

ORIGINAL
15-007

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**RECEIVED**

FEB 04 2015

This Section must be completed for all projects.HEALTH FACILITIES &
SERVICES REVIEW BOARD**Facility/Project Identification**

Facility Name:	Herrin Hospital		
Street Address:	201 South 14 th Street		
City and Zip Code:	Herrin, Illinois 62948		
County:	Williamson	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:	Southern Illinois Hospital Services d/b/a Herrin Hospital
Address:	201 South 14 th Street Herrin, Illinois 62948
Name of Registered Agent:	Mr. William F. Sherwood
Name of Chief Executive Officer:	Mr. Terence Farrell
CEO Address:	201 South 14 th Street Herrin, Illinois 62948
Telephone Number:	618-942-2171 X35189

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship
Other ☐	
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact**[Person to receive ALL correspondence or inquiries]**

Name:	Mr. Philip L. Schaefer, FACHE
Title:	Vice President, Ambulatory and Physician Services
Company Name:	Southern Illinois Healthcare
Address:	1239 E. Main Street P.O. Box 3988 Carbondale, IL 62902
Telephone Number:	618-457-5200 X67961
E-mail Address:	phil.schaefer@sih.net
Fax Number:	618-529-0568

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

Name:	Ms. Andrea R. Rozran
Title:	Principal
Company Name:	Diversified Health Resources, Inc.
Address:	65 E. Scott Street Suite 9A
Telephone Number:	312-266-0466
E-mail Address:	arozran@diversifiedhealth.net
Fax Number:	312-266-0715

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

Exact Legal Name:	Southern Illinois Healthcare Enterprises, Inc.
Address:	1239 E. Main Street P.O. Box 3988 Carbondale, Illinois 62901
Name of Registered Agent:	Mr. William F. Sherwood
Name of Chief Executive Officer:	Mr. Rex P. Budde, President and CEO
CEO Address:	1239 E. Main Street P. O. Box 3988 Carbondale, Illinois 62901
Telephone Number:	618-457-5200

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

Type of Ownership

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

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:	Ms. Cathy Blythe
Title:	System Manager, Planning & Physician Recruitment
Company Name:	Southern Illinois Healthcare
Address:	1239 E. Main Street P.O. Box 3988 Carbondale, IL 62902
Telephone Number:	618-457-5200 X67963
E-mail Address:	cathy.blythe@sih.net
Fax Number:	618-529-0568

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Southern Illinois Hospital Services
Address of Site Owner:	1239 E. Main Street P.O. Box 3988 Carbondale, IL 62902
Street Address or Legal Description of Site:	201 South 14 th Street Herrin, Illinois 62948
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:	Southern Illinois Hospital Services d/b/a Herrin Hospital		
Address:	201 South 14 th Street Herrin, Illinois 62948		
☒	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☐	Limited Liability Company	☐	Sole Proprietorship
☐	Other		
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

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:

- ☐ Substantive
- ☒ Non-substantive

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 project proposes to expand and modernize several departments at Herrin Hospital.

The project includes the following Clinical Service Areas:

- Replacement and expansion of the Surgical Suite (Class C Surgical Operating Suite), including an increase of 3 general (multi-specialty) operating rooms;
- Replacement of Endoscopy and Minor Procedures (Class B Surgical Procedure Suite);
- Replacement and expansion of Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit (PACU));
- Replacement and expansion of Surgical Prep (for both A.M. Admits and Same Day Surgery Patients) and Post-Anesthesia Recovery Phase II;
- Replacement and expansion of Prep/Recovery Phase II for the Class B Surgical Procedure Suite.

This project will also include the following Non-Clinical Service Areas:

- Administrative Offices;
- Storage Closet;
- Entrances, Lobbies, Central Public Space;
- Interdepartmental Circulation Space;
- Mechanical/Electrical Space and Equipment, including a Mechanical Penthouse and an Emergency Generator;
- Stairwells;
- Mechanical/Electrical/Data Shafts;
- Data Closet;
- Housekeeping Closet;
- Demolition and Replacement of the Emergency Department Canopy.

The project will consist of the construction of an addition to the hospital that will be constructed on top of a one-story building and the modernization of space that is adjacent to the newly constructed addition. The addition will be mostly on the second floor, and it will include an entrance on the first floor and a Mechanical Penthouse on the third floor.

This project will not affect any categories of service.

This project will not result in any change in authorized beds.

This project is "non-substantive" in accordance with 20 ILCS 3960/12 because it does not meet the criteria for classification as a "substantive" project.

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	\$88,958	\$38,125	\$127,083
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$40,314	\$17,278	\$57,592
Off Site Work	\$0	\$234,389	\$234,389
New Construction Contracts	\$5,641,611	\$2,555,919	\$8,197,530
Modernization Contracts	\$5,150,747	\$1,570,057	\$6,720,804
Contingencies	\$1,079,235	\$412,596	\$1,491,831
Architectural/Engineering Fees	\$691,877	\$296,519	\$988,396
Consulting and Other Fees	\$458,668	\$196,572	\$655,240
Movable or Other Equipment (not in construction contracts)	\$4,541,022	\$0	\$4,541,022
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$0	\$0	\$0
Other Costs To Be Capitalized	\$8,000	\$647,082	\$655,082
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$17,700,432	\$5,968,537	\$23,668,969
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$17,700,432	\$5,968,537	\$23,668,969
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$17,700,432	\$5,968,537	\$23,668,969
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

For facilities in which prior permits have been issued please provide the permit numbers.	
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): <u>December 31, 2018</u>	
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.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		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.

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: Herrin Hospital			CITY: Herrin		
REPORTING PERIOD DATES: From: January 1, 2013 to: December 31, 2013					
Category of Service	Authorized Beds	Admissions	Patient Days Incl. Observ.	Bed Changes	Proposed Beds
Medical/Surgical	77	4,432	19,479*	0	77
Obstetrics	0	0	0	0	0
Pediatrics	0	0	0	0	0
Intensive Care	8	787	2,162*	0	8
Comprehensive Physical Rehabilitation	29	597	7,244*	0	29
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	0	0	0	0	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify))	0	0	0	0	0
TOTALS:	114	5,612**	28,885*	0	114

*Patient Days include Observation Days

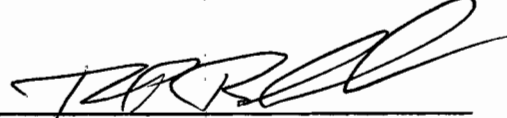
**Total Admissions include ICU Direct Admissions only, excluding transfers from other services

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Southern Illinois Hospital Services d/b/a Herrin 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

Rex P. Buddle

PRINTED NAME

President + CEO

PRINTED TITLE



SIGNATURE

Mike Kasser

PRINTED NAME

VP + Chief Financial Officer

PRINTED TITLE

Notarization:

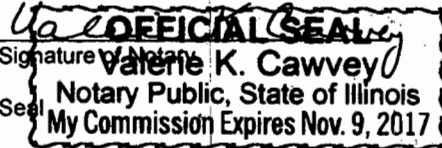
Subscribed and sworn to before me

this 28th day of January 2015

Notarization:

Subscribed and sworn to before me

this 28th day of January 2015


Signature of Notary
Valerie K. Cawvey
Notary Public, State of Illinois
My Commission Expires Nov. 9, 2017


Signature of Notary


OFFICIAL SEAL
Valerie K. Cawvey
Notary Public, State of Illinois
My Commission Expires Nov. 9, 2017

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Southern Illinois Healthcare Enterprises, Inc., in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Rex P. Buddle

PRINTED NAME

President & CEO

PRINTED TITLE

SIGNATURE

Mike Kasser

PRINTED NAME

VP & Chief Financial Officer

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 28th day of January 2015

Notarization:

Subscribed and sworn to before me
this 28th day of January 2015

Valerie K. Cawvey
Signature of Notary

Seal

OFFICIAL SEAL
Valerie K. Cawvey
Notary Public, State of Illinois
My Commission Expires Nov. 9, 2017

Valerie K. Cawvey
Signature of Notary

Seal

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*Insert EXACT legal name of the applicant

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 Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION 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.

NOT APPLICABLE**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 to 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.

NOT APPLICABLE**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.

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Surgery (Class C Surgical Operating Suite)	4 Operating Rooms - all General (Multi-Specialty)	7 Operating Rooms - All General (Multi-Specialty)
☒ Post-Anesthesia Recovery Phase I (PACU)	4 Stations	9 Stations
☒ Post-Anesthesia Recovery Phase II	15 Stations	34 Stations: 21 Stations for Surgery 13 Stations for Endoscopy/ Minor Procedures
☒ Endoscopy/Minor Procedures (Class B Surgical Procedures Suite)	4 Procedure Rooms: 2 Endoscopy Procedure Rooms 2 Minor Procedure Rooms	4 Procedure Rooms: 2 Endoscopy Procedure Rooms 2 Minor Procedure Rooms

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

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

APPEND DOCUMENTATION AS ATTACHMENT-34, 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

SEE ATTACHMENTS 36-38 FOR PROOF OF "A" BOND RATING

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:**

	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;
	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;
	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.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 36 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability**SEE ATTACHMENTS 36-38 FOR PROOF OF "A" BOND RATING**

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. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. 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
4. 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-37, 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:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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 38, 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**SEE ATTACHMENTS 36-38 FOR PROOF OF "A" BOND RATING**

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:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

COST AND GROSS SQUARE FEET							
	A	B	C	D	E	F	G
	Cost/Sq. Foot		Gross Sq. Ft.	Gross Sq. Ft.	New Const. \$	Mod. \$	Total Costs
Department	New	Mod.	New	Mod.	(A x C)	(B x D)	(E + F)
Clinical Service Areas:							
Surgical Suite (Class C Surgical Operating Suite)	\$418.58	\$320.38	12,830	3,083	\$5,370,359	\$987,719	\$6,358,078
Endoscopy/Minor Procedures (Class B Surgical Procedure Suite)	\$0.00	\$307.44	0	2,294	\$0	\$705,268	\$705,268
Post-Anesthesia Recovery Phase I (PACU)	\$0.00	\$319.57	0	1,827	\$0	\$583,850	\$583,850
Surgical Prep/Post-Anesthesia Recovery Phase II for Surgery	\$404.25	\$314.29	671	6,001	\$271,252	\$1,886,032	\$2,157,284
Prep/Recovery Phase II for Class B Surgical Procedure Suite	\$0.00	\$305.37	0	3,235	\$0	\$987,878	\$987,878
SUBTOTAL CON COMPONENTS	\$417.87	\$313.31	13,501	16,440	\$5,641,611	\$5,150,747	\$10,792,358
Contingency					\$564,161	\$515,074	\$1,079,235
TOTAL - CLINICAL SERVICE AREAS	\$459.65	\$344.64	13,501	16,440	\$6,205,772	\$5,665,821	\$11,871,593
Non-Clinical Service Areas:							
Administrative Office	\$282.18	\$0.00	394	0	\$111,178	\$0	\$111,178
Storage	\$0.00	\$157.29	0	63	\$0	\$9,909	\$9,909
Entrances, Lobbies, Central Public Space (this project)							
1st Floor	\$267.06	\$93.04	308	393	\$82,254	\$36,565	\$118,819
2nd Floor	\$0.00	\$249.86	0	2,824	\$0	\$705,600	\$705,600
TOTAL ENTRANCES, LOBBIES, CENTRAL PUBLIC SPACE	\$267.06	\$230.70	308	3,217	\$82,254	\$742,165	\$824,419
Interdepartmental Circulation Space - 2nd Floor	\$307.35	\$127.42	520	1,154	\$159,821	\$147,040	\$306,861
Mechanical/Electrical Space and Equipment - 3rd Floor	\$323.79	\$463.27	5,422	1,370	\$1,755,582	\$634,681	\$2,390,263
Stairwells:							
1st Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
2nd Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
3rd Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
TOTAL STAIRWELLS	\$222.70	\$0.00	828	0	\$184,392	\$0	\$184,392
Mechanical/Electrical/Data Shafts - 2nd Floor	\$291.06	\$151.00	140	17	\$40,748	\$2,567	\$43,315
Data Closet - 2nd Floor	\$0.00	\$204.24	0	67	\$0	\$13,684	\$13,684
Housekeeping Closet	\$0.00	\$217.51	0	92	\$0	\$20,011	\$20,011
Emergency Department Canopy	\$99.75	\$0.00	2,225	0	\$221,944	\$0	\$221,944
SUBTOTAL NON-CON COMPONENTS	\$259.83	\$262.55	9,837	5,980	\$2,555,919	\$1,570,057	\$4,125,976
Contingency					\$255,591	\$157,005	\$412,596
TOTAL NON-CLINICAL SERVICE AREAS	\$285.81	\$288.81	9,837	5,980	\$2,811,510	\$1,727,062	\$4,538,572
PROJECT TOTAL	\$386.38	\$329.75	23,338	22,420	\$9,017,282	\$7,392,883	\$16,410,165

Factors Influencing Additional Construction Costs for this Project

- Herrin Hospital is located on the New Madrid Earthquake Fault, as a result of which both the new addition and the existing hospital buildings must meet the current seismic codes for buildings located in an earthquake area.

The new construction must meet the current seismic codes which have unique requirements for buildings located in an earthquake area.

In addition, existing Herrin Hospital buildings must include structural upgrades that are required to meet the current standards of the seismic code.

- This project is being constructed over an existing Emergency Department. The structural, mechanical, and electrical tie-ins required for this expansion will have to be coordinated with the operations of the Emergency Department, which will continued to be operational during the construction period.
- This project will need to be phased so the construction can take place around the existing operating rooms, patient prep/recovery areas, which will remain in operation during construction.

In addition, the construction must include additional infection control measures.

- The construction will overhang the existing Emergency Department ambulance and walk-in entries. Special care will need to be taken to always keep the entrances open to the Emergency Department.
- The project site is very tight, which will make the proposed construction difficult.
- The north side of the hospital property will not be able to be accessed during construction because the property adjacent to the construction site is not owned by the hospital. This project includes the use of pre-cast panels in order to minimize impact on owners of neighboring property.

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.

HERRIN HOSPITAL FOR FY2019: \$ 1,225.11

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.

HERRIN HOSPITAL FOR FY2019: \$ 137.32

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

XI. Safety Net Impact Statement

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

NOT APPLICABLE BECAUSE THIS IS A "NON-SUBSTANTIVE" PROJECT

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)	Year	Year	Year
Inpatient			
Outpatient			
Total			

MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

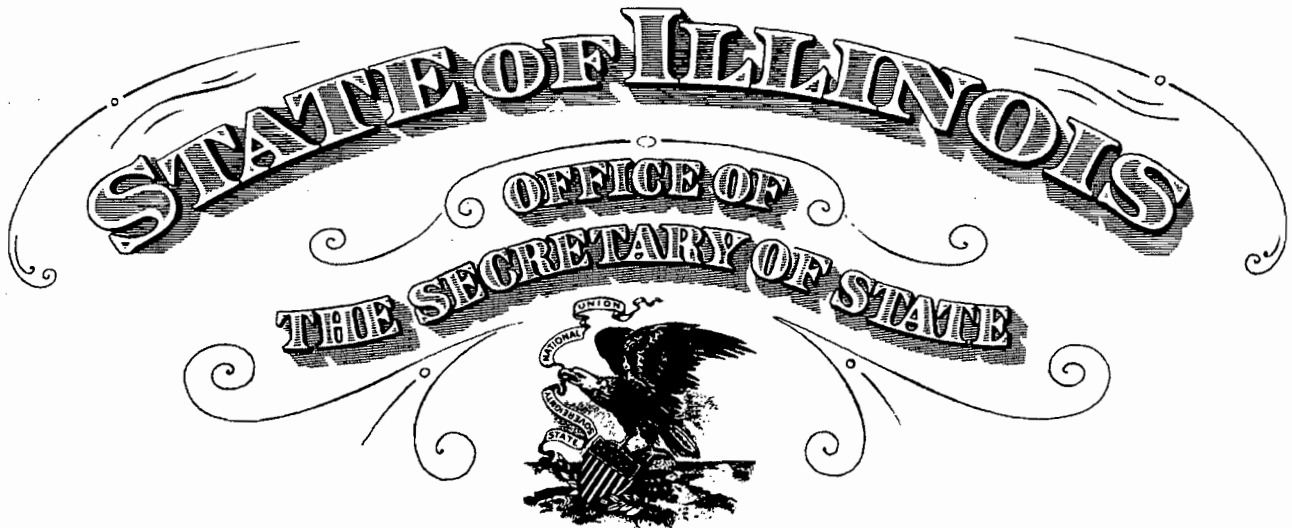
A table in the following format must be provided for all facilities as part of Attachment 44.

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

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

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	25
2	Site Ownership	27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	30
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	31
5	Flood Plain Requirements	33
6	Historic Preservation Act Requirements	46
7	Project and Sources of Funds Itemization	47
8	Obligation Document if required	
9	Cost Space Requirements	58
10	Discontinuation	
11	Background of the Applicant	60
12	Purpose of the Project	71
13	Alternatives to the Project	97
14	Size of the Project	99
15	Project Service Utilization	110
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	Selected Organ Transplantation	
29	Kidney Transplantation	
30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
32	Community-Based Residential Rehabilitation Center	
33	Long Term Acute Care Hospital	
34	Clinical Service Areas Other than Categories of Service	118
35	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
36	Availability of Funds	140
37	Financial Waiver	
38	Financial Viability	
39	Economic Feasibility	152
40	Safety Net Impact Statement	
41	Charity Care Information	157



To all to whom these Presents Shall Come, Greeting:

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

SOUTHERN ILLINOIS HOSPITAL SERVICES, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 15, 1946, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



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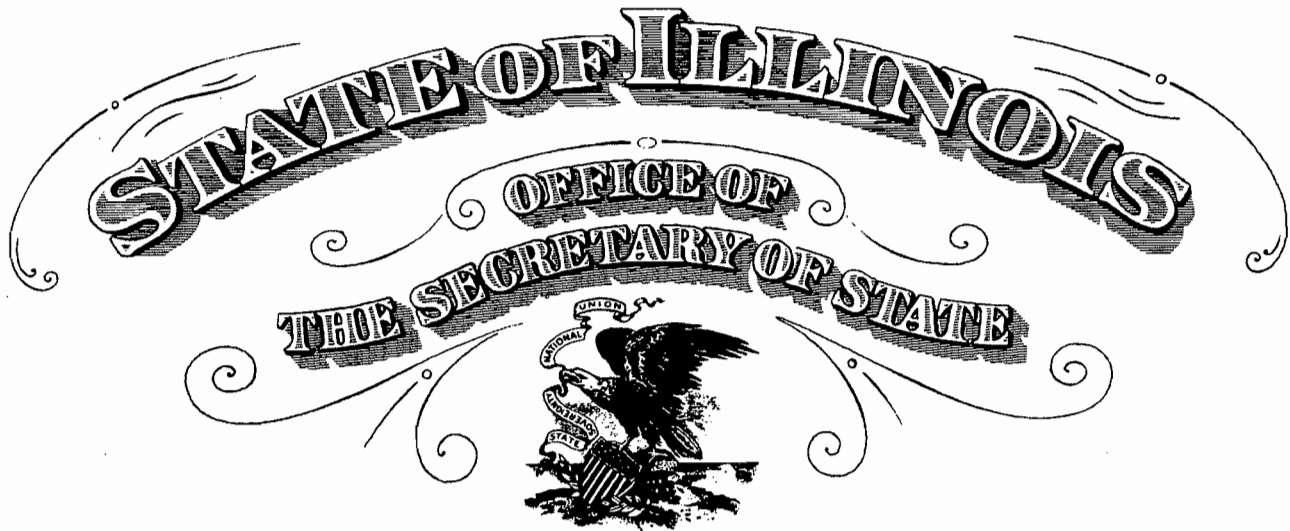
Authenticate at: <http://www.cyberdriveillinois.com>

*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 23RD
day of DECEMBER A.D. 2014*

Jesse White

SECRETARY OF STATE

ATTACHMENT 1, PAGE 1



To all to whom these Presents Shall Come, Greeting:

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

SOUTHERN ILLINOIS HEALTHCARE ENTERPRISES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 06, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1435702942

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of DECEMBER A.D. 2014 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1, PAGE 2

I.
Site Ownership

Proof of Southern Illinois Hospital Services' ownership of the site on which Herrin Hospital is located is found in the Warranty Deed for the hospital site that appears on the following pages of this Attachment.

WARRANT DEED - Statutory
(Individual to Individual)
Approved By (Chicago Title and Trust Co.
Chicago Real Estate Board

(The Above Space For Recorder's Use Only)

THE GRANTOR S, Louie K. Granneman and Billie Granneman, husband and wife
of the City of Herrin County of Williamson State of Illinois
for and in consideration of Ten Dollars and other good and valuable considerations-- in hand paid, CONVEY and WARRANT to Southern Illinois Hospital Corporation, a corporation
of the City of Carbondale County of Jackson State of Illinois
the following described Real Estate situated in the County of Williamson in the State of Illinois, to wit:

Lots 2 and 3 in Block 16 in the Original Survey of Herrin, Illinois, situated in the County of Williamson, State of Illinois;

1969 General Real Estate Taxes payable in 1970 assumed by the Grantors. 1970 General Real Estate Taxes payable in 1971 and all subsequent taxes assumed by the Grantees by the acceptance of this Deed.

hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

DATED this 24th day of March 1970

PLEASE PRINT OR TYPE NAME(S) BELOW SIGNATURE(S)
Louie K. Granneman (Seal)
Billie Granneman (Seal)

State of Illinois, County of Williamson ss., I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Louie K. Granneman and Billie Granneman, husband and wife personally known to me to be the same persons whose names are subscribed to the foregoing instrument appeared before me this day in person, and acknowledged that they signed, sealed and delivered the said instrument as their free and voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.

Given under my hand and official seal, this 24th day of March 1970
Commission expires Dec. 29 1970

ADDRESS OF PROPERTY: 704 West Main St. Herrin, Illinois
THE ABOVE ADDRESS IS FOR STATUTORY PURPOSES ONLY AND IS NOT A PART OF THIS DEED

WARRANTY DEED

THIS INDENTURE WITNESSETH, that the grantor, FIRST CHRISTIAN CHURCH OF HERRIN, WILLIAMSON COUNTY, ILLINOIS, a religious corporation created and existing under and by virtue of the Laws of the State of Illinois, by C. H. Bonds, John W. Reed, L. E. Stotlar and Jo V. Walker, all of the City of Herrin, County of Williamson and State of Illinois, as Trustees of said religious corporation and for and by direction of the congregation of said religious corporation, for the consideration of Ten and no/100 Dollars (\$10.00), CONVEYS and WARRANTS to LOUIE KENNETH GRANNEMAN and BILLIE R. GRANNEMAN, husband and wife, of the City of Herrin, County of Williamson and State of Illinois, not in Tenancy in Common, but in JOINT TENANCY, the following described real estate, to-wit:

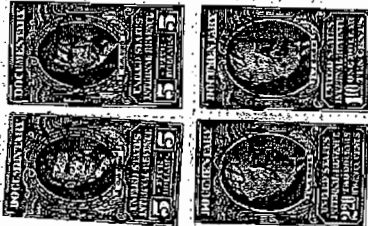
Lot Three (3) in Block Sixteen (16) in the Original Survey of the City of Herrin, Illinois, reference being had to the recorded plat thereof duly recorded in the Office of the Recorder of Williamson County, Illinois, in Plat Record "1" on page 50,

situated in the City of Herrin, County of Williamson, in the State of Illinois.

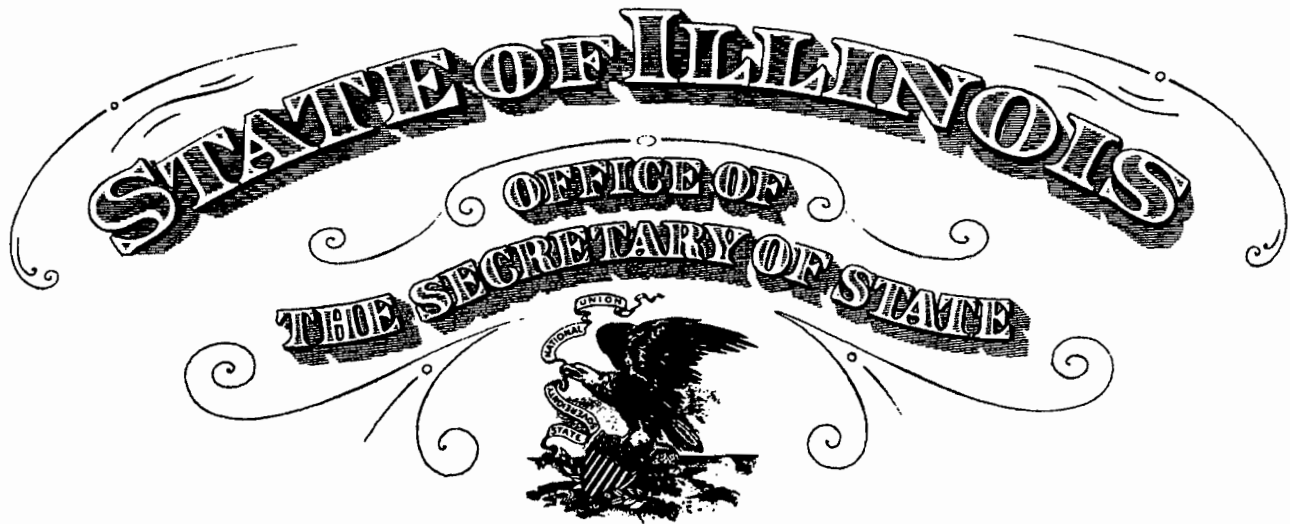
This conveyance is executed and delivered by First Christian Church of Herrin, Williamson County, Illinois, an Illinois religious corporation, through its Trustees, pursuant to a resolution passed by the members of the congregation of said church at a special congregational meeting held on the 15th day of November, 1959, authorizing and directing the Trustees to execute this conveyance, and pursuant to a resolution passed by said Trustees at a meeting of the Trustees held on the 22nd day of November, 1959.

IN WITNESS WHEREOF, said grantor has caused its name to be signed to these presents by its Trustees, this 2nd day of November, 1959.

First Christian Church of Herrin, Williamson County, Illinois (SEAL)
First Christian Church of Herrin, Williamson County, Illinois



C. H. Bonds, Trustee
John W. Reed, Trustee
L. E. Stotlar, Trustee
Jo V. Walker, Trustee



To all to whom these Presents Shall Come, Greeting:

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

SOUTHERN ILLINOIS HOSPITAL SERVICES, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 15, 1946, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1435702918

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of DECEMBER A.D. 2014 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

I.
Organizational Relationships

This project has 2 co-applicants: Southern Illinois Hospital Services d/b/a Herrin Hospital and Southern Illinois Healthcare Enterprises, Inc.

As will be seen on the Organizational Chart that appears on the following page and as discussed in Attachment 11, Southern Illinois Healthcare Enterprises, Inc., is the sole corporate member of Southern Illinois Hospital Services (SIHS).

This entire project will be funded through equity (cash and securities).

Although there is no debt financing for this project, it should be noted that SIHS is part of the Southern Illinois Healthcare Enterprises obligated group.

Southern Illinois Healthcare Enterprises, Inc.

Health Services of
Southern Illinois, Inc.

Southern Illinois Hospital Services

System Office

SIH Cayman
SPC Group, Ltd.

Southern Illinois
Medical
Services, NFP

SIH Foundation,
NFP

Quality Health
Partners LLC

St. Joseph
Memorial
Hospital

Memorial
Hospital of
Carbondale

Herrin
Hospital

Rehabilitation Institute of Chicago

partner

Rehabilitation Institute of Chicago and
Southern Illinois Hospital Services
Rehabilitation Services, LLC

Southern Orthopedic Associates, SC
dba The Orthopedic Institute of Southern Illinois

partner

Southern Illinois Orthopedic Center, LLC

Physicians' Surgery Center, LLC

Joint ventures

I.
Flood Plain Requirements

The following pages of this Attachment include the following documents regarding flood hazard determinations for the Herrin Hospital campus. These documents confirm that the location of this project complies with Illinois Executive Order #2006-5.

1. A Letter of Map Revision Determination Document issued by the Federal Emergency Management Agency (FEMA) on January 31, 2014, that had an effective date of June 20, 2014.

This document stated that FEMA revised the effective National Flood Insurance Program (NFIP) map which had an effective date of August 4, 2008.

The Letter of Map Revision Determination Document stated that FEMA would "not physically revise and republish the FIRM (Flood Insurance Rate Map) and FIS report" for the Herrin community, which had an effective date of August 4, 2008.

This document is found on Pages 2 through 7 of this Attachment.

2. The most-recently issued Flood Insurance Rate Map that includes the Herrin Hospital campus, which had an effective date of August 4, 2008.

This document is found on Pages 8 and 9 of this Attachment.

3. The most recent Special Flood Hazard Area Determination issued by the Illinois State Water Survey for the Herrin Hospital campus that was issued in 2003 based upon a previous Flood Insurance Rate Map.

This determination is found on Pages 10 through 12 of this Attachment.

This Attachment includes a notarized statement from Rex P. Budde, President and CEO of Southern Illinois Hospital Services d/b/a Herrin Hospital, and Michael Kasser, Vice President/ CFO/ Treasurer of Southern Illinois Hospital Services d/b/a Herrin Hospital, attesting to the project's compliance with the requirements of Illinois Executive Order #2006-5, Construction Activities in Special Flood Hazard Areas, because Herrin Hospital's campus is currently located in Zone X, which is a 500 year flood plain.

The attestation is found on Page 13 of this Attachment.



Federal Emergency Management Agency

Washington, D.C. 20472

LETTER OF MAP REVISION DETERMINATION DOCUMENT

COMMUNITY AND REVISION INFORMATION		PROJECT DESCRIPTION	BASIS OF REQUEST
COMMUNITY	City of Herrin Williamson County Illinois	NO PROJECT	HYDRAULIC ANALYSIS NEW TOPOGRAPHIC DATA
	COMMUNITY NO.: 170717		
IDENTIFIER	17th Street Flood Study	APPROXIMATE LATITUDE & LONGITUDE: 37.807, -89.028 SOURCE: Other DATUM: NAD 83	
ANNOTATED MAPPING ENCLOSURES		ANNOTATED STUDY ENCLOSURES	
TYPE: FIRM* NO.: 17199C0042D DATE: August 4, 2008 TYPE: FIRM* NO.: 17199C0041D DATE: August 4, 2008		DATE OF EFFECTIVE FLOOD INSURANCE STUDY: August 04, 2008 PROFILE(S): 01P FLOODWAY DATA TABLE: 7	

Enclosures reflect changes to flooding sources affected by this revision.

* FIRM - Flood Insurance Rate Map

FLOODING SOURCE(S) & REVISED REACH(ES)

17th Street Ditch - From 150 feet downstream of 18th Street to just downstream of Oak Street.

SUMMARY OF REVISIONS

Flooding Source	Effective Flooding	Revised Flooding	Increases	Decreases
17th Street Ditch	Zone AE	Zone AE	YES	YES
	BFEs *	BFEs	YES	YES
	Zone X (unshaded)	Zone X (unshaded)	YES	YES

* BFEs - Base Flood Elevations

DETERMINATION

This document provides the determination from the Department of Homeland Security's Federal Emergency Management Agency (FEMA) regarding a request for a Letter of Map Revision (LOMR) for the area described above. Using the information submitted, we have determined that a revision to the flood hazards depicted in the Flood Insurance Study (FIS) report and/or National Flood Insurance Program (NFIP) map is warranted. This document revises the effective NFIP map, as indicated in the attached documentation. Please use the enclosed annotated map panels revised by this LOMR for floodplain management purposes and for all flood insurance policies and renewals in your community.

This determination is based on the flood data presently available. The enclosed documents provide additional information regarding this determination. If you have any questions about this document, please contact the FEMA Map Information eXchange (FMIX) toll free at 1-877-336-2627 (1-877-FEMA MAP) or by letter addressed to the Engineering Library, 847 South Pickett Street, Alexandria, VA 22304-4605. Additional Information about the NFIP is available on our website at <http://www.fema.gov/nfip>.

Luis Rodriguez, P.E., Chief
Engineering Management Branch
Federal Insurance and Mitigation Administration

13-05-6622P

102-I-A-C



Federal Emergency Management Agency

Washington, D.C. 20472

LETTER OF MAP REVISION DETERMINATION DOCUMENT (CONTINUED)

COMMUNITY INFORMATION

APPLICABLE NFIP REGULATIONS/COMMUNITY OBLIGATION

We have made this determination pursuant to Section 206 of the Flood Disaster Protection Act of 1973 (P.L. 93-234) and in accordance with the National Flood Insurance Act of 1968, as amended (Title XIII of the Housing and Urban Development Act of 1968, P.L. 90-448), 42 U.S.C. 4001-4128, and 44 CFR Part 65. Pursuant to Section 1361 of the National Flood Insurance Act of 1968, as amended, communities participating in the NFIP are required to adopt and enforce floodplain management regulations that meet or exceed NFIP criteria. These criteria, including adoption of the FIS report and FIRM, and the modifications made by this LOMR, are the minimum requirements for continued NFIP participation and do not supersede more stringent State/Commonwealth or local requirements to which the regulations apply.

COMMUNITY REMINDERS

We based this determination on the 1-percent-annual-chance flood discharges computed in the FIS for your community without considering subsequent changes in watershed characteristics that could increase flood discharges. Future development of projects upstream could cause increased flood discharges, which could cause increased flood hazards. A comprehensive restudy of your community's flood hazards would consider the cumulative effects of development on flood discharges subsequent to the publication of the FIS report for your community and could, therefore, establish greater flood hazards in this area.

Your community must regulate all proposed floodplain development and ensure that permits required by Federal and/or State/Commonwealth law have been obtained. State/Commonwealth or community officials, based on knowledge of local conditions and in the interest of safety, may set higher standards for construction or may limit development in floodplain areas. If your State/Commonwealth or community has adopted more restrictive or comprehensive floodplain management criteria, those criteria take precedence over the minimum NFIP requirements.

We will not print and distribute this LOMR to primary users, such as local insurance agents or mortgage lenders; instead, the community will serve as a repository for the new data. We encourage you to disseminate the information in this LOMR by preparing a news release for publication in your community's newspaper that describes the revision and explains how your community will provide the data and help interpret the NFIP maps. In that way, interested persons, such as property owners, insurance agents, and mortgage lenders, can benefit from the information.

This determination is based on the flood data presently available. The enclosed documents provide additional information regarding this determination. If you have any questions about this document, please contact the FEMA Map Information eXchange (FMIX) toll free at 1-877-336-2627 (1-877-FEMA MAP) or by letter addressed to the Engineering Library, 847 South Pickett Street, Alexandria, VA 22304-4605. Additional Information about the NFIP is available on our website at <http://www.fema.gov/nfip>.

Luis Rodriguez, P.E., Chief
Engineering Management Branch
Federal Insurance and Mitigation Administration



Federal Emergency Management Agency
Washington, D.C. 20472

**LETTER OF MAP REVISION
DETERMINATION DOCUMENT (CONTINUED)**

We have designated a Consultation Coordination Officer (CCO) to assist your community. The CCO will be the primary liaison between your community and FEMA. For information regarding your CCO, please contact:

Ms. Christine Stack
Director, Mitigation Division
Federal Emergency Management Agency, Region V
536 South Clark Street, Sixth Floor
Chicago, IL 60605
IL:(312) 408-5500

STATUS OF THE COMMUNITY NFIP MAPS

We will not physically revise and republish the FIRM and FIS report for your community to reflect the modifications made by this LOMR at this time. When changes to the previously cited FIRM panel(s) and FIS report warrant physical revision and republication in the future, we will incorporate the modifications made by this LOMR at that time.

This determination is based on the flood data presently available. The enclosed documents provide additional information regarding this determination. If you have any questions about this document, please contact the FEMA Map Information eXchange (FMIX) toll free at 1-877-336-2627 (1-877-FEMA MAP) or by letter addressed to the Engineering Library, 847 South Pickett Street, Alexandria, VA 22304-4605. Additional Information about the NFIP is available on our website at <http://www.fema.gov/nfip>.

Luis Rodriguez, P.E., Chief
Engineering Management Branch
Federal Insurance and Mitigation Administration



Federal Emergency Management Agency

Washington, D.C. 20472

LETTER OF MAP REVISION DETERMINATION DOCUMENT (CONTINUED)

PUBLIC NOTIFICATION OF REVISION

A notice of changes will be published in the *Federal Register*. This information also will be published in your local newspaper on or about the dates listed below and through FEMA's Flood Hazard Mapping website at:

https://www.floodmaps.fema.gov/fhm/Scripts/bfe_main.asp.

LOCAL NEWSPAPER

Name: *Courier Independent*

Dates: February 13, 2014 and February 20, 2014

Within 90 days of the second publication in the local newspaper, a citizen may request that we reconsider this determination. Any request for reconsideration must be based on scientific or technical data. Therefore, this letter will be effective only after the 90-day appeal period has elapsed and we have resolved any appeals that we receive during this appeal period. Until this LOMR is effective, the revised flood hazard determination information presented in this LOMR may be changed.

This determination is based on the flood data presently available. The enclosed documents provide additional information regarding this determination. If you have any questions about this document, please contact the FEMA Map Information eXchange (FMIX) toll free at 1-877-336-2627 (1-877-FEMA MAP) or by letter addressed to the Engineering Library, 847 South Pickett Street, Alexandria, VA 22304-4605. Additional Information about the NFIP is available on our website at <http://www.fema.gov/nfip>.

Luis Rodriguez, P.E., Chief
Engineering Management Branch
Federal Insurance and Mitigation Administration

13-05-6622P

102-I-A-C

FLOODING SOURCE		FLOODWAY			1-PERCENT-ANNUAL-CHANCE-FLOOD WATER SURFACE ELEVATION (FEET NAVD)			
CROSS SECTION	DISTANCE ¹	WIDTH (FEET)	SECTION AREA (SQUARE FEET)	MEAN VELOCITY (FEET PER SECOND)	REGULATORY	WITHOUT FLOODWAY	WITH FLOODWAY	INCREASE (FEET)
17th Street Ditch								
A	2,850 ¹	*	*	*	395.1	395.1	*	*
B	3,000 ¹	*	*	*	400.0	400.0	*	*
C	4,150 ¹	*	*	*	403.0	403.0	*	*
D	4,884 ¹	*	*	*	405.1	405.1	*	*
Crab Orchard Creek	*	*	*	*	*	*	*	*
Campground Creek								
A	5,320 ²	897	3,806	0.4	423.4	423.4	423.5	0.1
B	6,000 ²	288	913	1.6	424.2	424.2	424.3	0.1
C	6,640 ²	369	1,041	1.4	425.1	425.1	425.2	0.1
D	7,130 ²	397	1,777	0.8	426.6	426.6	426.7	0.1
East Fork Campground Creek								
A	2,600 ²	1,024	1,246	0.6	422.5	422.5	422.6	0.1
B	3,510 ²	275	563	1.3	424.0	424.0	424.1	0.1
C	4,460 ²	163	512	1.4	427.4	427.4	427.5	0.1
D	5,070 ²	377	1,213	0.6	429.2	429.2	429.3	0.1
Fairgrounds Creek	*	*	*	*	*	*	*	*

¹Feet above Union Pacific Railroad

²Feet above mouth

*Data not available

REVISED DATA

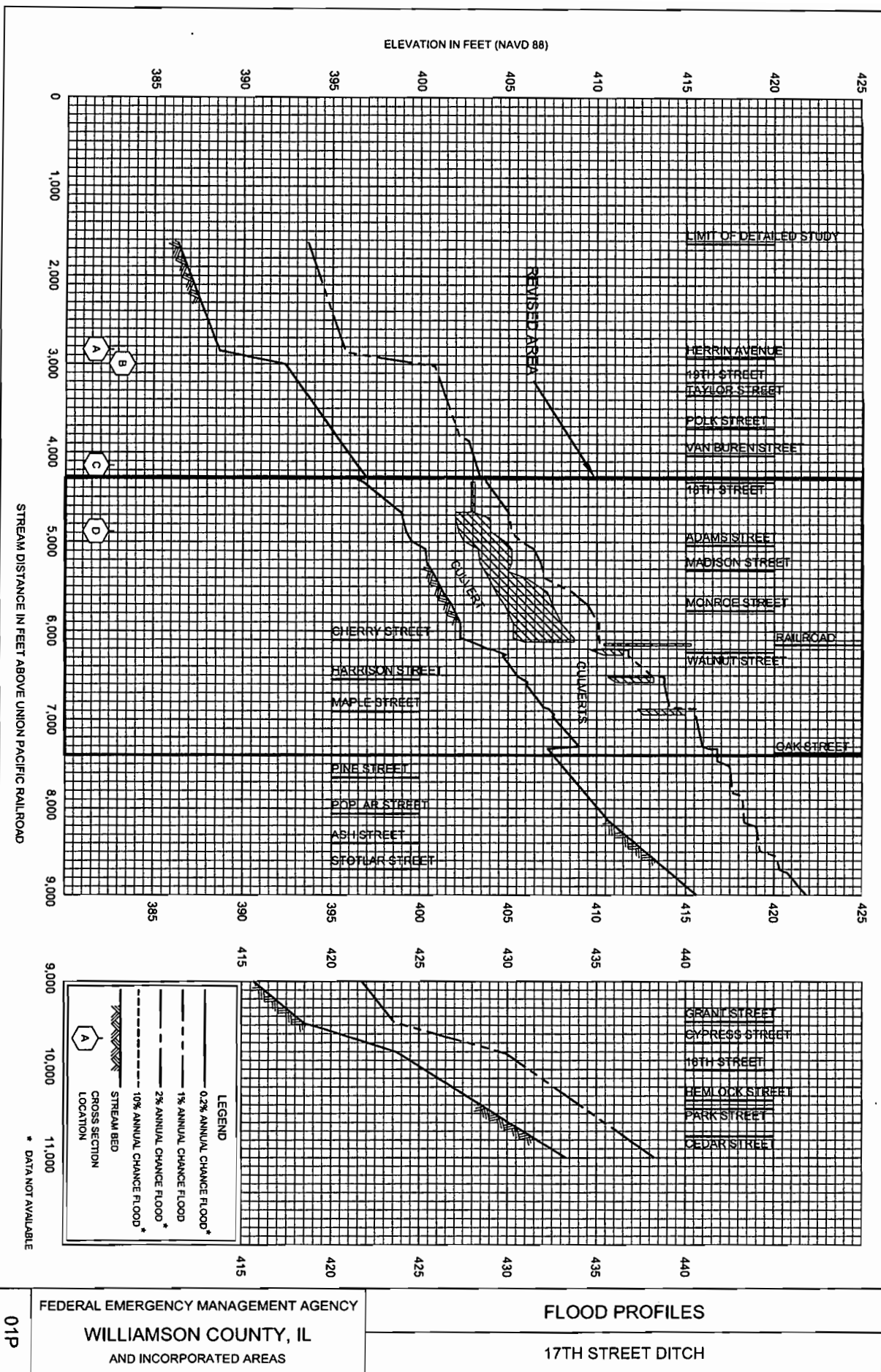
TABLE 7

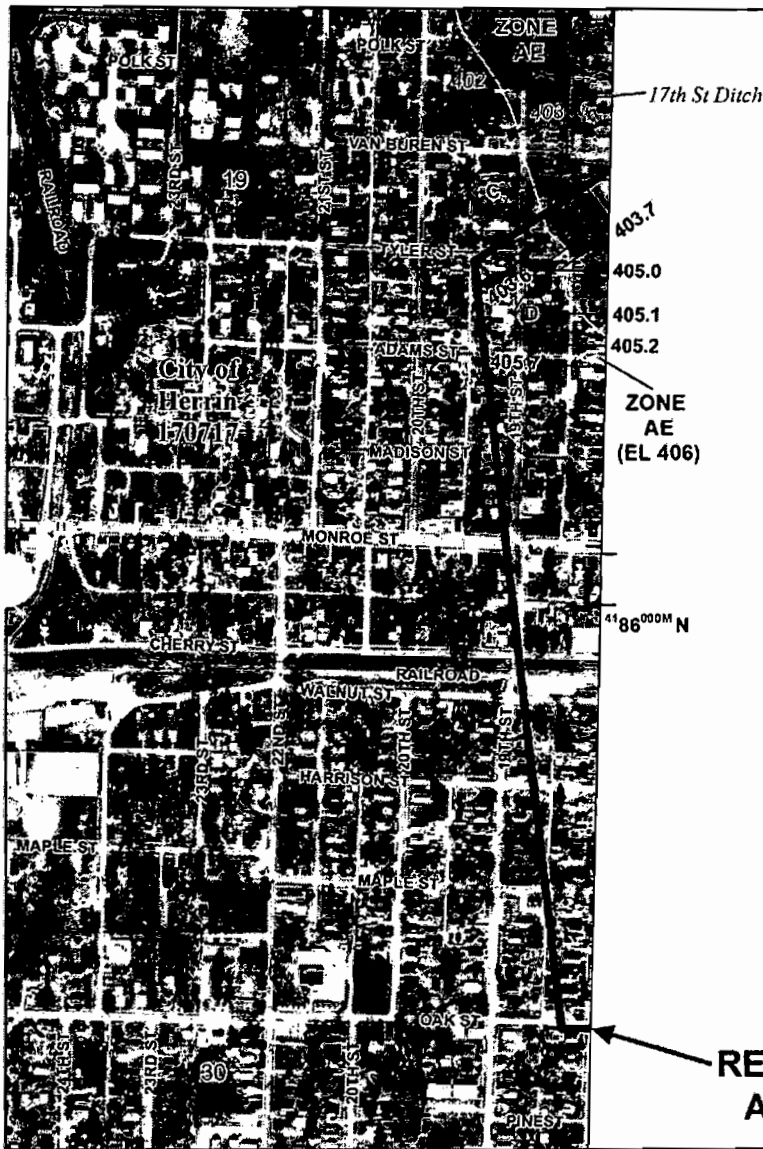
FEDERAL EMERGENCY MANAGEMENT AGENCY

WILLIAMSON COUNTY, IL
AND INCORPORATED AREAS

FLOODWAY DATA

17TH STREET DITCH - CRAB ORCHARD CREEK -
CAMPGROUND CREEK - EAST FORK CAMPGROUND CREEK
- FAIRGROUNDS CREEK





FLOOD HAZARD INFORMATION

SPECIAL FLOOD HAZARD AREAS

- Without Base Flood Elevation (BFE)
Zone AE, A99
- With BFE of Depth Zone AE, X0, AH, VE, AR
- Regulatory Floodway
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X



NATIONAL FLOOD INSURANCE PROGRAM FLOOD INSURANCE RATE MAP

WILLIAMSON COUNTY, ILLINOIS
and Incorporated Areas

PANEL 41 OF 375

Panel Contains:
COMMUNITY

LAFARGE VILLAGE, IL
HERRIN, CITY OF
WILLIAMSON COUNTY

NUMBER	PANEL	SUFFIX
170951	0041	U
170717	0041	N
170954	0041	O

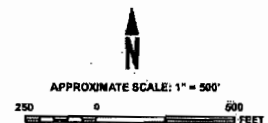


VERSION NUMBER
2.3.2.3
MAP NUMBER
17199C0041D
EFFECTIVE DATE
AUGUST 4, 2008



FLOOD HAZARD INFORMATION

SPECIAL FLOOD HAZARD AREAS		Without Base Flood Elevation (BFE) Zone X, V, A99
		With BFE or Depth Zone AE, AO, AH, VE, AR
		Regulatory Floodway
		0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X



NATIONAL FLOOD INSURANCE PROGRAM FLOOD INSURANCE RATE MAP

WILLIAMSON COUNTY, ILLINOIS
and Incorporated Areas

PANEL 42 OF 375

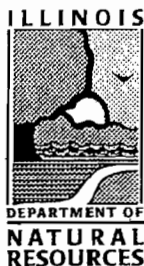
Panel Contains:

COMMUNITY
LINDSEY VILLAGE OR
HERRIN, CITY OF
WILLIAMSON COUNTY

NUMBER	PANEL	SUFFIX
17051	0042	U
17057	0042	D
17094	0042	D



VERSION NUMBER
2.3.2.3
MAP NUMBER
17199C0042D
EFFECTIVE DATE
AUGUST 4, 2008



Illinois State Water Survey

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



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

Requester: Andrea Rozran, Diversified Health Resources
Address: 875 North Michigan Ave., Suite 3250
City, state, zip: Chicago, IL 60611 Telephone: (312) 266-0466

Site description of determination:

Site address: Herrin Hospital, 201 S. 14th St.
City, state, zip: Herrin, IL 62948
County: Williamson Sec/4: NW¼ of NE¼ Section: 30 T. 8 S. R. 2 E. PM: 3rd
Subject area: Area bounded by 14th St. on the west, 12th St. on the east, Harrison St. on the north, and Oak St. on the south:

The property described above IS NOT located in a Special Flood Hazard Area (SFHA).

Floodway mapped: N/A Floodway on property: No
Source used: FEMA Flood Insurance Rate Map (FIRM). An annotated copy is attached.
Community name: City of Herrin, IL Community number: 170717
Panel/map number: 170717 0003 B Effective Date: April 16, 1990
Flood zone: X [unshaded] Base flood elevation: N/A ft NGVD 1929

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

The primary structure on the property:

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

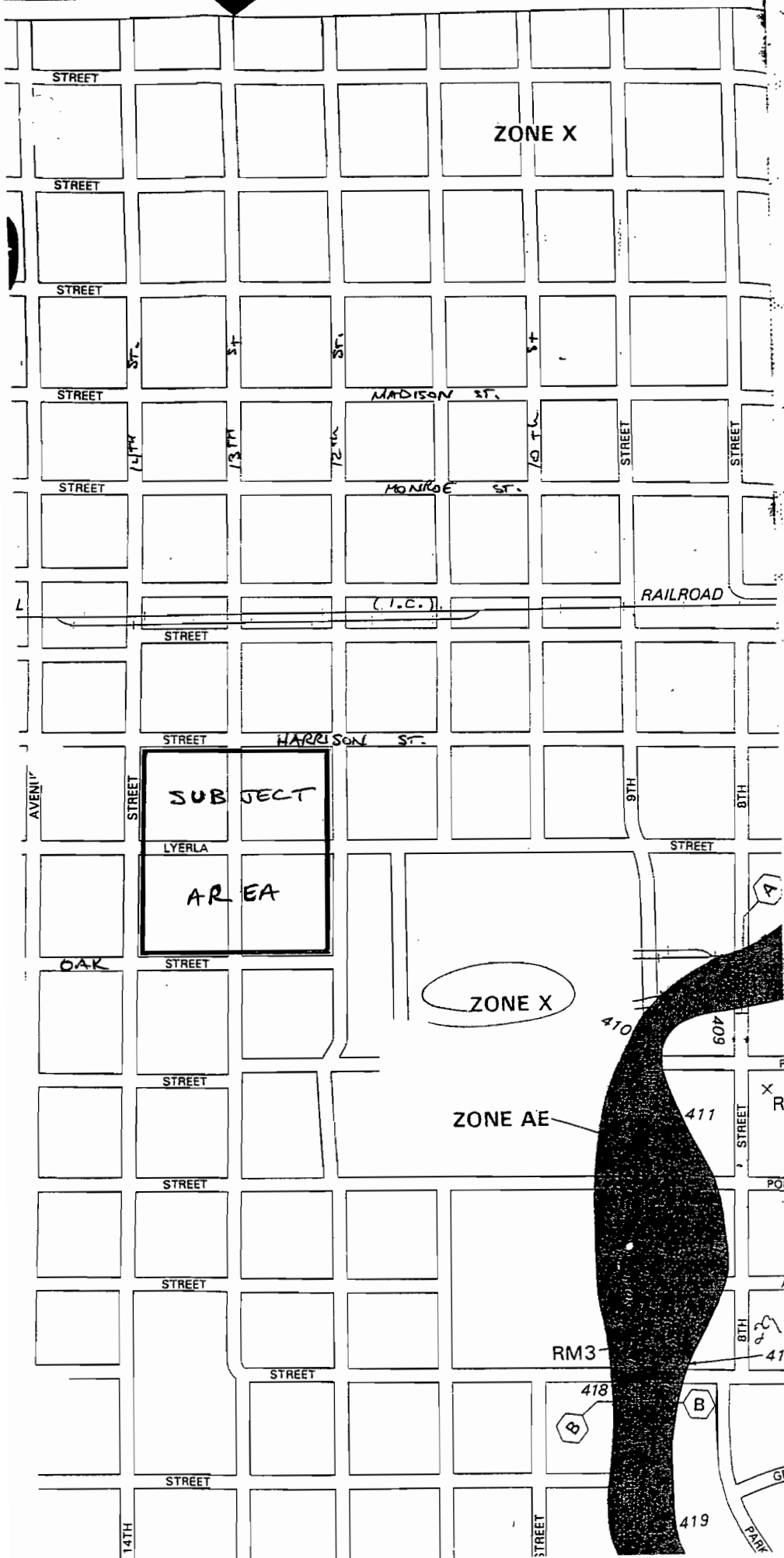
Note: This determination is based on the current Federal Emergency Management Agency (FEMA) flood hazard map for the community. This letter does not imply that the referenced property will or will not be free from flooding or damage. A property or structure not in a Special Flood Hazard Area may be damaged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

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) or Sally McConkey (217/333-5482) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 4 (1979), or State floodplain regulations, may be directed to Paul Osman (217/782-3862) at the IDNR Office of Water Resources.

William Saylor
William Saylor, Illinois State Water Survey

Title: ISWS Surface Water and Floodplain Information Date: 8/11/2003

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LEGEND

SPECIAL FLOOD HAZARD AREAS INUNDED BY 100-YEAR FLOOD



ZONE A No base flood elevations determined.

ZONE AE Base flood elevations determined.

ZONE AH Flood depths of 1 to 3 feet (usually areas of ponding); base flood elevations determined.

ZONE AO Flood depths of 1 to 3 feet (usually sheet flow on sloping terrain); average depths determined. For areas of alluvial fan flooding, velocities also determined.

ZONE A99 To be protected from 100-year flood by Federal flood protection system under construction; no base elevations determined.

ZONE V Coastal flood with velocity hazard (wave action); no base flood elevations determined.

ZONE VE Coastal flood with velocity hazard (wave action); base flood elevations determined.

FLOODWAY AREAS IN ZONE AE

OTHER FLOOD AREAS

ZONE X Areas of 500-year flood; areas of 100-year flood with average depths of less than 1 foot or with drainage areas less than 1 square mile; and areas protected by levees from 100-year flood.

OTHER AREAS

ZONE X Areas determined to be outside 500-year flood plain.

ZONE D Areas in which flood hazards are undetermined.



UNDEVELOPED COASTAL BARRIERS

Flood Boundary

Floodway Boundary

Zone D Boundary

Boundary Dividing Special Flood Hazard Zones, and Boundary Dividing Areas of Different Coastal Base Flood Elevations Within Special Flood Hazard Zone.

Base Flood Elevation Line; Elevation in Feet*

Cross Section Line

Base Flood Elevation in Feet Where Uniform Within Zone*

Elevation Reference Mark

Mile Mark

*Referenced to the National Geodetic Vertical Datum of 1929

NOTES

This map is for administering the National Flood Insurance Program; it does not necessarily identify all planimetric features outside Special Flood Hazard Area or all areas subject to flooding, particularly from local drainage sources.

AH, AO, A99, V, VE and VI-V30.

Certain areas not in Special Flood Hazard Areas may be protected by flood control structures.

Boundaries of the floodways were computed at cross sections and interpolated between cross sections. The floodways were based on hydraulic considerations with regard to requirements of the Federal Emergency Management Agency. Floodway widths in some areas may be too narrow to show to scale. Refer to Floodway Data Table where floodway width is shown at 1/20 inch.

Coastal base flood elevations apply only landward of the shoreline. This map incorporates approximate boundaries of coastal barriers established under the Coastal Barrier Resources Act (PL 97-340).

Elevation reference marks are described in the Flood Insurance Study Report. Corporate limits shown are current as of the date of this map. The user should contact appropriate community officials to determine if corporate limits have changed subsequent to the issuance of this map.

For adjoining panels, see separately printed Map Index.

MAP REPOSITORY

Clerk's Desk, City Hall, 300 North Park Avenue, Herrin, Illinois.
(Maps available for reference only, not for distribution.)

INITIAL IDENTIFICATION:

FEBRUARY 15, 1974

FLOOD HAZARD BOUNDARY MAP REVISION:

DECEMBER 5, 1975

FLOOD INSURANCE RATE MAP EFFECTIVE:

APRIL 18, 1990

FLOOD INSURANCE RATE MAP REVISIONS:

CITY OF HERRIN, IL
FILED 170717 0003 B

To determine if flood insurance is available, contact an insurance agent or call the National Flood Insurance Program at (800) 638-6620.



APPROXIMATE SCALE IN FEET



SOUTHERN ILLINOIS HEALTHCARE

January 21, 2015

Mr. Michael Constantino
Project Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson
Springfield, Illinois 62702

Re: Compliance with Requirements of Illinois Executive Order #2006-5 regarding Construction Activities in Special Flood Hazard Areas

Dear Mr. Constantino:

The undersigned are authorized representatives of Southern Illinois Hospital Services, the owner of the site on which Herrin Hospital is located.

We hereby attest that this site is in compliance with the Flood Plain Rule and the requirements stated under Illinois Executive Order #2006-5, "Construction Activities in Special Flood Hazard Areas."

The proposed project is an addition to Herrin Hospital and the modernization of existing space within the hospital. Most of the addition will be constructed on top of an existing single-story hospital building, with a portion constructed adjacent to the existing hospital building as well.

The current designation of the Herrin Hospital campus is in Zone X of a 500-year flood plain. As an addition and modification of an existing "critical facility," this construction is in compliance with Executive Order #2006-5.

Signed and dated as of January 21, 2015.

Southern Illinois Hospital Services
An Illinois Not-For-Profit Corporation

Rex P. Budde, President and CEO
Southern Illinois Hospital Services d/b/a Herrin Hospital

Michael Kasser, Vice President/CFO/Treasurer
Southern Illinois Hospital Services d/b/a Herrin Hospital



Valerie K. Cawvey



Valerie K. Cawvey



FAX (217) 524-7525

Williamson County

Herrin

New Construction of an Addition for Replacement and Expansion of Surgical Services and Rehabilitation,
Herrin Hospital
201 S. 14th St.
IHPA Log #009110514

November 18, 2014

Andrea Rozran
Diversified Health Resources
65 E. Scott, Suite 9A
Chicago, IL 60610-5274

Dear Ms. Rozran:

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

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

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

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker
Deputy State Historic
Preservation Officer

Herrin Hospital Itemized Project Costs

USE OF FUNDS	Clinical Service Areas	Non-Clinical Service Areas	TOTAL
Pre-Planning Costs:			
Program/Planning Services	\$42,700	\$18,300	\$61,000
Pre-Construction Services - Construction Manager/Estimating	\$46,258	\$19,825	\$66,083
Total Pre-Planning Costs	\$88,958	\$38,125	\$127,083
Site Preparation:			
Excavation & Grading	\$40,314	\$17,278	\$57,592
Total Site Preparation	\$40,314	\$17,278	\$57,592
Off-Site Work:			
Demolition	\$0	\$26,751	\$26,751
Excavation & Grading	\$0	\$10,000	\$10,000
Utilities	\$0	\$95,375	\$95,375
Paving	\$0	\$82,263	\$82,263
Landscaping	\$0	\$20,000	\$20,000
Total Off Site Work	\$0	\$234,389	\$234,389
New Construction Contracts	\$5,641,611	\$2,555,919	\$8,197,530
Modernization Contracts	\$5,150,747	\$1,570,057	\$6,720,804
Contingencies	\$1,079,235	\$412,596	\$1,491,831
Architectural and Engineering Fees:			
Architecture/Engineering	\$656,877	\$281,519	\$938,396
Interior Design	\$21,000	\$9,000	\$30,000
Architecture/Engineering Reimbursements	\$14,000	\$6,000	\$20,000
Total Architecture/Engineering Fees	\$691,877	\$296,519	\$988,396
Consulting and Other Fees:			
Inspections and Testing	\$13,374	\$5,732	\$19,106
Commissioning	\$84,000	\$36,000	\$120,000
CON Planning and Consultation	\$52,500	\$22,500	\$75,000
CON Application Processing Fee	\$38,500	\$16,500	\$55,000
IDPH Plan Review Fee	\$14,000	\$6,000	\$20,000
SIH Management Fee	\$218,494	\$93,640	\$312,134
Construction Auditing	\$12,600	\$5,400	\$18,000
Builders' Risk Insurance	\$25,200	\$10,800	\$36,000
Total Consulting and Other Fees	\$458,668	\$196,572	\$655,240
Movable or Other Equipment (not in Construction Contracts):			
Medical Equipment	\$4,122,106	0	\$4,122,106
Systems/Modular Furniture	\$58,900	0	\$58,900
Furniture/Furnishings	\$206,603	0	\$206,603
Telecom Equipment	\$5,000	0	\$5,000
Information Systems Equipment	\$128,913	0	\$128,913
Artwork & Plants	\$19,500	0	\$19,500
(see listing by department on the following pages)			
Total Movable or Other Equipment	\$4,541,022	\$0	\$4,541,022
Other Costs to be Capitalized:			
Temporary Department Relocations	\$8,000	\$0	\$8,000
Signage/Graphics	\$0	\$2,000	\$2,000
Emergency Generator	\$0	\$645,082	\$645,082
Total Other Costs to be Capitalized	\$8,000	\$647,082	\$655,082
TOTAL ESTIMATED PROJECT COSTS	\$17,700,432	\$5,968,537	\$23,668,969

Herrin Hospital: Surgery Addition - Equipment Schedule

10/22/2014

Update of 10/22/2014 provided by Tynette Jansen on 10/20/14 via email.

Revised: 12/08/2014, 1/20/2015

Equipment Cost provided by SIH PD&C with input from Herrin Hospital

Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	Consult Room	Table and Chairs	2		0		\$1,260	
Surgery	Anesthesia Offices	Office Workstations	3		0		\$6,500	
Surgery	Control Desk	Chairs	2		0		\$840	
Surgery	Control Desk	Monitors	2		0		\$5,250	
Surgery	Soil Holding	Trash Cans Large	2		0		\$630	
Surgery	Soil Holding	Soiled Linen Cart	1		0		\$1,260	
Surgery	Male/Female Locker	Scrub X Machine	2		0		\$21,000	
Surgery	Staff Lounge	Tables	3		0		\$1,260	
Surgery	Staff Lounge	Chairs	12		0		\$3,780	
Surgery	Staff Lounge	Refrigerator	2		0		\$5,250	
Surgery	Staff Lounge	Office Chairs	2		0		\$1,260	
Surgery	Staff Lounge	Trash Cans	2		0		\$189	
Surgery	Staff Lounge	Microwave	2		0		\$315	
Surgery	Staff Lounge	Coffee Maker	2		0		\$420	
Surgery	Staff Lounge	Trash Container Large	1		0		\$315	
Surgery	Staff Lounge	Lounge Seating	1		0		\$2,520	
Surgery	Staff Lounge	T.V. 48 Inch	1		0		\$1,575	
Surgery	Surgery Supply Storage	Shelving	1		0		\$25,000	
Total								\$78,624

048

Herrin Hospital: Surgery Addition - Equipment Schedule

10/22/2014

Update of 10/22/2014 provided by Tynette Jansen on 10/20/14 via email.

Revised: 12/08/2014, 1/20/2015

Equipment Cost provided by SIH PD&C with input from Herrin Hospital

Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	Med Phs 2	Omni Cell	2		1		\$31,500	
Surgery	Med Phs 2	Refrigerator	1		0		\$2,625	
Surgery	Med Phs 2	Warmer	1		0		\$16,016	
Surgery	Med Phs 2	Ice Machine	1		0		\$4,725	
Surgery	Soiled Utility	Large Trash Cans	4		0		\$630	
Surgery	Soiled Utility	Soiled Linen Cart	1		0		\$600	
Surgery	Soiled Utility	Infectious Waste Container	1		0		\$300	
Surgery	Soiled Utility	Paper Towel	1	Supplied by Vendor	0		\$0	
Surgery	Soiled Utility	Soap Container	1		0		\$32	
Surgery	O.R. 1	Table	2	Relocate Table	2	Relocate Existing	\$0	
Surgery	O.R. 1	Equipment Relocation Costs		Stryker		Relocation costs	\$35,000	
Surgery	O.R. 1	Integrated Equipment	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 1	Lights	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 1	Equipment Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 1	Anesthesia Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 1	Nurses Desk in room	1	Stryker	0		\$4,600	
Surgery	O.R. 1	Anesthesia Machine	1	Relocate Existing	1	Relocate Existing	\$0	
Surgery	O.R. 1	Howard Instr. Table and Stool	1	SMS	0		\$851	
Surgery	O.R. 1	Howard Back Table	1	SMS	0		\$1,260	
Surgery	O.R. 1	Mayo Stands	2	SMS	0		\$2,688	
Surgery	O.R. 1	Blanket Warmer	1		1		\$0	
Surgery	O.R. 2	Table	1	Stryker	0		\$94,500	
Surgery	O.R. 2	Equipment Relocation Costs		Stryker	0	Relocation costs	\$35,000	
Surgery	O.R. 2	Integrated Equipment	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 2	Lights	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 2	Equipment Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 2	Anesthesia Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R. 2	Nurses Desk in room	1	Steris	0		\$4,600	
Surgery	O.R. 2	Anesthesia Machine	1	Relocate Existing	0	Relocate Existing	\$0	
Surgery	O.R. 2	Howard Instr. Table and Stool	1	SMS	0		\$851	

Herrin Hospital: Surgery Addition - Equipment Schedule

10/22/2014

Update of 10/22/2014 provided by Tynette Jansen on 10/20/14 via email.

Revised: 12/08/2014, 1/20/2015

Equipment Cost provided by SIH PD&C with input from Herrin Hospital

Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	O.R.2	Howard Back Table	1	SMS	0		\$1,260	
Surgery	O.R.2	Mayo Stands	2	SMS	0		\$2,688	
Surgery	O.R.2	Blanket Warmer	1		1		\$0	
Surgery	O.R.3	Table	1	Stryker	0		\$90,000	
Surgery	O.R.3	Equipment Relocation Costs		Stryker		Relocation costs	\$35,000	
Surgery	O.R.3	Integrated Equipment	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R.3	Lights	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R.3	Equipment Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R.3	Anesthesia Boom	1	Stryker	1	Relocate Existing	\$0	
Surgery	O.R.3	Nurses Desk in room	1	Stryker	0		\$4,600	
Surgery	O.R.3	Anesthesia Machine	1	Relocate Existing	0	Relocate Existing	\$0	
Surgery	O.R.3	Howard Instr Table and Stool	1	SMS	0		\$851	
Surgery	O.R.3	Howard Back Table	1	SMS	0		\$1,260	
Surgery	O.R.3	Mayo Stands	2	SMS	0		\$2,688	
Surgery	O.R.3	Blanket Warmer	1		1	Relocate Existing	\$0	
Surgery	O.R.4	Tables	1	Stryker	1		\$63,000	
Surgery	O.R.4	Integrated Equipment	1	Stryker	0		\$213,150	
Surgery	O.R.4	Lights	1	Stryker			\$0	
Surgery	O.R.4	Equipment Boom	1	Stryker			\$0	
Surgery	O.R.4	Anesthesia Boom	1	Stryker			\$0	
Surgery	O.R.4	Nurses Desk in room	1	Stryker			\$4,600	
Surgery	O.R.4	Anesthesia Machine	1	Blue Bells \$3,000 +Carts	1	Relocate Existing	\$0	
Surgery	O.R.4	Howard Instr. Table and Stool	1	Move Existing	1	Relocate Existing	\$0	
Surgery	O.R.4	Howard Back Table	1	Move Existing	1	Relocate Existing	\$0	
Surgery	O.R.4	Mayo Stands	2	Move Existing	2	Relocate Existing	\$0	
Surgery	O.R.4	Blanket Warmer	1	Move Existing	1	Relocate Existing	\$0	
Surgery	O.R.5	Tables	1	Steris	0		\$90,000	
Surgery	O.R.5	Integrated Equipment	1	Stryker	0		\$213,150	
Surgery	O.R.5	Lights	1	Stryker	0		\$0	
Surgery	O.R.5	Equipment Boom	1	Stryker	0		\$0	

Herrin Hospital: Surgery Addition - Equipment Schedule

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	O.R.5	Anesthesia Boom	1	Stryker	0		\$0	
Surgery	O.R.5	Nurses Desk in room	1	Stryker	0		\$4,600	
Surgery	O.R.5	Anesthesia Machine	1	Blue Bells \$3,000 +Carts	0		\$71,400	
Surgery	O.R.5	Howard Instr. Table and Stool	1		1		\$0	
Surgery	O.R.5	Howard Back Table	1		1		\$0	
Surgery	O.R.5	Mayo Stands	2		2		\$0	
Surgery	O.R.5	Blanket Warmer	1		0		\$16,065	
Surgery	O.R.6	Tables	1	Steris	0		\$90,000	
Surgery	O.R.6	Integrated Equipment	1	Stryker	0		\$213,150	
Surgery	O.R.6	Lights	1	Stryker	0		\$0	
Surgery	O.R.6	Equipment Boom	1	Stryker	0		\$0	
Surgery	O.R.6	Anesthesia Boom	1	Stryker	0		\$0	
Surgery	O.R.6	Nurses Desk in room	1	Stryker	0		\$4,600	
Surgery	O.R.6	Anesthesia Machine	1	Blue Bells \$3,000 +Carts	0		\$71,400	
Surgery	O.R.6	Howard Instr. Table and Stool	1		0		\$851	
Surgery	O.R.6	Howard Back Table	1		0		\$1,260	
Surgery	O.R.6	Mayo Stands	2		0		\$2,688	
Surgery	O.R.6	Blanket Warmer	1		0		\$16,065	
Surgery	O.R.7	Tables	1	Steris			\$90,000	
Surgery	O.R.7	Integrated Equipment	1	Stryker	0		\$213,150	
Surgery	O.R.7	Lights	1	Stryker	0		\$0	
Surgery	O.R.7	Equipment Boom	1	Stryker	0		\$0	
Surgery	O.R.7	Anesthesia Boom	1	Stryker	0		\$0	
Surgery	O.R.7	Nurses Desk in room	1	Stryker	0		\$4,600	
Surgery	O.R.7	Anesthesia Machine	1	Blue Bells \$3,000 +Carts	0		\$71,400	
Surgery	O.R.7	Howard Instr. Table and Stool	1		0		\$851	
Surgery	O.R.7	Howard Back Table	1		0		\$1,260	
Surgery	O.R.7	Mayo Stands	2		0		\$2,688	
Surgery	O.R.7	Blanket Warmer	1		0		\$16,065	
Surgery	Inner Core - Scrub 1 - 7	Paper Towel	8	Supplied by Vendor	0		\$0	
Surgery	Inner Core - Scrub 1 - 7	Soap Container	8		0		\$252	

Herrin Hospital: Surgery Addition - Equipment Schedule
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Equipment Cost provided by SIH PD&C with input from Herrin Hospital

Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	Inner Core - Scrub 1 - 7	Trash Cans Fire Rated Large	7		0		\$1,103	
Surgery	Inner Core - Scrub 1 - 7	Glove Dispensers	7		0		\$368	
Surgery	Inner Core - Scrub 1 - 7	Scrub Sink	7		0		\$54,390	
Surgery	Inner Core	Blanket & Fluid Warmer	2	Steris	1		\$16,065	
Surgery	Inner Core	Sterilizer	2		1		\$52,500	
Surgery	Inner Core	Shelving	27		3		\$25,000	
Surgery	Inner Core	Omni Cell	7		4		\$189,000	
Surgery	Equipment Room	Warmer	1	Steris	0		\$16,065	
Surgery	Equipment Room	Shelving	1		0		\$25,000	
Surgery	Passage	Carts	5		0		\$5,250	
Surgery	Offices	Office Furniture Allowance	8		0		\$28,000	
Surgery	Director Office	New Furniture Allowance	1		0		\$6,000	
Surgery	Anesthesia Work Rm	Furniture Allowance	1		0		\$6,000	
Surgery	Case Cart Storage	Carts	6	For additional 4 O.R.	0		\$15,000	
Surgery	PKG, 1488 HD 3 CHIP CAMERA CONTROL UNIT (CCU)		5		0		\$30,081	
Surgery	SDC3 BASE SYSTEM		9		0		\$41,475	
Surgery	L9000 LIGHT SOURCE		5		0		\$16,223	
Surgery	PNEUMO SURE XL HIGH FLOW INSUFFLATOR		5		0		\$15,818	
Surgery	PKG, VISIONPRO 26" LED DISPLAY		10		0		\$13,913	
Surgery	KODAK ESP 7250 PRINTER		5		0		\$1,136	
Surgery	Trash/Linen Cart	Medline	8		0		\$2,000	
Surgery	Art Work / Plants						\$12,500	
Surgery	CCTV System						\$62,330	
Surgery	Access Control						\$34,265	
Total								\$2,519,847

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Endo/Minor Proc	Scope Room	Mediators	2		2	Relocate existing	\$0	
Endo/Minor Proc	Scope Room	Scope Storage Cabinets	6		0	Plan is for 6 new - 30"w	\$12,600	
Endo/Minor Proc	Procedure & Exam	Booms/Lights	4	Relocate lights in rooms 3.	1		\$111,052	
Endo/Minor Proc	Procedure & Exam	Warmer	4		4	Relocate existing	\$0	
Endo/Minor Proc	Procedure & Exam	Light Source (Olympus)	2		1		\$148,749	
Endo/Minor Proc	Procedure & Exam	Video Processor					\$0	
Endo/Minor Proc	Procedure & Exam	OEP-5 Printer					\$0	
Endo/Minor Proc	Procedure & Exam	Olympus WM-D60 Mobile work station					\$0	
Endo/Minor Proc	Procedure & Exam	Olympus Evis Exera III					\$0	
Endo/Minor Proc	Procedure & Exam	Mayo Stand	4		4		\$0	
Endo/Minor Proc	Procedure & Exam	Phillips Monitor	4		0	Figure one for each rm.	\$147,000	
Endo/Minor Proc	Procedure & Exam	Anesthesia Cart	0		4	Relocate existing	\$0	
Endo/Minor Proc	Procedure & Exam	Omni Cell	0		4	Relocate existing	\$0	
Endo/Minor Proc	Procedure & Exam	Trash Can	4		0		\$1,260	
Endo/Minor Proc	Procedure & Exam	Trash Hopper	4		0		\$1,260	
Endo/Minor Proc	Procedure & Exam	Bio Bin	4		0	Relocate existing	\$0	
Endo/Minor Proc	Procedure & Exam	Rolling stools	4		0		\$1,470	
Total								\$423,391

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	Recovery Suite Phs 1	Nurse Station	1		0		\$4,725	
Surgery	Recovery Suite Phs 1	Nurse Chairs	4		0		\$1,680	
Surgery	Recovery Suite Phs 1	Patient Monitors & Central	9		6	Additional stations	\$157,500	
Surgery	Recovery Suite Phs 1	Stretchers	9		0		\$61,425	
Surgery	Recovery Suite Phs 1	Wheel Chairs	6		0		\$4,095	
Surgery	Recovery Suite Phs 1	Glove Dispensers	12		6		\$315	
Surgery	Recovery Suite Phs 1	Headwalls	9		0		\$61,425	
Surgery	Recovery Suite Phs 1	Soap Container	6		0		\$189	
Surgery	Recovery Suite Phs 1	Paper Towel	6	Supplied by Vendor	0		\$0	
Surgery	Recovery Suite Phs 1	Trash Cans	15		0		\$1,418	
Surgery	Recovery Suite Phs 1	Printer	1	Travis	1	Relocate existing	\$0	
Surgery	Recovery Suite Phs 1	Copier	1		1	Relocate existing	\$0	
Surgery	Recovery Suite Phs 1	Fax	1		0		\$1,307	
Surgery	Recovery Suite Phs 1	Crash Cart	2		2	Relocate existing	\$0	
Surgery	Recovery Suite Phs 1	Side Chairs	9		0		\$3,308	
Surgery	Recovery Suite Phs 1	Omni Cell	1		0		\$31,500	
Surgery	Recovery Suite Phs 1	Refrigerator - under counter	1		0		\$2,625	
Surgery	Recovery Suite Phs 1	Blanket Warmer	1	Full Height	0		\$16,065	
Total								\$347,576

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Herrin Hospital: Surgery Addition - Equipment Schedule

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Surgery	Recovery Supply Phs 2	Blanket Warmer	1	Full Height	1	Relocate existing	\$0	
Surgery	Recovery Supply Phs 2	Supply Cart	2		0		\$5,250	
Surgery	Recovery Supply Phs 2	Omni Cell	2	Existing	2	Relocate existing	\$0	
Surgery	Recovery Supply Phs 2	Return Bin	1	Existing	1	Relocate existing	\$0	
Surgery	Recovery Supply Phs 2	Shelving	1		0		\$8,400	
Surgery	Recovery Supply Phs 2	Med Refrig	1		0		\$1,050	
Surgery	Recovery Suite Phs 2	Nurse Station	3		0		\$14,175	
Surgery	Recovery Suite Phs 2	Nurse Chairs	9		0		\$5,670	
Surgery	Recovery Suite Phs 2	Patient Monitors & Central	21		0		\$617,400	
Surgery	Recovery Suite Phs 2	Stretchers	21		3		\$160,000	
Surgery	Recovery Suite Phs 2	Wheel Chairs	3		0		\$2,000	
Surgery	Recovery Suite Phs 2	Glove Dispensers	31		0		\$1,628	
Surgery	Recovery Suite Phs 2	Headwalls	21		0		\$140,000	
Surgery	Recovery Suite Phs 2	Soap Container	14		0		\$441	
Surgery	Recovery Suite Phs 2	Paper Towel	14	Supplied by Vendor	0		\$0	
Surgery	Recovery Suite Phs 2	Trash Cans	30		0		\$900	
Surgery	Recovery Suite Phs 2	Printer	1	Travis	0		\$2,625	
Surgery	Recovery Suite Phs 2	Copier	1		0		\$5,250	
Surgery	Recovery Suite Phs 2	Fax	1		0		\$1,250	
Surgery	Recovery Suite Phs 2	Crash Cart	2		2		\$0	
Surgery	Recovery Suite Phs 2	Side Chairs	21		0		\$7,000	
Total								\$973,039

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Herrin Hospital: Surgery Addition - Equipment Schedule

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
Endo/Minor Proc	Prep/Recovery	T.V's	5	For new stations - others exist	0		\$3,675	
Endo/Minor Proc	Prep/Recovery	Trash Cans	5	For new stations - others exist	0		\$473	
Endo/Minor Proc	Prep/Recovery	Linen Cart	5	For new stations - others exist	0		\$1,313	
Endo/Minor Proc	Prep/Recovery	Crash Cart	1		0		\$10,500	
Endo/Minor Proc	Prep/Recovery	Curtains	5	For new stations - others exist	0		\$5,250	
Endo/Minor Proc	Prep/Recovery	Patient Monitor	5	For new stations - others exist	0		\$78,750	
Endo/Minor Proc	Prep/Recovery	Stretchers	5	For new stations - others exist	0		\$44,625	
Endo/Minor Proc	Prep/Recovery	Oto Scopes	2		0		\$1,680	
Endo/Minor Proc	Nourishment	Under Counter Refrig	1		0		\$525	
Endo/Minor Proc	Nourishment	Counter mounted Ice Machine	1		0		\$4,725	
Endo/Minor Proc	Nourishment	Warmer in Nourishment	1		0		\$2,625	
Endo/Minor Proc	Storage Room	Frame X shelving	1		0		\$5,250	
Endo/Minor Proc	Nurse Station	Chair	4		0		\$1,680	
Endo/Minor Proc	Nurse Station	Phones			X	See below	\$0	
Endo/Minor Proc	Nurse Station	Computers	4		0		\$10,500	
Endo/Minor Proc	Office	Furniture	1		0		\$3,675	
Endo/Minor Proc	Soil Holding	Move All existing					\$0	
Endo/Minor Proc	Clean Room	Drying Cabinets	3		0		\$6,300	
Endo/Minor Proc	Art Work / Plants						\$7,000	
Total								\$188,545

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Area	Room Description	Equipment Description	Quantity	New	Existing	Notes	Equipment Budget	Sub-Total
General	New Work Switches	Nathan E-Mail	1	Pricing from Nathan	0		\$5,000	
General	Phones	Bill Pricing	1	Cisco Systems	0		\$5,000	
Total								\$10,000
Totals							\$4,541,022	\$4,541,022

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ATTACHMENT 9
Space Requirements

<u>Department</u>	<u>Total Departmental Gross Square Footage</u>						
	<u>Entire Hospital</u>			<u>This Project</u>			<u>Vacated as a</u>
	<u>Cost</u>	<u>Existing</u>	<u>Upon Project Completion</u>	<u>New</u>	<u>Modernized</u>	<u>As Is</u>	
Clinical Components:							
Surgical Suite (Class C Surgical Operating Suite)	\$10,333,588	8,347	15,913	12,830	3,083	0	7,280 ^a
Endoscopy/Minor Procedures (Class B Surgical Procedures Suite)	\$1,288,038	2,488	2,294	0	2,294	0	2,240 ^b
Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)	\$1,063,366	1,388	1,827	0	1,827	0	1,388 ^c
Surgical Prep/Post-Anesthesia Recovery Phase II for Surgical Suite	\$3,615,773	1,684	6,672	671	6,001	0	1,684 ^d
Prep/Post-Anesthesia Recovery Phase II for Class B Procedures Suite	\$1,399,667	2,807	3,235	0	3,235	0	2,279 ^e
TOTAL CLINICAL COMPONENTS	\$17,700,432	16,714	29,941	13,501	16,440	0	14,871
Non-Clinical Components:							
Administrative Office	\$152,516	0	394	394	0	0	0
Storage (this project)	\$15,412	63	63	0	63	0	0
Entrances, Lobbies, Central Public Space (this project)							
1st Floor		393	701	308	393	0	0
2nd Floor		3,433	2,824	0	2,824	0	515 ^f
TOTAL ENTRANCES, LOBBIES, CENTRAL PUBLIC SPACE	\$1,267,619	3,826	3,525	308	3,217	0	515
Interdepartmental Circulation Space: (this project) - 2nd Floor	\$446,743	0	1,674	520	1,154	0	0
Mechanical /Electrical Space and Equipment (this project)							
2nd Floor		46	0	0	0	0	46 ^g
3rd Floor		3,285	8,707	5,422	1,370	1,915	0
TOTAL MECHANICAL/ELECTRICAL SPACE AND EQUIPMENT	\$3,374,733	3,331	8,707	5,422	1,370	1,915	46
Stairwells: (this project)							
1st Floor		0	276	276	0	0	0
2nd Floor		0	276	276	0	0	0
3rd Floor		0	276	276	0	0	0
TOTAL STAIRWELLS	\$257,487	0	828	828	0	0	0
Mechanical/Electrical/Data Shafts: (this project) - 2nd Floor	\$59,777	27	157	140	17	0	27 ^h
Data Closet - 2nd Floor	\$21,284	90	157	0	67	90	0
Housekeeping Closet	\$31,125	46	92	0	92	0	0
ED Canopy	\$341,841	1,252	2,225	2,225	0	0	1252 ⁱ
TOTAL NON-CLINICAL COMPONENTS	\$5,968,537	8,635	17,822	9,837	5,980	2,005	1,840
TOTAL PROJECT (CLINICAL + NON-CLINICAL COMPONENTS)	\$23,668,969	25,349	47,763	23,338	22,420	2,005	16,711

Re-Use of Space Being Vacated as a Result of this Project

- a. The Surgical Suite will vacate 7,280 DGSF, 768 DGSF of which will become part of Interdepartmental Circulation Space, 2,183 DGSF of which will become Post-Anesthesia Recovery Phase I (PACU), and 4,329 DGSF of which will become part of Prep/Post-Anesthesia Recovery Phase II for the Surgical Suite
- b. Endoscopy/Minor Procedures (Class B Procedures Suite) will vacate 2,240 DGSF, 878 DGSF of which will become part of the Surgical Suite, and 1,362 DGSF will become part of Prep/Post-Anesthesia Phase II for the Surgical Suite
- c. Post-Anesthesia Recovery Phase I (PACU) will vacate 1,388 DGSF, 1,104 DGSF of which will become part of the Surgical Suite and 284 DGSF of which will become part of Interdepartmental Circulation Space
- d. Prep/Post-Anesthesia Recovery Phase II for the Surgical Suite will vacate 1,684 DGSF, which will become part of Prep/Post-Anesthesia Recovery Phase II for Class B Procedures Suite
- e. Prep/Post-Anesthesia Recovery Phase II for Class B Procedures Suite will vacate 2,279 DGSF, of which 2,263 DGSF will become part of Endoscopy/Minor Procedures (Class B Procedures Suite) and 16 DGSF will become part of the Surgical Suite
- f. Entrances, Lobbies, Central Public Space will vacate 515 DGSF, of which 442 DGSF will become part of Prep/Post-Anesthesia Recovery Phase II for Class B Procedures Suite, 56 DGSF will become part of the Surgical Suite, and 17 DGSF will become part of Endoscopy/Minor Procedures (Class B Procedures Suite)
- g. Mechanical/Electrical Space and Equipment will vacate its entire space on the second floor (46 DGSF), which will become part of the Housekeeping Closet
- h. Mechanical/Electrical/Data Shafts will vacate its entire space on the second floor (27 DGSF), which will become part of Interdepartmental Circulation Space
- i. The current Emergency Department Canopy, which is 1,252 DGSF, will be demolished and replaced with a new canopy that is part of this project

III.

Criterion 1110.230 - Background of Applicant

1. Herrin Hospital is owned and operated by Southern Illinois Hospital Services.

The identification numbers for the health care facilities owned or operated by Southern Illinois Hospital Services are shown below.

<u>Name and Location of Facility</u>	<u>Identification Numbers</u>
Herrin Hospital, Herrin	Illinois Hospital License ID# 0000935 The Joint Commission ID# 7357
Memorial Hospital of Carbondale, Carbondale	Illinois Hospital License ID# 0000513 The Joint Commission ID# 7252
St. Joseph Memorial Hospital, Murphysboro (Critical Access Hospital)	Illinois Hospital License ID# 0004614
Physicians Surgery Center, LLC, Carbondale	Illinois Ambulatory Surgical Treatment Center License ID# 7003128 Accreditation Association for Ambulatory Health Care, Inc. Accreditation ID# 4398

Proof of the current licensure and accreditation for all facilities owned or operated by Southern Illinois Hospital Services will be found beginning on Page 2 of this Attachment.

- 2, 3. This Attachment includes a certification letter from Rex P. Budde, President and CEO of Southern Illinois Hospital Services and of Southern Illinois Healthcare, the sole corporate member of Southern Illinois Hospital Services. In his letter, Mr. Budde (1) documents that Herrin Hospital and the other health care facilities owned or operated by Southern Illinois Hospital Services have not had any adverse action taken against them during the past three years and (2) authorizes the Illinois Health Facilities and Services Review Board and Illinois Department of Public Health to access any documents necessary to verify the information submitted in response to this subsection.
4. This item is not applicable to this application because the requested materials are being submitted as part of this application, beginning on Page 2 of this Attachment.

DISPLAY THIS PART IN A
CONSPICUOUS PLACE

Exp. Date 12/31/2015
Lic. Number 0000935

Date Printed 11/25/2014

Herrin Hospital
201 S. 14th Street
Herrin, IL 62948

FEE RECEIPT NO.

 Illinois Department of PUBLIC HEALTH		HF 1070910	
LICENSE, PERMIT, CERTIFICATION, REGISTRATION			
This person, firm or corporation whose name appears on this certificate has completed with the provisions of the Illinois statutes and rules and regulations and is hereby authorized to engage in the activity as indicated below.			
LaMar Hasbrouck MD, MPH Acting Director		Issued under the authority of the Illinois Department of Public Health	
EXPIRATION DATE 12/31/2015	CATEGORY General Hospital	LIC. NO. 0000935	
Effective 01/01/2015			
Herrin Hospital 201 S. 14th Street Herrin, IL 62948			
This license is issued on a probationary background checked by a third party. Licensee must report any change in information to the Department of Public Health.			

Herrin Hospital

Herrin, IL

has been Accredited by



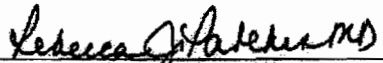
The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

March 22, 2013

Accreditation is customarily valid for up to 36 months.



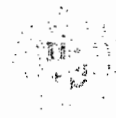
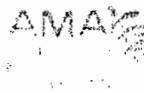
Rebecca J. Patchin, MD.
Chair, Board of Commissioners

Organization ID #: 7357
Print/Reprint Date: 06/13/13



Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Summary of Quality Information

Symbol Key

- ★ This organization achieved the best possible results.
- ⊕ This organization's performance is above the target range/value.
- ⊙ This organization's performance is similar to the target range/value.
- ⊖ This organization's performance is below the target range/value.
- ⊘ This Measure is not applicable for this organization.
- ⊘ Not displayed

Footnote Key

1. The Measure or Measure Set was not reported.
2. The Measure Set does not have an overall result.
3. The number of patients is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The Measure results are not statistically valid.
7. The Measure results are based on a sample of patients.
8. The number of months with Measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Hospital	Accredited	3/23/2013	3/22/2013	5/3/2013
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Hospital

● Joint Replacement - Hip	Certification	8/7/2013	8/6/2013	8/6/2013
● Joint Replacement - Knee	Certification	8/7/2013	8/6/2013	8/6/2013
● Stroke Rehabilitation	Certification	8/15/2013	8/14/2013	8/14/2013

Special Quality Awards

2013 Silver Plus Get With The Guidelines - Stroke

Compared to other Joint Commission Accredited Organizations

Hospital

Hospitals voluntarily participate in the Survey of Patients' Hospital Experiences (HCAHPS). Pediatric and psychiatric hospitals are not eligible to participate in the HCAHPS survey based on their patient population.

⊘ The Joint Commission only reports measures endorsed by the National Quality Forum



**Illinois Department of
PUBLIC HEALTH**

HF106007

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.

LaMar Hasbrouck, MD MPH
Acting Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LIC. NUMBER
6/30/2015	General Hospital	0000513

General Hospital

Effective: 07/01/2014

Memorial Hospital of Carbondale
404 West Jackson
Carbondale, IL 62902

The face of this license has a colored background. Printed by Authority of the State of Illinois, PO #4062320 10M 3/12

← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

Exp. Date 6/30/2015

Lic Number 0000513

Date Printed 6/5/2014

Memorial Hospital of Carbondale

404 West Jackson
Carbondale, IL 62902

FEE RECEIPT NO.

Memorial Hospital of Carbondale

Carbondale, IL

has been Accredited by

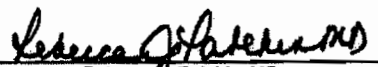


The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

April 27, 2013

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD.
Chair, Board of Commissioners

Organization ID #: 7252
Print/Reprint Date: 08/21/13


Mark R. Chassin, MD, FACP, MPP, MPH
President

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AMA
AMERICAN
MEDICAL
ASSOCIATION



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Summary of Quality Information

Symbol Key

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- ⊘ This Measure is not applicable for this organization.
- ⊘ Not displayed

Footnote Key

1. The Measure or Measure Set was not reported.
2. The Measure Set does not have an overall result.
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10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Hospital	Accredited	4/27/2013	4/26/2013	4/26/2013
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Hospital

Primary Stroke Center	Certification	10/6/2012	10/5/2012	10/5/2012
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Other Accredited Programs/Services

- Hospital (Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC))

Special Quality Awards

2013 Gold Plus Get With The Guidelines - Stroke

Compared to other Joint Commission Accredited Organizations

Hospital

Hospitals voluntarily participate in the Survey of Patients' Hospital Experiences (HCAHPS). Pediatric and psychiatric hospitals are not eligible to participate in the HCAHPS survey based on their patient population.

The Joint Commission only reports measures endorsed by the National Quality Forum



**Illinois Department of
PUBLIC HEALTH**

HF106194

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.

LaMar Hasbrouck, MD, MPH
Acting Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LD NUMBER
07/04/2015		0004614
Critical Access Hospital		
Effective: 07/05/2014		

St. Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro, IL 62966

This face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

← **DISPLAY THIS PART IN A
CONSPICUOUS PLACE**

Exp. Date 07/04/2015

Lic Number 0004614

Date Printed 07/02/2014

St. Joseph Memorial Hospital

2 South Hospital Drive
Murphysboro, IL 62966

FEE RECEIPT NO.



**Illinois Department of
PUBLIC HEALTH**

HF106943

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.

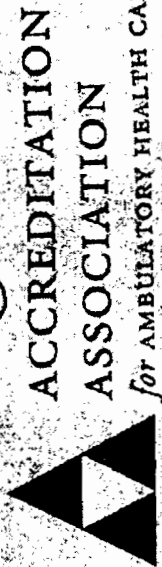
LaMar Hasbrouck, MD, MPH
Acting Director

Issued under the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	LC NUMBER
12/2/2015		7003128
Ambulatory Surgery Treatment Center		
Effective: 12/03/2014		

Physicians Surgery Center, LLC
2601 West Main Street
Carbondale, IL 62901

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grants this

CERTIFICATE OF ACCREDITATION

to

PHYSICIANS' SURGERY CENTER, LLC

2601 W MAIN ST
CARBONDALE, IL 62901

In recognition of its commitment to high quality of care and substantial compliance
with the Accreditation Association for Ambulatory Health Care standards for ambulatory health care organizations.

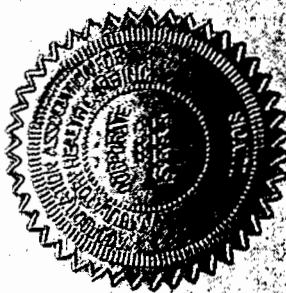
4398

Organization Identification Number

W. Patrice Day, MD, MBA, FACP

W. PATRICK DAY, MD, MBA, FACP

Chair of the Board



MAY 20, 2017

The Award of Accreditation expires on the above date

John E. Burke, PhD
JOHN E. BURKE, PH.D.
President and CEO

ASSOCIATION MEMBERS

Ambulatory Surgery Foundation • American Academy of Cosmetic Surgery • American Academy of Dental Group Practices • American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery • American Association of Oral and Maxillofacial Surgeons • American College of Gastroenterology
American College Health Association • American College of Obstetrics and Gynecology • American College of Ophthalmology • American College of Podiatry
American College of Sports Medicine • American College of Surgeons • American College of Tissue Banks • American College of Veterinary Medicine
American Society for Gastrointestinal Endoscopy • American Society of Hospital Administrators • American Society of Health Care Administrators

1501 ORCHARD ROAD, SUITE 200, SKOKIE, IL 60077
PHONE: 847-306-1500 FAX: 847-306-1501 WEB SITE: WWW.AAHC.ORG



SOUTHERN ILLINOIS HEALTHCARE

January 21, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Second Floor
Springfield, Illinois 62702

Dear Ms. Avery:

Herrin Hospital is a licensed hospital in Herrin, Illinois, that is accredited by The Joint Commission.

Herrin Hospital is owned and operated by Southern Illinois Hospital Services, an Illinois not for profit corporation ("SIHS"). Southern Illinois Healthcare Enterprises, Inc., is the sole corporate member of SIHS.

SIHS also owns and operates the following health care facilities, as defined under the Illinois Health Facilities Planning Act (20 ILCS 3960/3):

Memorial Hospital of Carbondale, Carbondale, Illinois
St. Joseph Memorial Hospital, Murphysboro, Illinois

In addition, SIHS owns fifty-five per cent (55%) of Physicians' Surgery Center, LLC, which is located in Carbondale, Illinois.

I hereby certify that there has been no adverse action taken against any health care facility owned and/or operated by SIHS during the three years prior to the filing of this application.

This letter also authorizes the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access any documents necessary to verify the information submitted, including but not limited to the following: official records of IDPH or other state agencies; the licensing or certification records of other states, where applicable; and the records of nationally recognized accreditation organizations, as identified in the requirements specified in 77 Ill. Adm. Code 1110.230.a).

Sincerely,

Rex P. Budde
President and CEO
Southern Illinois Hospital Services d/b/a Herrin Hospital

1239 East Main Street | PO Box 3988
Carbondale, IL 62902-3988

TEL 618-457-5200
FAX 618-529-0568



Valerie K. Cawvey

www.sih.net

III.

Criterion 1110.230.b - Purpose of Project

1. This project will improve the health care and well-being of the market area population by expanding and modernizing surgical, endoscopic, minor procedures, and related clinical service areas at Herrin Hospital, a hospital that provides health care to residents of Southern Illinois with a wide range of services.

This project is designed to accomplish the following:

- Replace and expand the Surgical Suite (Class C Surgical Operating Suite), including the replacement of the 4 existing general (multi-specialty) operating rooms and the addition of 3 general operating rooms;
- Replace Endoscopy and Minor Procedures (Class B Surgical Procedure Suite), including the replacement of the 2 existing endoscopic procedure rooms and the 2 existing minor procedure rooms;
- Replace and expand Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, (PACU);
- Replace and expand Surgical Prep (for both A.M. Admits and Same Day Surgery Patients) and Post-Anesthesia Recovery Phase II in order to provide appropriate facilities for the current mix of inpatient/outpatient surgical patients and to meet current Illinois Hospital Licensing Requirements;
- Construct Prep/Recovery Phase II for the Class B Surgical Procedure Suite.

As a result, this project will improve Herrin Hospital's ability to provide essential surgical, endoscopic, and minor procedure services to all the patients it serves, including the uninsured and underinsured residents of Planning Area F-06, the State-defined planning area in which the hospital is located.

Planning Area F-06 includes Franklin, Williamson, Johnson, and Massac Counties and the following townships of Pope County: Jefferson #4; Webster #5; Golconda #1; and Golconda #3.

As discussed later in this section and under Item 2. below, Herrin Hospital's market area is a 7-county area in Southern Illinois (consisting of Franklin, Jackson, Johnson, Perry, Saline, Union and Williamson Counties) that includes part or all of the State-designated Planning Areas F-05, F-06, and F-07.

This project is a necessary modernization of existing services at Herrin Hospital.

The project includes the following Clinical Service Areas, all of which currently exist at Herrin Hospital (Herrin Hospital).

Surgery
Endoscopy
Minor Procedures
Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)
Surgical Prep (for both A.M. Admits and Same-Day Surgery Patients) and
Post-Anesthesia Recovery Phase II
Prep/Post-Anesthesia Recovery Phase II for the Class B Surgical
Procedure Suite

The need for this project is based upon the following.

- This project is needed to modernize and expand existing services for the patients who receive care at Herrin Hospital.
- This project is needed to modernize and expand existing services for the increasing acuity levels of patients who receive inpatient care at Herrin Hospital.
- This project is needed to modernize and expand existing services for patients who reside in Herrin Hospital's market area but who currently travel outside the market area, often leaving the State of Illinois to travel to Missouri, Kentucky, and Indiana to receive medical care.
- This project is needed to modernize and expand existing services for residents of Herrin Hospital's 7-county market area in Southern Illinois, all of which has been designated as Health Professional Shortage Areas and much of which has been designated as Medically Underserved Areas.
- Many of the patients that receive care at Herrin Hospital are low-income and otherwise vulnerable, as documented by their residing in Health Professional Shortage Areas for Primary Medical Care.

There are a number of federally-designated Health Professional Shortage Areas in Herrin Hospital's market area, as identified below.

Health Professional Shortage Areas are designated by the federal government because they have a shortage of primary medical care providers ([http://bhpr.hrsa.gov/shortage/Health Resources and Services Administration](http://bhpr.hrsa.gov/shortage/HealthResourcesandServicesAdministration), U.S. Department of Health and Human Services).

The federal criteria for HPSA designation are found on Pages 10 through 20 of this Attachment.

- As of December 30, 2014, the federal government designated all 7 counties in the market area as being Health Professional Shortage Areas (HPSAs).

Franklin County
Jackson County
Johnson County
Perry County
Saline County
Union County
Williamson County

Documentation of these Health Professional Shortage Areas is found on Page 21 of this Attachment.

- Many of the patients that receive care at Herrin Hospital are low-income and otherwise vulnerable, as documented by their residing in Medically Underserved Areas or being part of Medically Underserved Populations.

There are a number of federally-designated Medically Underserved Areas and Medically Underserved Populations in Herrin Hospital's market area, as identified below.

The designation of a Medically Underserved Area (MUA) by the federal government is based upon the Index of Medical Underservice (IMU), which generates a score from 0 to 100 for each service area (0 being complete underservice and 100 being best served), with each service area with an IMU of 62.0 or less qualifying for designation as an MUA. The IMU involves four weighted variables (ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population aged 65 or over).

The designation of a Medically Underserved Population (MUP) by the federal government is based upon applying the IMU to an underserved population group within its area of residence. Population groups requested for designation as MUPs should be those with economic barriers (low-income or Medicaid-eligible populations) or cultural and/or linguistic access barriers to primary medical care services.

The designation of a MUP is based upon the same assessment as the determination of a MUA, except that the population assessed is the

population of the requested group within the area rather than the total resident civilian population of the area, and the number of FTE primary care physicians would include only those serving the requested population group. There are also provisions for a population group that does not meet the established criteria of an IMU less than 62.0 to be considered for designation if "unusual local conditions which are a barrier to access to or the availability of personal health services" exist and are documented and if the designation is recommended by the State in which this population resides.

The federal criteria for designation of Medically Underserved Areas and Populations are found on Pages 22 through 24 of this Attachment.

- The federal government has designated the following Medically Underserved Areas (MUAs) in the market area for this project.

Franklin County
Jackson County
Johnson County
Beaucoup and Cutler Precincts in Perry County
Union County
Blairsville, Cartersville, and Williamson Service Areas in
Williamson County

Documentation of these Medically Underserved Areas is found on Page 25 of this Attachment.

- The federal government has designated the following Medically Underserved Population (MUP) in the market area for this project.

Low income population in Saline County

Documentation of this Medically Underserved Population is also found on Page 25 of this Attachment.

- This project will have a positive impact on essential safety net services in Herrin Hospital's market area, which includes part or all of Planning Areas F-05, F-06, and F-06, because the patients that will be served by this facility, a significant percentage of whom are elderly and/or low income, uninsured, and otherwise vulnerable, will be able to receive care in modernized and expanded facilities.
- This project is needed to modernize and expand Herrin Hospital's facilities.

- Herrin Hospital must address the standards found in the Illinois Health Care Facilities Plan, 77 Ill. Adm. Code 1100.310(a), 1100.360, 1100.370, 1100.380, 1100.390, 1100.400, 1100.410, 1100.430, 1110.230, 1110.234, 1110.3030, 1110.APPENDIX B State Guidelines - Square Footage and Utilization, and 1120.140 for the clinical service areas included in this project.
- Herrin Hospital needs to comply with the standards found in the Illinois Health Care Facilities Plan, 77 Ill. Adm. Code 1110.230, 1110.234(a)-(c) and (e)(1), 1110.3030, 1110.APPENDIX B State Guidelines - Square Footage and Utilization, and 1120.140 for the clinical service areas included in this project.

Specific information regarding the need to modernize the Clinical Service Areas included in this project is presented in Attachment 34.

The project will be sized to accommodate the projected utilization in each of the included services during the second full year of operation of the phase of the project in which each service becomes operational.

Population statistics for the zip codes that constitute the market area for Herrin Hospital were reviewed to identify recent population figures and five-year projections. Truven Health Analytics (formerly Thomson Reuters Medstat) is the source of these population statistics.

This review revealed that the population in the market area is expected to remain constant from 2014 to 2019, with little change over this five-year period.

2. The market area for this project consists of the following counties in Southern Illinois.

Franklin County
 Jackson County
 Johnson County
 Perry County
 Saline County
 Union County
 Williamson County

These counties constitute parts of Planning Areas F-05, F-06, and F-07.

The patient origin data, found on Page 26 of this Attachment, demonstrate that Herrin Hospital serves Planning Area F-06 and the market area population.

In addition to Herrin Hospital, Southern Illinois Hospital Services owns and operates the following facilities: Memorial Hospital of Carbondale, Physicians Surgery Center, LLC, and Memorial Hospital Breast Center, all of which are located in Carbondale; St. Joseph Memorial Hospital, which is located in Murphysboro; and Memorial Hospital Cancer Center, which is located in Marion. SIH Cancer Center in Carterville is currently under construction.

Herrin Hospital, Memorial Hospital Cancer Center, as well as SIH Cancer Center, which is currently under construction, are located in Williamson County, which is part of Planning Area F-06, while Memorial Hospital of Carbondale, St. Joseph Memorial Hospital, Physicians Surgery Center, and Memorial Hospital Breast Center are located in Jackson County, which is part of Planning Area F-07.

During the recent 12-month period of September, 2013, through August, 2014, nearly 95% of Herrin Hospital's patients resided within its market area, and more 72.50% of its patients resided in Planning Area F-06, the planning area in Herrin Hospital is located.

During FY12, 80% of Herrin Hospital's discharges resided in zipcodes in which 1% or more of the year's discharges resided. Most of these zipcodes are located in Planning Area F-06.

Herrin Hospital's 7-county market area had a 2013 population of 242,697 and accounted for more than 92% of the discharges to the SIHS hospitals: Herrin Hospital in Herrin; Herrin Hospital in Carbondale; and St. Joseph Memorial Hospital in Murphysboro.

The SIHS hospitals' marketshare penetration in its market area is significant. During the year ending June 30, 2012, these hospitals had a 50% marketshare of all inpatient discharges within the 7-county market area.

3. The following problems will be addressed by this project. These needs are discussed in Attachment 34.
 - a. Herrin Hospital has an inadequate number of operating rooms to accommodate its historic surgical caseload, and the shortage of operating rooms will increase in the next few years due to the projected increases in surgical utilization resulting from newly-recruited physicians.
 - b. Herrin Hospital's endoscopic and minor procedure rooms need to be replaced in order to permit the modernization of the Surgical Suite and Recovery Suite as well as to create a Class B Surgical Procedures Suite with the procedure and recovery rooms located contiguous to each other.

- c. The increased number of operating rooms at Herrin Hospital will create a need to increase the number of post-anesthesia recovery stations in order to meet the licensing standards of the Illinois Department of Public Health (IDPH).
- d. Historic increases in outpatient surgery have resulted in a need to increase the number of Phase II recovery stations in order to meet IDPH's licensing standards.
- e. Historic increases in outpatient endoscopic and minor procedures have resulted in a need to construct a Prep/Phase II Recovery Room that is dedicated to these patients.
- f. As Herrin Hospital continues to implement its Physician Development Plan, the recruitment of additional physicians will result in an increased caseload for Surgery, Endoscopy, and Minor Procedures.

As of June, 2014, Herrin Hospital had recruited 6 physicians representing a range of surgical specialties, as discussed in Attachments 15 and 34. The implementation of the Physician Development Plan and Herrin Hospital's physician recruitment efforts are continuing.

Herrin Hospital's plan is to recruit additional surgeons by the time this project is completed and becomes operational.

- g. The recruitment of additional physicians to Herrin Hospital will help to meet the needs identified by the federal government in its designation of the state-designated planning area and the hospital's market area as Health Professional Shortage Areas and Medically Underserved Area.

As a result, the project will provide much-needed services to the market area and, in doing so, will provide health care services to the low income and uninsured.

Documentation of this project's ability to address this issue is found in Item 5. below.

- 4. The sources of information provided as documentation are the following:
 - a. Hospital records;
 - b. Illinois Hospital Licensing Requirements (77 Ill. Adm. Code 250);
 - c. Reports by the hospital's architects;

- d. The Facilities Guidelines Institute with assistance from the U.S. Department of Health and Human Services, Guidelines for Design and Construction of Health Care Facilities, 2010 Edition. 2010: ASHE (American Society for Healthcare Engineering).
- e. Standards for Accessible Design: ADA Accessibility Guidelines for Buildings and Facilities, 28 Code of Federal Regulations, 36.406.ADAAG (Americans with Disabilities Act [ADA]);
- f. National Fire Protection Association, NFPA 101: Life Safety Code, 2012 Edition.
- g. Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Health Professional Shortage Areas, (<http://hpsafind.hrsa.gov/HPSASearch.aspx>), for all the counties in Herrin Hospital's market area: Franklin County; Jackson County; Johnson County; Perry County; Saline County; Union County; and Williamson County.

A print-out of this information and a discussion of Health Professional Shortage Areas is found on Pages 10 through 20 of this Attachment.

- l. Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Medically Underserved Areas and Populations by State and County, (<http://muafind.hrsa.gov/index.aspx>), for the following areas in Herrin Hospital's market area: Franklin County; Jackson County; Johnson County; Beaucoup and Cutler Precincts in Perry County; Union County; and Blairsville, Carterville, Corinth, Creal Springs, East Marion, and Lake Creek Townships in Williamson County as Medically Underserved Areas and the Low Income Population in Saline county as the Medically Underserved Population.

A print-out of this information and a discussion of Medically Underserved Areas and Medically Underserved Populations is found on Pages 22 through 24 of this Attachment.

- 5. This project will address and improve the health care and well-being of residents of Herrin Hospital's market area, including Planning Area F-06, because it will enable the hospital to provide surgical services in facilities that meet contemporary standards.

By improving the acute care facilities of Herrin Hospital, this project will improve the quality of health care services for all residents of the market area, including the low income and uninsured. In that way, this project will have a particular impact on those areas within Planning Area F-06 and Herrin Hospital's market

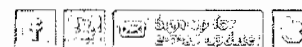
area that are identified by the federal government (Health Resources and Services Administration of the U.S. Department of Health and Human Services) as Health Professional Shortage Areas and Medically Underserved Areas and Populations.

These designated areas are identified in charts on Pages 21 and 25 of this Attachment.

6. This project will address and improve the health care of residents of the market area and fulfill MHC's goal to continue providing quality health care to residents of its market area.



Health Resources and Services Administration



Shortage Designation

Find Shortage Areas

Health Professional Shortage Areas (HPSAs)

Medically Underserved Areas and Populations (MUAs/Ps)

Frequently Asked Questions

Negotiated Rulemaking Committee

Contact: SDB@hrsa.gov or 1-888-275-4772

Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations

Share 2

Online processing of shortage designation applications will resume in December 2014. Please direct any questions to your State Primary Care Office and/or the appropriate Shortage Designation Officer.

HRSA develops shortage designation criteria and uses them to decide whether or not a geographic area, population group or facility is a Health Professional Shortage Area or a Medically Underserved Area or Population.

Find Shortage Areas

Programs that use HPSAs to determine eligibility may utilize the HPSA data as of a certain date in time in order to facilitate program operations. To locate NHSC approved sites with eligible HPSAs and the corresponding HPSA scores for use in the National Health Service Corps programs, individuals should refer to the [NHSC Jobs Center](#). Find HPSAs, MUAs and MUPs by state, county or street address.

Please note: not all programs that use the HPSA or MUAMUP designation to determine eligibility use them in the same way. The National Health Service Corps uses HPSA data as of a certain date.

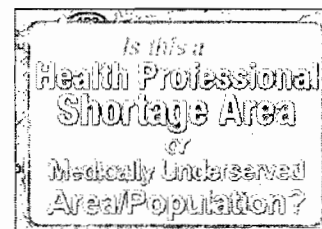
To find approved National Health Service Corps sites and their HPSA scores, please use the [NHSC Jobs Center](#). The Medicare Physician Bonus Payment program uses only geographic HPSAs. To find eligible HPSAs, please use [Find HPSAs eligible for the Medicare Physician Bonus Payment](#).

Health Professional Shortage Areas

HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

As of June 19, 2014:

- There are currently approximately 6,100 designated Primary Care HPSAs. Primary Care HPSAs are based on a physician to population ratio of 1:3,500. In other words, when there are 3,500 or more people per primary care physician, an area is eligible to be designated as a primary care HPSA. Applying this formula, it would take approximately 8,200 additional primary care physicians to eliminate the current primary care HPSA designations. While the 1:3,500 ratio has been a long standing ratio used to identify high need areas, it is important to note that there is no generally accepted ratio of physician to population ratio. Furthermore, primary care needs of an individual community will vary by a number of factors such as the age of the community's population. Additionally, the formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area. Other sources describing primary care supply use other ratios; for example, a ratio of 1 physician to 2,000 population. To meet this ratio, approximately 16,000 more primary care physicians would need to be added to the current supply in HPSAs.
- There are currently approximately 4,900 Dental HPSAs. Dental HPSAs are based on a dentist to population ratio of 1:5,000. In other words, when there are 5,000 or more people per dentist, an area is eligible to be designated as a dental HPSA. Applying this formula, it would take approximately 7,300 additional dentists to eliminate the current dental HPSA designations.
- There are currently approximately 4,000 Mental Health HPSAs. Mental Health HPSAs are based on a psychiatrist to population ratio of 1:30,000. In other words, when there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health HPSA. Applying this



Programs

These programs benefit HPSAs and MUAs/Ps

[Health Center Program](#) grants support access to primary care in underserved areas

[Rural Health Clinic Program](#) provides cost-based reimbursement from Medicare and Medicaid

[Medicare HPSA Bonus Payment](#) provides reimbursement to physicians in underserved areas

[National Health Service Corps Loan Repayment and Scholarship Programs](#) helps underserved communities recruit and retain primary medical, dental and mental/behavioral health professionals

[Indian Health Service Scholarship Program](#) supports health professions students who will work in IHS facilities after graduation

[Exchange Visitor Program](#) enables foreign physicians to obtain J-1 visas and work in shortage areas

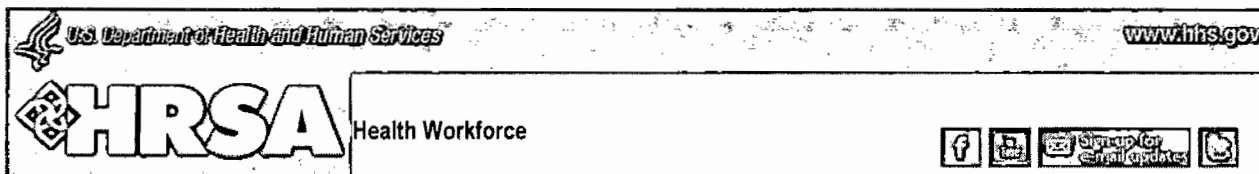
[Conrad State 30 Program](#) allows States 30 J-1 visa waivers each year in exchange for service in a shortage area

formula, it would take approximately 2,800 additional psychiatrists to eliminate the current mental HPSA designations.

Medically Underserved Areas and Populations

Medically Underserved Areas (MUAs) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services.

Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.


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Primary Medical Care HPSA Designation Overview

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There are three different types of HPSA designations, each with its own designation requirements:

- Geographic Area
- Population Groups
- Facilities

Geographic Areas must:

- Be a rational area for the delivery of primary medical care services
- Meet one of the following conditions:
 - Have a population to full-time equivalent primary care physician ratio of at least 3,500:1
 - Have a population to full-time equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and have unusually high needs for primary care services or insufficient capacity of existing primary care providers
- Demonstrate that primary medical professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population under consideration.

Population Groups must:

- Reside in an area in that is rational for the delivery of primary medical care services as defined in the Federal code of regulations.
- Have access barriers that prevent the population group from use of the area's primary medical care providers.
- Have a ratio of persons in the population group to number of primary care physicians practicing in the area and serving the population group ratio of at least 3,000:1
- Members of Federally recognized Native American tribes are automatically designated. Other groups may be designated if the meet the basic criteria described above.

Facilities must:

- Be either Federal and/or State correctional institutions or public and/or non-profit medical facilities
- Be maximum or medium security facilities
- Federal/State Correctional Institutions must have at least 250 inmates and the ratio of the number of internees/year to the number of FTE primary care physicians serving the institution must be at least 1,000:1
- Public and/or non-profit medical Facilities must demonstrate that they provide primary medical care services to an area or population group designated as a primary care HPSA and must have an insufficient capacity to meet the primary care needs of that area or population group.



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Primary Medical Care HPSA Designation Criteria

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Part I -- Geographic Areas

A. Criteria.

A geographic area will be designated as having a shortage of primary medical care professionals if the following three criteria are met:

1. The area is a rational area for the delivery of primary medical care services.
2. One of the following conditions prevails within the area:
 - (a) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.
 - (b) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.
3. Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. Methodology.

In determining whether an area meets the criteria established by paragraph A of this part, the following methodology will be used:

1. Rational Areas for the Delivery of Primary Medical Care Services.

- (a) The following areas will be considered rational areas for the delivery of primary medical care services:
 - (i) A county, or a group of contiguous counties whose population centers are within 30 minutes travel time of each other.
 - (ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns, distinctive population characteristics or other factors, has limited access to contiguous area resources, as measured generally by a travel time greater than 30 minutes to such resources.
 - (iii) Established neighborhoods and communities within metropolitan areas which display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 20,000.
- (b) The following distances will be used as guidelines in determining distances corresponding to 30 minutes travel time:
 - (i) Under normal conditions with primary roads available: 20 miles.
 - (ii) In mountainous terrain or in areas with only secondary roads available: 15 miles.
 - (iii) In flat terrain or in areas connected by interstate highways: 25 miles.

Within inner portions of metropolitan areas, information on the public transportation system will be used to determine the distance corresponding to 30 minutes travel time.

2. Population Count.

The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions with the following adjustments, where appropriate:

- (a) The effect of transient populations on the need of an area for primary care professional(s) will be taken into account as follows:
 - (i) Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 2 to 8 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.
 - (ii) Other tourists (non-resident) may be included in an area's population but only with a weight of 0.25, using the following formula: Effective tourist contribution to population = $0.25 \times (\text{fraction of year tourists are present in area}) \times (\text{average daily number of tourists during portion of year that tourists are present})$.
 - (iii) Migratory workers and their families may be included in an area's population, using the following formula: Effective migrant contribution to population = $(\text{fraction of year migrants are present in area}) \times (\text{average daily number of migrants during portion of year that migrants are present})$.

3. Counting of Primary Care Practitioners.

- (a) All non-Federal doctors of medicine (M.D.) and doctors of osteopathy (D.O.) providing direct patient care who practice principally in one of the four primary care specialties -- general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology -- will be counted. Those physicians engaged solely in administration, research, and teaching will be excluded. Adjustments for the following factors will be made in computing the number of full-time-equivalent (FTE) primary care physicians:

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(i) Interns and residents will be counted as 0.1 full-time equivalent (FTE) physicians.

(ii) Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts.

(iii) Those graduates of foreign medical schools who are citizens or lawful permanent residents of the United States, but do not have unrestricted licenses to practice medicine, will be counted as 0.5 FTE physicians.

(b) Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who provide patient care services to the residents of the area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in these cases. For practitioners working less than a 40-hour week, every four (4) hours (or 1/2 day) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1 FTE (with numbers obtained for FTE's rounded to the nearest 0.1 FTE), and each physician providing patient care 40 or more hours a week will be counted as 1.0 FTE physician. (For cases where data are available only for the number of hours providing patient care in office settings, equivalencies will be provided in guidelines.)

(c) In some cases, physicians located within an area may not be accessible to the population of the area under consideration. Allowances for physicians with restricted practices can be made, on a case-by-case basis. However, where only a portion of the population of the area cannot access existing primary care resources in the area, a population group designation may be more appropriate (see part II of this appendix).

(d) Hospital staff physicians involved exclusively in inpatient care will be excluded. The number of full-time equivalent physicians practicing in organized outpatient departments and primary care clinics will be included, but those in emergency rooms will be excluded.

(e) Physicians who are suspended under provisions of the Medicare-Medicaid Anti-Fraud and Abuse Act for a period of eighteen months or more will be excluded.

4. Determination of Unusually High Needs for Primary Medical Care Services.

An area will be considered as having unusually high needs for primary health care services if at least one of the following criteria is met:

(a) The area has more than 100 births per year per 1,000 women aged 15 - 44.

(b) The area has more than 20 infant deaths per 1,000 live births.

(c) More than 20% of the population (or of all households) have incomes below the poverty level.

5. Determination of Insufficient Capacity of Existing Primary Care Providers.

An area's existing primary care providers will be considered to have insufficient capacity if at least two of the following criteria are met:

(a) More than 8,000 office or outpatient visits per year per FTE primary care physician serving the area.

(b) Unusually long waits for appointments for routine medical services (i.e., more than 7 days for established patients and 14 days for new patients).

(c) Excessive average waiting time at primary care providers (longer than one hour where patients have appointments or two hours where patients are treated on a first-come, first-served basis).

(d) Evidence of excessive use of emergency room facilities for routine primary care.

(e) A substantial proportion (2/3 or more) of the area's physicians do not accept new patients.

(f) Abnormally low utilization of health services, as indicated by an average of 2.0 or less office visits per year on the part of the area's population.

6. Contiguous Area Considerations.

Primary care professional(s) in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area:

(a) Primary care professional(s) in the contiguous area are more than 30 minutes travel time from the population center(s) of the area being considered for designation (measured in accordance with paragraph B.1(b) of this part).

(b) The contiguous area population-to-full-time-equivalent primary care physician ratio is in excess of 2000:1, indicating that practitioners in the contiguous area cannot be expected to help alleviate the shortage situation in the area being considered for designation.

(c) Primary care professional(s) in the contiguous area are inaccessible to the population of the area under consideration because of specified access barriers, such as:

(i) Significant differences between the demographic (or socio-economic) characteristics of the area under consideration and those of the contiguous area, indicating that the population of the area under consideration may be effectively isolated from nearby resources. This isolation could be indicated, for example, by an unusually high proportion of non-English-speaking persons.

(ii) A lack of economic access to contiguous area resources, as indicated particularly where a very high proportion of the population of the area under consideration is poor (i.e., where more than 20 percent of the population or the households have incomes below the poverty level), and Medicaid-covered or public primary care services are not available in the contiguous area.

Part II -- Population Groups

A. Criteria.

1. In general, specific population groups within particular geographic areas will be designated as having a shortage of primary medical care professional(s) if the following three criteria are met:

(a) The area in which they reside is rational for the delivery of primary medical care services, as defined in paragraph B.1 of part I of this appendix.

(b) Access barriers prevent the population group from use of the area's primary medical care providers. Such barriers may be economic, linguistic, cultural, or architectural, or could involve refusal of some providers to accept certain types of patients or to accept Medicaid reimbursement.

(c) The ratio of the number of persons in the population group to the number of primary care physicians practicing in the area and serving the population group is at least 3,000:1.

2. Indians and Alaska Natives will be considered for designation as having shortages of primary care professional(s) as follows:

(a) Groups of members of Indian tribes (as defined in section 4(d) of Pub. L. 94 - 437, the Indian Health Care Improvement Act of 1976) are automatically designated.

(b) Other groups of Indians or Alaska Natives (as defined in section 4(c) of Pub. L. 94 - 437) will be designated if the general criteria in paragraph A are met.

Part III -- Facilities

A. Federal and State Correctional Institutions.

1. Criteria.

Medium to maximum security Federal and State correctional institutions and youth detention facilities will be designated as having a shortage of primary medical care professional(s) if both the following criteria are met:

(a) The institution has at least 250 inmates.

(b) The ratio of the number of internees per year to the number of FTE primary care physicians serving the institution is at least 1,000:1.

Here the number of internees is defined as follows:

(i) If the number of new inmates per year and the average length-of-stay (ALOS) are not specified, or if the information provided does not indicate that intake medical examinations are routinely performed upon entry, then -- Number of internees = average number of inmates.

(ii) If the ALOS is specified as one year or more, and intake medical examinations are routinely performed upon entry, then -- Number of internees = average number of inmates + (0.3) x number of new inmates per year.

(iii) If the ALOS is specified as less than one year, and intake examinations are routinely performed upon entry, then -- Number of internees = average number of inmates + (0.2) x (1+ALOS/2) x number of new inmates per year where ALOS = average length-of-stay (in fraction of year). (The number of FTE primary care physicians is computed as in part I, section B, paragraph 3 above.)

B. Public or Non-Profit Medical Facilities.

1. Criteria.

Public or non-profit private medical facilities will be designated as having a shortage of primary medical care professional(s) if:

(a) the facility is providing primary medical care services to an area or population group designated as having a primary care professional(s) shortage; and

(b) the facility has insufficient capacity to meet the primary care needs of that area or population group.

2. Methodology

In determining whether public or nonprofit private medical facilities meet the criteria established by paragraph B.1 of this Part, the following methodology will be used:

(a) Provision of Services to a Designated Area or Population Group.

A facility will be considered to be providing services to a designated area or population group if either:

(i) A majority of the facility's primary care services are being provided to residents of designated primary care professional(s) shortage areas or to population groups designated as having a shortage of primary care professional(s); or

(ii) The population within a designated primary care shortage area or population group has reasonable access to primary care services provided at the facility. Reasonable access will be assumed if the area within which the population resides lies within 30 minutes travel time of the facility and non-physical barriers (relating to demographic and socioeconomic characteristics of the population) do not prevent the population from receiving care at the facility.

Migrant health centers (as defined in section 319(a)(1) of the Act) which are located in areas with designated migrant population groups and Indian Health Service facilities are assumed to be meeting this requirement.

(b) Insufficient capacity to meet primary care needs.

A facility will be considered to have insufficient capacity to meet the primary care needs of the area or population it serves if at least two of the following conditions exist at the facility:

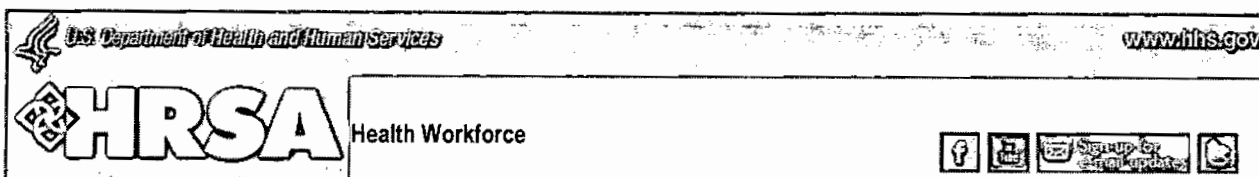
(i) There are more than 8,000 outpatient visits per year per FTE primary care physician on the staff of the facility. (Here the number of FTE primary care physicians is computed as in Part I, Section B, paragraph 3 above.)

(ii) There is excessive usage of emergency room facilities for routine primary care.

(iii) Waiting time for appointments is more than 7 days for established patients or more than 14 days for new patients, for routine health services.

(iv) Waiting time at the facility is longer than 1 hour where patients have appointments or 2 hours where patients are treated on a first-come, first-served basis.

Relevant excerpts from 42 Code of Federal Regulations (CFR), Chapter 1, Part 5, Appendix A (October 1, 1993, pp. 34-48) Criteria for Designation of Areas Having Shortages of Primary Medical Care Professionals [45 FR 76000, Nov. 17, 1980, as amended at 54 FR 8737, Mar. 2, 1989; 57 FR 2480, Jan. 22, 1992]


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Guidelines for Primary Medical Care/Dental HPSA Designation

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Background/Summary

Section 332 of the Public Health Service Act provides that the Secretary of Health and Human Services shall designate health professional shortage areas, or HPSAs, based on criteria established by regulation. The authority for designation of HPSAs is delegated to the Bureau of Primary Health Care's Office of Shortage Designation (OSD). Criteria and the process used for designation of HPSAs were developed in accordance with the requirements of Section 332.

HPSA designation is a prerequisite for participation in a number of Federal programs, including National Health Service Corps approved sites.

The HPSA criteria require three basic determinations for a geographic area request:

- the geographic area involved must be rational for the delivery of health services,
- a specified population-to- practitioner ratio representing shortage must be exceeded within the area, and
- resources in contiguous areas must be shown to be overutilized, excessively distant, or otherwise inaccessible.

These criteria have been defined for shortage of primary medical care physicians, dentists, and mental health professionals. The particular level used to indicate primary medical care, dental, and mental health shortage is referenced in the Criteria for Designation of HPSAs, codified at [42 CFR Chapter 1, PART 5 - DESIGNATION OF HEALTH PROFESSIONAL\(S\) SHORTAGE AREAS, 10-1-93 edition](#).

Where a geographic area does not meet the shortage criteria, but a population group within the area has access barriers, a population group designation may be possible. In such cases the population group and the access barriers must be defined/described, and the ratio of the number of persons in the population group to the number of practitioners serving it must be determined. These ratios are also referenced in the Criteria for Designation of HPSAs.

In some cases, facilities may be designated as HPSAs. This applies to correctional facilities and to State mental hospitals. In addition, public and non-profit private facilities located outside designated HPSAs may receive facility HPSA designation if they are shown to be accessible to and serving a designated geographic area or population group HPSA.

A current list of designated HPSAs is published periodically; the most recent was published in the Federal Register on February 2, 2002. Designations more than 3 years old are subject to updating as part of the OSD's annual review of HPSAs. At that time, new data relevant to the designation should be submitted to the OSD in support of its continued status as a HPSA.

Required Information for HPSA Requests

1. Rational Service Area - A map showing the boundaries of the area for which designation is being requested should be provided. The rationale for the selection of a particular service area definition (in terms of travel times, composition of the population, etc.) should be described, particularly for non-whole- county service areas and population groups. The area should be defined in terms of counties or whole census tracts (CTs), census county divisions (CCDs), block numbering areas (BNAs), or minor civil divisions (MCDs).

2. Population Count - the number of persons in the requested area (or population group), based on the latest available Census Bureau or State population estimates (population projections will not be accepted). Any adjustments to the population count for the service area and contiguous areas should be explained.

3. Practitioner Count - the number of full-time- equivalent (FTE) non-Federal practitioners available to provide patient care to the area or population group. "Non-Federal" means practitioners who are not Federal employees and are not obligated-service members of the National Health Service Corps. It would include non-obligated-service hires of Federal grantees.

"Practitioner" means allopathic (M.D.) or osteopathic (D.O.) primary medical care physicians for primary medical care HPSA requests; dentists, for dental HPSA requests; and psychiatrists or core mental health providers for psychiatric/mental health HPSA requests. Core mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family specialists.

"Patient care" for primary care physicians includes seeing patients in the office, on hospital rounds and in other settings, and activities such as interpreting laboratory tests and X-rays and consulting with other physicians.

To develop a comprehensive list of practitioners in an area, the applicant should check State licensure lists, State and local medical or dental society directories, local hospital admitting physician listings, Medicaid and Medicare practitioner lists, and the local yellow pages listings. For practitioners who serve in the requested area less than full-time (40 hours a week in patient care activities), an explanation is needed concerning a practitioner's part-time status (i.e. semi-retired, other practice location outside service area, teaching, etc.).

Calculating Primary Care FTE When Only Office Hours are Known

To determine primary medical care FTE in cases where only a physician's office hours are known, and information is not available on a physician's hours spent in other patient care activities, an upward adjustment must normally be made from the number of office hours per week to obtain the total estimated number of hours spent in direct patient care per week. The adjustment factors provided in the table below are designed to take into consideration the hours of direct patient care provided in both office and inpatient settings.

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The first column of the table below lists the average number of hours per week that each type of primary care physician spends providing patient care in the office setting. The second column lists the average number of hours each spends in all direct patient care. The ratio of office hours to total direct patient care hours is shown in the third column. The last column presents the reciprocal of that ratio - the factor by which each type of physician's office hours should be multiplied to obtain his/her total hours in direct patient care.

Primary Care Specialty	Average Office Hours per Week ^{1/}	Average Hours All Direct Patient Care per Week ^{2/}	Ratio of Office Hours to All Direct Patient Care Hours	Office Hours to All Direct Patient Care Hours Adjustment Factor
General/Family	35.1	49.9	.703	1.4
Practice Pediatrics	31.9	46.0	.693	1.4
Internal	27.1	49.5	.547	1.8
Medicine Obstetrics / Gynecology	29.2	55.5	.526	1.9
All Primary Care ^{3/}	30.8	50.1	.618	1.6

To obtain a full-time-equivalency for a given physician, his/her total office hours per week should be multiplied by the appropriate factor for his/her specialty. In the event that the primary care specialty is unspecified, the factor shown for "all primary care" should be used. If this calculation yields a number greater than 40, the physician should be considered as 1.0 FTE; otherwise, this number of hours should be divided by 40 to obtain the physician's FTE.

^{1/} American Medical Association, *Socioeconomic Characteristics of Medical Practice, 1990-1991*, Table 14, p. 58. ^{2/} Ibid, Table 11, p. 52.

^{3/} This is a weighted average, weighted by the percentage that each specialty represents of all primary care physicians, using data from American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1993 Edition, Table B-11a, p. 59.

The criteria provides for counting primary medical care interns and residents as 0.1 FTE. This FTE should be counted at the location the intern or resident provides primary care, such as a hospital outpatient clinic or local health department clinic. If the clinic or other service site has "slots" which interns or residents rotate through during the year, then that slot will be counted at 0.1 FTE.

There is no provision in the HPSA criteria for counting dental interns or residents.

Psychiatric residents are counted at 0.5 FTE at their service site; the slot approach outlined above for primary care may be used in determining FTE.

4. Contiguous Resources - the availability and accessibility of health providers in contiguous areas. When showing that contiguous resources are excessively distant (greater than 30 minutes travel time for primary medical care, greater than 40 minutes for dental and mental health), the driving distance and travel time between the population center of the requested area and the population centers of the contiguous areas should be provided.

In inner portions of metropolitan areas travel time by public transportation will be used. By this is meant those inner city neighborhoods with significant poverty levels (20 percent or higher) indicative of a dependence on public transportation. In those city neighborhoods with relatively low poverty levels (where residents may elect to use public transportation), driving times will be used.

5. High Needs/Insufficient Capacity - the presence of indicators of unusually high needs of the population or insufficient capacity of health care resources in the area. The high needs factors for primary care, dental and mental health, and the insufficient capacity factors for existing primary care and dental providers, are detailed in the criteria.

Population Group HPSA Requests

The following is an update and clarification to the "Guidelines on Designation of Population Groups with Health Manpower Shortages" published in the *Federal Register* on November 5, 1982.

The geographic area within which the population group resides should be defined in terms of counties, civil divisions or census tracts, in accordance with the same rational service area criteria for designation of geographic areas.

The request should contain a description of the barriers to access, in the area of residence and contiguous areas, experienced by the population group. This description should contain appropriate supporting data and should address the following points:

- 1. Whether the barriers to access for the population group are primarily economic in nature, or primarily due to non-economic factors such as minority status, language differences, or cultural differences. If significant numbers of practitioners (public and/or private) refuse to accept patients on the basis of non-economic factors, this problem and its extent should be discussed. If an access barrier appears to exist because of demographic or other differences between the population group and available practitioner(s) (public and/or private), this should also be discussed and evidence of it should be presented.
- 2. With respect to economic barriers, whether the major difficulty is lack of access for the low-income population or lack of access for the Medicaid-eligible population, the applicant should provide information on the number of persons in the category for which designation is requested. A minimum of 30 percent of the service area's population must be at or below 200 percent of poverty for consideration as a low-income or Medicaid-eligible population group HPSA.
- 3. Whether practitioners, health centers, or hospital outpatient clinics (public and/or private) in the area accept Medicaid reimbursement and/or provide patient care on an ability-to-pay or sliding-fee-scale basis. The applicant should list the practitioners, their practice locations and the approximate percentage of the practice devoted to the Medicaid-eligible population and the percentage of the practice devoted to other low-income persons in each such setting. FTE practitioners (D) is the number of practitioners involved, adjusted by the percentage of their time in patient care in the area, further adjusted by the estimated percentage of the time devoted to serving the population group in question.

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In order to calculate the appropriate population-to-practitioner ratio (R) for consideration as a primary medical care, dental or mental health HPSA, the request should include the total number of persons in the population group for which designation is requested and the total number of FTE practitioners (D) in the defined area that are serving that population. The appropriate ratio (R) will then be computed as follows for these specific population groups:

Low-income populations

Low-income population, defined as those persons with incomes at or below 200 percent of the poverty level. A minimum of 30 percent of the requested area of residence's population must be at or below 200 percent of poverty for consideration under this population group category. This is also the population eligible to receive services on a sliding-fee scale at Federally-funded projects. This includes and replaces the previously separate category of medically indigent population.

N = Population with incomes at or below 200 percent of the poverty level
D = FTE non-Federal practitioners serving the Medicaid population
+ FTE non-Federal practitioners offering care on a sliding-fee- scale, ability-to-pay basis, or free-of-charge basis
 $R = N/D$

Medicaid-eligible populations

A minimum of 30 percent of the requested area of residence's population must have incomes at or below 200 percent of the poverty level for consideration under this population group category.

N = population eligible for Medicaid under applicable State's medical assistance program
D = FTE non-Federal practitioners accepting Medicaid
 $R = N/D$

Migrant (or Migrant and Seasonal) Farmworkers and their families (Revised to explicitly include Seasonals where appropriate)

N = (average daily number of migrant workers, or migrant and seasonal workers, and dependents present in the area during portion of year that migrants, or migrant and seasonal workers, are present) X (fraction of year migrants, or migrant and seasonal workers, are present)
D = FTE non-Federal practitioners serving migrants, or migrants and seasonal workers
 $R = N/D$

American Indians or Alaskan Natives

N = number of American Indians or Alaskan Natives
D = FTE non-Federal practitioners serving Indians or Alaskan natives
 $R = N/D$

Other populations isolated by linguistic or cultural barriers or by handicaps

N = number of people in language or cultural or handicapped group involved
D = FTE non-Federal practitioners speaking language involved (or using interpreter), or familiar with culture involved, or serving handicapped group
 $R = N/D$

Homeless Populations

Public Law 100-77 included a provision amending Section 332 of the PHS Act to specifically state that the homeless are one of the population groups eligible for health professional shortage area (HPSA) designation. In fact, designation of homeless populations as HPSAs was already possible under existing legislation, regulations and criteria, and such designations already exist. The area where the homeless congregate should be defined in terms of census tracts, and information on the location of any homeless shelters, clinics, or other facilities serving the homeless should be provided.

N = The estimated number of homeless persons in the area, as recognized by local officials for planning of shelters/services to the homeless. Please include a brief description (or enclose an existing report) on how the count was obtained.
D = The number of full-time-equivalent (FTE) non-Federal practitioners, if any, currently serving the population. This would include time devoted to the homeless by practitioners at any local health care facilities which provide some ambulatory care services to the homeless, or by private practitioners who volunteer some of their time to serve the homeless at shelters or other locations accessible to homeless persons.
 $R = N/D$

Federal Programs Using HPSA Designations Include:

National Health Service Corps (Section 333 of the Public Health Service Act) - provides for assignment of federally-employed and/or service- obligated physicians, dentists, and other health professionals to designated HPSAs

National Health Service Corps Scholarship Programs (Section 338A) - provides scholarships for training of health professionals who agree to serve in designated HPSAs through the NHSC or the private practice option

National Health Service Corps Loan Repayment Program (Section 338B) - provides loan repayment to health professionals who agree to serve in the NHSC in HPSAs selected by the Secretary

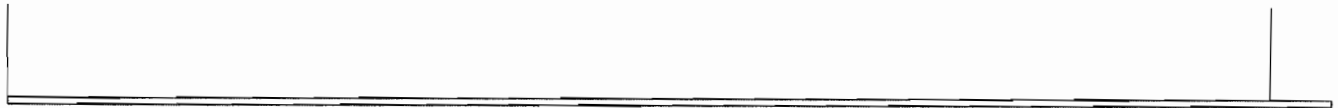
Rural Health Clinics Act (Public Law 95-210) - provides Medicare and Medicaid reimbursement for services provided by physician assistants and nurse-practitioners in clinics in rural HPSAs

Medicare Incentive Payments for Physician's Services Furnished in HPSAs (Public Law 100-203, Section 4043, as amended) - CMS (formerly HCFA) gives 10 percent bonus payment for Medicare-reimbursable physician services provided within geographic HPSAs. This payment does not apply to population group HPSAs.

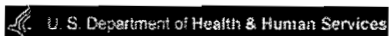
Higher "Customary Charges" for New Physicians in HPSAs (Public Law 100-203, Section 4047) - CMS (formerly HCFA) exempts new physicians opening practices in non-metropolitan geographic HPSAs from new Medicare limitations on "customary charges"

Area Health Education Center Program (Section 781(a)(1)) - gives special consideration to centers that would serve HPSAs with higher percentages of underserved minorities; gives funding priority to centers providing substantial training experience in HPSAs

Federal Employees Health Benefits Programs - provides reimbursement for non-physician services in States with high percentages of their population residing in HPSAs



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HPSA & MUA/P
by Address

HPSA Eligible
for the Medicare
Physician Bonus
Payment

MUA/P by State
& County

Criteria:

State: Illinois
County: Franklin County
Jackson County
Johnson County
Perry County
Saline County
Union County
Williamson County
ID: All

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Date of Last Update: All Dates
HPSA Score (lower limit): 0

Results: 23 records found.

(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE *	Score
055 - Franklin County				
Franklin Rural Health Clinic II	117999177K	Rural Health Clinic		0
Christopher Rural Health Planning Corporation	117999171R	Comprehensive Health Center	1	5
Low Income - Franklin County	117999177D	HPSA Population	1	18
Franklin		Single County		
077 - Jackson County				
Southern Illinois University Family Practice Center	117999177F	Rural Health Clinic		0
Low Income - Jackson County	117999174S	HPSA Population	6	14
Jackson		Single County		
087 - Johnson County				
Shawnee Correctional Center	117999170J	Correctional Facility	1	12
Johnson County	117087	HPSA Geographic	1	14
Johnson		Single County		
145 - Perry County				
Pinkneyville Correctional Center	117999179P	Correctional Facility	1	15
Low Income - Perry County	117999170B	HPSA Population	2	13
Perry		Single County		
165 - Saline County				
Low Income - Saline County	117999171W	HPSA Population	2	16
Saline		Single County		
181 - Union County				
Rural Health, Inc.	117999175Q	Comprehensive Health Center	1	5
Low Income - Union County	117999172K	HPSA Population	1	15
Union		Single County		
199 - Williamson County				
Marion Rural Health Clinic	117999177T	Rural Health Clinic		0
United States Penitentiary - Marion	1179991760	Correctional Facility	0	12
Shawnee Health Services Corporation	117999174Z	Comprehensive Health Center	1	6
Low Income - Williamson County	117999174C	HPSA Population	2	17
Williamson		Single County		

Data as of: 12/30/2014

* This attribute represents the number of non-federal practitioners providing ambulatory patient care in the Health Professional Shortage Area (HPSA) expressed as full-time equivalents.

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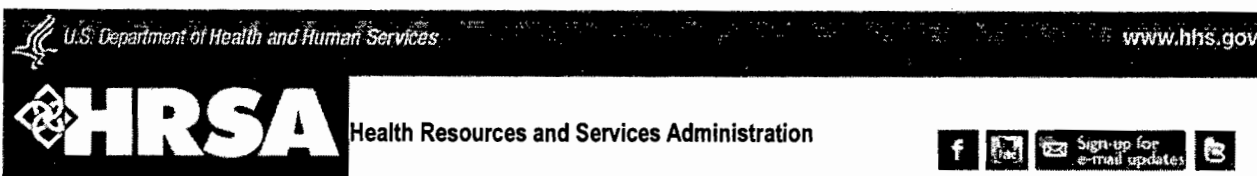
June 25, 2014 Federal Register Notice

NOTE: Below are lists of designated HPSAs that reflect the publication of the Federal Register notice on June 25, 2014. This Federal Register notice reflects the status of HPSAs as of May 23, 2014. The main impact of this Federal Register publication will be to officially withdraw those HPSAs that have been in "proposed for withdrawal" status since the last Federal Register notice was published on June 27, 2013. HPSAs that have been placed in "proposed for withdrawal" status since May 23, 2014 will remain in that status until the publication of the next Federal Register notice. If there are any questions about the status of a particular HPSA or area, we recommend that you contact the state primary care office in your state; a listing can be obtained at <http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html>.

- [County and County Equivalent Listing - Primary Care](#) (approx. 359 KB)
- [County and County Equivalent Listing - Dental Care](#) (approx. 297 KB)
- [County and County Equivalent Listing - Mental Care](#) (approx. 355 KB)

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Shortage Designation

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Guidelines for MUA and MUP Designation

These guidelines are for use in applying the established Criteria for Designation of Medically Underserved Areas (MUAs) and Populations (MUPs), based on the Index of Medical Underservice (IMU), published in the *Federal Register* on October 15, 1976, and in submitting requests for exceptional MUP designations based on the provisions of Public Law 99-280, enacted in 1986.

The three methods for designation of MUAs or MUPs are as follows:

I. MUA Designation

This involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area's IMU score.

The MUA designation process therefore requires the following information:

(1) Definition of the service area being requested for designation. These may be defined in terms of:

- (a) a whole county (in non-metropolitan areas);
- (b) groups of contiguous counties, minor civil divisions (MCDs), or census county divisions (CCDs) in non-metropolitan areas, with population centers within 30 minutes travel time of each other;
- (c) in metropolitan areas, a group of census tracts (C.T.s) which represent a neighborhood due to homogeneous socioeconomic and demographic characteristics.

In addition, for non-single-county service areas, the rationale for the selection of a particular service area definition, in terms of market patterns or composition of population, should be presented. Designation requests should also include a map showing the boundaries of the service area involved and the location of resources within this area.

(2) The latest available data on:

- (a) the resident civilian, non-institutional population of the service area (aggregated from individual county, MCD/CCD or C.T. population data)
- (b) the percent of the service area's population with incomes below the poverty level
- (c) the percent of the service area's population age 65 and over
- (d) the infant mortality rate (IMR) for the service area, or for the county or subcounty area which includes it. The latest five-year average should be used to ensure statistical significance. Subcounty IMRs should be used only if they involve at least 4000 births over a five-year period. (If the service area includes portions of two or more counties, and only county-level infant mortality data is available, the different county rates should be weighted according to the fraction of the service area's population residing in each.)
- (e) the current number of full-time-equivalent (FTE) primary care physicians providing patient care in the service area, and their locations of practice. Patient care includes seeing patients in the office, on hospital rounds and in other settings, and activities such as laboratory tests and X-rays and consulting with other physicians. To develop a comprehensive list of primary care physicians in

**Health Professional Shortage Area
or
Medically Underserved Area/Population?**

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an area, an applicant should check State and local physician licensure lists, State and local medical society directories, local hospital admitting physician listings, Medicaid and Medicare provider lists, and the local yellow pages.

(3) The computed ratio of FTE primary care physicians per thousand population for the service area (from items 2a and 2e above).

(4) The IMU for the service area is then computed from the above data using the attached conversion Tables V1-V4, which translate the values of each of the four indicators (2b, 2c, 2d, and 3) into a score. The IMU is the sum of the four scores. (Tables V1-V4 are reprinted from earlier Federal Register publications.)

II. MUP Designation, using IMU

This involves application of the Index of Medical Underservice (IMU) to data on an underserved population group within an area of residence to obtain a score for the population group. Population groups requested for MUP designation should be those with economic barriers (**low-income or Medicaid-eligible populations**), or cultural and/or linguistic access barriers to primary medical care services.

This MUP process involves assembling the same data elements and carrying out the same computational steps as stated for MUAs in section I above. The population is now the population of the requested group within the area rather than the total resident civilian population of the area. The number of FTE primary care physicians would include only those serving the requested population group. Again, the sample survey on page 8 may be used as a guide for this data collection. The ratio of the FTE primary care physicians serving the population group per 1,000 persons in the group is used in determining weighted value V4. The weighted value for poverty (V1) is to be based on the percent of population with incomes at or below 100 percent of the poverty level in the area of residence for the population group. The weighted values for percent of population age 65 and over (V2) and the infant mortality rate (V3) would be those for the requested segment of the population in the area of residence, if available and statistically significant; otherwise, these variables for the total resident civilian population in the area should be used. If the total of weighted values V1 - V4 is 62.0 or less, the population group qualifies for designation as an IMU-based MUP.

Tables V1 - V4 for Determining Weighted Values

Table V1: Percentage of Population Below Poverty Level

Table V2: Percentage of Population Age 65 and Over

Table V3: Infant Mortality Rate

Table V4: Ratio of Primary Care Physicians per 1,000 Population

III. Exceptional MUP designations

Under the provisions of Public law 99-280, enacted in 1986, a population group which does not meet the established criteria of an IMU less than 62.0 can nevertheless be considered for designation if "unusual local conditions which are a barrier to access to or the availability of personal health services" exist and are documented, and if such a designation is recommended by the chief executive officer and local officials of the State where the requested population resides.

Requests for designation under these exceptional procedures should describe in detail the unusual local conditions/access barriers/availability indicators which led to the recommendation for exceptional designation and include any supporting data.

Such requests must also include a written recommendation for designation from the Governor or other chief executive officer of the State (or State-equivalent) and local health official.

Federal Programs Using MUA/MUP Designations

Recipients of Community Health Center (CHC) grant funds are legislatively required to serve areas or populations designated by the Secretary of Health and Human Services as medically underserved. Grants for the planning, development, or operation of community health centers under section 330 of the Public Health Service Act are available only to centers which serve designated MUAs or MUPs.

Systems of care which meet the definition of a community health center contained in Section 330 of the Public Health Service Act, but are not funded under that section, and are serving a designated MUA or MUP, are eligible for certification as a Federally Qualified Health Center (FQHC) and thus for cost-based reimbursement of services to Medicaid-eligibles.

Clinics serving rural areas designated as MUAs are eligible for certification as Rural Health Clinics by the Centers for Medicare and Medicaid Services under the authority of the Rural Health Clinics Services Act (Public Law 95-210, as amended).

PHS Grant Programs administered by HRSA's Bureau of Health Professions - gives funding preference to Title VII and VIII training programs in MUAs/PS.

Revised June, 1995

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State &
County

HPSA
Eligible for
the
Medicare
Physician
Bonus
Payment

Criteria:

State: Illinois
County: Franklin County
Jackson County
Johnson County
Perry County
Saline County
Union County
Williamson County
ID #: All

Results: 17 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Franklin County					
Franklin County	00805	MUA	55.60	1981/04/10	
Jackson County					
Jackson County	00808	MUA	45.70	1994/04/12	
Johnson County					
Johnson County	00810	MUA	57.00	1978/11/01	
Perry County					
Beaucoup Precinct - County	05001	MUA	61.10	1998/08/31	
MCD (00342) Beaucoup precinct					
Cutler Precinct - County	05002	MUA	51.70	1998/08/31	
MCD (00936) Cutler precinct					
Saline County					
Low Income - Saline	07098	MUA	56.60	2001/05/11	
Union County					
Union County	00819	MUA	58.20	1978/11/01	
Williamson County					
Blairsville/ Cartersville Service Area					
MCD (00432) Blairsville precinct	00865	MUA	60.90	1994/05/18	
MCD (00648) Cartersville precinct					
Williamson Service Area	00866	MUA	59.00	1994/05/11	
MCD (00846) Corinth precinct					
MCD (00918) Creal Springs precinct					
MCD (01062) East Marion precinct					
MCD (01836) Lake Creek precinct					

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HERRIN HOSPITAL							
Inpatient Origin: September 1, 2013 - August 31, 2014							
			Percentage				
Community	Zip Code	Admissions	of Admissions	Cumulative %	County	In PA F-06?	In Market Area?
Herrin	62948	1,353	0.1484	14.84%	Williamson	Yes	Yes
Marion	62959	1,172	0.1285	27.69%	Williamson	Yes	Yes
West Frankfort	62896	977	0.1071	38.40%	Franklin	Yes	Yes
Carterville	62918	508	0.0557	43.97%	Franklin	Yes	Yes
Benton	62812	470	0.0515	49.13%	Franklin	Yes	Yes
Johnston City	62951	437	0.0479	53.92%	Williamson	Yes	Yes
Christopher	62822	229	0.0251	56.43%	Franklin	Yes	Yes
Murphysboro	62966	207	0.0227	58.70%	Jackson	No	Yes
Carbondale	62901	203	0.0223	60.93%	Jackson	No	Yes
Harrisburg	62946	194	0.0213	63.06%	Saline	No	Yes
DuQuoin	62832	173	0.0190	64.95%	Perry	No	Yes
Goreville	62939	169	0.0185	66.81%	Johnson	Yes	No
Thompsonville	62890	167	0.0183	68.64%	Franklin	Yes	Yes
Zeigler	62999	164	0.0180	70.44%	Franklin	Yes	Yes
Creal Springs	62922	151	0.0166	72.09%	Williamson	Yes	Yes
Energy	62933	143	0.0157	73.66%	Williamson	Yes	Yes
Royalton	62983	132	0.0145	75.11%	Franklin	Yes	Yes
Mulkeytown	62865	119	0.0130	76.41%	Franklin	Yes	Yes
Sesser	62884	114	0.0125	77.66%	Franklin	Yes	Yes
Anna	62906	93	0.0102	78.68%	Union	No	Yes
ElDorado	62930	93	0.0102	79.70%	Saline	No	Yes
Carbondale	62902	89	0.0098	80.68%	Jackson	No	Yes
Pittsburg	62974	82	0.0090	81.58%	Williamson	Yes	Yes
Carrier Mills	62917	74	0.0081	82.39%	Saline	No	Yes
Vienna	62995	70	0.0077	83.16%	Johnson	Yes	No
Metropolis	62960	53	0.0058	83.74%	Massac	Yes	No
Cambria	62915	52	0.0057	84.31%	Williamson	Yes	No
Galatia	62935	52	0.0057	84.88%	Saline	No	Yes
Hurst	62949	49	0.0054	85.42%	Williamson	Yes	No
De Soto	62924	46	0.0050	85.92%	Jackson	No	Yes
Pinckneyville	62274	45	0.0049	86.41%	Perry	No	No
Elkville	62932	44	0.0048	86.90%	Jackson	No	Yes
Mount Vernon	62864	42	0.0046	87.36%	Jefferson	No	No
Other Zipcodes*		1,153	0.1264	100.00%			
Total, All of These Zipcodes		7,966					
Total Patients		9,119					
Total These Zipcodes within PA F-06			6,611	72.50%			
Total, These Zipcodes within Market Area			8,639	94.74%			

*Other Zipcodes are Zipcodes that had fewer than 42 admissions during this period (0.5% of total admissions)

III.

Criterion 1110.230 - Alternatives

1. The following alternatives to the proposed project were considered and found to be infeasible and less desirable than the alternative that is the subject of this CON application.
 - a. Modernize and expand the departments included in this project by constructing a one-story addition adjacent to the existing hospital on the site of the hospital's chapel and the Herrin Medical Arts Building, both of which would be demolished to accommodate the new addition.
 - b. Modernize and expand the departments included in this project by constructing the new addition to the north of the existing hospital, rather than to the south of the existing hospital building, as proposed.
2. These alternatives were found to be infeasible and less desirable than the alternative that is the subject of this CON application for the following reasons.
 - a. Modernize and expand the departments included in this project by constructing a one-story addition adjacent to the existing hospital on the site of the hospital's chapel and the Herrin Medical Arts Building, both of which would be demolished to accommodate the new addition.

Capital Costs: \$32,000,000

This alternative was considered to be infeasible for the following reasons.

- 1) This alternative would result in higher costs than the selected project because the existing tenants in the 3-story Medical Arts Building would need to be relocated in order to demolish that building since it sits on the site proposed in this alternative.
- 2) This project would take longer to complete because of the time necessary to relocate the tenants in the 3-story Medical Arts Building and to demolish the Medical Arts Building and hospital chapel prior to the initiation of the construction of the new addition could begin.
- 3) Implementation of this alternative would result in the Surgical Suite and post-anesthesia recovery facilities being located too far from the hospital's Emergency Department, Intensive Care Unit, and inpatient nursing units.

- b. Modernize and expand the departments included in this project by constructing the new addition to the north of the existing hospital, rather than to the south of the existing hospital building, as proposed.

Capital Costs: \$26,000,000

This alternative was considered to be infeasible because of the additional costs required to purchase and demolish a funeral home that is currently located on property north of the Herrin Hospital campus, the site proposed for this alternative.

3. This item is not applicable to this project.

The purpose of this project is to modernize and expand existing services at Herrin Hospital in order to meet the needs generated by current and proposed increased utilization, not to establish new categories of service or a new health care facility.

IV.
Project Scope, Utilization:
Size of Project

This project includes both Clinical and Non-Clinical Service Areas.

There are no Categories of Service included in this project.

This project includes the following Clinical Service Areas Other than Categories of Service, as discussed in Attachment 34.

Surgical Suite (Class C Surgical Recovery Suite)
Endoscopy/Minor Procedures (Class B Surgical Procedure Suite)
Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)
Surgical Prep (for both A.M. Admits and Same-Day Surgery Patients) /
Post-Anesthesia Recovery Phase II for Surgical Suite
Prep/Recovery Phase II for Class B Surgical Procedure Suite

1. The Illinois certificate of need (CON) Rules include State Guidelines (77 Ill. Adm. Code 1110.APPENDIX B) for all of the Clinical Service Areas that are included in this project.

Surgical Operating Suite (Class C)
Endoscopy and Minor Procedures (Class B Surgical Procedure Suite)
Post-Anesthesia Recovery Phase I
Post-Anesthesia Recovery Phase II - 2 separate units for Surgery
and for Endoscopy/Minor Procedures

An analysis of the proposed size (number of rooms or stations and gross square footage) of the Clinical Service Areas for which there are State Guidelines is found below.

This analysis is based upon historic utilization at Herrin Hospital during CY2013 (January 1 - December 31, 2013) and projected utilization for the first and second full years of operation after this project is completed for those services for which the approvable number of rooms or stations is based upon utilization.

The chart on the next page identifies the State Guidelines for each of the Clinical Service Areas included in this project for which State Guidelines exist.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINE</u>
Surgery (Surgical Operating Suite Class C)	1,500 hours of surgery per operating room 2,750 DGSF per operating room
Endoscopy/Minor Procedures (Surgical Procedure Suite Class B)	1,500 hours of surgery per procedure room 1,100 DGSF per procedure room
Post-Anesthesia Recovery Phase I (PACU, Recovery)	180 DGSF per Recovery Station
Post-Anesthesia Recovery Phase II	400 DGSF per Recovery Station

It should be noted that Phase II Recovery is combined with Surgical Prep for A.M. Admissions and Same-Day Surgical Patients.

Herrin Hospital will have 2 separate Phase II Recovery Areas, 1 for Surgical Recovery and 1 for Endoscopy/Minor Procedures (Class B Surgical Procedures)

Attachment 15 includes historic and projected utilization for each of the Clinical Service Areas in this project for which there are utilization data.

The justification for the number of operating rooms, endoscopy procedure rooms, and minor procedure rooms is presented in this Attachment and in Attachments 15 and 34.

The number of key rooms and square footage proposed for each Clinical Service Area for which State Guidelines exist is presented below.

<u>CLINICAL SERVICE AREA</u>	<u>STATE STANDARD</u>	<u>PROJECTED FY2020 VOLUME</u>	<u>TOTAL EXISTING BEDS/ ROOMS</u>	<u>TOTAL PROPOSED BEDS/ ROOMS</u>
Surgery	1,500 hours/ operating room	9,187 hours	4	7
Endoscopy/ Minor Procedures	1,500 hours/ procedure room	2,898 Endoscopy hours 3,061 Minor Procedures Hours	4	4
Post- Anesthesia Recovery Phase I	N/A*	N/A*	N/A*	N/A*
Post- Anesthesia Recovery Phase II	N/A*	N/A*	N/A*	N/A*

*N/A refers to there being no State Guideline for number of rooms.
A State Guideline for approvable GSF will be found in the next chart.

The proposed number of rooms for the Clinical Service Areas included in this project for which there are State Guidelines are justified except for Post-Anesthesia Recovery Phase I.

The square footage proposed for each Clinical Service Area for which State Guidelines exist is shown on the next page.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINE/ UNIT</u>	<u>TOTAL PROPOSED UNITS</u>	<u>TOTAL DGSF JUSTIFIED PER PROGRAM</u>	<u>TOTAL PROPOSED DGSF</u>
Surgery (Class C)	2,750 DGSF per operating room	7 operating rooms	19,250	15,913
Endoscopy/ Minor Procedures (Class B)	1,100 DGSF per procedure room	4 procedure rooms*: 2 Endoscopy 2 Minor Procedures	4,400	2,294
Recovery Phase I	180 DGSF per recovery station	9 Recovery Bays	1,620	1,827
Recovery Phase II	400 DGSF per Bed (Total)	34 Stations*	13,600	9,907

*There will be 4 procedure rooms in the Class B Procedures Suite:
2 Endoscopy Procedure Rooms;
2 Minor Procedure Rooms.

**There will be 2 Phase II Recovery Rooms:
The Post-Surgical Phase II Recovery Room will have 21 stations and
6,672 DGSF;
The Endoscopy/Minor Procedures Phase II Recovery Room will have
13 stations and 3,235 DGSF.

Space programs for each of the Clinical Service Areas included in this project are appended to this Attachment.

The following published data and studies identify the contemporary standards of care and the scope of services that MHC addressed in developing the proposed project .

- Illinois Hospital Licensing Requirements (77 Ill. Adm. Code 250.2440);
- Standards for Accessible Design: ADA Accessibility Guidelines for Buildings and Facilities (28 Code of Federal Regulations, 36.406.ADAAG, Sections 4.1 through 4.35 and 6.1 through 6.4);
- National Fire Protection Association, NFPA 101: Life Safety Code, 2012 Edition.

2. The proposed square footage for the Clinical Service Areas included in this project exceeds the State Guideline found in 77 Ill. Adm. Code 1110.APPENDIX B for Post-Anesthesia Recovery Phase I as shown below.

<u>CLINICAL SERVICE AREAS</u>	<u>PROPOSE D DGSF</u>	<u>STATE STANDARD</u>	<u>DIFFERENCE</u>	<u>MET STANDARD?</u>
Surgery (Class C)	15,913 for 7 operating rooms	2,750 DGSF per operating room	under by 3,337 DGSF (476.7 DGSF/ operating room)	Yes
Endoscopy/ Minor Procedures (Class B)	2,294 for 4 procedure rooms	1,100 DGSF per procedure room	under by 2,106 DGSF (526.5 DGSF/ procedure room)	Yes
Recovery Phase I	1,827 for 9 recovery bays	180 DGSF per recovery bay	207 DGSF (23 DGSF/ recovery bay)	No
Recovery Phase II	9,907 for 34 stations	400 DGSF per station	under by 3,693 DGSF (108.6 DGSF/ station)	Yes

Upon completion of this project, the floor area of Recovery Phase I (PACU) will exceed the guidelines utilized by the Illinois Health Facilities and Services Review Board, as identified in 77 Ill. Adm. Code, Chapter II, Section 1110. Appendix B, for the following reasons.

- a. The PACU is being constructed in existing space that is part of the space that will be vacated by the Surgical Suite.

This space has column placements that necessitate constructing 8 of the 9 PACU stations with more space than the minimum requirements in order to meet the clearances required by IDPH.

There are 3 columns in the space where the PACU stations will be constructed, which results in the stations being required to have more space between the carts and in front of the foot areas. Because of these columns, additional space is required to meet the requirements of 4'0" clear area between the sides of the beds and at least 6' between the foot end of any bed and other equipment or fixed device, as required in 77 Ill. Adm. Code 250.2440.i.4(C).

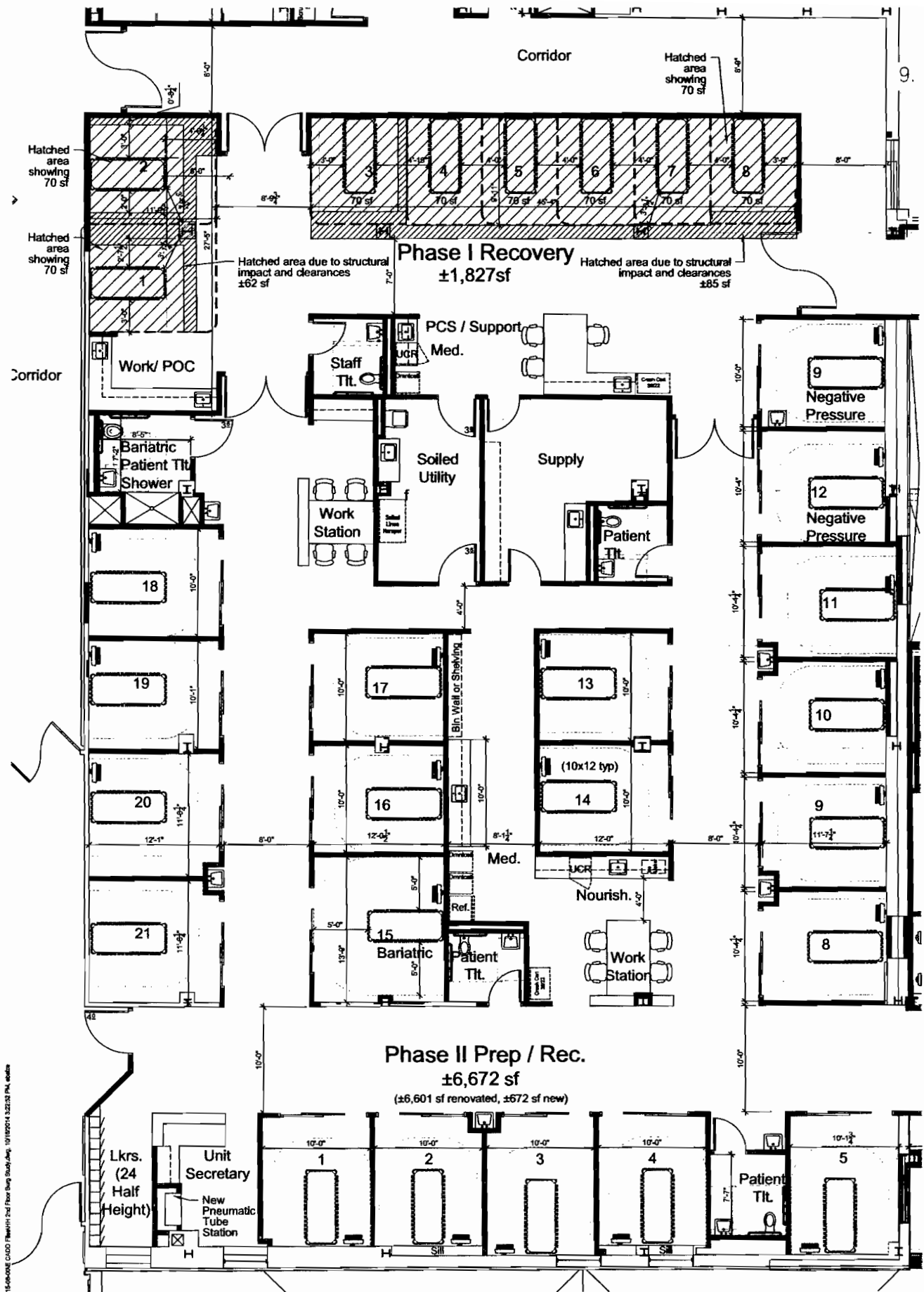
The additional space that is required to address this issue and compensate for the columns in the PACU station area totals 147 SF.

- b. The PACU was designed with 8' clear area at the foot of each station, rather than 6' which is required in the Illinois Hospital Licensing Requirements, in order to assist in the movement of stretchers in and out of the PACU stations.

The additional space that is required to address this issue totals 80 SF.

Justification of the additional space was prepared by the architect for this project and appears on the next page of this Attachment.

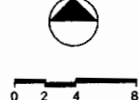
In addition, it should be noted that one of the PACU stations will be an isolation room that will be constructed as a separate room with negative pressure, and it will have a handwashing sink.



*Note:
Total blue hatched area due to structural impact and clearances = 147 sf.

SIH Herrin Hospital
Second Floor
Proposed PACU Base Option

TKH TCHOUKALEFF KELLY HARTKE
Project #: 10.13.14
File Name: 10.13.14
Drawn By: ab



SPACE PROGRAM

SURGICAL SUITE (CLASS C SURGICAL OPERATING SUITE)

- 7 Operating Rooms, 1 of which will be designed to convert to a Hybrid Operating Room
- 7 Stretcher Alcoves
- 1 Scrub Sub-Sterile Room
- 1 Scrub Dispensing Room
- 1 Clean Core/Sub-Sterile Area
- 1 Specimen Room
- 1 Equipment/Supply Room
- 2 Equipment Storage Rooms
- 2 Surgery Support Rooms
- 1 Anesthesia Supply/Workroom
- 3 C-Arm Alcoves
- 1 Soiled Utility Room
- 1 Soiled Case Cart Room
- 1 Staff Lounge
- 1 Male Locker Room with Toilets and Showers
- 1 Female Locker Room with Toilets and Showers
- 1 Anesthesia Office
- 1 OR Manager's Office
- 7 Staff Workstations
- 1 Administrative Assistant's Office
- 1 Copy Workroom
- 2 Consultation Rooms - shared with Endoscopy/Minor Procedure Suite
- 1 Waiting Room - shared with Endoscopy/Minor Procedure Suite
- 1 Vending Alcove - shared with Endoscopy/Minor Procedure Suite
- 1 Oxygen Tank Room - shared with Endoscopy/Minor Procedure Suite

SPACE PROGRAM

ENDOSCOPY/MINOR PROCEDURES (CLASS B SURGICAL PROCEDURE SUITE)

- 2 Endoscopy Procedure Rooms
- 2 Multi-Specialty Procedure Rooms
- 1 Equipment Alcove
- 1 Supply/Equipment Room - shared with Prep/Recovery Phase II for Class B Surgical Procedure Suite
- 1 Decontamination Room (Soiled)
- 1 Clean Processing Room
- 6 Scope Storage Closets
- 1 Physician TD Desk
- 1 Staff Lounge - shared with Prep/Recovery Phase II for Class B Surgical Procedure Suite
- 1 Staff Toilet
- 2 Consultation Rooms - shared with Surgical Suite
- 1 Waiting Room - shared with Surgical Suite
- 1 Vending Alcove - shared with Surgical Suite
- 1 Oxygen Tank Room - shared with Surgical Suite

SPACE PROGRAM

POST-ANESTHESIA RECOVERY PHASE I (POST-ANESTHESIA CARE UNIT, PACU)

8 PACU Recovery Bays

1 Isolation PACU Negative Pressure Room

1 Point of Care Testing (POC) Work Area

1 PCS/Support/Medication Alcove

1 Supply Area - shared with Recovery Phase II for Surgical Suite

1 Soiled Utility Room - shared with Recovery Phase II for Surgical Suite

1 Staff Toilet

SPACE PROGRAM

SURGICAL PREPARATION FOR A.M. ADMITS/SAME-DAY SURGERY PATIENTS AND POST-ANESTHESIA RECOVERY PHASE II FOR SURGICAL SUITE

21 Surgical Prep/Stage II Private Recovery Rooms

1 Patient Locker Alcove

3 Patient Toilet Rooms

, 1 Bariatric Patient Toilet/Shower Room

1 Control Desk

2 Charting/Work Areas

1 Medication Alcove

1 Nourishment Alcove

1 Supply Area - shared with PACU

1 Soiled Utility Room - shared with PACU

1 Emergency Equipment Alcove

1 Unit Secretary

SPACE PROGRAM

PREP/RECOVERY PHASE II FOR CLASS B SURGICAL PROCEDURE SUITE

8 Prep/Phase II Private Recovery Rooms

5 Prep/Phase II Recovery Bays

2 Patient Toilet Rooms, 1 of which is for Bariatric patients

1 Nourishment Alcove

1 PCS/Support Area

7 Supply Cabinets

1 Storage/Equipment Room - shared with Endoscopy/Minor Procedures Suite

1 Soiled Utility Room

1 Wheelchair Alcove

1 Staff Lounge - shared with Endoscopy/Minor Procedures Suite

IV.
Criterion 1110.234 - Project Services Utilization

There are no Clinical Service Areas included in this project that are Categories of Service.

This modernization project includes the following Clinical Service Areas Other than Categories of Service, all of which currently exist at Herrin Hospital (Herrin).

Surgery (Class C Surgical Operating Suite)
Endoscopy/Minor Procedures (Class B Surgical Procedure Suite)
Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)
Surgical Prep (for both A.M. Admits and Same-Day Surgery Patients) and
Post-Anesthesia Recovery Phase II for Surgical Suite
Prep/Recovery Phase II for Class B Surgical Procedure Suite

The Illinois certificate of need (CON) Rules include State Guidelines (77 Ill. Adm. Code 1110.APPENDIX B) for the following Clinical Service Areas included in this project.

Surgical Operating Suite (Class C)
Endoscopy and Minor Procedures (Class B Surgical Procedure Suite)
Post-Anesthesia Recovery Phase I
Post-Anesthesia Recovery Phase II - 2 separate units for Surgery and for
Endoscopy/Minor Procedures

The chart below identifies the State Guidelines that exist for the Clinical Service Areas included in this project.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINE</u>
Surgery (Surgical Operating Suite Class C)*	1,500 hours of surgery per operating room* 2,750 DGSF per operating room
Endoscopy/Minor Procedures** (Surgical Procedure Suite Class B)	1,500 hours per procedure room** 1,100 DGSF per procedure room
Post-Anesthesia Recovery Phase I (PACU, Recovery)	180 DGSF per Recovery Station
Post-Anesthesia Recovery Phase II***	400 DGSF per Recovery Station

*Herrin Hospital is proposing to have 7 General (multi-specialty) operating rooms

**Herrin Hospital is proposing to have 2 Endoscopy Procedure Rooms and
2 Minor Procedure Rooms in a combined Class B Surgical Procedure Suite

***Phase II Recovery is combined with Surgical Prep for A.M. Admissions and
Same-Day Surgical patients;

Herrin Hospital will have 2 separate Phase II Recovery Areas,

1 for Surgical Prep and Recovery of Surgical patients (Class C Surgery) and
1 for Recovery of Patients undergoing Endoscopy/Minor Procedures (Class B
Surgical Procedures)

The Clinical Service Areas included in this project for which there are State Guidelines based upon utilization are Surgery, Endoscopy, and Minor Procedures. Historic utilization for the last 2 years and projected utilization for the first 2 years of operation for these Clinical Service Areas are found below.

CLINICAL SERVICE AREAS	<u>HISTORIC YEARS</u>		<u>PROJECTED YEARS</u>		<u>STATE GUIDELINE</u>	<u>MET STANDARD?</u>
	<u>CY12</u>	<u>CY13</u>	<u>FY19</u>	<u>FY20</u>		
Total Surgery Cases	3,285	2,997	3,342	3,392	N/A	
Total Surgery Hours	6,951	7,282	9,060	9,187	1,500 hours per operating room (OR)	Yes
Total Endoscopy Cases	1,739	1,944	2,169	2,220	N/A	
Total Endoscopy Hours	1,996	2,538	2,832	2,898	1,500 hours per procedure room	Yes
Total Minor Procedures Cases	1,680	1,068	2,601	2,650	N/A	
Total Minor Procedures Hours	1,050	1,142	3,006	3,061	1,500 hours per procedure room	Yes

The number of key rooms proposed for each Clinical Service Area for which there are State Guidelines based on utilization is presented on the next page.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINE UNITS/ROOM</u>	<u>PROJECTED FY20 VOLUME</u>	<u>TOTAL EXISTING ROOMS</u>	<u>TOTAL PROPOSED ROOMS</u>
Surgery	1,500 hours/ operating room*	9,187 hours	4 multi-specialty operating rooms	7 multi-specialty operating rooms
Endoscopy	1,500 hours/ procedure rooms	2,898 hours	2 endoscopy procedure rooms	2 endoscopy procedure rooms
Minor Procedures	1,500 hours/ procedure room	3,061 hours	2 minor procedure rooms	2 minor procedure rooms

The proposed number of operating rooms , endoscopy procedure rooms, and minor procedure rooms is justified based on the projected utilization for FY2020.

The assumptions underlying the projected increases in are presented below and in Attachment 34.

Surgery

Herrin Hospital's surgical utilization is projected to continue to increase based on the following factors.

- Herrin Hospital's surgical cases have increased 21% since 2010.
- Herrin Hospital's surgical hours have increased annually since 2010, increasing by 67% during the 4 year period from 2010 through 2013.
- Herrin Hospital's surgical utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 34.
 - Total surgical cases at Herrin Hospital are projected to increase by 2% by FY2019, the first complete year of operation after the replacement and expansion of the Surgical Suite is completed.

This increase in surgical cases is expected to be due to the following factors.

- The continued implementation of Herrin Hospital's Physician Recruitment Plan, which has already resulted in the recruitment of 8 surgeons representing a range of surgical specialties, is projected to result in an increase in the number of surgical cases at Herrin Hospital.

As of January, 2015, the following surgeons had been recruited to Herrin Hospital's medical staff as part of the implementation of the hospital's Physician Recruitment Plan.

- 1 Gastroenterologist
- 1 General Surgeon
- 1 Bariatric Surgeon
- 2 Orthopedic Surgeons
- 2 Podiatrists
- 1 Urologist

In addition, the following additional surgeons are currently being recruited to the Herrin Hospital medical staff.

- 1 General Surgeon
- 1 Gynecologist
- 1 Otolaryngologist

- As a result of recruiting additional surgeons to its medical staff, Herrin Hospital will be able to reduce outmigration from its market area for both inpatient and outpatient surgery. This reduction in outmigration is projected to result in an increase in the number of surgery cases at Herrin Hospital.

The reduction in outmigration of surgical cases is particularly important because of the designation of Herrin Hospital's entire market area as a Health Professional Shortage Area and the designation of much of its market area as Medically Underserved Areas. This means that additional physician resources are needed in Herrin Hospital's market area in order to meet the medical needs of residents of this area.

- Total surgical cases at Herrin Hospital are projected to increase by 1.5% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Suite is completed. This increase is far less than the historic annual increase in surgical cases in recent years.
- Total surgical hours at Herrin Hospital are projected to increase by 24% by FY2019, the first complete year of operation after the replacement and expansion of the Surgical Suite is completed.

The increased surgical hours will be due to both an increased number of surgical cases and the increased surgical time that will be required to perform an increased number of more lengthy surgical cases, as discussed below.

- As a result of Herrin Hospital's physician recruitment plan, it is projected that newly recruited surgeons will perform an increased number of cases that have longer surgical times.

- Performing an increased number of more lengthy surgical cases will result in increased surgical time per case.
- When the new Surgical Suite and Surgical Procedures Suite become operational, Herrin Hospital will transfer a number of the cases currently performed in the operating rooms to the new minor procedure rooms that will become part of the Surgical Procedures Suite. These cases have a shorter time per case, as a result of which the surgical cases that will remain in the operating rooms will have a longer average time per case.
- Total surgical hours at Herrin Hospital are projected to increase by 1.4% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Suite is completed. This increase is far less than the historic annual increase in surgical hours in recent years.

Endoscopy

Herrin Hospital's endoscopic utilization is projected to continue to increase based on the following factors.

- Herrin Hospital's endoscopy cases have increased 18.5% since 2010.
- Herrin Hospital's endoscopy hours have increased annually since 2010, increasing by 34.8% during the 4 year period from 2010 through 2013.
- Herrin Hospital's 2010 through 2013 endoscopy hours justified 2 endoscopy procedure rooms (Dedicated Gastrointestinal Procedure Rooms) based upon the Illinois CON State Guidelines (77 Ill. Adm. Code 1110.APPENDIX B).
- Herrin Hospital's endoscopy utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 34.
- Endoscopy cases are projected to increase by 11.6% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of less than 2% per year, far less than the historic annual increase in endoscopy cases in recent years.
- Endoscopy cases are projected to increase by 2.4% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic annual increase in endoscopy cases in recent years.
- Endoscopy hours are also projected to increase by 11.6% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of less than 2% per year, far less than the historic annual increase in endoscopy hours in recent years.

- Endoscopy hours are projected to increase by 2.3% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic annual increase in endoscopy hours in recent years.

Minor Procedures

Herrin Hospital's minor procedures utilization is projected to continue to increase based on the following factors.

- Herrin Hospital's minor procedures cases increased 379% between 2010 and 2013. In 2011 and 2012, pain management cases were included in minor procedures, which was not the case in either 2010 or the corrected data for 2013, which has been submitted to the Illinois Health Facilities and Services Review Board.

It should be noted that pain management cases will not be performed in Herrin Hospital's minor procedures rooms once these rooms are replaced as part of this project.

Herrin Hospital performed pain management cases in its minor procedure rooms during CY2011 and CY2012 and included this caseload as part of the caseload for its Minor Procedures Rooms in its Annual Hospital Questionnaires (AHQs) for those years. In CY2010, pain management cases were performed in a dedicated surgical procedure room (Class B Surgical Procedure Room), and a corrected AHQ was submitted to the Illinois Health Facilities and Services Review Board, removing pain management cases and hours from the 2013 caseload for Minor Procedures Rooms.

- Herrin Hospital's minor procedures hours increased 355% between 2010 and 2013. In 2011 and 2012, pain management cases were included in minor procedures, which was not the case in either 2010 or the corrected data for 2013, which has been submitted to the Illinois Health Facilities and Services Review Board.
- Herrin Hospital's minor procedures utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 34.
 - Minor procedures cases are projected to increase by 144% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of 24% per year, far less than the historic annual increase in minor procedures cases in recent years.
 - Another reason for the projected increase in minor procedures cases is the proposed transfer of a number of the cases currently performed in the operating rooms to the new minor procedure rooms that will become part of the Surgical Procedures Suite.

Surgical and administrative staff at Herrin Hospital and Southern Illinois Healthcare reviewed the hospital's surgical caseload and identified cases that could be performed in the Minor Procedure Rooms.

The following procedures that are currently being performed in Herrin Hospital's operating rooms were identified as procedures that could appropriately be performed in the Minor Procedure Rooms.

- Closed reductions
 - Hip injections
 - Minor skin lesion removal
 - Pacemaker
 - PETS (ENT tubes)
 - Port Placement
 - Stimulator lead changes and/or battery change
- Minor procedures cases are projected to increase by 1.9% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic increase in minor procedures cases in recent years and does not even include consideration of any increase due to the minor procedures that will be relocated from the operating rooms in the Surgical Suite to the Minor Procedures Rooms in the Surgical Procedures Suite.
 - Minor procedures hours are projected to increase by 163% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This increase is far less annually than the increase that was experienced between 2010 and 2013.
 - Minor procedures hours are projected to increase by 1.8% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed.



SOUTHERN ILLINOIS HEALTHCARE

January 21, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Second Floor
Springfield, Illinois 62702

Dear Ms. Avery:

I am an applicant representative of Southern Illinois Hospital Services d/b/a Herrin Hospital who has signed the CON application for the modernization and expansion of the following Clinical Service Areas that are not Categories of Service:

Surgery (Class C Surgical Operating Suite)
Endoscopy/Minor Procedures (Class B Surgical Procedures Suite);
Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU);
Surgical Prep (for both A.M. Admits and Same Day Surgical Patients)/
Post-Anesthesia Recovery Phase II for Surgical Suite;
Prep/Recovery Phase II for Class B Surgical Procedure Suite.

The co-applicants for this project are Southern Illinois Hospital Services d/b/a Herrin Hospital and Southern Illinois Healthcare Enterprises, Inc.

In accordance with 77 Ill. Adm. Code 1110.234(e)(1), I hereby attest to the understanding of the co-applicants for this project that, by the end of the second year of operation after project completion, Herrin Hospital will meet or exceed the utilization standards specified in 77 Ill. Adm. Code 1110.Appendix B for the clinical service areas included in this project.

Sincerely,

Rex P. Budde
President and CEO
Southern Illinois Hospital Services d/b/a Herrin Hospital



Valerie K. Cawvey

VII.R.3.(c)(2), (c)(3)(B)

Service Specific Review Criteria: Clinical Service Areas Other than Categories of Service:

Service Modernization: Necessary Expansion

Utilization - Services

The project includes the modernization of the following Clinical Service Areas that are not Categories of Service, all of which currently exist at Herrin Hospital.

- Surgery (Class C Surgical Operating Suite)
- Endoscopy/Minor Procedures (Class B Surgical Procedure Suite)
- Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)
- Surgical Prep (for both A.M. Admits and Same-Day Surgery Patients) and Post-Anesthesia Recovery Phase II for Surgical Suite
- Prep/Recovery Phase II for Class B Surgical Procedure Suite

The project includes new construction and the modernization of existing space for the following Clinical Service Areas Other than Categories of Service that are included in this project.

Replacement and expansion of the Surgical Operating Suite (Class C) in both new construction and modernized space

Replacement of Endoscopy and Minor Procedures (Class B Surgical Procedure Suite) in reduced square footage in modernized space

Replacement and expansion of Post-Anesthesia Recovery Phase I (PACU) in modernized space

Replacement and expansion of Surgical Prep/Post-Anesthesia Recovery Phase II for the Surgical Operating Suite (Class C) in both new construction and modernized space

Replacement and expansion of Prep/Recovery Phase II for the Class B Surgical Procedure Suite (Endoscopy/Minor Procedures) in modernized space

The discussion of the replacement and expansion of Surgical Prep/Post-Anesthesia Recovery Phase II for the Surgical Operating Suite and Prep/Recovery Phase II for the Endoscopy/Minor Procedures Suite will be combined in this Attachment.

It should be noted that the following Clinical Service Areas listed in 77 Ill. Adm. Code 1110.3030(a)(1) as being subject to this Attachment are Surgical Operating Suite Class C and Surgical Procedure Suite Class B, which includes Endoscopy and Minor Procedures.

Utilization standards for Surgery as well as for Post-Anesthesia Recovery Phases I and II are identified in 77 Ill. Adm. Code 1110.APPENDIX B.

- A. The proposed project meets the specified review criterion: Necessary Expansion (77 Ill. Adm. Code 1110.3030(c)(2)).

The clinical service areas included in this project that are not categories of service need to be replaced and/or expanded for the following reasons.

1. Surgery (Surgical Operating Suite Class C)

This project proposes to replace and expand the Surgical Suite in order to accommodate the current and proposed utilization in the Surgery Service.

- a. Expansion of the Surgery Suite is necessary because Herrin Hospital has too few operating rooms to accommodate the hospital's surgical utilization.

Herrin Hospital currently has a total of 4 operating rooms, which are too few operating rooms to accommodate the historic surgical volume.

Total surgical cases at Herrin Hospital increased by 21% since 2010.

Total surgical hours at Herrin Hospital increased annually since 2010, increasing by 67% during the 4 year period from 2010 through 2013.

- b. Herrin Hospital's current operating rooms need to be replaced in order to be appropriately sized and configured to meet current standards of care and to accommodate contemporary surgical equipment.
- c. An increase in the number of operating rooms at Herrin Hospital is necessary to enable the hospital to handle its anticipated future increases in surgical volume.
- d. The expansion of Herrin Hospital's surgical capacity is particularly important because, as a result of recruiting additional surgeons, Herrin Hospital will be able to reduce outmigration from its market area for both inpatient and outpatient surgical care.

The reduction of outmigration is particularly important because of the designation of Herrin Hospital's entire market area as a Health

Professional Shortage Area and the designation of much of its market area as Medically Underserved Areas.

- e. The replacement of Herrin Hospital's Surgical Suite will result in additional surgical capability in the area since one of the new operating rooms will be designed to convert to a hybrid imaging/operating room in the future.

A hybrid room combines a standard operating room with advanced imaging functions, thereby incorporating both the imaging and surgical technologies required for a range of both minimally invasive and open surgical procedures on high-risk patients. As a result, a surgical patient will be able to undergo required imaging procedures during surgery without having to be moved to a different room.

2. Endoscopy/Minor Procedures (Surgical Procedure Suite Class B)

This project proposes to replace and expand the Endoscopy/Minor Procedures Rooms in a consolidated Class B Surgical Procedure Suite in order to accommodate the current and proposed utilization of these services.

- a. Herrin Hospital needs to replace its 2 existing Endoscopy Procedure Rooms and its 2 existing Minor Procedures Rooms in order to create a Class B Surgical Procedure Suite with the procedure and recovery rooms located contiguous with each other.
 - 1) The procedure rooms are too small.
 - 2) The Endoscopy Procedure Rooms and Minor Procedure Rooms are not located in a combined suite with prep/recovery areas at the present time.
 - 3) Two of the procedure rooms open directly on a public corridor and lack access to appropriate patient and staff support space.
 - 4) There is inadequate space for instrument cleaning for endoscopy instruments.
 - 5) The support space is inadequate.
- b. Herrin Hospital's endoscopy utilization is projected to continue to increase in the future.

c. Herrin Hospital's minor procedures utilization is projected to continue to increase based on the following factors.

- 1) Pain Management cases, which were moved from the Minor Procedures Rooms in 2013, will not be performed in Herrin Hospital's minor procedures rooms once these rooms are replaced as part of this project.
- 2) Herrin Hospital's minor procedures utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented later in this Attachment.
- 3) When this project is completed, the number of procedures cases performed in the Minor Procedures Rooms will increase because of the proposed transfer of a number of the cases currently performed in the operating rooms to the new minor procedure rooms that will become part of the Surgical Procedures Suite.

Surgical and administrative staff at Herrin Hospital and Southern Illinois Healthcare reviewed the hospital's surgical caseload and identified cases that could be performed in the Minor Procedure Rooms.

The following procedures that are currently being performed in Herrin Hospital's operating rooms were identified as procedures that could appropriately be performed in the Minor Procedure Rooms:

- Closed Reductions;
- Hip Injections;
- Minor Skin Lesion Removal;
- Pacemakers;
- PETS (ENT Tubes);
- Port Placement;
- Stimulator Lead Changes and/or Battery Changes.

3. Post-Anesthesia Recovery Phase I (Post-Anesthesia Care Unit, PACU)

This project proposes to replace Herrin Hospital's existing PACU for the following reasons.

- a. The PACU must be relocated to maintain its adjacency to the Surgical Suite, as required by the Illinois Department of Public

Health's (IDPH's) Hospital Licensing Requirements (77 Ill. Adm. Code 250.i.4.A.)

- b. The number of post-anesthesia recovery stations must be increased to meet IDPH's Hospital Licensing Requirements that there be a minimum of 1 PACU station per operating room (77 Ill. Adm. Code 250.i.4.B.)
- c. The number of post-anesthesia recovery stations must be increased beyond the minimum requirements because of the hospital's experience with its caseload.

The new PACU will provide appropriately sized and configured post-surgical facilities for Herrin Hospital's surgical patients in a location that is adjacent to the new Surgical Suite. The contiguity of the Surgical Suite and the PACU is mandated under Illinois Hospital Licensing Requirements (77 Ill. Adm. Code 250.2440(i)(4)(A) and 250.2630(i)(3).

- 4. Surgical Prep (for both A.M. Admission of Surgical Inpatients and Same-Day Surgical Patients) and Post-Anesthesia Recovery Phase II for Surgical Suite and Prep/Recovery Phase II for Class B Surgical Procedure Suite

Replacement and expansion of these functions is needed for the following reasons.

- a. This department is located across a public corridor from the Surgical Suite and needs to be relocated for patient privacy and patient flow.
- b. The current number of Phase II recovery stations for post-surgical patients does not meet the requirements specified in the IDPH Hospital Licensing Requirements (77 Ill. Adm. Code 250.2440(i)(5)(B) because it has only 15 stations, and additional stations are required.
- c. Historic increases in outpatient endoscopic and minor procedures have resulted in a need to construct a Phase II Recovery Department for patients undergoing these procedures.
- d. Many of the stations in this department lack direct visual observation from the nursing station.

B. Utilization for Services Other than Categories of Service

The Illinois certificate of need (CON) Rules include State Guidelines (77 Ill. Adm. Code 1110.APPENDIX B) for the following Clinical Service Areas Other than Categories of Service that are included in this project.

Surgical Operating Suite (Class C)
Endoscopy/ and Minor Procedures (Class B Surgical Procedure Suite)
Post-Anesthesia Recovery Phase I (PACU)
Post-Anesthesia Recovery Phase II - 2 separate units for Surgery and f
Endoscopy/Minor Procedures

Space programs for all Clinical Service Areas included in this project, none of which are categories of service, are found in Attachment 14 and in this Attachment.

The chart below identifies the State Guidelines for each of the Clinical Service Areas included in this project that are not Categories of Service for which State Guidelines exist.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINES</u>
Surgery (Surgical Operating Suite Class C)	1,500 hours of surgery per operating room 2,750 DGSF per operating room
Endoscopy/Minor Procedures (Surgical Procedure Suite Class B)	1,500 hours of surgery per procedure room 1,100 DGSF per procedure room
Post-Anesthesia Recovery Phase I (PACU, Recovery)	180 DGSF per Recovery Station
Post-Anesthesia Recovery Phase II**	400 DGSF per Recovery Station

*Please note that Stage II Recovery is combined with Surgical Prep for A.M. Admissions and Same-Day Surgical Patients

Herrin Hospital will have 2 separate Phase II Recovery Areas, one for Surgical Recovery and one for Endoscopy/Minor Procedures (Class B Surgical Procedures).

The Clinical Service Areas included in this project that are not Categories of Service for which there are State Guidelines based upon utilization are Surgery, Endoscopy, and Minor Procedures..

The following chart identifies historic utilization (Surgical hours) and projected utilization for the first 2 years of operation of this project for Surgery, Endoscopy, and Minor Procedures.

CLINICAL SERVICE AREAS	<u>HISTORIC YEARS</u>		<u>PROJECTED YEARS</u>	
	<u>CY2012</u>	<u>CY2013</u>	<u>FY2019</u>	<u>FY2020</u>
Surgery Cases	3,285	2,997	3,342	3,392
Surgery Hours	6,951	7,282	9,060	9,187
Endoscopy Cases	1,739	1,944	2,169	2,220
Endoscopy Hours	1,996	2,538	2,832	2,898
Minor Procedures Cases	1,680	1,068	2,601	2,650
Minor Procedures Hours	1,050	1,142	3,006	3,061

1. The assumptions underlying the projected increase in Surgery Hours are as follows.
 - a. Herrin Hospital's surgical utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 15.
 - 1) Total surgical cases at Herrin Hospital increased by 21% during the 4 year period from 2010 through 2013.
 - 2) Herrin Hospital's surgical hours have increased annually since 2010, increasing by 67% during the 4 year period from 2010 through 2013.
 - 3) Total surgical cases at Herrin Hospital are projected to increase by 2% by FY2019, the first complete year of operation after the expansion of the Surgical Suite is completed.

This increase in surgical cases is expected to be due to the following factors.

- a) The continued implementation of Herrin Hospital's Physician Recruitment Plan, which has already resulted in the recruitment of 8 surgeons representing

a range of surgical specialties, is projected to result in an increase in the number of surgical cases at Herrin Hospital.

As of January, 2015, the following surgeons had been recruited to Herrin Hospital's medical staff as part of the implementation of the hospital's Physician Recruitment Plan.

- 1 Gastroenterologist
- 1 General Surgeon
- 1 Bariatric Surgeon
- 2 Orthopedic Surgeons
- 2 Podiatrists
- 1 Urologist

In addition, the following additional surgeons are currently being recruited to the Herrin Hospital medical staff.

- 1 General Surgeon
- 1 Gynecologist
- 1 Otolaryngologist

- b) As a result of recruiting additional surgeons to its medical staff, Herrin Hospital will be able to reduce the outmigration from its market area for both inpatient and outpatient surgery. This reduction in outmigration is expected to result in an increase in the number of surgical cases that will be performed at Herrin Hospital.

The reduction in outmigration of surgical cases is particularly important because of the designation of Herrin Hospital's entire market area as a Health Professional Shortage Area and the designation of much of its market area as Medically Underserved Areas. This means that additional physician resources are needed in Herrin Hospital's market area in order to meet the medical needs of residents of this area.

- 4) Total surgical cases at Herrin Hospital are projected to increase by 1.5% from FY2019 to FY2020, the second complete year of operation after the replacement and

expansion of the Surgical Suite is completed. This is an increase that is far less than the historic annual increase in surgical cases in recent years.

- 5) Total surgical hours at Herrin Hospital are projected to increase by 24% by FY2019, the first complete year of operation after the replacement and expansion of the Surgical Suite is completed.

These increased surgical hours will be due to both an increased number of surgical cases and the increased surgical time that will be required to perform an increased number of more lengthy surgical cases, as discussed below.

- a) As a result of Herrin Hospital's physician recruitment plan, it is projected that newly recruited physicians will perform an increased number of cases that have longer surgical times.
 - b) Performing an increased number of more lengthy surgical cases will result in increased surgical time per case.
 - c) When the new Surgical Suite and Surgical Procedures Suite become operational, Herrin Hospital will transfer a number of the cases currently performed in the operating rooms to the new minor procedure rooms that will become part of the Surgical Procedures Suite. These cases will have a shorter time per case, as a result of which the surgical cases that will remain in the operating rooms will have a longer average time per case.
- 6) Total surgical hours at Herrin Hospital are projected to increase by 1.4% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Suite is completed. This increase is far less than the historic annual increase in surgical hours in recent years.

2. The assumptions underlying the projected increase in Endoscopy Hours are as follows.

- a. Herrin Hospital's endoscopy cases have increased 18.5% since 2010.

- b. Herrin Hospital's endoscopy hours have increased annually since 2010, increasing by 34.8% during the 4 year period from 2010 through 2013.
- c. Herrin Hospital's endoscopy utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 15.
 - 1) Endoscopy cases are projected to increase by 11.6% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of less than 2% per year, far less than the historic annual increase in endoscopy cases in recent years.
 - 2) Endoscopy cases are projected to increase by 2.4% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic annual increase in endoscopy cases in recent years.
 - 3) Endoscopy hours are also projected to increase by 11.6% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of less than 2% per year, far less than the historic annual increase in endoscopy hours in recent years.
 - 4) Endoscopy hours are projected to increase by 2.3% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic annual increase in endoscopy hours in recent years.
- 3. The assumptions underlying the projected increase in Minor Procedures Hours are as follows.
 - a. Herrin Hospital's minor procedures cases increased 379% between 2010 and 2013. In 2011 and 2012, pain management cases were included in minor procedures, which was not the case in either 2010 or the corrected data for 2013, which has been submitted to the Illinois Health Facilities and Services Review Board.

It should be noted that pain management cases will not be performed in Herrin Hospital's minor procedures rooms once these rooms are replaced as part of this project.

Herrin Hospital performed pain management cases in its minor procedure rooms during CY2011 and CY2012 and included this caseload as part of the caseload for its Minor Procedures Rooms in its Annual Hospital Questionnaires (AHQs) for those years. In CY2010, pain management cases were performed in a dedicated surgical procedure room (Class B Surgical Procedure Room), and a corrected AHQ was submitted to the Illinois Health Facilities and Services Review Board, removing pain management cases and hours from the 2013 caseload for Minor Procedures Rooms.

- b. Herrin Hospital's minor procedures hours increased 355% between 2010 and 2013. In 2011 and 2012, pain management cases were included in minor procedures, which was not the case in either 2010 or the corrected data for 2013, which has been submitted to the Illinois Health Facilities and Services Review Board.
- c. Herrin Hospital's minor procedures utilization is projected to continue to increase in the future, as indicated by the assumptions underlying presented below and in Attachment 15.
 - 1) Minor procedures cases are projected to increase by 144% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase of 24% per year, far less than the historic annual increase in minor procedures cases in recent years.
 - 2) Another reason for the projected increase in minor procedures cases is the proposed transfer of a number of the cases currently performed in the operating rooms to the new minor procedure rooms that will become part of the Surgical Procedures Suite.

Surgical and administrative staff at Herrin Hospital and Southern Illinois Healthcare reviewed the hospital's surgical caseload and identified cases that could be performed in the Minor Procedure Rooms.

The following procedures that are currently being performed in Herrin Hospital's operating rooms were identified as procedures that could appropriately be performed in the

Minor Procedure Rooms: closed reductions; hip injections; minor skin lesion removal; pacemakers; PETS (ENT tubes); port placement; stimulator lead changes and/or battery changes.

- 3) Minor procedures cases are projected to increase by 1.9% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This is an increase that is far less than the historic increase in minor procedures cases in recent years and does not even include consideration of any increase due to the minor procedures that will be relocated from the operating rooms in the Surgical Suite to the Minor Procedures Rooms in the Surgical Procedures Suite.
- 4) Minor procedures hours are projected to increase by 163% from 2013 to FY2019, the first complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed. This increase is far less annually than the increase that was experienced between 2010 and 2013.
- 5) Minor procedures hours are projected to increase by 1.8% from FY2019 to FY2020, the second complete year of operation after the replacement and expansion of the Surgical Procedures Suite is completed.

- C. Justification for the number of key rooms and square footage proposed for each Clinical Service Area for which State Guidelines exist is presented on the next page of this Attachment, based upon projected volume for FY2020, the second complete year of operation after this project is completed.

CLINICAL SERVICE AREA	STATE GUIDELINE (UNITS/ ROOM)	PROJECTED FY2020 VOLUME	TOTAL EXISTING ROOMS/ STATIONS	TOTAL APPROVABLE ROOMS/ STATIONS
Surgery	1,500 hours/ operating room	9,187 hours	4	7
Endoscopy	1,500 hours/ operating room	2,898 hours	2	2
Minor Procedures	1,500 hours/ operating room	3,061 hours	2	2
Recovery Phase I (PACU)	N/A*	N/A*	9 Recovery Bays	N/A*
Recovery Phase II**	N/A**	N/A**	34 Stations**	N/A*

*N/A refers to there being no State Norm for number of rooms. A State Guideline for approvable DGSF will be found in the last chart of this Attachment.

**There will be 2 Phase II Recovery Rooms:

The Post-Surgical Phase II Recovery Room will have 21 stations;

The Endoscopy/Minor Procedures Phase II Recovery Room will have 13 stations.

Surgery (Class C Surgical Operating Rooms) and Endoscopy/Minor Procedures (Class B Surgical Procedure Rooms) are the only Clinical Service Areas included in this project for which there are State Guidelines for the number of rooms or stations.

The proposed number of operating rooms, procedure rooms, and stations for these clinical service areas is shown in the chart on the next page.

<u>CLINICAL SERVICE AREA</u>	<u>TOTAL APPROVABLE ROOMS</u>	<u>TOTAL PROPOSED ROOMS/ STATIONS</u>	<u>MET STANDARD?</u>
Surgery	7	7	Yes
Endoscopy	2	2	Yes
Minor Procedures	2	2	Yes
Recovery Phase I	N/A*	9 Recovery Bays (Stations)	N/A
Recovery Phase II**	N/A*	34 Stations	N/A

*N/A refers to there being no State Norm for number of rooms. A State Guideline for approvable DGSF will be found in the next chart.

**There will be 2 Phase II Recovery Rooms:

The Post-Surgical Phase II Recovery Room will have 21 stations;

The Endoscopy/Minor Procedures Phase II Recovery Room will have 13 stations.

Surgery (Class C Surgical Operating Rooms) and Endoscopy/Minor Procedures (Class B Surgical Procedure Rooms) are the only Clinical Service Areas included in this project for which there are State Guidelines for the number of rooms or stations, and Herrin Hospital is proposing to have the number of operating rooms and procedure rooms that are permitted under the State Guideline for the number of operating rooms and procedure rooms, as shown in the table above.

The proposed square footage for these Clinical Service Areas is shown on the chart on the next page.

<u>CLINICAL SERVICE AREA</u>	<u>STATE GUIDELINE (DGSF/ROOM OR UNIT)</u>	<u>TOTAL PROPOSED ROOMS OR UNITS</u>	<u>TOTAL DGSF JUSTIFIED PER PROGRAM</u>	<u>TOTAL PROPOSED DGSF</u>
Surgery (Class C)	2,750 DGSF per operating room	7 Operating Rooms	19,250	15,913
Endoscopy/ Minor Procedures (Class B)	1,100 DGSF per procedure room	4 Procedure Rooms*: 2 Endoscopy 2 Minor Procedures	4,400	2,294
Recovery Phase I	180 DGSF per recovery station	9 Recovery Bays (Stations)	1,620	1,827
Recovery Phase II*	400 DGSF per recovery station	34 stations	13,600	9,907

*There will be 4 procedure rooms in the Class B Procedures Suite:
2 Endoscopy Procedure Rooms;
2 Minor Procedure Rooms.

**There will be 2 Phase II Recovery Rooms;
The Post-Surgical Phase II Recovery Room will have 21 stations and 6,672 DGSF;
The Endoscopy/Minor Procedures Phase II Recovery Room will have 13 stations and 3,235 DGSF.

As seen in the table above, the proposed square footage for each of the Clinical Service Areas that are not Categories of Service for which State Guidelines exist is within the State Guidelines found in 77 Ill. Adm. Code 1110.APPENDIX B except for Recovery Phase I.

- D. Upon completion of this project, the floor area of Recovery Phase I (PACU) will exceed the guidelines utilized by the Illinois Health Facilities and Services Review Board, as identified in 77 Ill. Adm. Code, Chapter II, Section 1110.Appendix B, for the following reasons.
1. The PACU is being constructed in existing space that is part of the space that will be vacated by the Surgical Suite.

This space has column placements that necessitate constructing 8 of the 9 PACU stations with more space than the minimum requirements in order to meet the clearances required by IDPH.

There are 3 columns in the space where the PACU stations will be constructed, which results in the stations being required to have more space between the carts and in front of the foot areas. Because of these columns, additional space is required to meet the requirements of 4'0" clear area between the sides of the beds and at least 6' between the foot end of any bed and other equipment or fixed device, as required in 77 Ill. Adm. Code 250.2440.i.4(C).

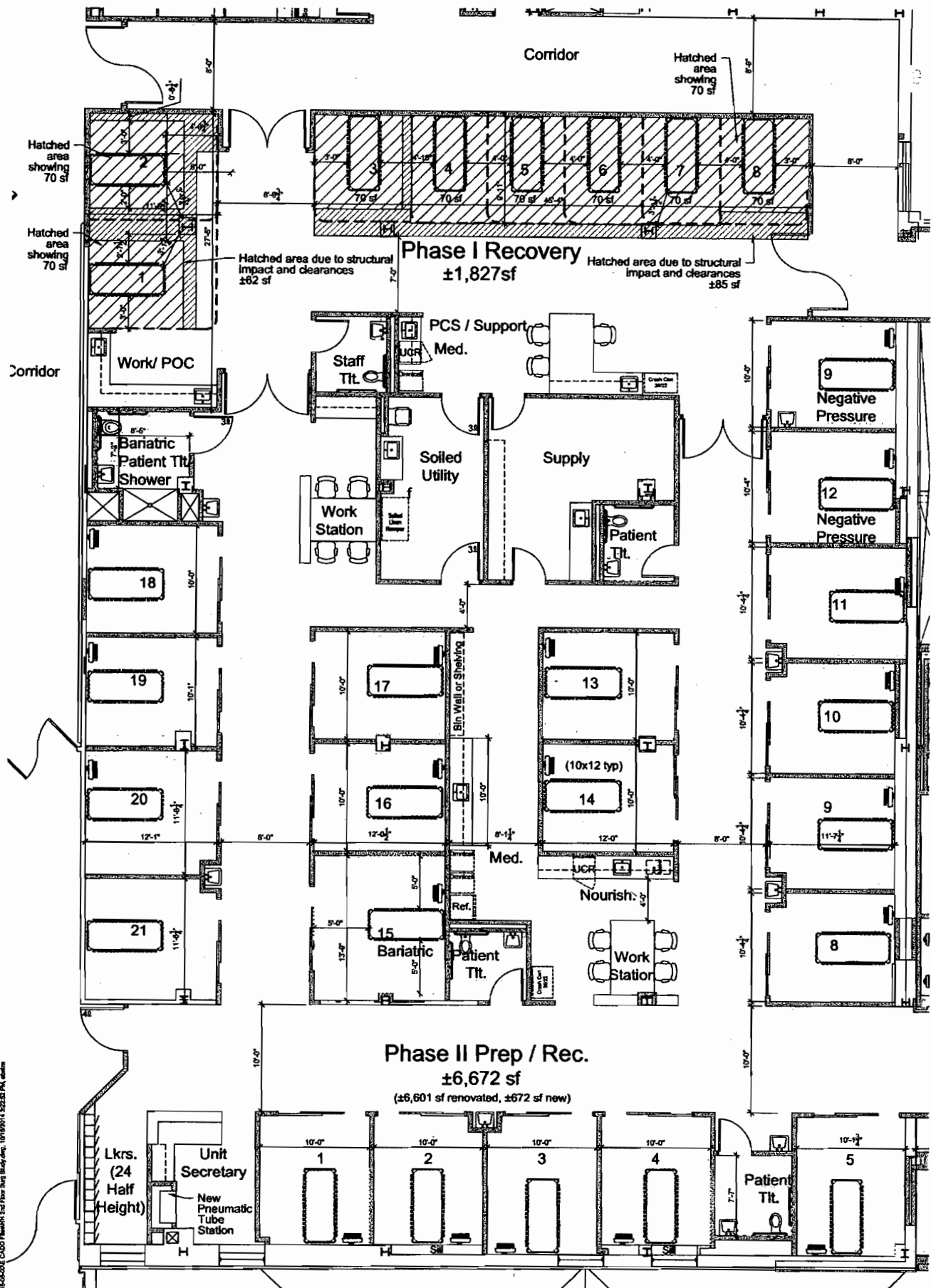
The additional space that is required to address this issue and compensate for the columns in the PACU station area totals 147 SF.

2. The PACU was designed with 8' clear area at the foot of each station, rather than 6' which is required in the Illinois Hospital Licensing Requirements, in order to assist in the movement of stretchers in and out of the PACU stations.

The additional space that is required to address this issue totals 80 SF.

Justification of the additional space was prepared by the architect for this project and appears on the next page of this Attachment.

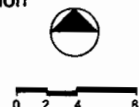
In addition, it should be noted that one of the PACU stations will be an isolation room that will be constructed as a separate room with negative pressure, and it will have a handwashing sink.



*Note:
Total blue hatched area due to structural impact and clearances = 147 sf.

SIH Herin Hospital
Second Floor
Proposed PACU Base Option

TKH TCHOOKALEFF KELLY HARTY
10.13.14
Project #: F16 Herin
Drawn By: ds



SPACE PROGRAM

SURGICAL SUITE (CLASS C SURGICAL OPERATING SUITE)

- 7 Operating Rooms, 1 of which will be designed to convert to a Hybrid Operating Room
- 7 Stretcher Alcoves
- 1 Scrub Sub-Sterile Room
- 1 Scrub Dispensing Room
- 1 Clean Core/Sub-Sterile Area
- 1 Specimen Room
- 1 Equipment/Supply Room
- 2 Equipment Storage Rooms
- 2 Surgery Support Rooms
- 1 Anesthesia Supply/Workroom
- 3 C-Arm Alcoves
- 1 Soiled Utility Room
- 1 Soiled Case Cart Room
- 1 Staff Lounge
- 1 Male Locker Room with Toilets and Showers
- 1 Female Locker Room with Toilets and Showers
- 1 Anesthesia Office
- 1 OR Manager's Office
- 7 Staff Workstations
- 1 Administrative Assistant's Office
- 1 Copy Workroom
- 2 Consultation Rooms - shared with Endoscopy/Minor Procedure Suite
- 1 Waiting Room - shared with Endoscopy/Minor Procedure Suite
- 1 Vending Alcove - shared with Endoscopy/Minor Procedure Suite
- 1 Oxygen Tank Room - shared with Endoscopy/Minor Procedure Suite

SPACE PROGRAM

ENDOSCOPY/MINOR PROCEDURES (CLASS B SURGICAL PROCEDURE SUITE)

- 2 Endoscopy Procedure Rooms
- 2 Multi-Specialty Procedure Rooms
- 1 Equipment Alcove
- 1 Supply/Equipment Room - shared with Prep/Recovery Phase II for Class B Surgical Procedure Suite
- 1 Decontamination Room (Soiled)
- 1 Clean Processing Room
- 6 Scope Storage Closets
- 1 Physician TD Desk
- 1 Staff Lounge - shared with Prep/Recovery Phase II for Class B Surgical Procedure Suite
- 1 Staff Toilet
- 2 Consultation Rooms - shared with Surgical Suite
- 1 Waiting Room - shared with Surgical Suite
- 1 Vending Alcove - shared with Surgical Suite
- 1 Oxygen Tank Room - shared with Surgical Suite

SPACE PROGRAM

POST-ANESTHESIA RECOVERY PHASE I (POST-ANESTHESIA CARE UNIT, PACU)

8 PACU Recovery Bays

1 Isolation PACU Negative Pressure Room

1 Point of Care Testing (POC) Work Area

1 PCS/Support/Medication Alcove

1 Supply Area - shared with Recovery Phase II for Surgical Suite

1 Soiled Utility Room - shared with Recovery Phase II for Surgical Suite

1 Staff Toilet

SPACE PROGRAM

SURGICAL PREPARATION FOR A.M. ADMITS/SAME-DAY SURGERY PATIENTS AND POST-ANESTHESIA RECOVERY PHASE II FOR SURGICAL SUITE

21 Surgical Prep/Stage II Private Recovery Rooms

1 Patient Locker Alcove

3 Patient Toilet Rooms

, 1 Bariatric Patient Toilet/Shower Room

1 Control Desk

2 Charting/Work Areas

1 Medication Alcove

1 Nourishment Alcove

1 Supply Area - shared with PACU

1 Soiled Utility Room - shared with PACU

1 Emergency Equipment Alcove

1 Unit Secretary

SPACE PROGRAM

PREP/RECOVERY PHASE II FOR CLASS B SURGICAL PROCEDURE SUITE

8 Prep/Phase II Private Recovery Rooms

5 Prep/Phase II Recovery Bays

2 Patient Toilet Rooms, 1 of which is for Bariatric patients

1 Nourishment Alcove

1 PCS/Support Area

7 Supply Cabinets

1 Storage/Equipment Room - shared with Endoscopy/Minor Procedures Suite

1 Soiled Utility Room

1 Wheelchair Alcove

1 Staff Lounge - shared with Endoscopy/Minor Procedures Suite

PROOF OF BOND RATINGS OF "A" AND HIGHER

ATTACHMENTS-36 THROUGH 38

FITCH AFFIRMS SOUTHERN ILLINOIS HEALTHCARE'S REVS AT 'A+'; OUTLOOK STABLE

Fitch Ratings-Chicago-11 December 2013: Fitch Ratings has affirmed the 'A+' rating on the following bonds issued by the Illinois Finance Authority on behalf of Southern Illinois Healthcare Enterprises, Inc. (SIHE).

--\$69 million series 2005 revenue refunding bonds;
--\$51.75 million series 2008 variable rate demand bonds.

The Rating Outlook is Stable.

SECURITY

Bond payments are secured by a pledge of the gross revenues of the obligated group.

KEY RATING DRIVERS

STRONG PROFITABILITY AND LOW DEBT BURDEN: Operating profitability has been consistently strong with operating margin averaging 3.9% since fiscal 2008. SIHE's strong profitability and low debt burden, with maximum annual debt service (MADS) equal to a light 2% of revenue in fiscal 2013, allow for strong MADS coverage by EBITDA of 8.3x.

ROBUST LIQUIDITY METRICS: Strong cash flows and moderate capital spending increased unrestricted liquidity by 48% since fiscal 2010 to \$349.7 million at Sept. 30, 2013, equating to a very strong 39.0x cushion ratio and 265.5% cash to debt.

INCREASED CAPITAL SPENDING: Capital expenditures are expected to increase in fiscal years 2014 and 2015 primarily due to investments in renovating and expanding surgical suites and a new cancer center. The projects are expected to be funded by a debt issuance in early fiscal 2015 and cash flows, with no adverse impact to liquidity metrics.

LEADING MARKET SHARE: A stable leading primary service area market share of 50.6% in fiscal 2012 has supported consistent revenue generation and is approximately twice the share of its nearest competitor.

UNFAVORABLE PAYOR MIX: With Medicare and Medicaid accounting for a high 63% of gross revenues, SIHE remains vulnerable to potential state and federal budget cuts. Additionally, bad debt expense remains high at 8.4% of patient service revenue in fiscal 2013.

RATING SENSITIVITIES

MAINTENANCE OF CREDIT PROFILE: Fitch believes that SIHE has the capacity to absorb the additional debt expected to be issued in early fiscal 2015 at the current rating. However, Fitch expects that SIHE will maintain coverage metrics that are consistent with the 'A+' rating and that capital projects will not negatively impact unrestricted liquidity.

CREDIT PROFILE

SIHE is a three-hospital health system headquartered in Carbondale, IL, approximately 105 miles from St. Louis. Total revenues equaled \$439.9 million in fiscal 2013. SIHE covenants to disclose both annual and quarterly financial statements through the Municipal Securities Rulemaking Board's EMMA system.

STRONG PROFITABILITY AND LOW DEBT BURDEN

Operating profitability has consistently exceeded the 'A' category medians, with operating margin averaging 3.9% since fiscal 2008 relative to Fitch's 'A' category median of 3.3%. Operating margin declined to 0.7% in fiscal 2012 primarily due to an unexpected drop in high acuity cardiology and neurology volumes. Volumes rebounded in fiscal 2013 and operating margin rebounded to 3.8% in fiscal 2013.

Consistently strong profitability and a low debt burden allow for strong debt service coverage. SIHE's debt burden is low with MADS equal to 2% of revenue in fiscal 2013, comparing favorably to Fitch's 'A' category median of 3.1%. MADS coverage by EBITDA is strong at 8.3x in fiscal 2012 and the interim period, easily exceeding Fitch's 'A' category median of 3.8x.

ROBUST LIQUIDITY METRICS

Unrestricted cash and investments increased 48% since fiscal 2010 to \$349.7 million at Sept. 30, 2013.

The liquidity growth reflects SIHE's strong cash flow generation and moderate capital spending. Liquidity metrics are strong across the board with 298.6 days cash on hand, 39.0x cushion ratio and 265.5% cash to debt, easily exceeding Fitch's 'A' category medians of 196.3 days, 15.6x and 129.2%.

The strong liquidity provides significant cushion for payment of debt service.

INCREASED CAPITAL SPENDING

Capital spending is projected to increase to \$59 million in fiscal 2014 and \$101 million in fiscal 2015 after a period of more moderate capital spending, averaging \$30 million since fiscal 2008. The increased capital spending includes strategic investments in renovated and expanded surgical suites, a new cancer center and a new energy center to insulate SIHE from adverse weather events such as tornados. SIHE broke ground on the new cancer center in fall 2013 with an expected completion date in fiscal 2015.

The projects are expected to be funded by a debt issuance in early fiscal 2015 with a maximum par amount of \$80 million and cash flows from operations with no impact to SIHE's liquidity position.

The expected bond issuance has not yet been board approved and is not incorporated into Fitch's credit analysis. Fitch will assess the impact of the additional debt on SIHE's credit profile as plans become more certain. However, Fitch believes that SIHE currently has the capacity to absorb the additional debt at the current rating level. Additionally, Fitch views the capital projects favorably as they should bolster SIHE's already strong competitive position and help to reduce outmigration.

The increased capital spending reflects strategic choices as opposed to capital requirements to maintain its existing facilities. Historic capital spending, averaging 130% of depreciation expense, has sustained a low average age of plant of 8.8 years at Sept. 30, 2013 relative to Fitch's 'A' category median of 10.3 years.

LEADING MARKET SHARE

SIHE's stable leading primary service area market share, equal to 50.6% in fiscal 2012, is approximately twice the share of its nearest competitor and has supported consistent revenue generation. The limited competition is a primary credit strength. However, the service area is characterized by high levels of outmigration to St. Louis area hospitals. Management is taking steps

to decrease outmigration, including the recruitment of additional specialists in oncology, cardiology, orthopedics and surgical specialties; construction of the new cancer center and renovated surgical suites; and SIHE's participation in the BJC Collaborative.

The BJC Collaborative, founded in 2012 by BJC HealthCare in St. Louis, is a partnership amongst six health care systems located in Illinois, Missouri and Eastern Kansas. The collaboration allows members to remain independent while achieving cost savings, sharing clinical data, developing clinical protocols and improving access to high acuity services through BJC's flagship Barnes Jewish Hospital in St. Louis.

UNFAVORABLE PAYOR MIX

Credit concerns include a challenging payor mix and relatively high bad debt levels. Medicare and Medicaid account for over 60% of gross revenues, leaving the system vulnerable to potential federal and state budget cuts. Additionally, SIHE received roughly \$18 million in supplemental government funding in fiscal 2013, or 4% of total operating revenue. Bad debt as a percent of revenue remains high in fiscal 2013 at 8.4%, but did decrease from 9.1% in fiscal 2012.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated May 30, 2013.

Applicable Criteria and Related Research:
U.S. Nonprofit Hospitals and Health Systems Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=708361

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Illinois Educational Finance Authority Southern Illinois Healthcare Enterprises; System

Credit Profile

Illinois Educl Fac Auth, Illinois

Southern Illinois Healthcare Enterprises, Illinois

(Southern Illinois Healthcare Enterprises) series 2005

Unenhanced Rating

A+(SPUR)/Stable

Affirmed

Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services affirmed its 'A+' underlying rating (SPUR) on the Illinois Educational Finance Authority's series 2005 bonds issued for Southern Illinois Healthcare Enterprises (SIHE). The outlook is stable.

The rating reflects our assessment of SIHE's very strong financial profile, as its excellent financial performance and exceptional liquidity and financial flexibility demonstrate. The rating also reflects SIHE's strong enterprise profile. SIHE's management has continued to focus on enhancing its offered services. Combined, these credit factors lead to an indicative rating of 'a+'. In our view, SIHE's remarkable unrestricted reserves and maximum annual debt service (MADS) coverage are consistent with the final rating of 'A+' as well as 'A+' medians. SIHE will be opening a new Cancer Center in March 2015 that is expected to help solidify its healthy market position. While expenses associated with the new cancer center weakened the financial performance of SIHE, overall the profile remained superior to others in the area. Finally, SIHE is benefiting from cost savings associated with its membership in the BJC collaborative.

The rating further reflects:

- A robust leadership team that continues to prepare for the future of health care while maintaining its market position;
- Marked MADS coverage even after issuing debt to support capital expenditures; and
- A good relationship with area physicians and Southern Illinois University Medical School which helps when recruiting physicians to the area.

Offsetting factors include:

- Poor contingent liability debt to long term debt after the issuance of debt to support the capital plans; and
- Softer operations in the first half of fiscal 2015 that could have an impact on the financial performance if not rectified in the near future.

The 'A+' rating is based on our view of SIHE's group credit profile (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP. Historically, we viewed SIHE as a health care system, but with the release of our revised criteria, SIHE does not qualify as its operating revenues are less than \$750 million.

SIHE, through its Southern Illinois Hospital Services division, operates three hospitals: Memorial Hospital of Carbondale, a 146-staffed-bed, acute-care hospital in Carbondale; Herrin Hospital, a 114-staffed-bed, acute-care hospital in Herrin that includes 29 rehabilitation beds through a joint venture with the Rehabilitation Institute of Chicago; and St. Joseph Memorial Hospital, a 25-staffed-bed, critical-access hospital in Murphysboro.

Outlook

The stable outlook reflects SIHE's very strong financial profile, coupled with its strong enterprise profile.

Upgrade Scenario: A higher rating would be likely within the two-year outlook period if SIHE can grow its unrestricted reserves to eclipse 350 days for a two-year period while also bringing the contingent liabilities to a more acceptable level of less than 50% of long-term debt. This also assumes that all other medians will be at a level commensurate with an upgrade.

Downgrade Scenario: We could lower the rating in the two-year outlook horizon if the current operations of SIHE do not achieve a level close to the historical performance. Also, if the softer operations begin to affect days' cash, we could lower the rating.

Industry Risk

Industry risk addresses the health care sector's overall cyclical and competitive risk and growth by applying various stress scenarios and evaluating barriers to entry; the level and trend of industry profit margins; risk from secular change and substitution of products, services, and technologies; and risk in growth trends. We believe the health care services industry represents medium credit risk when compared to other industries and sectors, which equates to a '3' on a six-point scale.

Economic Fundamentals

SIHE is in southern Illinois and defines its primary service area (PSA) as Franklin, Jackson, and Williamson counties. The PSA population, totaling 167,049 in 2014, is adequate and there is minor growth anticipated over the next five years. Wealth and income levels within the PSA are limited, all measuring below national averages. Unemployment rates remain higher than the national average.

Market position

SIHE maintains a consistent 59% share of the market within its PSA, operating as a regional service provider. It continues to focus on stemming some of the outmigration in its markets. One step that the leadership team is pursuing is to achieve Level II Trauma status, which it believes could help stem some of that outmigration. Also helping to solidify the market share is SIHE's ability to maintain its good relationship with the physicians and also some of the smaller hospitals in the greater market that refers higher acuity patients to SIHE. SIHE's primary competitor is Heartland Regional Medical Center, a 92-bed hospital 13 miles away.

Table 1

Southern Illinois Healthcare Enterprises -- Selected enterprise statistics

	Six-month interim ended Sept. 30, 2014	Fiscal year ended March 31	
		2014	2013
PSA population		167,049	165,940
PSA market share %		59.3	59.9
Inpatient admissions	8,492	16,359	16,661
Equivalent inpatient admissions	24,435	42,236	41,938
Emergency visits	36,799	67,720	67,985
Inpatient surgeries	2,341	5,245	5,077
Outpatient surgeries	2,901	5,301	4,934
Medicare case mix index	1.569	1.601	1.55
FTE employees	3,062	2,943	2,744
Active physicians	264	254	245
Based on net/gross revenues	Net	Net	Net
Medicare %	33.2	34.3	35.2
Medicaid %	8.5	6.4	6.4
Commercial/Blues %	52.5	53.5	53.2

*Inpatient admissions exclude newborns, psychiatric, and rehabilitation admissions. FTE--Full-time equivalent.

SIHE's payor mix is satisfactory, in our opinion, as it has limited contracts that incorporate full risk outside of the shared-risk contracts in which it currently participates. However, its membership in the BJC Collaborative is believed to be a positive factor as full-risk contracts begin to emerge in the market. Currently, there are no payors offering full-risk contracts.

SIHE's medical staff has shown consistent growth and had 264 active physicians as of Sept. 30, 2014. It employs 61 of the physicians, as it continues to focus on strengthening its strategic specialties--including oncology--through its cancer center and recently recruited neurointensivist to help build up its stroke program, pediatrics with the new children's hospital, and general surgery.

Management and governance

SIHE's management and governance remain a robust factor in our view of the rating. The leadership has consistently been able to implement financial and long-term strategic plans to help sustain the market leadership and financial profile of SIHE. The leadership team recent added a new chief medical officer that previously was a member of the Southern Illinois University faculty. The leadership team along with the board uses a Lean approach to building the strategic plan for the system and reviews the progress using dash boards.

Financial Policies

We currently view SIHE's financial policies as neutral. However, it should be noted that we consider its debt policy negative as contingent liabilities are more than 50% of total long-term debt.

Financial performance

SIHE's operations are respectable, although margins have softened in the interim period of fiscal 2015. Management indicated that the softer operations in the first half of fiscal 2015 reflect expenses associated with bringing its new cancer center (that will not open until March 2015) online. The added expense without the revenue is dragging down the operations. For the year, SIHE is budgeting for an operating margin that will be more in line with historical operations. Revenue continues to demonstrate solid growth, benefiting, in part, from the state's provider tax program. Management stated that it receives between \$9 million and \$10 million annually from that program.

SIHE continues to realize significant gains on investments, contributing to ample excess income and MADS coverage. Fiscal 2014 excess income totaled \$53.4 million (10.4% margin). As a result, coverage of MADS was an abundant 4.8x and 4.1x when adjusted for operating leases.

Liquidity and financial flexibility

We consider SIHE's reserves exceptional. Management has consistently been able to maintain the unrestricted reserves while investing in its facilities. As a result, SIHE has a superior average age of plant. Unrestricted reserves have declined in the interim period as SIHE expended monies on capital projects. The decline is not likely to affect the rating as we anticipate that SIHE will be able to rebuild its unrestricted reserves as measured by days' cash.

Debt and contingent liabilities

SIHE has noted that it currently has no plans to issue new debt in the near future. It has contingent liability risk exposures from financial instruments with payment provisions that may change on the occurrence of certain events, but we consider the risk manageable at the current rating level. SIHE's unrestricted reserves provide ample coverage in the event of acceleration, at 278%. As of Sept. 30, 2014, SIHE's contingent liabilities totaled \$127.215 million, and consisted of two direct-placement transactions with JPMorgan Chase Bank and BMO Harris, respectively. The direct-placement debt includes acceleration clauses in event of default, including covenant defaults.

Table 2

Southern Illinois Healthcare Enterprises -- Selected financial statistics

		Fiscal year ended March 31		Medians
	Six-month interim ended Sept. 30, 2014	2014	2013	Stand-alone hospitals rated 'A+' 2013
Financial performance				
Net patient revenue (\$000s)	248,680	460,410	432,809	480,537
Total operating revenue (\$000s)	253,545	472,206	440,260	MNR
Total operating expenses (\$000s)	252,210	459,226	423,144	MNR
Operating income (\$000s)	1,335	12,980	17,116	MNR
Operating margin (%)	0.53	2.75	3.89	4
Net non-operating income (\$000s)	8,650	40,445	20,248	MNR
Excess income (\$000s)	9,985	53,425	37,364	MNR
Excess margin (%)	3.81	10.42	8.11	6.6
Operating EBIDA margin (%)	7.86	10.48	11.74	10.9
EBIDA margin (%)	10.9	17.55	15.62	13.6
Net available for debt service (\$000s)	28,584	89,952	71,929	78,541

Table 2

Southern Illinois Healthcare Enterprises -- Selected financial statistics (cont.)				
Maximum annual debt service (\$000s)	11,873	11,873	11,873	MNR
Maximum annual debt service coverage (x)	4.81	7.58	6.06	4.9
Operating lease-adjusted coverage (x)	4.11	6.43	5.39	3.9
Liquidity and financial flexibility				
Unrestricted reserves (\$000s)	355,590	353,946	334,060	398,859
Unrestricted days' cash on hand	273.2	300.4	308	290.9
Unrestricted reserves/total long-term debt (%)	248	282.7	259.9	185.8
Unrestricted reserves/contingent liabilities (%)	279.5	278.2	418	MNR
Average age of plant (years)	8.7	8.2	8.3	10
Capital expenditures/depreciation and amortization (%)	209.1	137.9	130.2	118
Debt and liabilities				
Total long-term debt (\$000s)	143,380	125,180	128,517	MNR
Long-term debt/capitalization (%)	22.6	20.5	22.6	26.7
Contingent liabilities (\$000s)	127,215	127,215	79,920	MNR
Contingent liabilities/total long-term debt (%)	88.7	101.6	62.2	MNR
Debt burden (%)	2.26	2.31	2.58	2.7
Defined benefit plan funded status (%)	N/A	N/A	N/A	86.7

MNR—median not reported. N/A--Not applicable.

Related Criteria And Research

Related Criteria

- USPF Criteria: U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals, Dec. 15, 2014
- USPF Criteria: Contingent Liquidity Risks, March 5, 201
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief, Dec. 17, 2014
- U.S. Not-For-Profit Health Care Stand-Alone Ratios: Operating Margin Pressure Signals More Stress Ahead, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

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ECONOMIC FEASIBILITY

ATTACHMENT-39



SOUTHERN ILLINOIS HEALTHCARE

January 21, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Second Floor
Springfield, Illinois 62702

Re: Southern Illinois Hospital Services d/b/a Herrin Hospital and
Southern Illinois Healthcare Enterprises, Inc.

Dear Ms. Avery:

The undersigned, as authorized representatives of Southern Illinois Hospital Services d/b/a Herrin Hospital and Southern Illinois Healthcare Enterprises, Inc., in accordance with 77 Ill. Adm. Code 1120.140(a)(1) and the requirements of Section X.A.1 of the CON Application for Permit, hereby attest that the total estimated project costs and related costs will be funded with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Signed and dated as of January 21, 2015.

Southern Illinois Hospital Services d/b/a Herrin Hospital
Southern Illinois Healthcare Enterprises, Inc.
Illinois Not-for-Profit Corporations

Rex P. Budde, President and CEO
Southern Illinois Hospital Services d/b/a Herrin Hospital

Michael Kasser, Vice President/CFO/Treasurer
Southern Illinois Hospital Services d/b/a Herrin Hospital



Valerie K. Cawvey



Valerie K. Cawvey

COST AND GROSS SQUARE FEET							
	A	B	C	D	E	F	G
	Cost/Sq. Foot		Gross Sq. Ft.	Gross Sq. Ft.	New Const. \$	Mod. \$	Total Costs
Department	New	Mod.	New	Mod.	(A x C)	(B x D)	(E + F)
Clinical Service Areas:							
Surgical Suite (Class C Surgical Operating Suite)	\$418.58	\$320.38	12,830	3,083	\$5,370,359	\$987,719	\$6,358,078
Endoscopy/Minor Procedures (Class B Surgical Procedure Suite)	\$0.00	\$307.44	0	2,294	\$0	\$705,268	\$705,268
Post-Anesthesia Recovery Phase I (PACU)	\$0.00	\$319.57	0	1,827	\$0	\$583,850	\$583,850
Surgical Prep/Post-Anesthesia Recovery Phase II for Surgery	\$404.25	\$314.29	671	6,001	\$271,252	\$1,886,032	\$2,157,284
Prep/Recovery Phase II for Class B Surgical Procedure Suite	\$0.00	\$305.37	0	3,235	\$0	\$987,878	\$987,878
SUBTOTAL CON COMPONENTS	\$417.87	\$313.31	13,501	16,440	\$5,641,611	\$5,150,747	\$10,792,358
Contingency					\$564,161	\$515,074	\$1,079,235
TOTAL - CLINICAL SERVICE AREAS	\$459.65	\$344.64	13,501	16,440	\$6,205,772	\$5,665,821	\$11,871,593
Non-Clinical Service Areas:							
Administrative Office	\$282.18	\$0.00	394	0	\$111,178	\$0	\$111,178
Storage	\$0.00	\$157.29	0	63	\$0	\$9,909	\$9,909
Entrances, Lobbies, Central Public Space (this project)							
1st Floor	\$267.06	\$93.04	308	393	\$82,254	\$36,565	\$118,819
2nd Floor	\$0.00	\$249.86	0	2,824	\$0	\$705,600	\$705,600
TOTAL ENTRANCES, LOBBIES, CENTRAL PUBLIC SPACE	\$267.06	\$230.70	308	3,217	\$82,254	\$742,165	\$824,419
Interdepartmental Circulation Space - 2nd Floor	\$307.35	\$127.42	520	1,154	\$159,821	\$147,040	\$306,861
Mechanical/Electrical Space and Equipment - 3rd Floor	\$323.79	\$463.27	5,422	1,370	\$1,755,582	\$634,681	\$2,390,263
Stairwells:							
1st Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
2nd Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
3rd Floor	\$222.70	\$0.00	276	0	\$61,464	\$0	\$61,464
TOTAL STAIRWELLS	\$222.70	\$0.00	828	0	\$184,392	\$0	\$184,392
Mechanical/Electrical/Data Shafts - 2nd Floor	\$291.06	\$151.00	140	17	\$40,748	\$2,567	\$43,315
Data Closet - 2nd Floor	\$0.00	\$204.24	0	67	\$0	\$13,684	\$13,684
Housekeeping Closet	\$0.00	\$217.51	0	92	\$0	\$20,011	\$20,011
Emergency Department Canopy	\$99.75	\$0.00	2,225	0	\$221,944	\$0	\$221,944
SUBTOTAL NON-CON COMPONENTS	\$259.83	\$262.55	9,837	5,980	\$2,555,919	\$1,570,057	\$4,125,976
Contingency					\$255,591	\$157,005	\$412,596
TOTAL NON-CLINICAL SERVICE AREAS	\$285.81	\$288.81	9,837	5,980	\$2,811,510	\$1,727,062	\$4,538,572
PROJECT TOTAL	\$386.38	\$329.75	23,338	22,420	\$9,017,282	\$7,392,883	\$16,410,165

Factors Influencing Additional Construction Costs for this Project

- Herrin Hospital is located on the New Madrid Earthquake Fault, as a result of which both the new addition and the existing hospital buildings must meet the current seismic codes for buildings located in an earthquake area.

The new construction must meet the current seismic codes which have unique requirements for buildings located in an earthquake area.

In addition, existing Herrin Hospital buildings must include structural upgrades that are required to meet the current standards of the seismic code.

- This project is being constructed over an existing Emergency Department. The structural, mechanical, and electrical tie-ins required for this expansion will have to be coordinated with the operations of the Emergency Department, which will continued to be operational during the construction period.
- This project will need to be phased so the construction can take place around the existing operating rooms, patient prep/recovery areas, which will remain in operation during construction.

In addition, the construction must include additional infection control measures.

- The construction will overhang the existing Emergency Department ambulance and walk-in entries. Special care will need to be taken to always keep the entrances open to the Emergency Department.
- The project site is very tight, which will make the proposed construction difficult.
- The north side of the hospital property will not be able to be accessed during construction because the property adjacent to the construction site is not owned by the hospital. This project includes the use of pre-cast panels in order to minimize impact on owners of neighboring property.

X.D. Projected Operating Costs

Projected Operating Costs Per EPD = FY19 Operating Expenses/FY19 EPD

FY19 Operating Expenses:

Salaries	\$41,702,100
Benefits	15,998,084
Supplies	<u>13,488,328</u>
	\$81,572,857

FY19 Equivalent Patient Days (EPD) =

$$\left[1 + \frac{(\text{Outpatient} + \text{Emergency Revenue})}{(\text{Inpatient Revenue})} \right] \times \text{Total Projected FY19 Inpatient Days} =$$

$$\left[1 + \frac{\$261,664,323}{\$167,372,174} \right] \times 25,975 =$$

$$[1 + 1.5634] \times 25,975 =$$

$$2.5634 \times 25,975 = 66,584$$

Projected Operating Costs Per EPD = FY19 Operating Expenses/FY19 EPD =

$$\frac{\$81,572,857}{66,584} = \$1,225.11$$

X.E. Total Effect of the Project on Capital Costs

Projected Capital Costs Per EPD = FY19 Capital Costs/FY19 EPD

FY19 Capital Costs:

Depreciation	\$6,897,863
Amortization	98,074
Interest	<u>2,147,400</u>
	\$9,143,337

FY19 Equivalent Patient Days (EPD) =

$$\left[1 + \frac{(\text{Outpatient} + \text{Emergency Revenue})}{(\text{Inpatient Revenue})} \right] \times \text{Total Projected FY19 Inpatient Days} =$$

$$\left[1 + \frac{\$261,664,323}{\$167,372,174} \right] \times 25,975 =$$

$$[1 + 1.5634] \times 25,975 =$$

$$2.5634 \times 25,975 = 66,584$$

Projected Capital Costs Per EPD = FY19 Capital Costs/FY19 EPD =

$$\frac{\$9,143,337}{66,584} = \$137.32$$

CHARITY CARE INFORMATION

ATTACHMENT-41

XII.**Charity Care Information**

1. The amount of charity care for the last 3 audited fiscal years for Herrin Hospital, the cost of charity care, and the ratio of that charity care cost to net patient revenue are presented below.

HERRIN HOSPITAL

	FY2012	FY2013	FY2014
Net Patient Revenue	\$111,240,187	\$114,469,305	\$125,131,014
Amount of Charity Care (charges)	\$11,212,705	\$12,250,466	\$14,168,026
Cost of Charity Care	\$3,205,768	\$3,545,886	\$3,672,371
Ratio of Charity Care to Net Patient Revenue (Based on Charges)	10.08%	10.70%	11.32%
Ratio of Charity Care to Net Patient Revenue (Based on Costs)	2.88%	3.10%	2.93%

2. This chart reports data for Herrin Hospital, which is an assumed name (d/b/a) of Southern Illinois Hospital Services. The charity costs and patient revenue are only for Herrin Hospital and are not consolidated with any other entities that are part of Southern Illinois Hospital Services or its parent, Southern Illinois Healthcare.
3. Because Herrin Hospital is an existing facility, the data are reported for the latest three audited fiscal years.