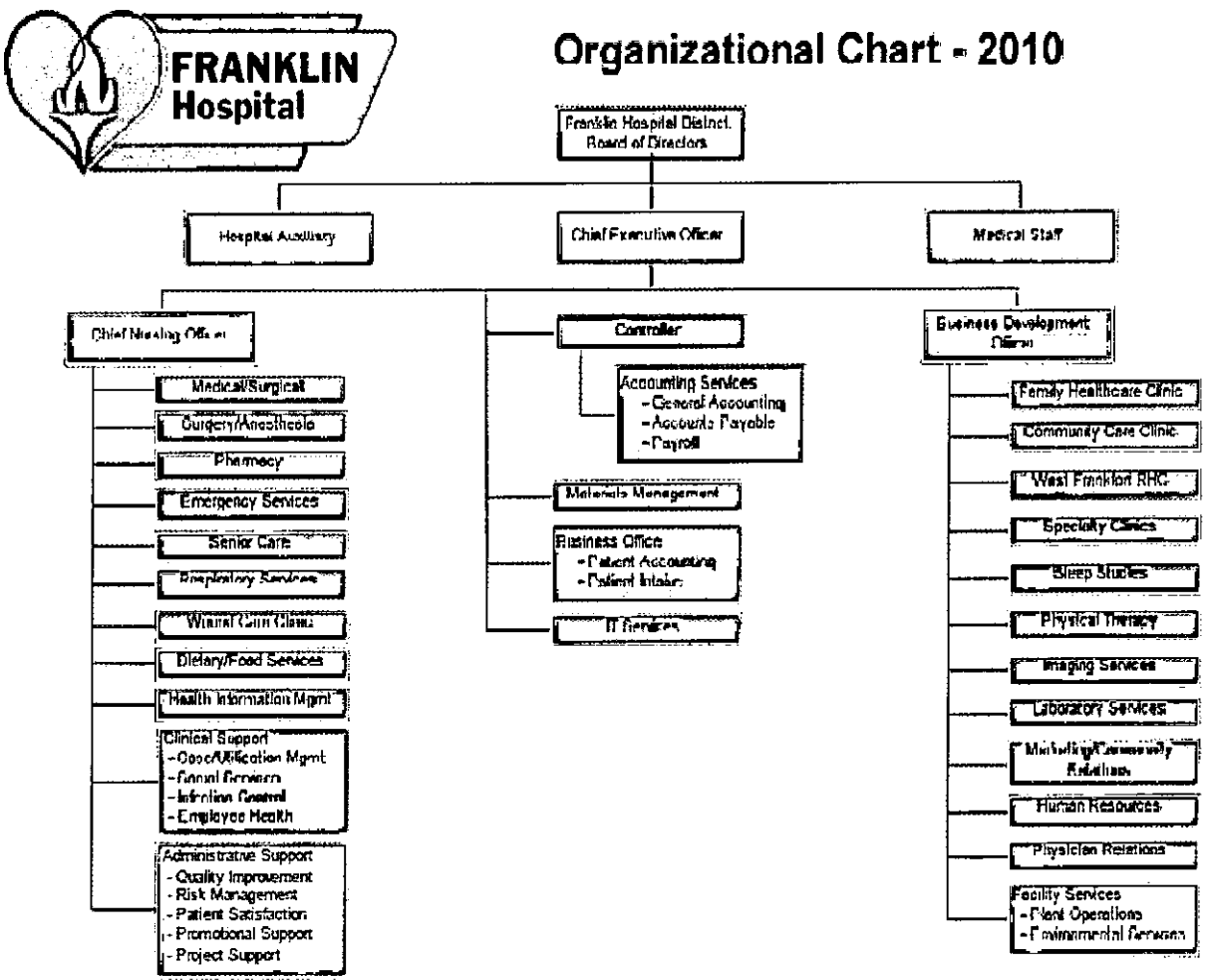
Non-applicable: Franklin Hospital District is a governmental (municipality) entity.

ATTACHMENT 3
Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership

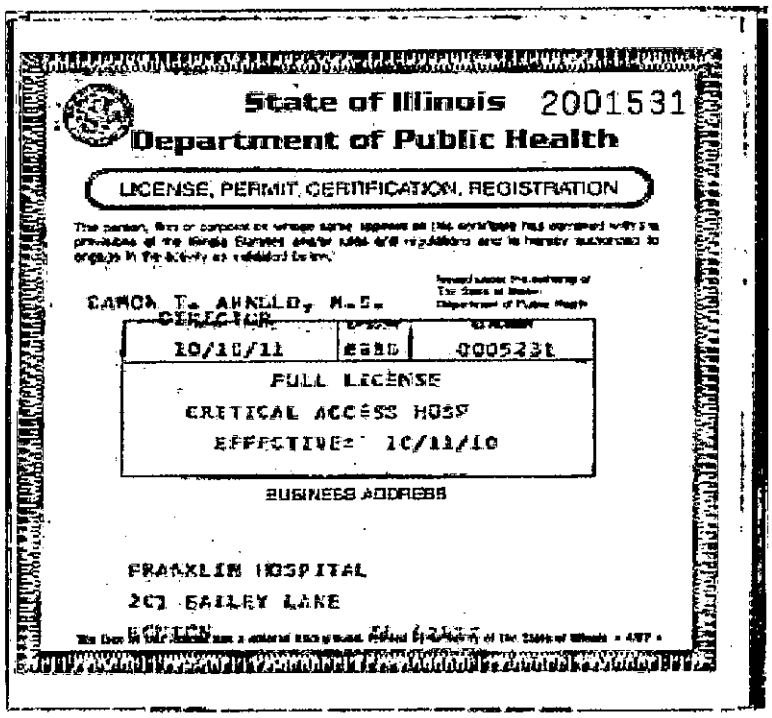
SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Operating Identity/Licensee
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.



ATTACHMENT 4
Organizational Relationships
(Organizational Chart)
Certificate of Good Standing, etc.



State of Illinois 2001531
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

CAROL T. ARNOLD, M.S.
DIRECTOR

10/10/11	EGHD	0005231

FULL LICENSE
CRITICAL ACCESS HOSP
EFFECTIVE: 10/11/10

BUSINESS ADDRESS

FRANKLIN HOSPITAL
207 BAILEY LANE
FOREST

ATTACHMENT 4 (continued)
Organizational Relationships
(Organizational Chart)
Certificate of Good Standing, etc.

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

NOT APPLICABLE: There is no project cost, construction or renovation associated with this discontinuation request as described.

ATTACHMENT 5
Flood Plain Requirements

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

NOT APPLICABLE: There is no project cost, construction or renovation associated with this discontinuation request as described.

ATTACHMENT 6
Historic Preservation Act Requirements

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

NOTE: There are no funds required due to no project cost, construction or renovation associated with this discontinuation request.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$0	$0	$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$0	$0	$0

ATTACHMENT 7
Project and Sources of Funds Itemization

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

NOT APPLICABLE: There are no funds required due to no project cost, construction or renovation associated with this discontinuation request.

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

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):
_____

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.

ATTACHMENT 8
Obligation Document (If required)

SECTION 1 - IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

NOTE: There are no funds required due to no project cost, construction or renovation associated with this discontinuation request.

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		1,603	0			0	
Diagnostic Radiology							
MRI							
Total Clinical		1,603	0			0	
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical		0	0			0	
TOTAL		**1,603**	**0**			**0**	

ATTACHMENT 9
Cost Space Requirements

SECTION II - DISCONTINUATION

GENERAL INFORMATION

1. This application is to seek approval to discontinue the use of 4 "intensive care" beds at Franklin Hospital District. This change request is the result of Franklin Hospital District no longer providing a level of inpatient care that complies with "intensive care" criteria. Patients requiring this prescribed level of care are currently transferred to tertiary level hospitals in Mt. Vernon, IL, Carbondale, IL, St. Louis, MO, and Evansville, IN. Excluding the large well equipped facilities in St. Louis, MO., and Evansville, IN., collectively there are 55 designated ICU beds located within 30 minutes of Franklin Hospital District. Referral processes are well established with these tertiary care facilities.

   The hospital's plan is to take the 1,603 sq. ft. that was formerly the intensive care unit and utilize this floor space as is, to function only an overflow area as needed for the outpatient services and ambulatory surgery unit adjacently located. When necessary, the 1,603 sq. ft. will be utilized for select ambulatory outpatient services (blood transfusions, IV antibiotic therapies, injections, etc.) as well as pre-op and post-op staging area for ambulatory surgery patients.

   PLEASE NOTE: Due to current room configuration, no remodeling or redecorating will be required and no expenditures of any type will be incurred as a result of this request. This is a full discontinuation of ICU services with no immediate or future plans at this time of re-implementing this or any other dedicated service on a full time basis, aside from occasional overflow of miscellaneous activities as described previously.

2. No other clinical services are to be discontinued as a direct or indirect result of this action.

3. The four intensive care beds will be discontinued subsequent to receiving authorization from the Health Facilities and Services Review Board.

4. The discontinuation space formerly occupied by the four intensive care beds will be used as described in answer #1.

ATTACHMENT 10
Discontinuation

5. There will be no disposition or relocation of any medical records. The records of any and all former patients will be maintained within the hospital's Medical Records Department in accordance with applicable law and policies.

6. Not applicable.

REASONS FOR DISCONTINUATION

Franklin Hospital District is no longer providing a level of care to inpatients that can be described as "intensive care." Patients requiring this prescribed level of care are now transferred to tertiary level hospitals in Mt. Vernon, IL, Carbondale, IL, St. Louis, MO., and Evansville, IN.

Discontinuation of these four licensed intensive care beds would allow enhanced functionality for the provision of outpatient services.

IMPACT ON ACCESS

1. There will be no adverse effect subsequent to the discontinuance of these "intensive care" beds. All patients requiring this level of care are currently being transferred to surrounding tertiary care hospitals for care by medical specialists and sub-specialists as previously described. As previously indicated in this attachment, excluding the large well equipped facilities in St. Louis, MO., and Evansville, IN., collectively there are 55 designated ICU beds located within 30 minutes of Franklin Hospital District. Referral processes are well established with these tertiary care facilities.

2. Not applicable. See answer question #1

3. Not applicable. See answer question #1

ATTACHMENT 10 (continued)
Discontinuation

SECTION XI - SAFETY NET IMPACT STATEMENT

7. No material impact will be realized. Franklin Hospital District is no longer providing a level of care that can be described as "intensive care" to inpatients. Patients requiring this prescribed level of care are now transferred to tertiary level hospitals in Mt. Vernon, IL, Carbondale, IL, St. Louis, MO., and Evansville, IN. Franklin Hospital District also provides an Emergency Department staffed 24/7 by physician and nursing personnel to effectively triage the patient for transfer if required to a tertiary care facility by ground or air transportation.

8. No additional impact on other providers. Referral patterns already established.

9. No additional impact on other providers. Referral patterns already established.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2008**	**Year 2009**	**Year 2010**
Inpatient	11	9	4
Outpatient	203	207	230
Total	**214**	**216**	**234**
Charity (cost In dollars)			
Inpatient	45,271	56,662	15,642
Outpatient	145,206	211,656	124,984
Total	**190,477**	**268,318**	**140,626**
MEDICAID			
Medicaid (# of patients)	**Year 2008**	**Year 2009**	**Year 2010**
Inpatient	56	33	35
Outpatient	9,750	10,644	11,590
Total	**9,806**	**10,677**	**11,625**
Medicaid (revenue)			
Inpatient	314,692	255,622	256,274
Outpatient	4,659,129	5,100,630	5,236,523
Total	**4,973,821**	**5,356,252**	**5,492,797**

ATTACHMENT 43
Safety Net Impact Statement

SECTION XII: CHARITY CARE INFORMATION

Franklin Hospital District is the only facility for which this application supporting discontinuation of a service has been prepared and data listed below is provided.

CHARITY CARE			
	Year 2008	Year 2009	Year 2010
Net Patient Revenue	12,093,140	11,304,486	11,783,237
Amount of Charity Care (charges)	190,477	268,318	140,626
Cost of Charity Care	1.58%	2.37%	1.19%

ATTACHMENT 44
Charity Care Information