Original 16-048

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
NOV 0 4 2016
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

Facility/Project Identification

Facility Name: Ferrell Hospital		
Street Address: 1201 Pine Street		
City and Zip Code: Eldorado 62930		
County: Saline	Health Service Area: 5	Health Planning Area: F-05

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

Exact Legal Name: Ferrell Hospital Community Foundation (Primary Applicant, Legal Entity)
Address: 1201 Pine Street, Eldorado, Illinois 62930
Name of Registered Agent: Joseph Hohenberger
Name of Chief Executive Officer: Alisa Coleman
CEO Address: 1201 Pine Street, Eldorado, Illinois 62930
Telephone Number: (618) 273-3361 ext. 150

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: Alisa Coleman
Title: Chief Executive Officer
Company Name: Ferrell Hospital Community Foundation
Address: 1201 Pine Street, Eldorado, Illinois 62930
Telephone Number: (618) 273-3361 ext. 150
E-mail Address: acoleman@ferrellhosp.org
Fax Number: (618) 273-2571

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

Name: Edward McGrath
Title: Partner
Company Name: Health Care Futures
Address: 300 Park Boulevard, Suite 200, Itasca, Illinois 60143
Telephone Number: (630) 467-1700 ext. 102
E-mail Address: e.klank@healthcarefutures.com
Fax Number: (630) 467-1701

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

Facility/Project Identification

Facility Name: Ferrell Hospital		
Street Address: 1201 Pine Street		
City and Zip Code: Eldorado 62930		
County: Saline	Health Service Area: 5	Health Planning Area: F-05

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

Exact Legal Name: Deaconess Regional Healthcare Services Illinois, Inc.
Address: 600 Mary Street, Evansville, IN 47747
Name of Registered Agent: CT Corporation
Name of Chief Executive Officer: Jared Florence
CEO Address: 600 Mary Street, Evansville, IN 47747
Telephone Number: (812) 450-2220

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: Jared Florence
Title: President
Company Name: Deaconess Regional Healthcare Services Illinois, Inc.
Address: 600 Mary Street, Evansville, IN 47747
Telephone Number: (812) 450-2220
E-mail Address: Jared.Florence@deaconess.com
Fax Number:

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

Name: Eric Klank
Title: Business Associate
Company Name: Health Care Futures
Address: 300 Park Boulevard, Suite 200, Itasca, Illinois 60143
Telephone Number: (630) 467-1700
E-mail Address: e.klank@healthcarefutures.com
Fax Number: (630) 467-1701

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: Alisa Coleman
Title: Chief Executive Officer
Company Name: Ferrell Hospital Community Foundation
Address: 1201 Pine Street, Eldorado, Illinois 62930
Telephone Number: (618) 273-3361 ext. 150
E-mail Address: acoleman@ferrellhosp.org
Fax Number: (618) 273-2571

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Ferrell Hospital Community Foundation
Address of Site Owner: 1201 Pine street, Eldorado, Illinois 62930
Street Address or Legal Description of Site: 1201 Pine Street, Eldorado, Illinois 62930 **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: Ferrell Hospital Community Foundation

Address: 1201 Pine Street, Eldorado, Illinois 62930

☒	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.

Ferrell Hospital Community Foundation, d.b.a. Ferrell Hospital proposes to expand and modernize its current facility located at 1201 Pine Street in Eldorado, Illinois. Eldorado is a rural community located in Saline County. Saline County is designated by the U.S. Department of Health and Human Services as a Medically Underserved Area (MUA). The county is also designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA).

Ferrell Hospital is a 25-bed facility that received Critical Access Hospital designation in 2003. The plan for the Project includes the renovation of the existing space and the expansion of the facility, while still remaining a 25-bed facility and retaining the designation as a Critical Access Hospital.

In 1925, Ferrell Hospital began as a small hospital on the 2nd floor of a business building, Ferrell Hospital then moved into its own building in 1928. Since then, Ferrell Hospital has undergone two major renovations; one occurring in 1958 and the second in 1973. Part of the Project will include the demolition of the original 1928 building. The work plan for the Project identifies that the hospital will continue normal operations as the renovations and additions take place on campus.

The proposed project will consist of 55,008 square feet of new space and 17,370 square feet of re-modernized spaces. New spaces will be developed for an emergency department, diagnostic imaging, front lobby and waiting area, exterior front canopy, registration, lab, phlebotomy, cafeteria, surgery department, post-anesthesia care unit, ambulatory care unit, central sterile unit and an addition for chemotherapy services. The Project will also correct and adjust facility deficiencies as identified in past facility assessments. Upon completion, total hospital square footage will consist of 88,000 square feet.

The work plan for the Project identified that the hospital will continue normal operations as renovations and additions take place on campus. Ferrell Hospital has not undergone major renovations in over 40 years and as a result, the facility is in need of modernization in order to continue to provide quality services in a safe environment. Areas re-modernized will include non-clinical areas such as business office functions, health information, accounting, human resources and personnel files, information technology and administration. In addition, demolition of the original building, constructed in 1928, is included in the scope of the project. The Project's new construction and re-modernization is substantive and will exceed total capital expenditures greater than the total capital expenditure minimum. The projected total costs of the Project are $37,353,666.

Ferrell Hospital Letters of Support

The Applicant received Letters of Support from the following:

- Gary Forby, State Senator – 59th District.
- Brandon Phelps, State Representative – 118th District.
- John Shimkus, Illinois Congressman.
- Pat Schou, Illinois Critical Access Hospital Network Executive Director.
- Rocky James, Eldorado Mayor.
- Olivia Bradley, Saline County Chamber of Commerce – President.
- Ryan Hobbs, Eldorado Community School District Superintendent.
- Keith Oglesby, Eldorado Community School District Board Member.
- Albert Bledig, M.D., Ferrell Hospital Physician.
- Joseph Jackson, M.D., Ferrell Hospital Physician.
- Nate Oldham, M.D., Ferrell Hospital Physician.
- Elliot Partridge, M.D., Ferrell Hospital Physician.

DISTRICT OFFICE:
903 W. WASHINGTON, SUITE 5
BENTON, ILLINOIS 62812
(618) 439-2504
(888) 439-2504
FAX (618) 439-3704

CAPITOL OFFICE:
339 STATE HOUSE
SPRINGFIELD, ILLINOIS 62706
(217) 782-5800
(217) 557-4878 FAX
www.SenGaryForby.com

GARY FORBY
STATE SENATOR · 59TH DISTRICT

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

I am writing to express my full support for Ferrell Hospital's efforts to modernize and expand the current facility. Ferrell Hospital has always placed a strong emphasis on providing quality health care to the residents of Eldorado and the surrounding communities.

Ferrell Hospital is definitely a staple of Eldorado as well as the surrounding communities throughout Saline County. While they already strive to provide outstanding care to patients, I believe the planned renovations would enhance and ensure the quality of care currently offered at Ferrell Hospital. This project will also allow Ferrell Hospital the opportunity to continue providing access to quality health care to members of our rural communities.

I support Ferrell Hospital's proposal to renovate and expand the current facility. Ferrell Hospital is a tremendous asset to the residents of Eldorado and to all of Saline County. This project will allow Ferrell Hospital the opportunity to better meet the healthcare needs of the communities they serve.

Sincerely,

Gary Forby
State Senator
59th District

STATE OF ILLINOIS GENERAL ASSEMBLY

COMMITTEES:
CHAIRPERSON,
PUBLIC UTILITIES
MEMBER:
APPROPRIATIONS - HIGHER EDUCATION
APPROPRIATIONS - PUBLIC SAFETY
ENVIRONMENT
HEALTH CARE LICENSES
LABOR & COMMERCE
VETERANS' AFFAIRS

SPRINGFIELD OFFICE:
200-95 STRATTON BUILDING
SPRINGFIELD, IL 62706
217/782-5131
217/557-0521 FAX

DISTRICT OFFICE:
607 S. COMMERCIAL ST., SUITE B
HARRISBURG, IL 62946
618/253-4189
618/253-3136 FAX

BRANDON W. PHELPS
STATE REPRESENTATIVE
118TH DISTRICT

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62946

I am writing in support of Ferrell Hospital's efforts to modernize and expand the current facility. Ferrell Hospital has always placed a strong emphasis on being a quality health care provider servicing Eldorado and the surrounding communities. This project will allow Ferrell Hospital to meet the demands of the community.

Ferrell Hospital is a staple of Eldorado and the surrounding communities. They strive to provide outstanding care to patients. I believe the renovations will enhance the already great quality of care provided at Ferrell Hospital, and it will also allow Ferrell Hospital to continue to provide accessible care to the members of our rural community.

I support Ferrell Hospital's efforts and plans to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Brandon W. Phelps

Brandon W. Phelps
State Representative
118th District

JOHN M. SHIMKUS
15TH DISTRICT, ILLINOIS

2217 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5271

ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEES:
ENVIRONMENT AND THE ECONOMY CHAIRMAN
HEALTH
ENERGY AND POWER
COMMUNICATIONS AND TECHNOLOGY

Congress of the United States
House of Representatives
Washington, DC 20515–1315

August 25, 2016

15 PROFESSIONAL PARK DRIVE
MARYVILLE, IL 62062
(618) 288-7100

CITY HALL, ROOM 12
110 EAST LOCUST STREET
HARRISBURG, IL 62946
(618) 252-8271

101 NORTH FOURTH STREET, SUITE 303
EFFINGHAM, IL 62401
(217) 347-7947

201 NORTH VERMILION STREET, SUITE 218
DANVILLE, IL 61832
(217) 446-0664

Ms. Courtney Avery
Administrator
Illinois Health Facilities And Services Review Board
525 West Jefferson Street, Floor 2
Springfield, IL 62702-5056

Dear Ms. Avery:

I am pleased to support Ferrell Hospital of Eldorado, Illinois', request to modernize and expand their facility. Having toured Ferrell Hospital, I know of their strong emphasis on being a quality health care provider for not only Eldorado but Saline County and the surrounding region.

Ferrell Hospital's application will allow them to meet the ever-changing health care demands of the community they serve. These proposed renovations will enhance quality of care and increase accessibility of care for this rural community.

Again, I offer my support for Ferrell Hospital's plans to renovate and expand. This is a vital health care and economic asset for the community, and this project will allow the hospital to care for local residents into the future.

Please direct any questions to Steve Tomaszewski in my Maryville district office.

Sincerely,

JOHN SHIMKUS
Member of Congress

JMS:2b

ICAHN
Illinois Critical Access Hospital Network

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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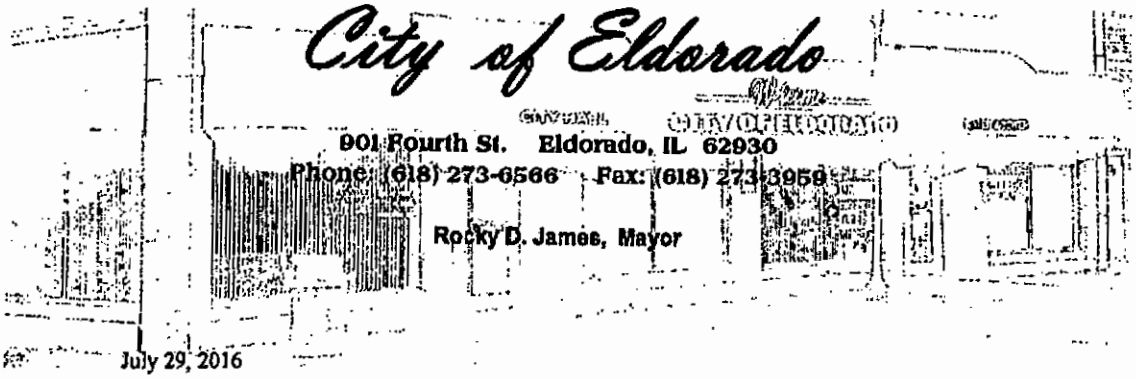
Ferrell Hospital is a staple of the Eldorado and surrounding communities. They strive to provide outstanding care to patients. I believe the renovations will enhance the already great quality of care provided at Ferrell Hospital, and as well will allow Ferrell Hospital to continue to provide accessible care to the members of our rural community.

I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Executive Director

245 Backbone Road East • Princeton, Illinois 61356 • Ph: 815.875.2999 • Fax: 815.875.2990 • www.icahn.org



July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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Ferrell Hospital is a staple of the Eldorado and surrounding communities. They strive to provide outstanding care to patients. I believe the renovations will enhance the already great quality of care provided at Ferrell Hospital, and as well will allow Ferrell Hospital to continue to provide accessible care to the members of our rural community.

I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Rocky D. James

Rocky D. James
Mayor

Narrative, Exhibit 1, Support Letters

Stacy James, City Clerk Pandy Minor, Treasurer Marty Watson, Attorney

Commissioners

Tim McGrath, Finance & Water • Jeff Minor, Public Property & Fire • Robby Price, Street & Sewer • Bob Briddick, Public Safety

Saline County Chamber of Commerce

August 4, 2016

Olivia Bradley
Saline County Chamber of Commerce
2 E Locust St Suite 200
Harrisburg Il 62946

I am writing to show my support for Ferrell Hospital's efforts to modernize and expand their current facility. Ferrell Hospital has always placed a strong emphasis on being a quality health care provider, while servicing the City of Eldorado and the surrounding communities. This project will allow Ferrell Hospital to meet the demands of the community.

Ferrell Hospital is a staple of the City of Eldorado and it's surrounding communities. They strive to provide outstanding care to their patients. I believe that the renovations will enhance the already great quality of care that is provided by Ferrell Hospital. This will also allow Ferrell Hospital to continue to provide accessible care to the members of our rural community.

I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow to ensure continuing care to the residents of Saline County and surrounding communities.

Sincerely,

Olivia Bradley

2 East Locust Street, Suite 200 Harrisburg, Illinois 62946
www.salinecountychamber.com

ELDORADO COMMUNITY UNIT SCHOOL DISTRICT NO. 4
2200A Illinois Avenue
Eldorado, Illinois 62930
Ryan Hobbs, Superintendent
Telephone: (618) 273-6394
Fax: (618) 273-9311

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

I am writing to show my support for Ferrell Hospital's efforts to modernize and expand the current facility. Ferrell Hospital has always placed a strong emphasis on being a quality health care provider servicing Eldorado and the surrounding communities. This project will allow Ferrell Hospital to meet the demands of the community.

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I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Ryan M. Hobbs

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Keith Oglesby

Keith Oglesby

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Albert Bledig, M.D.

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

I am writing to show my support for Ferrell Hospital's efforts to modernize and expand the current facility. Ferrell Hospital has always placed a strong emphasis on being a quality health care provider servicing Eldorado and the surrounding communities. This project will allow Ferrell Hospital to meet the demands of the community.

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I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Joseph Jackson, M.D.

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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Sincerely,

Nate Oldham, M.D.

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

July 29, 2016

Alisa Coleman
Chief Executive Officer
1201 Pine Street
Eldorado, IL 62930

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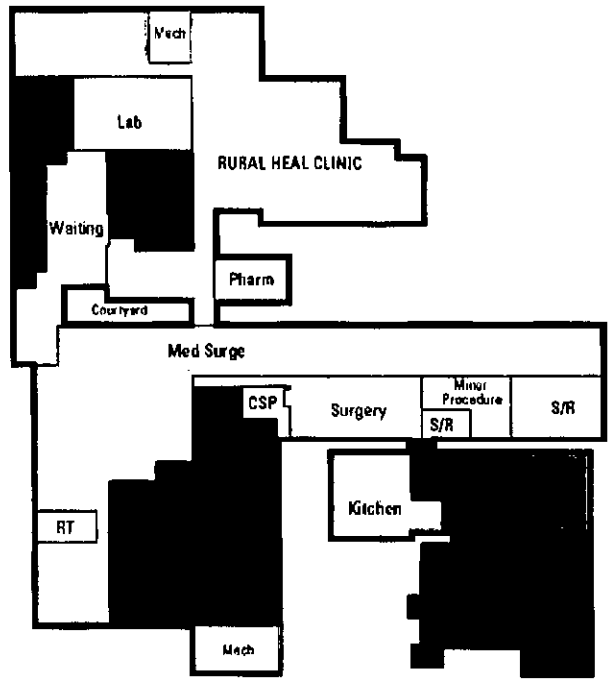
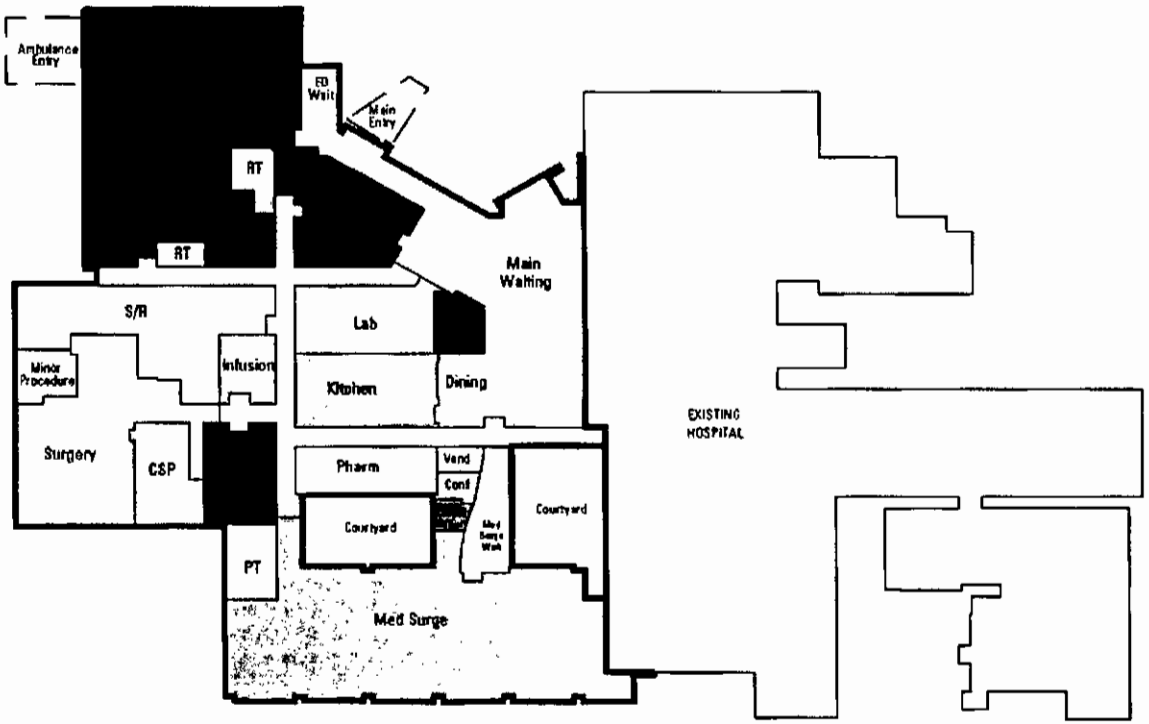
I support Ferrell Hospital's efforts and plan to renovate and expand the current facility. Ferrell Hospital is an incredible asset for the residents of Saline County and this project will allow Ferrell Hospital to ensure continuing care for Saline County.

Sincerely,

Elliott Partridge, M.D.

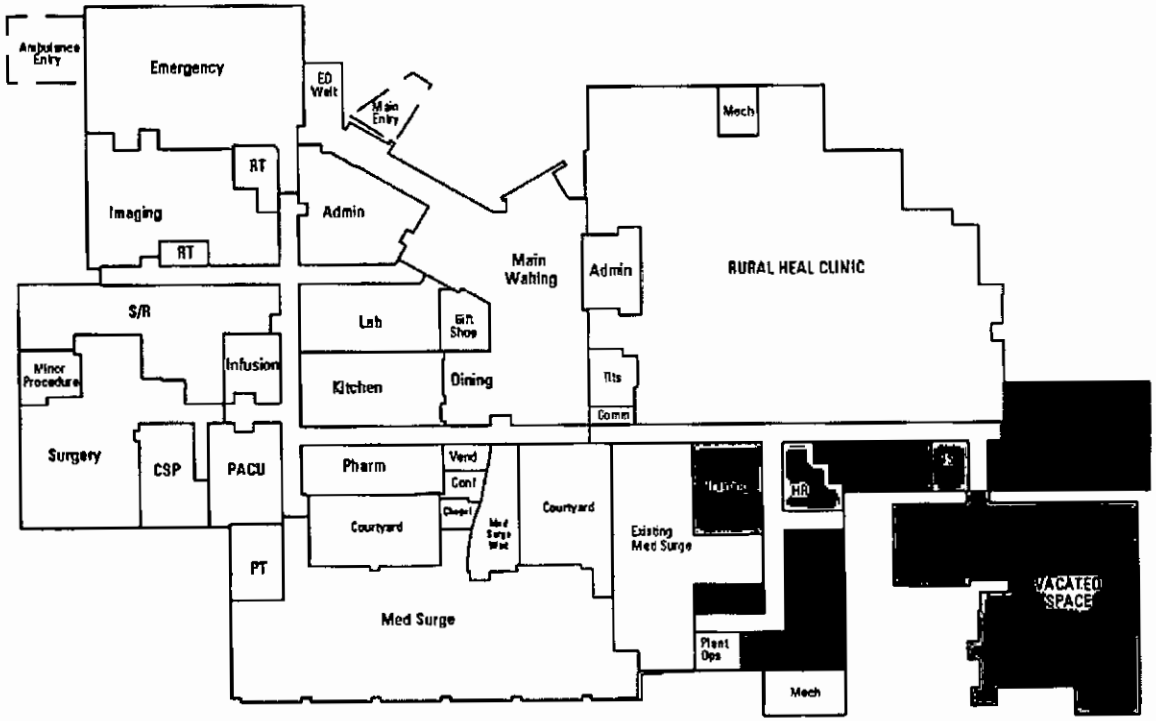


EXISTING HOSPITAL



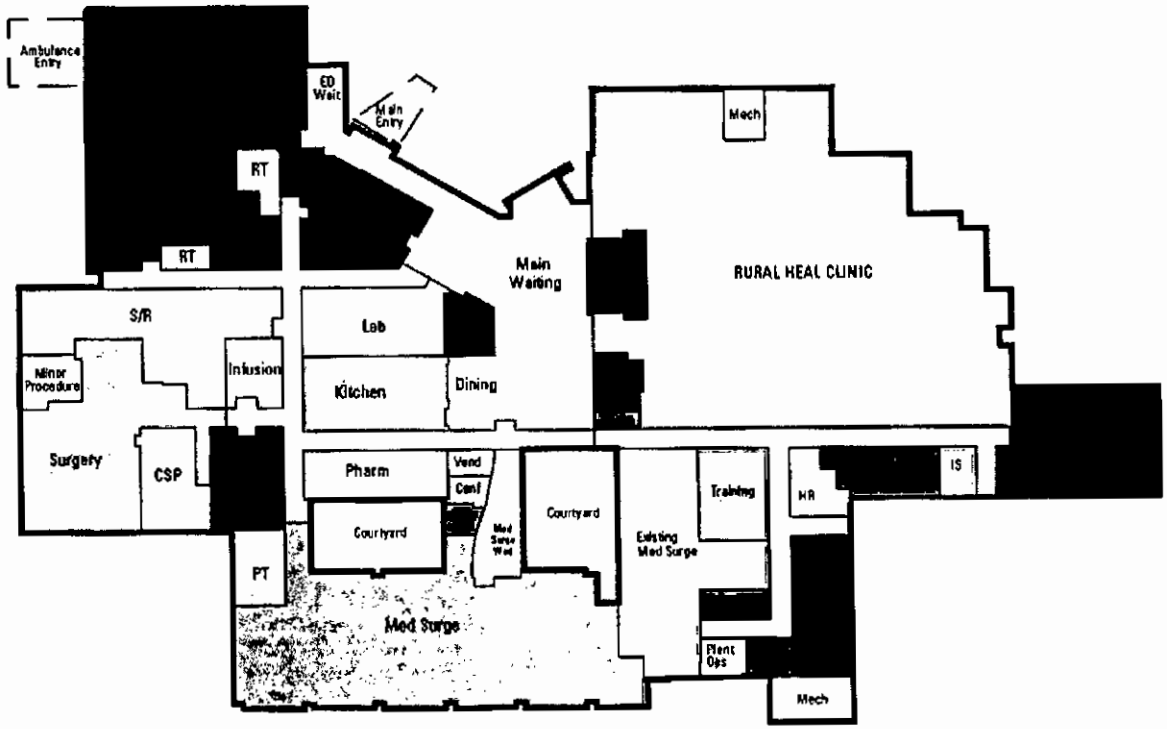
Hospital Expansion

New Construction



Existing Facility

Modernization



COMPLETED HOSPITAL

Section I. Identification, General Information, and Certification

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$38,043	$23,317	$61,360
Site Survey and Soil Investigation	$12,381	$7,589	$19,970
Site Preparation	$0	$0	$0
Off Site Work	$0	$0	$0
New Construction Contracts	$12,861,805	$7,238,305	$20,100,110
Modernization Contracts	$693,032	$1,020,166	$1,713,198
Contingencies			
New Construction	$1,286,181	$723,830	$2,010,011
Modernization	$103,955	$153,025	$256,980
Architectural/Engineering Fees	$818,217	$501,488	$1,319,705
Consulting and Other Fees	$743,014	$410,199	$1,153,213
Movable or Other Equipment (not in construction contracts)	$4,002,732	$460,440	$4,463,172
Bond Issuance Expense (project related)	$2,628,919	$1,611,273	$4,240,192
Net Interest Expense During Construction (project related)	$1,049,576	$643,289	$1,692,865
Fair Market Value of Leased Space or Equipment	$0	$0	$0
Other Costs To Be Capitalized	$200,192	$122,698	$322,890
Acquisition of Building or Other Property (excluding land)	$0	$0	$0
TOTAL USES OF FUNDS	**$24,438,049**	**$12,915,618**	**$37,353,666**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests	$334,050	$175,950	$510,000
Bond Issues (project related)	$24,132,601	$12,711,065	$36,843,666
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$24,466,651**	**$12,887,015**	**$37,353,666**

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

Attachment 7, Itemization	Clinical	Non-Clinical
Preplanning Costs		
Utility Locates	$ 1,773	$ 1,087
Conceptual Design - Options 1 and 2	$ 23,870	$ 14,630
State Fees	$ 12,400	$ 7,600
Site Survey and Soil Investigation		
Geotechnical Investigation (Initial Site Borings)	$ 3,391	$ 2,079
Site Survey	$ 8,990	$ 5,510
New Construction Contracts		
Emergency Department	$ 1,916,644	
Diagnostic Imaging	$ 640,775	
CT Scan	$ 190,707	
General Radiology	$ 236,477	
Ultrasound	$ 45,770	
Mammography	$ 34,709	
Nuclear Medicine	$ 152,566	
Surgical Operating Suite	$ 1,390,319	
Surgical Preparation	$ 408,811	
Post Anesthesia Recovery Phase I (PACU)	$ 431,143	
Post Anesthesia Recovery Phase II	$ 486,612	
Inpatient Physical Therapy	$ 215,723	
Medical / Surgical	$ 3,387,317	
Endoscopy	$ 452,641	
Laboratory	$ 437,401	
Pharmacy	$ 342,147	
Pain Management	$ 259,502	
Central Sterile Processing	$ 408,133	
Rural Health Clinic	$ 689,338	
Oncology Infusion Area	$ 396,551	
Pre-Admission Services (Draw Station)	$ 135,486	
Respiratory Therapy	$ 203,034	
Non-Clinical Areas		$ 7,238,305
Contigency (10% of New Construction)	$ 1,286,181	$ 723,830
Modernization Contracts		
Medical / Surgical	$ 162,578	
Rural Health Clinic	$ 455,474	
Oncology Infusion Area	$ 74,980	
Non-Clinical Areas		$ 1,020,166
Contigency (15% of Modernization)	$ 103,955	$ 153,025
Architectural/Engineering Fees		
Architecture Fees	$ 743,834	$ 455,898
Architecture Reimb.	$ 74,383	$ 45,590

Consulting and Other Fees				
Furniture/Artwork Planning	$	12,090	$	7,410
Furniture/Artwork Planning Procurement Option	$	5,890	$	3,610
Graphics/Wayfinding Design	$	14,791	$	9,065
Audio/Visual Consulting + Acoustics	$	4,650	$	2,850
Medical Equipment Planning	$	106,920		
Medical Equipment Planning Procurement Option	$	33,000		
Traffic Engineering	$	6,200	$	3,800
LV/IT/Communications Planning	$	47,616	$	29,184
LV/IT/Communications Planning Procurement Option	$	5,952	$	3,648
Food Service Planning			$	30,528
Food Service Planning Procurement			$	10,032
Shielding Consulting	$	2,232	$	1,368
Preconstruction Services	$	37,200	$	22,800
Program Management	$	251,720	$	154,280
Program Management Reimbursable	$	25,172	$	15,428
CON Fee	$	51,150	$	31,350
Materials Testing	$	62,000	$	38,000
Transition Planner	$	76,432	$	46,845
Movable or Other Equipment (not in construction contracts)				
Medical Equipment	$	3,740,962		
TV	$	38,440	$	23,560
Kitchen Equipment			$	300,000
Furniture/Furnishings	$	223,330	$	136,880
Bond Issuance Expense (project related)				
Debt Refinancing	$	1,736,000	$	1,064,000
Financing Fees & Costs of Issuance	$	892,919	$	547,273
Net Interest Expense During Construction (project related)				
Capitalized Interest (Construction Period)	$	1,049,576	$	643,289
Other Costs to be Capitalized				
Environmental Assessment	$	2,108	$	1,292
Hazardous Material Survey	$	7,434	$	4,556
Functional Program	$	5,890	$	3,610
CON Consultant	$	29,760	$	18,240
Network Electronics	$	124,000	$	76,000
Signage	$	31,000	$	19,000
Total	$	24,453,447	$	12,900,219

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): March 31, 2019

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.

Section I. Identification, General Information, and Certification

Cost Space Requirements

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

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

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

Department	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Clinical							
Emergency Department	$ 3,131,758	1,910	5,371	5,371	-	-	1,910
Diagnostic Imaging	$ 1,048,977	900	1,680	1,680	-	-	900
CT Scan	$ 314,117	500	500	500	-	-	500
General Radiology	$ 388,366	612	620	620	-	-	612
Ultrasound	$ 74,249	220	120	120	-	-	220
Mammography	$ 53,695	120	91	91	-	-	120
Nuclear Medicine	$ 247,497	-	400	400	-	-	-
Surgical Operating Suite	$ 2,273,175	973	3,860	3,860	-	-	973
Surgical Preparation	$ 665,124	-	1,135	1,135	-	-	-
Post Anesthesia Recovery Phase I (PACU)	$ 706,442	320	1,197	1,197	-	-	320
Post Anesthesia Recovery Phase II	$ 799,883	-	1,351	1,351	-	-	-
Inpatient Physical Therapy	$ 348,626	-	680	680	-	-	-
Medical / Surgical	$ 5,809,247	7,960	12,785	9,075	840	2,870	7,960
Mobile Technology Port (MRI)	-	-	-	-	-	-	-
Endoscopy	$ 737,433	330	1,357	1,357	-	-	330
Laboratory with Draw Station	$ 712,700	797	1,278	1,278	-	-	797
Pharmacy	$ 560,488	516	1,225	1,225	-	-	516
Pain Management	$ 420,884	-	818	818	-	-	-
Central Sterile Processing	$ 664,446	253	1,250	1,250	-	-	253
Rural Health Clinic	$ 1,875,779	8,410	18,100	3,370	6,254	8,476	-
Oncology Infusion Area	$ 775,309	-	1,750	1,250	500	-	-
Pre-Admission Services (Draw Station)	$ 220,924	300	422	422	-	-	-
Respiratory Therapy	$ 335,937	300	640	640	-	-	300
Clinical / Average Cost / Sq. Ft.	$ 342.52	-	-	-	-	-	-
Clinical Contingency	$ 2,272,991	-	-	-	-	-	-
Clinical Subtotal	$ 24,438,049	24,421	56,630	37,690	7,594	11,346	15,711
Non-Clinical							
Registration	$ 925,484	590	2,720	1,920	800	-	590
Chapel	$ 73,558	-	190	190	-	-	-
Lobby / Public Space	$ 1,372,599	200	3,882	3,382	500	-	200
Ambulance Vestibule	$ 35,341	57	90	90	-	-	57
Maintenance (b)	$ -	-	-	-	-	-	-
Materials Management	$ 153,325	935	1,442		1,442	-	935 (a)
Circulation / Building Gross	$ 1,312,639	5,725	6,175	3,450	-	2,725	512+2488 (a)
Health Information Management	$ 59,887	1,800	915	-	915	-	1800 (a)
Administration	$ 571,831	1,900	3,098	-	3,098	-	1900 (a)
Waiting / Dining	$ 1,858,183	1,550	3,980	3,980	-	-	2250 (a)
Gift Shop	$ 255,593	425	506	506	-	-	150 (a)
Kitchen	$ 863,874	1,210	1,850	1,850	-	-	1210 (a)
Information Management (IT)	$ 21,547	1,000	1,315	-	315	1,000	-
Plant Operations	$ 17,091	-	300	-	300	-	-
Environmental Services	$ 67,177	280	350	-	350	-	280 (a)
Conference Room	$ 68,212	532	1,100	-	1,100	-	750 (a)
Human Resources	$ 30,142	450	506	-	506	-	450 (a)
Mechanical / Electrical	$ 582,289	1,030	3,130	1,950	150	1,030	750 (a)
Storage (c)	$ -	-	-	-	-		2982 (a)
Housekeeping	$ 60,253	120	300	-	300	-	-
Demolition	$ 3,347,019	-	-	-	-	-	-
Non-Clinical Average Cost / Sq. Ft.	$ 285.36	-	-	-	-	-	-
Non-Clinical Contingency	$ 1,239,574	-	-	-	-	-	-
Non-Clinical Subtotal	$ 12,915,618	17,804	31,849	17,318	9,776	4,755	17,304
Total with Contingency/Average Cost/Sq. Ft.	$ 37,353,666	-	-	-	-	-	-

Footnotes:

(a) Denotes this vacated space will be completely demolished

(b) Maintenance will be in a separate building on campus

(c) Storage will be located within departments

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: Ferrell Hospital		**CITY: Eldorado, Illinois**			
REPORTING PERIOD DATES:		**From: January 1, 2015**			**to: December 31, 2015**
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical*	25	617	2,004	0	25
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)		64	467		
TOTALS:		681	2,471		

* Based on the 2015 IDPH Profile – Patient Days do not include 395 Observation Days utilized in the authorized beds.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Alisa Coleman
ADMINSTRATOR PHONE	618-297-9615
OWNERSHIP:	Ferrell Hospital Community Foundation
OPERATOR:	Ferrell Hospital Community Foundation
MANAGEMENT:	Not for Profit Corporation (Not Church-R
CERTIFICATION:	Critical Access Hospital
FACILITY DESIGNATION:	General Hospital
ADDRESS	1201 Pine Street **CITY:** Eldorado **COUNTY:** Saline County

Patients by Race

White	99.0%
Black	0.7%
American Indian	0.0%
Asian	0.0%
Hawaiian/ Pacific	0.0%
Unknown	0.3%

Patients by Ethnicity

Hispanic or Latino:	0.0%
Not Hispanic or Latino:	99.7%
Unknown:	0.3%

IDPH Number:	5363
HPA	F-05
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2015	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	25	25	14	617	2,004	395	3.9	6.6	26.3	26.3
0-14 Years				*6*	*8*					
15-44 Years				*67*	*153*					
45-64 Years				*159*	*452*					
65-74 Years				*108*	*384*					
75 Years +				*277*	*1,007*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				*0*	*0*					
Transfers				*0*	*0*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			6	64	467		7.3	1.3		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	*0*					*0*				
Facility Utilization	25			681	2,471	395	4.2	7.9	31.4	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	61.5%	16.0%	10.5%	10.5%	0.7%	0.8%	
	468	122	80	80	5	6	761
Outpatients	40.3%	32.9%	0.0%	24.5%	1.4%	0.9%	
	9140	7471	0	5566	314	208	22,699

Financial Year Reported: 4/1/2014 *to* 3/31/2015

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	29.8%	20.9%	5.2%	44.0%	0.1%	100.0%	
	650,734	456,663	112,670	962,980	3,260	2,186,307	56,283
Outpatient Revenue ($)	47.4%	20.6%	9.9%	21.0%	1.2%	100.0%	
	6,199,097	2,692,740	1,295,705	2,746,198	152,520	13,086,260	178,230

Total Charity Care Expense 234,513

Total Charity Care as % of Net Revenue 1.5%

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

	Level I	Level II	Level II+
Beds	0	0	0
Patient Days	0	0	0
Total Newborn Patient Days			0

Laboratory Studies

Inpatient Studies	702
Outpatient Studies	14,657
Studies Performed Under Contract	3,120

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	1	1	5	48	13	150	163	2.6	3.1
Gastroenterology	0	0	0	0	3	228	3	116	119	1.0	0.5
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	0	0	0	0	0.0	0.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	80	0	78	78	0.0	1.0
Orthopedic	0	0	0	0	0	0	0	0	0	0.0	0.0
Otolaryngology	0	0	0	0	0	0	0	0	0	0.0	0.0
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	0	0	0	0	0	0.0	0.0
Totals	**0**	**0**	**1**	**1**	**8**	**356**	**16**	**344**	**360**	**2.0**	**1.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 1 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	1	1	15	75	8	57	65	0.5	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	58	0	29	29	0.0	0.5
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
General	0	0	1	1	0	41	0	21	21	0.0	0.5
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	Level 1 (Not Answered)	Level 2 Not Answered
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Basic
Number of Emergency Room Stations		0
Persons Treated by Emergency Services:		7,054
Patients Admitted from Emergency:		345
Total ED Visits (Emergency+Trauma):		7,054

Free-Standing Emergency Center

Beds in Free-Standing Centers	0
Patient Visits in Free-Standing Centers	0
Hospital Admissions from Free-Standing Center	0

Outpatient Service Data

Total Outpatient Visits	22,699
Outpatient Visits at the Hospital/ Campus:	22,699
Outpatient Visits Offsite/off campus	0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	0
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Lab	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Diagnostic/Interventional Equipment	Owned	Contract	Examinations Inpatient	Outpt	Contract	Therapeutic Equipment	Owned	Contract	Therapies/ Treatments
General Radiography/Fluoroscopy	2	0	504	5,353	0	*Lithotripsy*	0	0	0
Nuclear Medicine	0	1	0	0	156	*Linear Accelerator*	0	0	0
Mammography	1	1	0	58	502	Image Guided Rad Therapy			0
Ultrasound	1	1	104	982	190	Intensity Modulated Rad Thrpy			0
Angiography	0	0				High Dose Brachytherapy	0	0	0
Diagnostic Angiography			0	0	0	*Proton Beam Therapy*	0	0	0
Interventional Angiography			0	0	0	*Gamma Knife*	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0	*Cyber knife*	0	0	0
Computerized Axial Tomography (CAT)	1	0	181	1,929	0				
Magnetic Resonance Imaging	0	1	0	0	514				

Source: 2015 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

CERTIFICATION

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

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

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

Alisa Coleman
SIGNATURE

Alisa Coleman
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of July

Bethany L. Reyling
Signature of Notary

Seal

BETHANY L REYLING
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
November 18, 2019

Joseph Hohenberger
SIGNATURE

Joseph Hohenberger
PRINTED NAME

CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of July

Bethany L. Reyling
Signature of Notary

BETHANY L REYLING
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
November 18, 2019

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Deaconess Regional Healthcare Network, LLC* **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

Jared Florence
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1 day of August

Julie Eades
Signature of Notary

Seal

SIGNATURE

Shawn McCoy
PRINTED NAME

Vice-Chairman
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1 day of August

Julie Eades
Signature of Notary

Seal

*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.

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

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

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

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

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

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

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

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

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

1. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:
2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ **Medical/Surgical**	**25**	**25**
☐ **Obstetric**		
☐ **Pediatric**		
☐ **Intensive Care**		

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

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

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(3) -	Documentation Related to Cited Problems			X
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	X

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

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
Emergency Department	4	8
Central Supply Processing	1	1
Nuclear Medicine	1	1
Ultrasound	1	1
Laboratory with Draw Station	1	1
Mammography	1	1
General Radiology	2	2
Post-Anesthesia Care Unit Phase I (PACU)	4	4
Post-Anesthesia Care Unit Phase II	2	2
Surgical Operating Suite	1	1
Physical Therapy	1	1
Pharmacy	1	1
Rural Health Clinic	10	14
Oncology Infusion	-	4

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**

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;
$510,000 _____	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;
$36,843,666 _____	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.
$37,353,666		**TOTAL FUNDS AVAILABLE**

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

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

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2014	FY 2015	FY 2016	FY 2022
Current Ratio	.98	1.21	1.48	3.33
Net Margin Percentage	4.34%	4.83%	5.30%	0.33%
Percent Debt to Total Capitalization	2542.07%	417.60%	167.72%	769.18%
Projected Debt Service Coverage	2.52	2.29	1.97	2.05
Days Cash on Hand	11.71	12.20	21.90	84.09
Cushion Ratio	0.90	0.76	1.06	2.85

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

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -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:

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)	**2013**	**2014**	**2015**
Inpatient	17	7	6
Outpatient	801	207	208
Total	**818**	**213**	**214**
Charity (cost In dollars)			
Inpatient	$218,155	$7,171	$56,283
Outpatient	$650,987	$172,103	$178,230
Total	**$869,142**	**$179,274**	**$234,515**
MEDICAID			
Medicaid (# of patients)	**2013**	**2014**	**2015**
Inpatient	112	126	122
Outpatient	2,912	7,681	7,471
Total	3,024	7,807	7,593
Medicaid (revenue)			
Inpatient	$425,571	$282,284	$456,663
Outpatient	$2,527,810	$1,192,049	$2,692,740
Total	**$2,953,381**	**$1,474,333**	**$3,149,403**

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			
	FY 2014	**FY 2015**	**FY 2016**
Net Patient Revenue	**$16,580,217**	**$16,347,058**	**$17,721,488**
Amount of Charity Care (charges)	$795,000	$235,000	$322,000
Cost of Charity Care	$329,000	$95,000	$148,000

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	48-50
2	Site Ownership	51-52
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	53-54
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	55-56
5	Flood Plain Requirements	57-60
6	Historic Preservation Act Requirements	61-68
7	Project and Sources of Funds Itemization	69-71
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10	Discontinuation	NA
11	Background of the Applicant	75-77
12	Purpose of the Project	78-112
13	Alternatives to the Project	113-121
14	Size of the Project	122-131
15	Project Service Utilization	132-143
16	Unfinished or Shell Space	NA
17	Assurances for Unfinished/Shell Space	NA
18	Master Design Project	NA
19	Mergers, Consolidations and Acquisitions	NA
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	144-179
21	Comprehensive Physical Rehabilitation	NA
22	Acute Mental Illness	NA
23	Neonatal Intensive Care	NA
24	Open Heart Surgery	NA
25	Cardiac Catheterization	NA
26	In-Center Hemodialysis	NA
27	Non-Hospital Based Ambulatory Surgery	NA
28	Selected Organ Transplantation	NA
29	Kidney Transplantation	NA
30	Subacute Care Hospital Model	NA
31	Children's Community-Based Health Care Center	NA
32	Community-Based Residential Rehabilitation Center	NA
33	Long Term Acute Care Hospital	NA
34	Clinical Service Areas Other than Categories of Service	180-189
35	Freestanding Emergency Center Medical Services	NA
	Financial and Economic Feasibility:	
36	Availability of Funds	190
37	Financial Waiver	191-194
38	Financial Viability	195-200
39	Economic Feasibility	201-207
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	Appendix:	
A	Ferrell Hospital's Fiscal Year 2016 Audited Financial Statements	211-235

Section 1. Identification, General Information, and Certification.

Applicant Identification

Exact Legal Name: Ferrell Hospital Community Foundation (Primary Applicant, Legal Entity)
Address: 1201 Pine Street, Eldorado, Illinois 62930
Name of Registered Agent: Joseph Hohenberger
Name of Chief Executive Officer: Alisa Coleman
CEO Address: 1201 Pine Street, Eldorado, Illinois 62930
Telephone Number: (618) 273-3361 ext. 150

Co-Applicant Identification

Exact Legal Name: Deaconess Regional Healthcare Services Illinois, Inc.
Address: 600 Mary Street, Evansville, IN 47747
Name of Registered Agent: CT Corporation
Name of Chief Executive Officer: Jared Florence
CEO Address: 600 Mary Street, Evansville, IN 47747
Telephone Number: (812) 450-2220

File Number 6343-405-1

To all to whom these Presents Shall Come, Greeting:

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

FERRELL HOSPITAL COMMUNITY FOUNDATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 31, 2004, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 29TH *day of* JULY *A.D.* 2016 .

Authentication #: 1621101670 verifiable until 07/29/2017
Authenticate at: http://www.cyberdrivelllinois.com

Jesse White

SECRETARY OF STATE

File Number 0539588-7

To all to whom these Presents Shall Come, Greeting:

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

DEACONESS REGIONAL HEALTHCARE NETWORK ILLINOIS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 16, 2015, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 28TH *day of* DECEMBER *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Authentication #: 1536201702 verifiable until 12/28/2016
Authenticate at: http://www.cyberdriveillinois.com

Section 1. Identification, General Information, and Certification.

Primary Contact

Name: Alisa Coleman
Title: Administrator / CEO
Company Name: Ferrell Hospital
Address: 1201 Pine Street, Eldorado, Illinois 62930
Telephone Number: (618) 273-3361 ext. 150
E-mail Address: acoleman@ferrellhosp.org
Fax Number: (618) 273-2571

Primary Contact

Name: Jared Florence
Title: President
Company Name: Deaconess Regional Healthcare Services Illinois, Inc.
Address: 600 Mary Street, Evansville, Indiana 47747
Telephone Number: (812) 450-2220
E-mail Address: Marc.Florence@deaconess.com

Additional Contact

Name: Eric Klank
Title: Business Associate
Company Name: Health Care Futures
Address: 300 Park Boulevard, Suite 200, Itasca, Illinois 60143
Telephone Number: (630) 467-1701
E-mail Address: e.klank@healthcarefutures.com
Fax Number: (630) 467-1701

Site Ownership

Exact Legal Name of Site Owner: Ferrell Hospital Community Foundation
Address of Site Owner: 1201 Pine Street, Eldorado, Illinois 62930
Street Address or Legal Description of Site: 1201 Pine Street, Eldorado, Illinois 62930

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

October 31, 2016

To whom it may concern:

I attest that Ferrell Hospital Community Foundation, an Illinois Not For Profit Corporation, is the legal owner of the following real properties as indicated by their property index numbers in the records of the Saline County Assessor and shown on the copies of the property tax invoices for the tax year 2015 and payable in 2016 herein attached:

INDEX NUMBER	PROPERTY DESCRIPTION
04-2-234-05	PARKING LOT
04-2-219-01	ADMINISTRATION BUILDING
04-2-219-05	HOSPITAL AND CLINIC BUILDING
04-2-220-02	SUPPORT BUILDING
04-2-115-03	PARKING LOT
04-2-137-01	SUPPORT BUILDING
04-2-137-02	PARKING LOT
04-2-137-03	SUPPORT BUILDING
04-2-218-06	SUPPORT BUILDING
04-2-219-03	PARKING LOT
04-2-220-01	SUPPORT BUILDING
04-2-220-03	SUPPORT BUILDING
04-2-234-07	SUPPORT BUILDING
04-2-234-08	PARKING LOT
04-2-220-05	SUPPORT BUILDING
04-2-115-02	SUPPORT LAND AND STRUCTURE
04-2-115-01	SUPPORT LAND AND STRUCTURE

Sincerely,

Joseph Hohenberger
Chief Financial Officer
Ferrell Hospital Community Foundation

R Robison 10/31/16

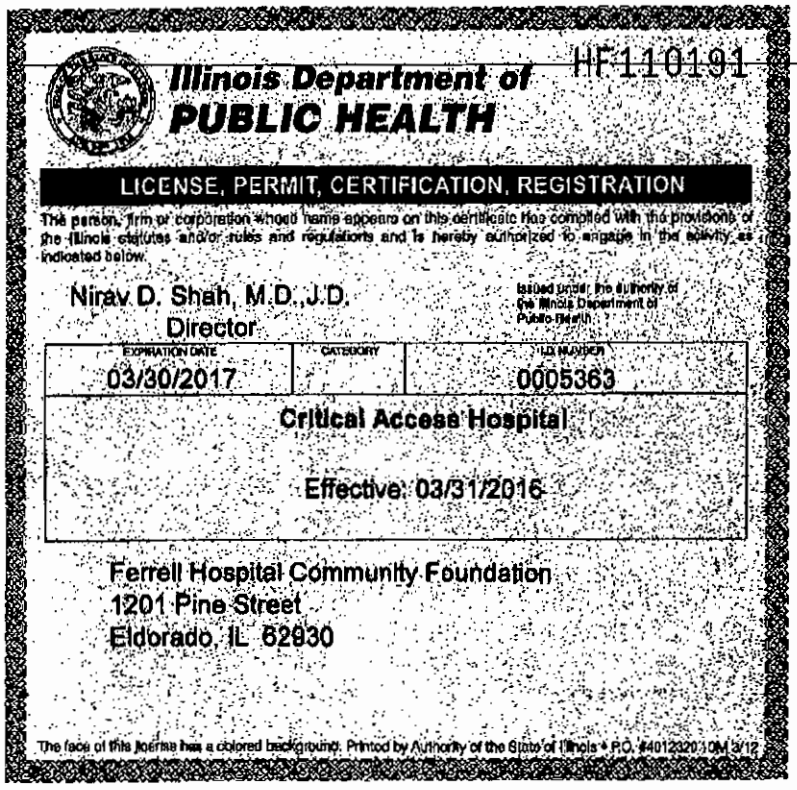
"OFFICIAL SEAL"
R. ROBISON
Notary Public, State of Illinois
My Commission Expires: 9/11/2017

"Healthcare Built on Excellence"

Section 1. Identification, General Information, and Certification.

Operating Identity/Licensee

Exact Legal Name: Ferrell Hospital Community Foundation
Address: 1201 Pine Street, Eldorado, Illinois 62930



Illinois Department of PUBLIC HEALTH

HF110191

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
03/30/2017		0005363

Critical Access Hospital

Effective: 03/31/2016

Ferrell Hospital Community Foundation
1201 Pine Street
Eldorado, IL 62930

The 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 03/30/2017

Lic Number 0005363

Date Printed 02/09/2016

Ferrell Hospital Community Foundatio

1201 Pine Street
Eldorado, IL 62930

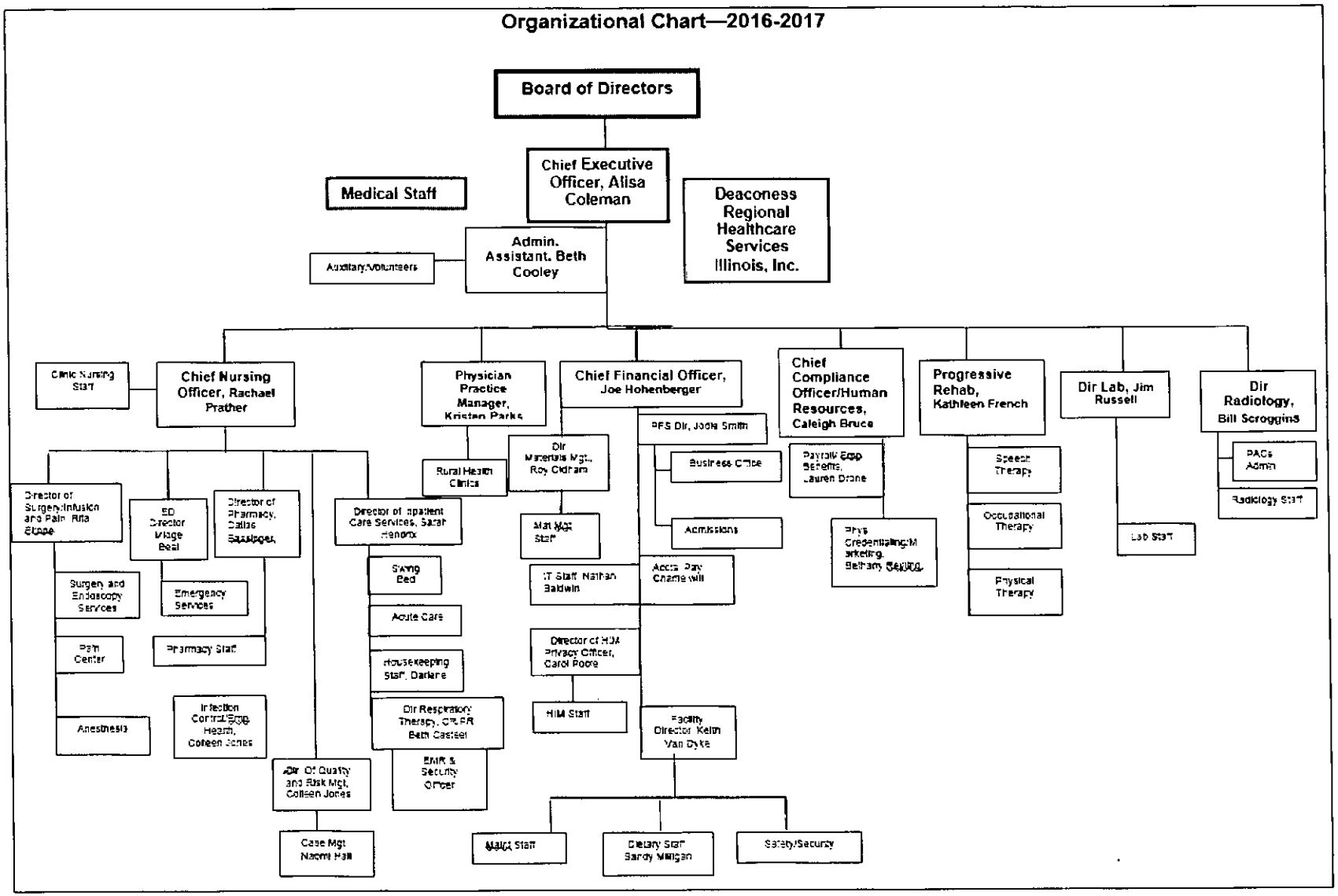
FEE RECEIPT NO.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Organizational Relationships

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

FERRELL HOSPITAL COMMUNITY FOUNDATION



SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

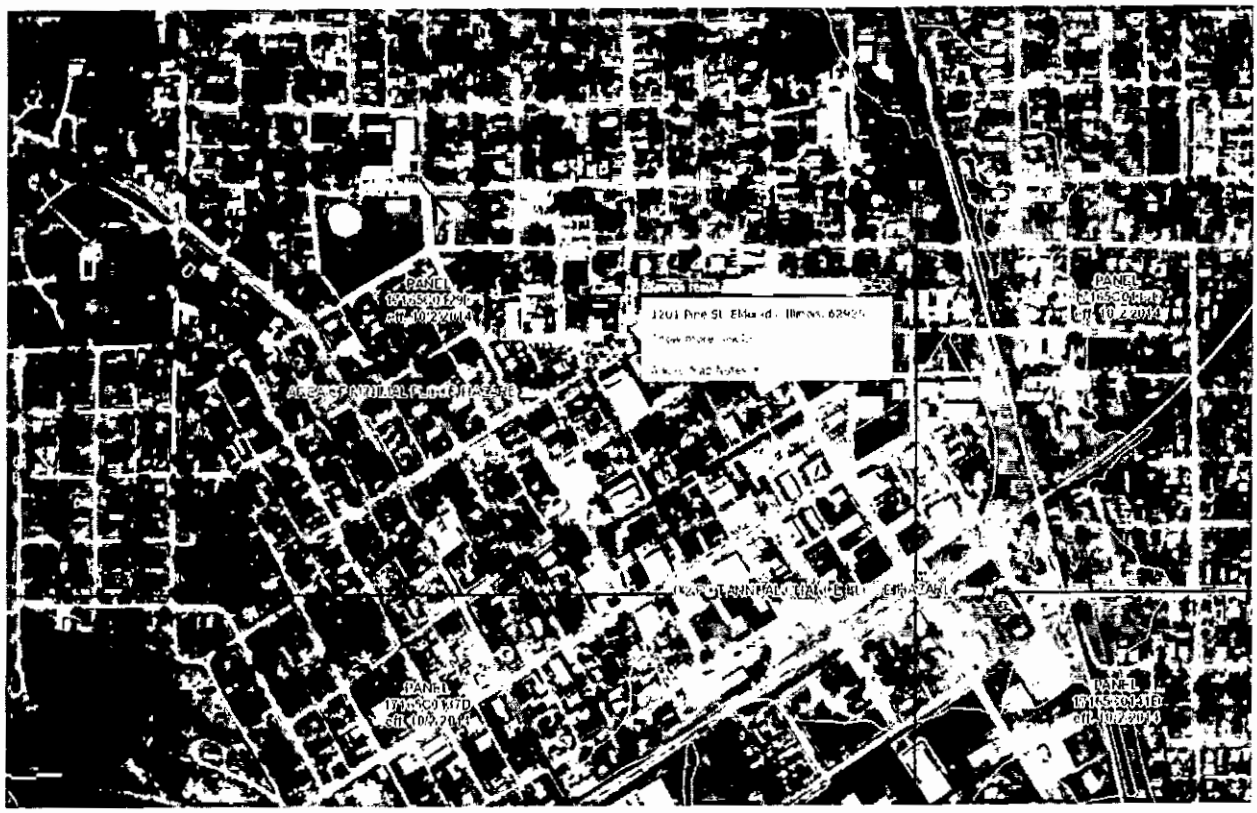
Flood Plain Requirements

[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)**.

Flood Plain Requirement

As seen in the attached map from FEMA.gov, Ferrell Hospital's campus resides in Zone X. This zone is defined as outside the 500 year Flood Plain, and as a result is compliant with Executive Order # 2005-5.



ZONE CLASSIFICATIONS

PLEASE PRINT A COPY FOR FUTURE REFERENCE

Zone C, Zone X - Areas determined to be outside 500-year floodplain determined to be outside the 1% and 0.2% annual chance floodplains.

Zone B, Zone X500 - 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. An area inundated by 0.2% annual chance flooding.

Zone A - An area inundated by 1% annual chance flooding, for which no BFEs have been determined.

Zone AE - An area inundated by 1% annual chance flooding, for which BFEs have been determined.

Zone AH - An area inundated by 1% annual chance flooding (usually an area of ponding), for which BFEs have been determined; flood depths range from 1 to 3 feet.

Zone AO - An area inundated by 1% annual chance flooding (usually sheet flow on sloping terrain), for which average depths have been determined; flood depths range from 1 to 3 feet.

Zone AR - .An area inundated by flooding, for which BFEs or average depths have been determined. This is an area that was previously, and will again, be protected from the 1% annual chance flood by a Federal flood protection system whose restoration is Federally funded and underway

Zone A1-A30 - An area inundated by 1% annual chance flooding, for which BFEs have been determined. .

Area Not Included (ANI),(N) - An area that is located within a community or county that is not mapped on any published FIRM.

Zone D - An area of undetermined but possible flood hazards.

Undescribed (UNDES) - Area of Undesignated Flood Hazard. A body of open water, such as a pond,lake, ocean, etc., located within a community's jurisdictional limits, that has no defined flood hazard.

Zone VE - An area inundated by 1% annual chance flooding with velocity hazard (wave action); BFEs have been determined.

Zone V(1-30) - Costal flood with velocity hazard (wave action); BFEs have not been determined.

FWIC - An area where the floodway is contained within the channel banks and the channel is too narrow to show to scale. An arbitrary channel width of 3 meters is shown. BFEs are not shown in this area, although they may be reflected on the corresponding profile. (Floodway Contained in Channel)

1001C - An area where the 1% annual chance flooding is contained within the channel banks and the channel is too narrow to show to scale. An arbitrary channel width

10/29/2016

of 3 meters is shown. BFEs are not shown in this area, although they may be reflected on the corresponding profile. (1% Annual Chance Flood Discharge Contained in Channel)

500IC - An area where the 0.2% annual chance flooding is contained within the channel banks and the channel is too narrow to show to scale. An arbitrary channel width of 3 meters is shown. (2% Annual Chance Flood Discharge Contained in channel)

Section 1. Identification, General Information, and Certification.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

Illinois Historic Preservation Act Requirements.

On July 13th, 2016 a State Project Review request was sent to the Illinois Historic Preservation Agency regarding the proposed Ferrell Hospital modernization project. Subsequent to the submission of the initial request, the Illinois Historic Preservation Agency has requested multiple additional items, including pictures of the houses and buildings surrounding the Applicant's campus and pictures of public spaces within buildings on the campus that will be demolished. As of October 7, 2016 the Illinois Historic Preservation Agency indicated receiving all the necessary information to complete their review. State law allows 30 days for completion. Once the determination is received it will be filed with the Illinois Health Facilities and Services Review Board.

HealthCareFUTURES.

300 Park Boulevard, Suite 200
Itasca, IL 60143
www.healthcarefutures.com

T (630) 467-1700
F (630) 467-1701

July 13, 2016

Illinois Historic Preservation Agency
Attn: Review and Compliance
1 Old State Capitol Plaza
Springfield, IL 62701

Re: Historic Preservation Act Determination Request
Ferrell Hospital
Eldorado, Illinois

To whom it may concern,

We are preparing a Certificate of Need Permit Application for the proposed renovations of Ferrell Hospital. In accordance with the Illinois Historic Preservation Act (IHPA), Section 4, the Health Facilities and Services Review Board (IHFSRB) requires a formal determination as to whether the proposed project to renovate and add to the hospital impacts on, or affects, historic resources. Site and project information follows below.

A. General Project Description and Address.

The applicant, Ferrell Hospital, is seeking a Certificate of Need to renovate and add approximately 36,000 sq. feet to their multi-level, 33,000 sq. foot hospital facility located at 1201 Pine Street in Eldorado, Illinois. Information attached to this letter provides site information. (Attachments A and B).

B. Topographic or Metropolitan Map.

A metropolitan map is attached for reference purposes (Attachment A).

C. Historic Architectural Resources GIS.

The property is not listed on a national register, within a local historical district, nor is the site a local landmark.

D. Standing Buildings / Structure Photographs.

Ferrell Hospital was originally constructed in 1928, with renovations occurring in 1958 and 1973, parts of the original building are still standing (Attachments C, D, and E). The renovations will occur within the current Ferrell Hospital campus.

E. Addresses for Building / Structures.

The address for the facility will remain 1201 Pine Street, Eldorado, Illinois.

F. Federal Involvement.

There is no federal involvement with the proposed development on the Ferrell Hospital site.

We appreciate your assistance in acquiring an approval from the Illinois Historic Preservation Agency to develop on the properties of 1201 Pine Street in Eldorado, Illinois. Please feel free to contact me by email at e.klank@healthcarefutures.com or at (630) 467-1700 extension 105 if you need any additional information.

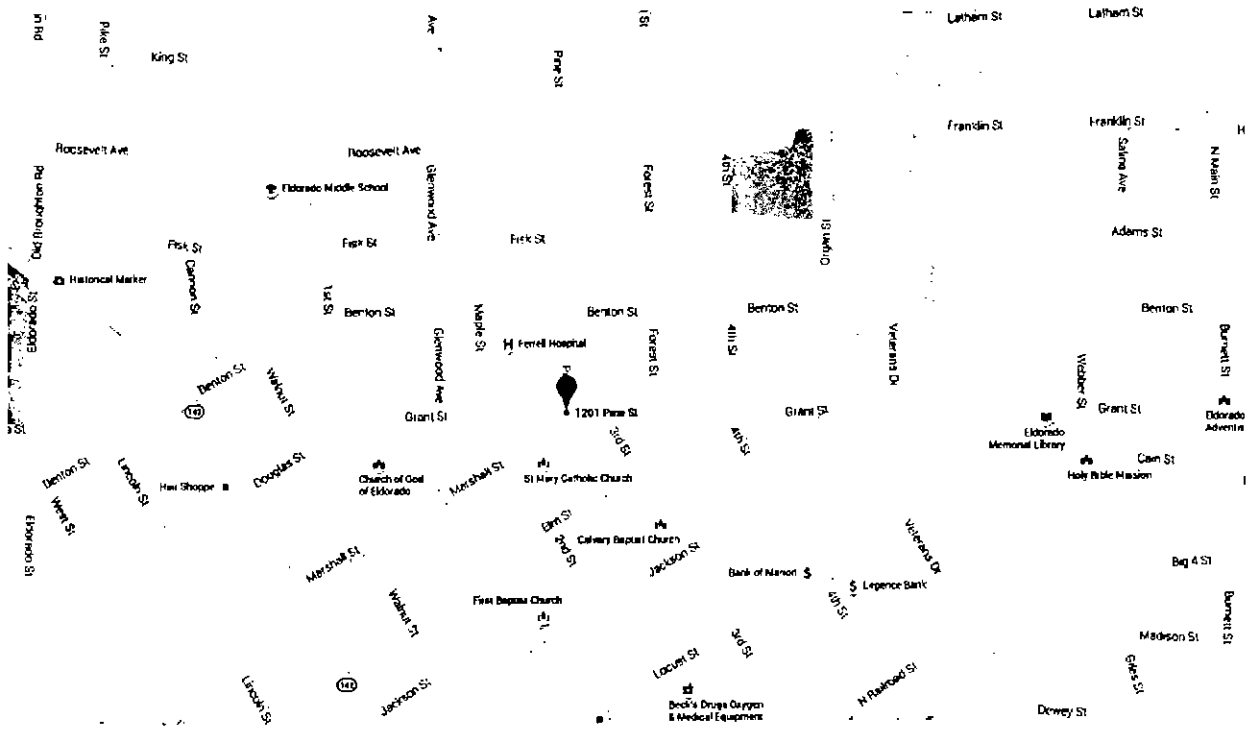
Very Truly Yours,
Health Care Futures L.P.

Eric Klank

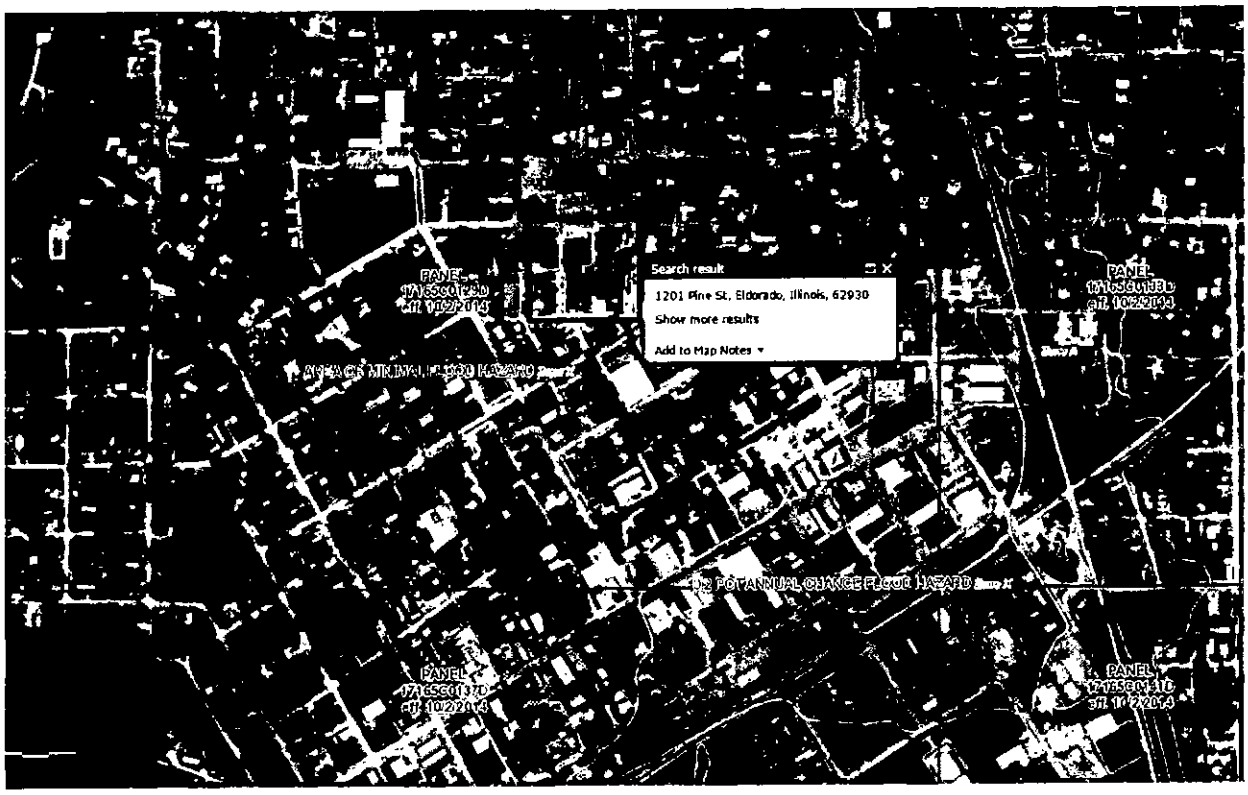
Eric A. Klank
Business Associate

Attachment A – Ferrell Hospital's location.
Attachment B – Ferrell Hospital's location in relation to Flood Plains.
Attachment C – Exterior photo of Ferrell Hospital.
Attachment D – Exterior photo of Ferrell Hospital.
Attachment E – Interior photo of Ferrell Hospital.

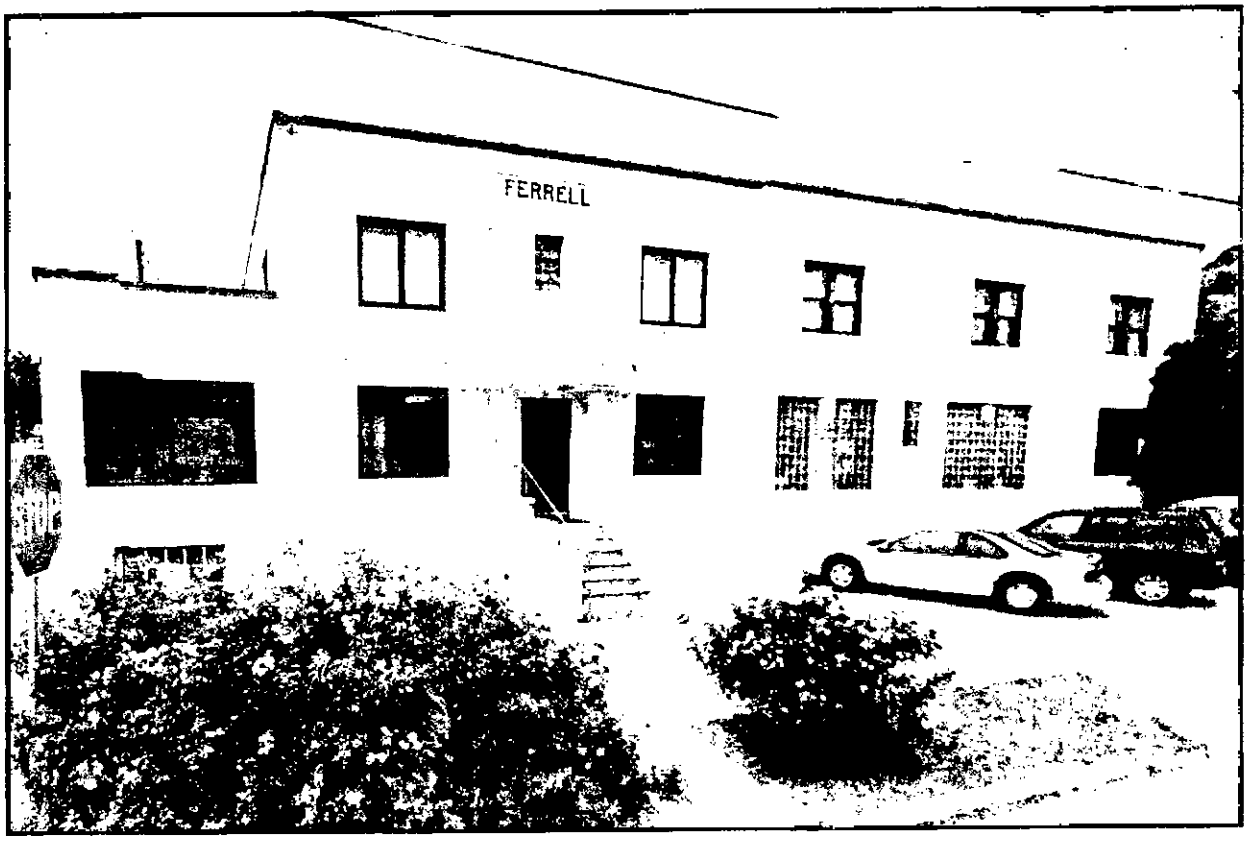
Attachment A



Attachment B

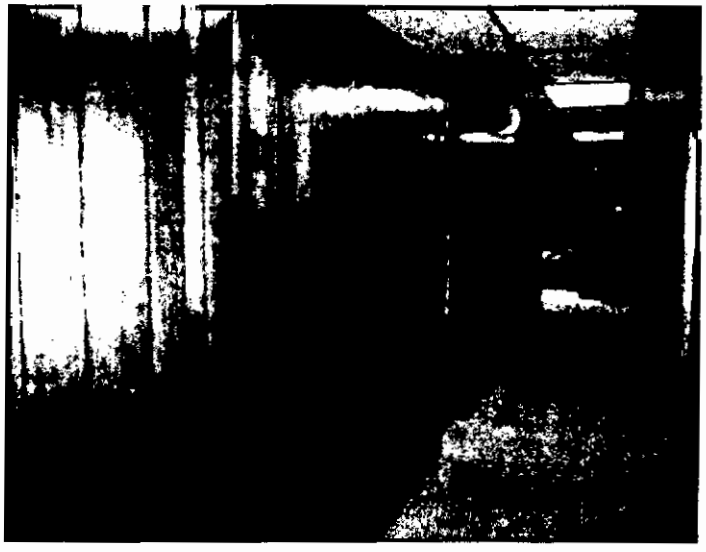


Attachment C



Attachment D

Attachment E



Section I. Identification, General Information, and Certification

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$38,043	$23,317	$61,360
Site Survey and Soil Investigation	$12,381	$7,589	$19,970
Site Preparation	$0	$0	$0
Off Site Work	$0	$0	$0
New Construction Contracts	$12,861,805	$7,238,305	$20,100,110
Modernization Contracts	$693,032	$1,020,166	$1,713,198
Contingencies			
New Construction	$1,286,181	$723,830	$2,010,011
Modernization	$103,955	$153,025	$256,980
Architectural/Engineering Fees	$818,217	$501,488	$1,319,705
Consulting and Other Fees	$743,014	$410,199	$1,153,213
Movable or Other Equipment (not in construction contracts)	$4,002,732	$460,440	$4,463,172
Bond Issuance Expense (project related)	$2,628,919	$1,611,273	$4,240,192
Net Interest Expense During Construction (project related)	$1,049,576	$643,289	$1,692,865
Fair Market Value of Leased Space or Equipment	$0	$0	$0
Other Costs To Be Capitalized	$200,192	$122,698	$322,890
Acquisition of Building or Other Property (excluding land)	$0	$0	$0
TOTAL USES OF FUNDS	**$24,438,049**	**$12,915,618**	**$37,353,666**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests	$334,050	$175,950	$510,000
Bond Issues (project related)	$24,132,601	$12,711,065	$36,843,666
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$24,466,651**	**$12,887,015**	**$37,353,666**

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

Attachment 7, Itemization	Clinical	Non-Clinical
Preplanning Costs		
Utility Locates	$ 1,773	$ 1,087
Conceptual Design - Options 1 and 2	$ 23,870	$ 14,630
State Fees	$ 12,400	$ 7,600
Site Survey and Soil Investigation		
Geotechnical Investigation (Initial Site Borings)	$ 3,391	$ 2,079
Site Survey	$ 8,990	$ 5,510
New Construction Contracts		
Emergency Department	$ 1,916,644	
Diagnostic Imaging	$ 640,775	
CT Scan	$ 190,707	
General Radiology	$ 236,477	
Ultrasound	$ 45,770	
Mammography	$ 34,709	
Nuclear Medicine	$ 152,566	
Surgical Operating Suite	$ 1,390,319	
Surgical Preparation	$ 408,811	
Post Anesthesia Recovery Phase I (PACU)	$ 431,143	
Post Anesthesia Recovery Phase II	$ 486,612	
Inpatient Physical Therapy	$ 215,723	
Medical / Surgical	$ 3,387,317	
Endoscopy	$ 452,641	
Laboratory	$ 437,401	
Pharmacy	$ 342,147	
Pain Management	$ 259,502	
Central Sterile Processing	$ 408,133	
Rural Health Clinic	$ 689,338	
Oncology Infusion Area	$ 396,551	
Pre-Admission Services (Draw Station)	$ 135,486	
Respiratory Therapy	$ 203,034	
Non-Clinical Areas		$ 7,238,305
Contigency (10% of New Construction)	$ 1,286,181	$ 723,830
Modernization Contracts		
Medical / Surgical	$ 162,578	
Rural Health Clinic	$ 455,474	
Oncology Infusion Area	$ 74,980	
Non-Clinical Areas		$ 1,020,166
Contigency (15% of Modernization)	$ 103,955	$ 153,025
Architectural/Engineering Fees		
Architecture Fees	$ 743,834	$ 455,898
Architecture Reimb.	$ 74,383	$ 45,590

Consulting and Other Fees		
Furniture/Artwork Planning	$ 12,090	$ 7,410
Furniture/Artwork Planning Procurement Option	$ 5,890	$ 3,610
Graphics/Wayfinding Design	$ 14,791	$ 9,065
Audio/Visual Consulting + Acoustics	$ 4,650	$ 2,850
Medical Equipment Planning	$ 106,920	
Medical Equipment Planning Procurement Option	$ 33,000	
Traffic Engineering	$ 6,200	$ 3,800
LV/IT/Communications Planning	$ 47,616	$ 29,184
LV/IT/Communications Planning Procurement Option	$ 5,952	$ 3,648
Food Service Planning		$ 30,528
Food Service Planning Procurement		$ 10,032
Shielding Consulting	$ 2,232	$ 1,368
Preconstruction Services	$ 37,200	$ 22,800
Program Management	$ 251,720	$ 154,280
Program Management Reimbursable	$ 25,172	$ 15,428
CON Fee	$ 51,150	$ 31,350
Materials Testing	$ 62,000	$ 38,000
Transition Planner	$ 76,432	$ 46,845
Movable or Other Equipment (not in construction contracts)		
Medical Equipment	$ 3,740,962	
TV	$ 38,440	$ 23,560
Kitchen Equipment		$ 300,000
Furniture/Furnishings	$ 223,330	$ 136,880
Bond Issuance Expense (project related)		
Debt Refinancing	$ 1,736,000	$ 1,064,000
Financing Fees & Costs of Issuance	$ 892,919	$ 547,273
Net Interest Expense During Construction (project related)		
Capitalized Interest (Construction Period)	$ 1,049,576	$ 643,289
Other Costs to be Capitalized		
Environmental Assessment	$ 2,108	$ 1,292
Hazardous Material Survey	$ 7,434	$ 4,556
Functional Program	$ 5,890	$ 3,610
CON Consultant	$ 29,760	$ 18,240
Network Electronics	$ 124,000	$ 76,000
Signage	$ 31,000	$ 19,000
Total	$ 24,453,447	$ 12,900,219

Section I. Identification, General Information, and Certification.

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): March 31, 2019
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.

Section I. Identification, General Information, and Certification

Cost Space Requirements

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

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Department	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Clinical							
Emergency Department	$ 3,131,758	1,910	5,371	5,371	-	-	1,910
Diagnostic Imaging	$ 1,048,977	900	1,680	1,680	-	-	900
CT Scan	$ 314,117	500	500	500	-	-	500
General Radiology	$ 388,366	612	620	620	-	-	612
Ultrasound	$ 74,249	220	120	120	-	-	220
Mammography	$ 53,695	120	91	91	-	-	120
Nuclear Medicine	$ 247,497	-	400	400	-	-	-
Surgical Operating Suite	$ 2,273,175	973	3,860	3,860	-	-	973
Surgical Preparation	$ 665,124	-	1,135	1,135	-	-	-
Post Anesthesia Recovery Phase I (PACU)	$ 706,442	320	1,197	1,197	-	-	320
Post Anesthesia Recovery Phase II	$ 799,883	-	1,351	1,351	-	-	-
Inpatient Physical Therapy	$ 348,626	-	680	680	-	-	-
Medical / Surgical	$ 5,809,247	7,960	12,785	9,075	840	2,870	7,960
Mobile Technology Port (MRI)	-	-	-	-	-	-	-
Endoscopy	$ 737,433	330	1,357	1,357	-	-	330
Laboratory with Draw Station	$ 712,700	797	1,278	1,278	-	-	797
Pharmacy	$ 560,488	516	1,225	1,225	-	-	516
Pain Management	$ 420,884	-	818	818	-	-	-
Central Sterile Processing	$ 664,446	253	1,250	1,250	-	-	253
Rural Health Clinic	$ 1,875,779	8,410	18,100	3,370	6,254	8,476	-
Oncology Infusion Area	$ 775,309	-	1,750	1,250	500	-	-
Pre-Admission Services (Draw Station)	$ 220,924	300	422	422	-	-	-
Respiratory Therapy	$ 335,937	300	640	640	-	-	300
Clinical / Average Cost / Sq. Ft.	$ 342.52	-	-	-	-	-	-
Clinical Contingency	$ 2,272,991	-	-	-	-	-	-
Clinical Subtotal	$ 24,438,049	24,421	56,630	37,690	7,594	11,346	15,711
Non-Clinical							
Registration	$ 925,484	590	2,720	1,920	800	-	590
Chapel	$ 73,558	-	190	190	-	-	-
Lobby / Public Space	$ 1,372,599	200	3,882	3,382	500	-	200
Ambulance Vestibule	$ 35,341	57	90	90	-	-	57
Maintenance (b)	$ -	-	-	-	-	-	-
Materials Management	$ 153,325	935	1,442		1,442	-	935 (a)
Circulation / Building Gross	$ 1,312,639	5,725	6,175	3,450	-	2,725	512+2488 (a)
Health Information Management	$ 59,887	1,800	915	-	915	-	1800 (a)
Administration	$ 571,831	1,900	3,098	-	3,098	-	1900 (a)
Waiting / Dining	$ 1,858,183	1,550	3,980	3,980	-	-	2250 (a)
Gift Shop	$ 255,593	425	506	506	-	-	150 (a)
Kitchen	$ 863,874	1,210	1,850	1,850	-	-	1210 (a)
Information Management (IT)	$ 21,547	1,000	1,315	-	315	1,000	-
Plant Operations	$ 17,091	-	300	-	300	-	-
Environmental Services	$ 67,177	280	350	-	350	-	280 (a)
Conference Room	$ 68,212	532	1,100	-	1,100	-	750 (a)
Human Resources	$ 30,142	450	506	-	506	-	450 (a)
Mechanical / Electrical	$ 582,289	1,030	3,130	1,950	150	1,030	750 (a)
Storage (c)	$ -	-	-	-	-		2982 (a)
Housekeeping	$ 60,253	120	300	-	300	-	-
Demolition	$ 3,347,019	-	-	-	-	-	-
Non-Clinical Average Cost / Sq. Ft.	$ 285.36	-	-	-	-	-	-
Non-Clinical Contingency	$ 1,239,574	-	-	-	-	-	-
Non-Clinical Subtotal	$ 12,915,618	17,804	31,849	17,318	9,776	4,755	17,304
Total with Contingency/Average Cost/Sq. Ft.	$ 37,353,666	-	-	-	-	-	-

Footnotes:

(a) Denotes this vacated space will be completely demolished

(b) Maintenance will be in a separate building on campus

(c) Storage will be located within departments

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.

Section III. Background, Purpose of the Project, and Alternatives

Background of Applicant

1. Ferrell Hospital Community Foundation owns and operates a fully licensed Critical Access Hospital and two Rural Health Clinics which are both located in Eldorado, Illinois.

Location	Address	City	State	Zip Code	License #
Ferrell Hospital	1201 Pine Street	Eldorado	Illinois	62930	0005363
Ferrell Hospital Family Practice	1306 Maple Street	Eldorado	Illinois	62930	0005363
Eldorado Family Medicine	1407 Locust Street	Eldorado	Illinois	62930	0005363

2. No adverse action has taken place against Ferrell Hospital over the last three years, which is confirmed in Attachment 11, Exhibit 1.

3. See Attachment 11, Exhibit 1.

4. Ferrell Hospital has not submitted an application in the previous calendar year.

Ferrell Hospital

1201 Pine Street
Eldorado, Illinois 62930
Phone (618) 273-3361
Fax (618) 273-2571

July 27, 2016

Ms. Kathryn Olsen, Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olsen,

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

1. Ferrell Hospital Community Foundation has not had any adverse action taken during the last three (3) year period prior to filing this application; and

2. Ferrell Hospital Community Foundation authorize the Health Facilities and Services Review Board and Illinois Department of Public Health access to any information necessary to verify documents or information submitted in response to the requirements of Criterion 1110.203.a, or to obtain documentation or information which the State Board or Agency finds pertinent to the application.

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

Respectfully,

Alisa Coleman

Alisa Coleman, CEO
Ferrell Hospital Community Foundation

Subscribed and sworn to before me
this 27 day of July 2016

Bethany L. Reyling
Notary Public

BETHANY L REYLING
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
November 18, 2019

"Healthcare Built On Excellence"

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.

Section III. Background, Purpose of the Project, and Alternatives

Purpose of Project

Ferrell Hospital has provided critical healthcare services to residents in 3 counties in Southern Illinois since 1925. These counties, Saline, Gallatin, and White are designated by the US Department of Health and Human Services as Medically Underserved Areas.

The 3 county Service Area encompasses 12 zip codes, but is not limited to the following communities, Harrisburg, Omaha, Junction, Carrier Milles, and Shawneetown.

Service Area

	CY 2015 Discharges		
Zip & City Name	#	% of Total	Cumulative %
62930 - Eldorado	269	44.1%	44.1%
62946 - Harrisburg	52	8.5%	52.6%
62984 - Shawneetown	39	6.4%	59.0%
62869 - Norris City	36	5.9%	64.9%
62979 - Ridgway	32	5.2%	70.1%
62934 - Equality	23	3.8%	73.9%
62935 - Galatia	18	3.0%	76.9%
62977 - Raleigh	14	2.3%	79.2%
62917 - Carrier Milles	14	2.3%	81.5%
62954 - Junction	9	1.5%	83.0%
62871 - Omaha	6	1.0%	84.0%
62965 - Muddy	5	0.8%	84.8%
PSA Total	517	84.8%	
Outside of PSA Total	93	15.2%	
Total	610	100.0%	

Approximately 44% of Ferrell Hospital's 2015 discharges originated in the Eldorado zip code (62930). The Hospital's Service Area, as defined, accounted for approximately 85% of Ferrell Hospital's 2015 discharges (COMPdata).

While the quality of healthcare provided at Ferrell Hospital has remained high, the limitations to providing modern patient care are severely limited by the current facility. Originally built in 1928, the core clinical patient care areas are highly lacking in necessary space and modern conveniences to provide the most up to date care. As Ferrell Hospital has seen tremendous growth in the types and number of services provided to patients in the last 3 years, it has been difficult to develop the necessary programs due to facility constraints.

Purpose

Ferrell Hospital's current facility is outdated and has an extensive list of issues that have been noted. Ferrell Hospital's architects, Johnson Johnson Crabtree Architects, have documented the facilities' deficiencies (see Attachment 12, Exhibit 1 & Attachment 20, Exhibit 2). In October 2014 Adams Group did an initial site review as well (see Attachment 12, Exhibit 2). Clinical deficiencies within the current facility include the following:

- The emergency department not having clear separation from other departments.

- Inadequate waiting space in the Clinic and no central waiting room for the hospital.
- A lack of ambulatory access to the emergency department, except through the ambulance ramp entrance.
- Concrete site work to repair sidewalks, ramps, curb and gutter, and building entrances, as well as asphalt repair to assist in flow of traffic around the facility.
- Exterior aesthetic maintenance will be needed throughout (aluminum-framed windows to replace wood-framed windows, caulking everywhere, mortar replacement, paint, stucco repair, signage, etc.) The 1958 and 1973 Building have mostly original exterior finishes.
- A roof that appears to need immediate maintenance, as at least 30 leaks were reported. At least 31,000 SF of the total 38,000 SF roof needs to be replaced as the average age is 18 years old. The last 7,000 SF of roof is in the oldest building from 1958 and was reported to be 10 years old.
- Facility maintenance and upgrades to mechanical, electrical, and plumbing equipment. Appears to be understaffed and not properly maintained. The current Facility Staff is doing a great job just keeping the Facility running. A lot of the equipment is original from 1958 or from 1973. It was reported that the Facility loses a portion of power once a week, which causes the Emergency Generator to run weekly.

The proposed modernization project will allow Ferrell Hospital to more appropriately fulfill its mission to provide quality healthcare services to the citizens in and around the Primary Service Area. Currently, many residents of the Eldorado community are traveling up to an hour to receive care, many times out of state. In addition, the elderly population (65 years and older) is anticipated to grow from 21% to 23% of the population by 2021 (Nielsen Pop-Facts). The modernization project will ensure that these patients can obtain modern, high quality care close to home without the need to travel out of state.

Ferrell Hospital has partnered with Deaconess Illinois, which is implementing an aggressive population health strategy aimed at improving care, improving quality, and reducing costs. As part of this initiative, Deaconess Illinois is working with many Critical Access Hospitals to assist with improving current services and developing new services in order to provide more seamless and coordinated care to patients. The modernization project contemplated by Ferrell Hospital is a key to implementing this strategy.

Saline, Gallatin, and White counties are underserved communities. Physician recruitment is the long-term key to be successful in allowing patients to receive care close to home. The current Ferrell Hospital facility makes it difficult to recruit physicians who are looking to practice in a modern day hospital. Competition for physicians is extremely tough and future success will rely on modern and up to date facilities.

After consultation with a number of external advisors, the Ferrell Hospital administrative staff and Board concluded that an extensive renovation and expansion on the current facility campus is appropriate.

After completion of the Project, the Hospital will be able to more appropriately fulfill its mission to provide quality healthcare services to the citizens in and around the Primary Service Area. Currently, many residents of the Eldorado community are traveling up to an hour to receive care, some of which can be provided at Ferrell Hospital. Approximately 21% of the market area's population is currently 65 or older, and by 2021 this number is anticipated to climb to

approximately 23% (Nielsen Pop-Facts). As the population in the Service Area continues to age, the renovation and expansion of the facility will allow for quality care that is accessible.

The Applicant anticipates to have the renovations completed early 2019. To ensure that the communities served have adequate access to care, Ferrell Hospital will continue to operate while the facility undergoes its renovations. Once completed, the modernized and expanded facility will be able to provide quality care that is easily accessible. The renovations will also address and correct the deficiencies within the current facility. Ferrell Hospital, and its advisors, have developed a plan to operate normally while the facility undergoes the Project. Goals and objectives will be measured by continuation of patient quality and patient satisfaction surveys.

DEJA

Memorandum	Date: 6/14/2016
To:	Jonathan Stern - ICLLC
Cc:	Alan Richman - ICLLC;Blake Daniels - DEJA;David Johnson - DEJA;Mark Richman - ICLLC
From:	Jason Putnal - DEJA
Project:	Ferrell Hospital Basic Services (16690.00) - Basic Services (00)
Owner Project #:	
Subject:	Facility Deficiencies

Following is a list of facility deficiencies associated with the existing Ferrell Hospital facility. Please note that this is not an exhaustive list of deficiencies.

1. **Building and Life Safety Code Deficiencies**
   a. Stairs not enclosed between floors.

Photo #19: Missing door at southwest stair - Basement

   b. Stairs between floors not proper width for egress.

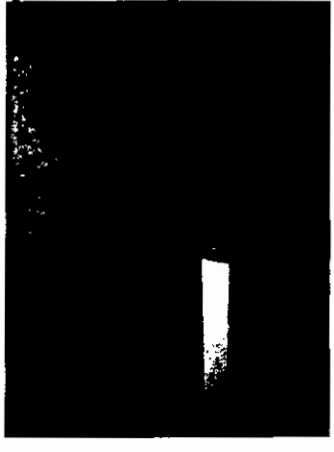


Photo #14: Open center stair at first floor with corridor discharge

David E. Johnson
Architect
4551 Trousdale Dr
Nashville, TN 37204
tel 615-837-0656
fax 615-837-0657

Photo #16: Open southwest stair at 1st floor with outside discharge

c. Combustible construction materials such as wood fiber ceiling tile on wood furring and wood paneling.

Photo #24: Combustible wood fiber ceiling tile - Basement; Break room

Photo #15: Pre-finished wood panelling on corridor wall - 1st floor

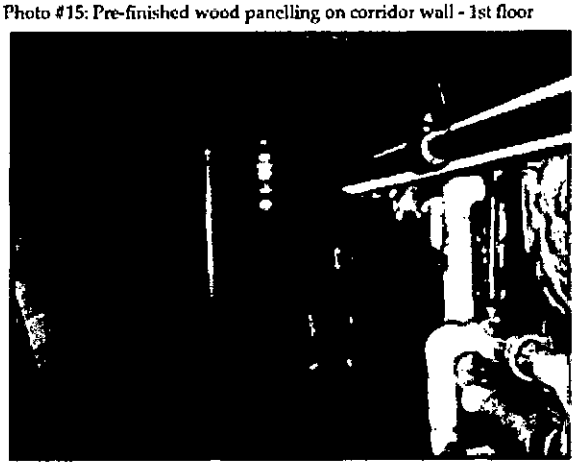


Photo #9: Interior of mech penthouse with wood frame structure - 1973 Hospital

d. Fire egress stairs that do not discharge to the outside or into an exit passageway leading to the outside.

Photo #21: Missing door to center stair - 2nd floor

e. Wood floor framing.

Photo #20: Floor framing in former courtyard now housing mechanical equipment - 1st floor

f. Missing guardrails on ramp.

g. Non-compliant fire door assemblies.

Photo #46: Non-fire-rated glazing in fire door at 2-hour barrier

h. Facility has only limited sprinkler coverage.

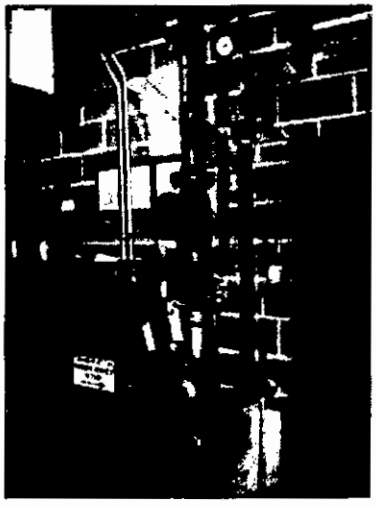


Photo #38: Automatic sprinkler alarm and control valves for limited coverage systems

i. Improper separation between mechanical rooms and other parts of the building

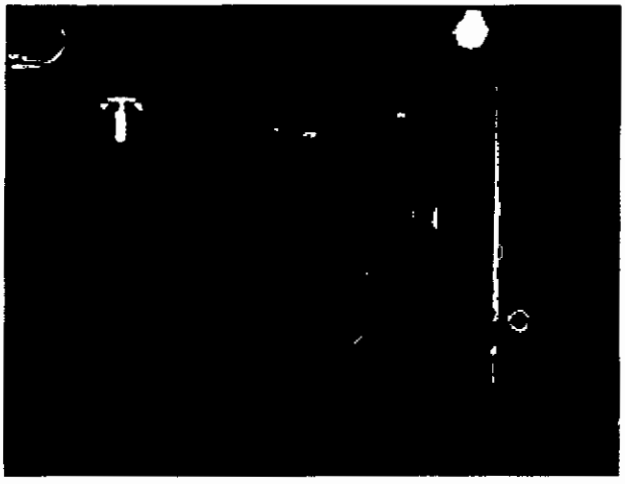


Photo #18: Boiler room with electrical panel and non-rated door - Basement

2. Functionality Deficiencies

a. Security within facility - No separation between public corridors and staff corridors. No separation between Emergency Department and rest of facility.
b. Departments are scattered around the facility with rooms of some departments being located on multiple floors in random places. Materials management, for instance, is located on the first floor of the 1973 building, but has multiple separate storage rooms scattered about the second floor of the 1958 building. This is the case for many departments including Human Resources, Emergency Department, Pharmacy, Environmental Services, Laboratory, Auxilary, Food Service, Medical Records, Registration, Education, Administration, Information Technology, and other departments. This leads to significant staffing and patient care inefficiencies.
c. No loading dock for Food Service. Deliveries are carried up and down multiple flights of stairs by hand.
d. Dining room is located in the first floor of the 1958 with no direct access to visitors or outpatients.
e. Existing clinical departments are not design to grow.

f. Older parts of building are in poor condition.

3. Clinical Deficiencies

a. Emergency Department does not have clear separation from other departments.
b. Inadequate Waiting Space in Clinic and no central Waiting Room for Hospital.
c. No direct ambulatory access to Emergency Department except through Ambulance Ramp entrance.

d. Surgery Department is grossly inefficient in its layout and is not separated from the med/surg patient wing. Corridors leading to the Operating Room are too narrow for proper patient transport and involve taking patients into more public corridors leading to recovery.
e. Many clinical spaces including Trauma Rooms, Triage, Operating Rooms do not meet current standards for size.

4. Systems Deficiencies

a. Patient rooms lack current code mandated complement of medical gases and emergency power outlets.
b. Inadequate code clearance and separation around the main switchgear which is located in common space with the boilers and chillers.
c. Medical gas alarm system is not up to date.
d. Some air handlers lack appropriate final filtration.
e. Emergency power is separated somewhat into code required branches but this has been compromised over time.

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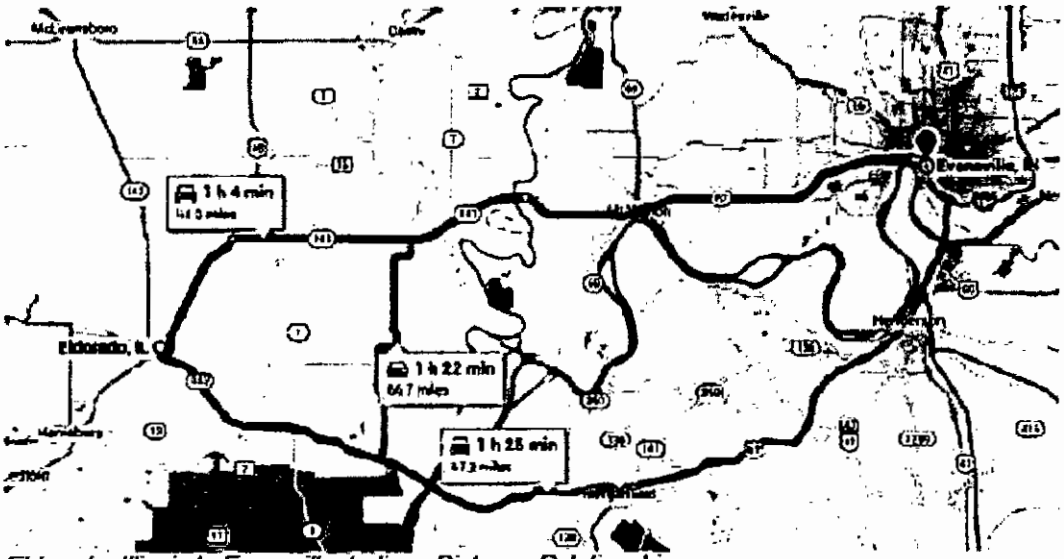
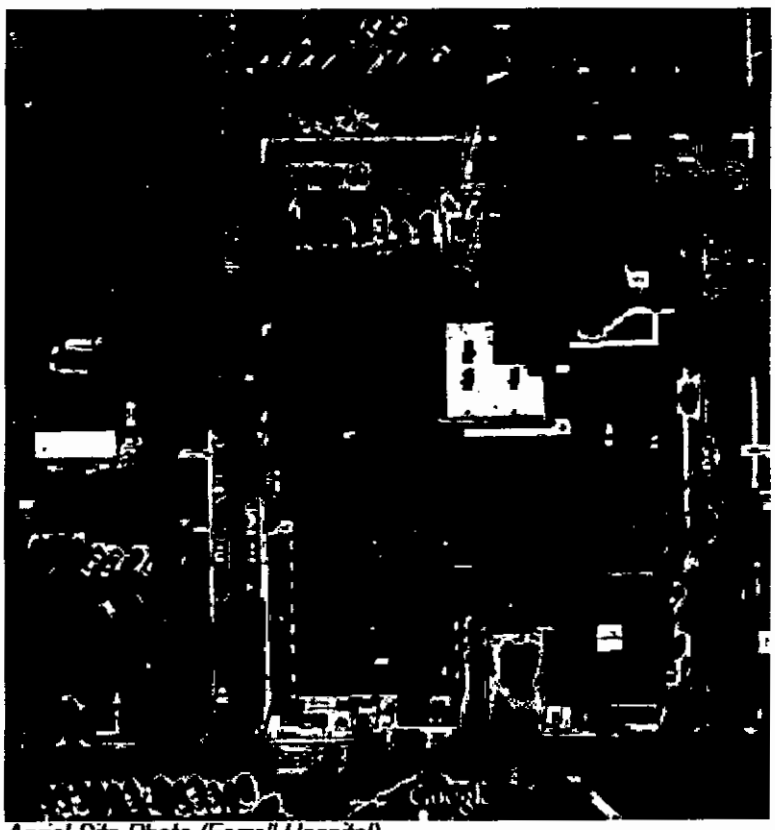
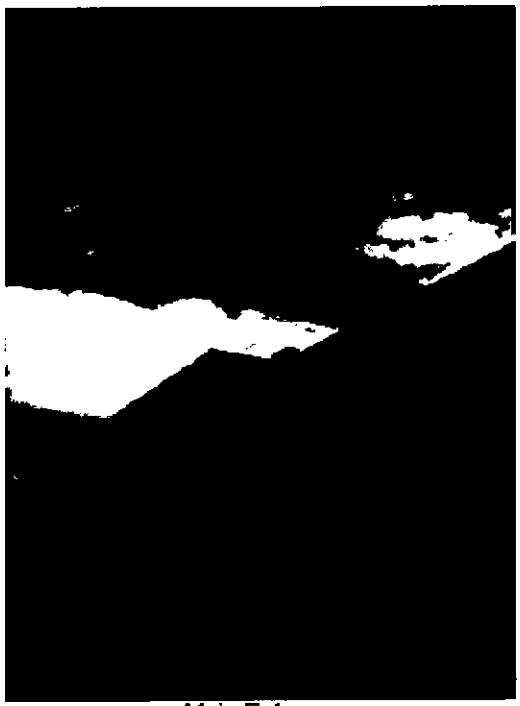


Eldorado, Illinois to Evansville, Indiana Distance Relationship



Aerial Site Photo (Ferrell Hospital)



Main Entrance

Main Entrance to Administration

EXECUTIVE SUMMARY

ADAMS was engaged to perform an evaluation of the property located at 1201 Pine Street, Eldorado, Illinois. There are also five properties across the street from the facility which the Hospital owns and two properties in town that are called the Eldorado Family Medicine Clinic and Physical Therapy. Our conclusions are based on estimates, assumptions, and other information developed during the brief on site surveys of the facility and our knowledge of building systems, medical equipment, and the regulations imposed upon the industry. Some assumptions utilized in the development of our findings will inevitably not materialize. Unanticipated events and circumstances may occur; therefore, actual results may vary from the estimates, and variations from this report may be realized.

PROPERTY OVERVIEW

The Ferrell Hospital is located at 1201 Pine Street, Eldorado, Illinois. There are also five properties across the street from the facility which the Hospital owns and two properties in town that the Hospital owns. The approximately 9.5-acre campus (6 City Blocks) contains the partial Hospital and has surface parking. (Building and lot sizes are based upon information from Facility.) The currently occupied Administration area was constructed in 1928 with major renovations done in 1942 and 1958. The currently occupied Hospital space was constructed in 1973. The Clinic building was also built in 1973. A recent addition the Clinic space was built in 2011.

The Square Footage breakout is as followed for the Main Building:

• Clinic:	11,366 SF
• Clinic Addition:	2,406 SF
• Administration 1st Floor:	6,908 SF
• Administration 2nd Floor:	6,458 SF
• Hospital:	18,253 SF
• Total Basement SF:	6,675 SF
• Business (IT) 2nd Floor above Clinic:	1,161 SF
o TOTAL SF:	53,227 SF

The Square Footage breakout for the surrounding properties is as followed:

• Maintenance Shop:	1,440 SF
• Sleep Study House:	1,127 SF
• 1510 Grant Property:	1,846 SF
• Senior Care Center:	2,532 SF
• Eldorado Family Medicine Clinics: (RENTAL PROPERTY)	5,156 SF
• Physical Therapy House: (RENTAL PROPERTY)	1,962 SF
• Laundry Building:	1,200 SF
o TOTAL SF:	15,263 SF

The Main Building has approximately 53,227 SF with 6,675 SF of that being unfinished Basement space and 7,619 SF of that being 2nd floor space. Based upon property research of the facility, the primary tenant is Ferrell Hospital. Across the 38,933 SF of 1st floor space, there is a partial basement, partial crawl space, and 2nd floor space. The non-functioning spaces at this time are the Basement space most of the 2nd Floor Administration space.

The following services are currently offered at the facility:

- Cardiac Rehabilitation
- Case Management
- Dietary
- Education and Infection Control
- Emergency Room
- Imaging
- Inpatient Services
- Laboratory
- Nursing
- Pharmacy
- Physical Therapy
- Respiratory Therapy
- Senior Care
- Surgery

The Administration Building's foundation appears to be on a 4" concrete slab-on-joists with a wood-frame structure throughout, two floors, and a basement. The second floor is supported by a wood-frame, joist, and underlayment type of system. The Main Hospital addition that was done in 1973 is also a 4" concrete slab-on-grade with spread footings and reinforced concrete columns and metal-stud framing (one-floor). The Clinic space was also built in 1973 with a 4" concrete slab-on-grade with spread footings and structural steel construction. The structural steel is not fireproofed as the building class that it falls into does not require this. The walls in the 1973 buildings have metal stud framing and the entire building that was renovated in 1958 still has wood framing. The roof construction is made up of multiple types of fully-adhered white/black EPDM roofing. The exterior envelope is constructed of brick veneer, a combination of wood-framed and aluminum-framed windows. The building is not fully sprinkled.

Refer to the photos in Section 4 of this report for representative views of the building and site. Definitions of terminology are located in Section 2 of this Survey Overview.

ANTICIPATED EXPENDITURES – excluding annual general maintenance

Refer to the Anticipated Expenditures Section for a specific list of the Deferred Maintenance and Recommended Capital Investment items for this property summarized above. We have included reasonable cost inflation, based on current industry trends, in all Anticipated Expenditure projections. However, all such expenditures must be verified at the time of the initiation of the work. The "Near Term Capital Investment" work includes projections to upgrade mechanical, electrical, and plumbing systems to alleviate immediate life safety concerns. It is not intended to plan for correction of underserved systems.

KEY POINTS AND CONCERNS

The main concerns are as follows:

Site and Facility Items

- Concrete site work to repair sidewalks, ramps, curb and gutter, and building entrances, as well as asphalt repair to assist in flow of traffic around the facility.
- Interior aesthetic overhaul will be needed throughout (casework, flooring, paint, wall covering, ceiling tiles, door hardware, doors, signage, etc.) The 1958 and 1973 Building have mostly original finishes.
- Exterior aesthetic maintenance will be needed throughout (aluminum-framed windows to replace wood-framed windows, caulking everywhere, mortar replacement, paint, stucco repair, signage, etc.) The 1958 and 1973 Building have mostly original exterior finishes. We would also recommend that an Exterior Envelope study take place.
- A roof that appears to need immediate maintenance, as at least 30 leaks were reported. At least 31,000 SF of the total 38,000 SF roof needs to be replaced as the average age is 18 years old. The last 7,000 SF of roof is in the oldest building from 1958 and was reported to be 10 years old.
- Facility maintenance and upgrades to mechanical, electrical, and plumbing equipment. Appears to be understaffed and not properly maintained. The current Facility Staff is doing a great job just keeping the Facility running. A lot of the equipment is original from 1958 or from 1973. It was reported that the Facility loses a portion of power once a week, which causes the Emergency Generator to run weekly.

SPECIFIC JURISDICTIONAL ELEMENTS

CODES

The building has been in operation since 1958, or approximately 52 years. Per the current Owner's, the original Owner was a couple of Physicians. No building, health code, or fire code violations were reported. The applicable Building Codes are as followed: 2003 International Building Code, 2003 International Fire Code, NPFA 101 Edition 1991, and Hospital Code 2003. There was quite a bit of clutter and storage taking place in mechanical and electrical rooms with doors being left unlocked.

A change in ownership or major renovation could, however, result in future and potentially more thorough inspections. These changes could result in governmental requirements to update all or part of the building and/or building systems to comply with current and potentially more stringent codes or laws not noted above.

HAZARDOUS WASTE

Reference should be made to a Phase I Environmental report as information on hazardous waste is also beyond the scope of this brief review. With the wet climate and high humidity levels, it was reported that the building has had minor mold problems, however all these items were reported to be abated. It was reported that the basement has flooded five times in the last 16 months. As a precaution, in all new renovated places, green board is being used on any potential wet wall areas. Asbestos has been found in the Facility, however the exact location was not given. All asbestos was abated and disposed of properly, however new renovations in the 1958 building will likely turn up more asbestos.

MIC – MICROBIOLOGICAL INDUCED CORROSION

The minimal fire sprinkler system showed no signs of MIC and no issues were noted by the facility staff.

HIGH WINDS

While onsite, it was reported that high winds occur occasionally. Items to keep in mind with high winds are the structural integrity of the exterior and if floors are going to be added in future development. High winds also have a potential to cause power outages. It was also found that tornados and earthquakes are slightly above the national average in this area.

FACILITY REVIEW

The Facility Condition Assessment was performed by ADAMS Management Services on October 6th and 7th, 2014. The following observations were recorded by ADAMS Management Services:

METHODOLOGY

The Facility Condition Assessment included a site visit and system survey, visual inspection, data research, and staff input.

A physical survey and inspection was conducted on October 6th and 7th, 2014. This inspection was considered non-invasive and visual inspection was used to determine the condition of the building interiors, exterior, structural issues and site. Supporting photographs are included in this report.

SITE OVERVIEW

The property is developed as a Hospital and Medical Office Building, and associated paved driveways, parking areas and planting beds.

Topography – The site is mostly flat. Without a soil test being performed, we are assuming that the building is situated on clay.

Landscaping – Landscaping and hardscaping was observed on the property. Landscaping and hardscaping appear to be in "Satisfactory" condition. A few plants are in need of replacement, as well as more rock and mulch in a few areas. There is minimal grass on the site, however the landscaping is contracted out and routine lawn care is performed once a week. There is no irrigation present. Snow removal is also contracted out.

Parking and Pavement – Surface parking is available on all sides of the building. Parking and pavement appears to be in "Serviceable" condition. There is quite a bit of gravel parking as well. For the current use of the entire building, the parking is at full capacity and has little staff parking. If the building gets repurposed and the occupancy numbers go up, either leased parking or possibly a parking garage may have to be looked at. There is also no valet area.

ADA Site Access – The exterior site does not appear to meet ADA accessible requirements, however there does not appear to be very many handicap parking spots. A complete ADA review has, however, not been completed as that is beyond the scope of this brief review. The ramps appear to comply but are not fully apparent by visual inspection. At each entrance, there is only one ADA ramp, which can easily block traffic when multiple vehicles are unloading. We would recommend tearing out the curb and gutter under the main canopy and creating an ADA ramp to better accommodate patients. There are also no Code Blue Stations in the parking lot.

Future Development Potential – It does appear that the site contains enough area for future development. Building a small parking garage can probably be accommodated. Increasing floors is a possibility, but keep in mind that most Mechanical Equipment is located on the roof. There is a street that is situated between the Facility Building and Main Hospital. This looks like the best opportunity to expand the building footprint or add buildings. If future development was needed, we would recommend building a parking garage, building out the footprint, or expanding across the through and across the street.

BUILDING

BUILDING OVERVIEW

Structure – The Administration Building's foundation appears to be on a 4" concrete slab-on-joists with a wood-framed structure throughout, two floors, and a basement. The second floor is supported by a wood-frame, joist, and underlayment type of system. The Main Hospital addition that was done in 1973 is also a 4" concrete slab-on-grade with spread footings and reinforced concrete columns and metal-stud framing (one-floor). The Clinic space was also built in 1973 with a 4" concrete slab-on-grade with spread footings and structural steel construction. The structural steel is not fireproofed as the building class that it falls into does not require this. The walls in the 1973 buildings have metal stud framing and the entire building that was renovated in 1958 still has wood framing. There is some steel and it is not fireproofed as the building class that it falls into does not require this. The walls have a mixture of wood framing and metal stud framing. The roof construction is made up of multiple types of fully-adhered white/black EPDM roofing. The exterior envelope is constructed of concrete, brick veneer, and a mixture of wood-framed and aluminum-framed windows. There is a few places where mortar is completely gone at the brick. The building is not fully sprinkled. There is also two monumental signs around the site, which do not work. It was reported that the power does not work on them. All sign foundations appear to be uncompromised, however aesthetic upgrades may need to be made to these signs. The building structure appears to be in "Satisfactory" condition.

Exterior – The exterior envelope is mostly comprised of exposed concrete and brick veneer. There is also a mixture of aluminum-framed and wood-framed windows. Aesthetically, the exterior on the 1973 building needs maintenance, and the exterior on the 1958 building needs extreme maintenance. The exterior is in "Serviceable" to "Satisfactory" condition. No exterior window washing is performed. There are no car charging stations and a couple bike racks located on the property. It was observed that there is a public transportation bus stop near the front of the property.

Interior Finishes – The interior walls of the 1973 Building consist of gypsum wallboard overlaying steel studs with paint and wall covering throughout. The interior walls of the 1958 Building consist of gypsum wallboard and plaster overlaying wood studs with paint and mostly wall covering throughout. Ceilings are painted, gypsum wallboard and acoustical lay-in tiles. Quite a bit of staining and black spots were observed on ceiling tiles. The door colors, age of doors, types of locksets, and types of hardware are not consistent throughout. There is no wellness center, artwork package, five plants, or a lot of dedicated storage space. Interior finishes in the building range from "Serviceable" to "Fair" condition.

Interior Casework – Casework is wood with mostly plastic laminate countertops throughout. The wood color and architectural design is not similar throughout. The casework in the occupied spaces appears to range from "Fair" to "Satisfactory" condition.

Windows and Caulk –The windows are a mixture of aluminum-framed and wood-framed, and are in "Serviceable" to "Good" condition depending on if the wood-framed window has been replaced. The majority of the caulking is in "Poor" condition. With quite a bit of snow and rain throughout the year in Eldorado this could potentially become a problem. With all the renovations potentially taking place inside, we would recommend an exterior envelope test on the building.

Roof – The roof is a fully-adhered white and black EPDM roof. The roof is entirely flat. There appears to be a quite a bit of locations that show staining occurring on the exterior walls. Walk pads were placed around some of the rooftop mechanical equipment for serviceability. There was also two penthouses on the roof, one small and one large. A roof that appears to need immediate maintenance, as at least 30 leaks were reported. At least 31,000 SF of the total 38,000 SF roof needs to be replaced as the average age is 18 years old. The last 7,000 SF of roof is in the oldest building from 1958 and was reported to be 10 years old. With roof maintenance, all vertical and horizontal flashings need to be replaced as well. In more than one location, we were able to pull the roof up at flashing locations. The roof is in "Serviceable" condition. Throughout the walk, we did observe many significantly stained ceiling tiles.

Shipping/Receiving – The building contains a minimal shipping and receiving area and does not have a loading dock. There is no dock leveler.

MECHANICAL ELECTRICAL AND PLUMBING OVERVIEW

HVAC SYSTEM OVERVIEW

The HVAC system for the Hospital building consists of multiple (3 located on the roof) air handling units and four-pipe fan coil systems. To keep up with the added needs and new equipment, multiple small split-systems units have been added throughout the facility. For the fan coil units that serve the Patient Rooms and some other miscellaneous rooms, these are original and not functioning properly. The chilled water and hot water come from the main mechanical room. It was reported that when a patient is to hot or too cold, that each fan coil unit has to have its front panel taken off and individually tempered with the valves because the controls do not work.

The HVAC system (cooling) for the Clinic building consists of one multi-zone air handling unit. The multi-zone air handling unit has 13 zones of temperature control. This system is original and is control by wall-mounted thermostats. The heat is produced by a single gas-fired/fuel oil hot water boiler. The system serves one multi-zone air handling unit. This does not serve the hot water. Please note that the building HVAC systems do not interconnect.

The HVAC system (cooling) for the Administration building mostly comes from many split-system air-cooled condensing units. Many are relatively new. The heat is produced from a Boiler (Crane), which then circulates hot water through a pipe system to radiant heaters. There is also wall-mounted thermostats, and is was reported that many do not work.

A Building Automation System (BAS) was not observed.

The Fan Coil Units Controls in the Patient Rooms do not work. When a patient needs the room either cooler or hotter, they have to call a maintenance man, who then have to take off the panels and temper the valves accordingly.

The Sequence of Operations and Inspections Logs for the Mechanical Equipment appear to not be up-to-date, or they do not have any record of them. It was reported that all mechanical maintenance services are done in-house, unless a subcontractor is needed. Again, keep in mind that this equipment is mostly original from 1958 or 1973.

Overall, the HVAC equipment is in "Serviceable to "Fair" condition.

ELECTRICAL & COMMUNICATION SYSTEMS OVERVIEW

Electrical power is provided to the building from one pad-mounted utility transformer with underground service from the street. The transformer is located outdoors that is piped to the main switchboard which feeds normal and emergency power, the chiller, and imaging equipment. There is also a 408V feed from a pole-mounted transformer which primarily serves the building that was built in 2011. The existing emergency generator is a Cummins Katolight 345 HP that is located outside. Even though the generator is original, it is in fairly good condition as it is running once a week. No issues were reported with the electrical system. The Rooms had above-normal storage items and need to be kept clean. Quarterly testing is not done on all receptacles, equipment and as needed throughout the building. It was also observed that proper circuitry labeling on switches and receptacles was poor throughout.

Building-mounted light fixtures beneath the canopies and pole-mounted parking lot lights were observed on the exterior of the facility. A few lights were reported to not be working.

It was reported that the monumental signs do not light up.

The building is equipped with one diesel emergency generator that has an exterior above-ground diesel holding tank that is integral to the generator. The generator is also started and tested every Friday. It was reported that the building can lose power up to once per week.

The property does not contain a trash compactor.

The property does contain a dock or a dock leveler. All trucks delivering and picking-up must have their own lift gates.

A lightning protection system on the exterior of the building was not observed, however the facility reported that they are properly grounded by a grounding rod that extends quite a bit taller than the building.

One potential item that will need to be observed closer is whether or not a GFCI overhaul will be required.

Overall, the electrical systems appeared to be in "Fair" condition.

The building is equipped with interior and exterior functioning security cameras. The control room for the security cameras are located in the Business Area where IT is located on the 2nd floor of the 1973 building.

Audio-Visual was observed in the Board Room of the Administration Building.

It was observed that the overhead PBX Communication and was reported to be functioning properly, however it is original from 1973.

It was reported that a Distributed Antenna System (DAS) was not installed in the building, however they do have Wireless Internet.

Auto Operating Doors appeared to be functioning properly.

The facility does not contain any Pneumatic Tube Systems.

There is no white noise system.

There is one main IT Room on the 2nd floor of the 1973 building, with IT equipment being located throughout the facility in different closets. The building does have Wi-Fi.

Overall, the Communication System appear to be in "Satisfactory" condition.

PLUMBING OVERVIEW

Domestic water is brought into the building and distributed through a conventional, steel and copper piping network. No PEX tubing was observed.

The domestic hot water system appears to be in "Serviceable" to "Fair" condition.

There is no snowmelt system installed.

Toilet fixtures are poor quality throughout the facility. Lavatories are both wall-mounted and counter-mounted with handle faucets. They appear in 'Fair" condition. The public restrooms do not appear to be ADA compliant.

A water softening system was not observed.

The Hospital contains one (1) chiller. The chiller is a 60-ton Dunham Bush and it was not reported on whether it was redundant or not. The chiller is original, and shows significant wear (maintenance is performed daily). The chilled water is distributed throughout the Hospital to serve AHU coils and 4-pipe fan coil units. The chiller appears to in "Fair" condition.

The Hospital does contain two (2) boilers. They are Iron Fireman and approximately 32 BHP. It was noted that in the winter these are always running. The boilers only operate on gas. The hot water is distributed throughout the hospital through zone pumping/piping systems serving 4-pipe fan coil units, AHU preheat coils, and duct-mounted reheat coils.

The Hospital does contain two cooling towers, which are located on the mechanical roof. They are original. A key note to keep in mind is that these towers are redundant.

The facility does not have an irrigation system.

The sanitary system is routed through the facility and gravity-drained from the facility to the public sewer. It was reported that there has been issues with the sanitary, including digging it up and replacing sections.

There are limited medical gases present at the facility; oxygen is the only piped medical gas and the incoming main is a 1-1/4" diameter line. There is a bulk Oxygen Storage Tank. The enclosure for the tank does not meet current code. The medical gas room is entered from the exterior of the building. The facility does have an emergency oxygen hook-up. Oxygen serves the following areas: Patient Rooms, Emergency Department, the Operating Room, and Recovery. The medical gas system appears to be in "Serviceable" to "Fair" condition.

The water runoff for the roof is captured by interior roof drains and are piped into the storm sewer. The roof drain system appears to be in "Satisfactory" condition.

Dishwashers and refrigerator hook-ups were observed.

There is natural gas in the facility. Three feeds come into the buildings (one at the 1958 building, one into the mechanical room where the boiler is, and one into the Clinic building).

In general, the plumbing systems all appear to be in "Fair" to "Satisfactory" condition.

FIRE PROTECTION OVERVIEW

The facility is not fully sprinkled. There is minimal sprinkler coverage (penthouses on roof and a couple mechanical rooms). Inspection tags were not up-to-date. There is a fire pump in the main Mechanical Room. It appears and is assumed coverage, head type, water pressures, flow rates, etc. are all adequate and have been monitored and maintained properly.

The fire alarm is tested monthly by the Facilities Director.

One fire department connection was reported on the exterior of the building. Fire hydrants were also observed around the perimeter of the facility.

Smoke detection devices, fire extinguishers, fire alarm pull devices and the main fire alarm panel all appear to be in place and in "Satisfactory" condition.

The fire alarm panel showed "normal" status. The fire alarm is zoned in one loop. It appeared that all inspections were up-to-date, however Life Safety Reviews have not been performed on the Facility.

In general, the fire suppression system appears to be in "Good" condition.

ELEVATOR OVERVIEW

The facility is equipped with one (1) hydraulic elevator. Zero elevators are equipped to accommodate patient beds. One Elevator Mechanical Room in the basement serves the elevator. The elevator is currently not equip for card readers. The elevator only serves the original building that currently serves the Administration area. At this time, the elevator serves some staff on the 2nd floor of the Administration Building and bringing storage from the 1st floor or basement. It was reported that the Building needs to get up-to-date on Elevator Inspections and Certification. The interior finishes of all the elevators also need attention.

KITCHEN OVERVIEW

The building was equipped with a full-service kitchen and cafeteria, however this area is only for staff. It is located on the 1st floor of the Administration Area. There is a couple small break areas throughout the Facility.

TERMINOLOGY

"Excellent" – Component or system is performing its function at specified levels of quality. Component or system is in new or like-new condition. No repair is required at this time.

"Good" – Component or system is performing its function at specified levels of quality. Component or system may show a normal level of wear and tear for its age. No significant repair is required at this time.

"Satisfactory" – Component or system is performing adequately at this time. Component or system shows a normal level of wear and tear for its age. Other than routine preventative maintenance, little or no repair is required at this time.

"Fair" – Component or system is performing adequately at this time but shows signs of deferred maintenance and/or substandard repairs or workmanship. Or, component or system is obsolete or approaching the end of its useful life. Replacement or prompt repair is required to prevent further deterioration, but it may be more cost-effective to increase preventative maintenance or perform periodic repairs than to replace or fully repair the system.

"Serviceable" – Component or system is at the end of its useful life, but can continue to function acceptably if immediate repairs and/or an increased proactive maintenance schedule are enacted. If maintenance is reactive rather than proactive, premature failure and/or costly repairs or replacement may become necessary.

"Poor" – Component or system cannot be relied upon to perform its original function, and may have already failed. Present condition could cause or contribute to the deterioration of other components or systems. Repair or replacement is required.

The table below catalogues and rates the observations by area from the October 2014 walkthrough of the Hospital/Clinic:

General Notes		
	Entire Facility	The entire Facility of the Administration Building (1958).
	Entire Facility	The entire Facility of the Building built in 2011.
	Exterior	Façade of the Hospital Building
	Exterior	Ramp Design and no Snowmelt at Emergency Department ramp
	Exterior	Generator located on outside of building.
	Exterior	Asphalt and re-striping.
	Exterior	Exterior Signage (is either obsolete or does not light up)
	Exterior	ADA Compliance
	Exterior	Site is graced with enough landscaping, which is well tended to.
	Exterior	Not enough parking
	Roof	Roof should be replaced. Over 30 leaks currently.
	Roof	Aluminum flashings.
	Roof	Penthouses.
	Roof	Lightning Protection.
	Roof	Flashings and roofing material pulling up in many places.
	Roof	Roof Drain System
	Entire Facility	Total Capacity; limited ER Department.
	Entire Facility	Restrooms
	Entire Facility	Fan Coil Units in Patient Rooms.
	Entire Facility	Asbestos and mold issue throughout facility (potentially).
	Entire Facility	Millwork and casework quality.
	Entire Facility	Consistency of finishes throughout building (ex: Patient Rooms)
	Entire Facility	Single Patient Rooms vs. Double Patient Rooms
	Entire Facility	Building is not sprinkled
	Entire Facility	Fire alarm is fully installed and functioning
	Entire Facility	Security (ex: Access into Pharmacy)
	Entire Facility	Signage and Life Safety Plans.
	Entire Facility	Low ceiling height prevents adequate space above ceiling panels for MEP.
	Entire Facility	Electrical systems (knowing which work and GFCI/non-GFCI, Labeling, etc.)
	Entire Facility	Exit signs are fully installed and functioning.
	Entire Facility	Building experiencing a humidity issue possibly (had a smell).
	Entire Facility	Flooring in Hospital/Clinic.
	Entire Facility	Water damage and potentially mold observed on many ceiling tiles.
	Entire Facility	Wall coverings and paint.
	Entire Facility	Cleanliness of Facility and of sterile areas.
	Entire Facility	Nurse Station setup.
	Entire Facility	Storage throughout facility (a lot of clutter).
	Entire Facility	Mechanical Equipment status.

	Entire Facility	Nurse Call System.
	Entire Facility	Functionality and layout of space.
	Entire Facility	Medical Equipment status and useful life.
	Entire Facility	Laundry service is currently located across the street in an original building.
	Entire Facility	Door hardware, doors, security hardware is lacking consistency.
	Entire Facility	Operating Room and adjoining spaces are not used much and appear dirty.

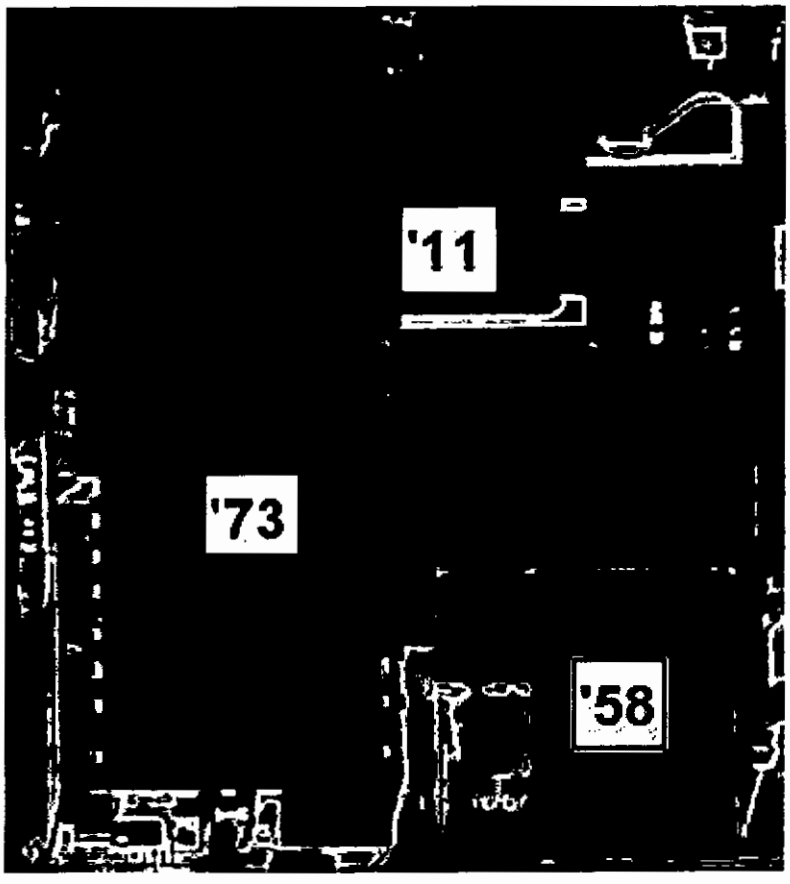
Mechanical, Electrical, and Plumbing Systems		
		Clinic Addition built in 2011.
	Entire Facility	Carrier High Efficiency Rooftop Air Conditioning Heat Pump Units (routine maintenance has occurred and will continue to be needed). No problems were observed or reported.
	Entire Facility	Electrical System. Would recommend proper circuitry labeling take place on receptacle cover plates and switch plates. No problems were observed or reported.
	Entire Facility	Domestic Hot/Cold Water. No problems were observed or reported.
		Clinic Addition built in 1973.
	Entire Facility	Multi-Zone Air Handling Unit with an air-cooled condensing unit. Original from 1973. (For cooling).
	Entire Facility	Iron Fireman single gas-fired hot water boiler serving a multi-zoned air handling unit heating coil. (For heating). Original from 1973.
	Entire Facility	Thirteen zones and controlled by wall-mounted thermostats.
	Entire Facility	Electrical System. Would recommend proper circuitry labeling, as well as having further investigation done on why the Facility loses power once a week (was reported). When they lose power, the emergency generator has to run. It was also observed where receptacles within the clinic do not work and are not energized.
	Entire Facility	Plumbing Systems. No problems were observed or reported.
		Hospital Addition built in 1973.
	Entire Facility	Original air handling units and split-system units around facility.
	Entire Facility	Fan Coil Units in Patient Rooms. (Need replaced and Hospital has a quote). Most of the controls do not work and each fan coil unit has to be manually tempered by adjusting the valves.
	Entire Facility	Electrical System. Would recommend proper circuitry labeling, as well as having further investigation done on why the Facility loses power once a week (was reported). When they lose power, the emergency generator has to run. It was also observed where receptacles within the Hospital do not work and are not energized (some Patient Rooms).
	Entire Facility	Domestic Hot Water from two gas-fired boilers manufactured by Iron Fireman. Distributed through Hospital by pumps. The boilers should be replaced. They are not redundant.
	Entire Facility	Chilled water from a 60 ton Dunham Bush chiller. Not redundant and original.
	Entire Facility	Medical Gas System.

		Administration building renovated in 1958.
	Entire Facility	The cooling is produced mostly from many small split-system air conditioning units. Relatively new.
	Entire Facility	Many of the wall-mounted thermostats do not work.
	Entire Facility	Heating is produced from an original Crane boiler and piped to radiant baseboard heating units.
	Entire Facility	Electrical System. Would recommend proper circuitry labeling, as well as having further investigation done on why the Facility loses power once a week (was reported). When they lose power, the emergency generator has to run. It was also observed where receptacles within the Administration Building do not work and are not energized.
	Entire Facility	Domestic cold water comes from the city.
	Entire Facility	Domestic hot water is produced from the Crane boiler and piped throughout the Administration Building.

The following diagrams reflect the following key property components graphically showing the level of viability for the facility:

- Aerial View
- Building age and renovations
- Stoplight summation

Figure Ground/Growth Pattern



The image above displays the growth pattern of the buildings on site represented by various shades of purple. Oldest buildings have the lightest shade of purple. Theoretically, in order to pursue efficient growth, the building locations should be organized in a progressive spectrum pattern seen below.

[redacted]

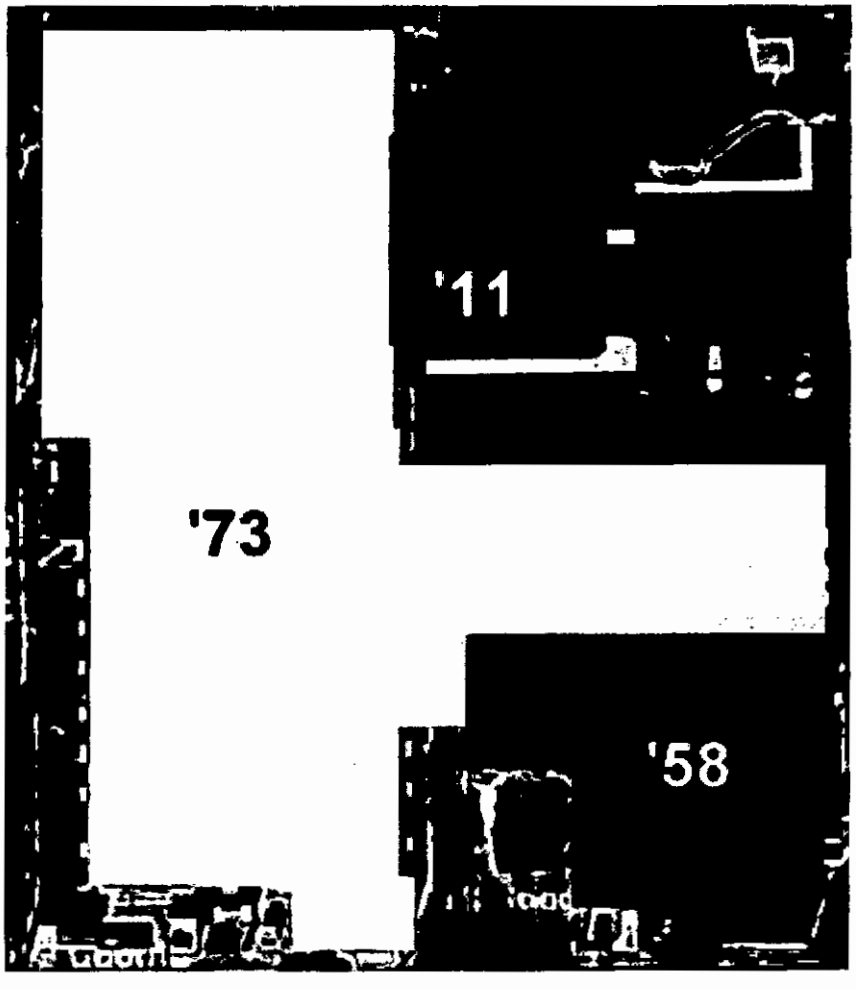
Facilities should avoid growing in a "donut" pattern, which proves inefficient in functionality and costs.

Architectural Stoplight

Stop.....Review redevelopment intentions for the building before any investment, severe concerns.

Caution...Be aware of costly issues in the building, healthcare reuse is limited and expensive, other re-use is possible dependent on non-patient oriented tenant needs.

Go.....No concerns with investment.



ESTIMATING METHOD

In this report, ADAMS evaluated the property repairs using the following methods to determine a reasonable estimated value:

MVS Analysis Approach

ADAMS uses Marshall Valuation Service (MVS) to develop estimates. Marshall Valuation is a nationally recognized service. It is a complete authoritative appraisal guide for developing costs. It contains indexes of building and equipment costs, as well as, factors relative to weather, location, market impacts and conditions, construction elements, and is updated monthly. It is a well-respected service and is used to justify hospital construction costs in some Certificate of Need states. The costs contain normal construction parameters that are adjusted according to location, and market conditions. All extraordinary costs are accounted for separately and are added to the overall project cost. This value is then adjusted for depreciation based on the age of the building and use. The costs are then adjusted by enhancements such as new additions, equipment, upgrades, etc. The calculations give an estimate of perceived value based on repair thresholds.

The following table reflects the prioritization and probable cost for repairs as noted within the report as well as an anticipated repair allowance as per FM.

	COST ITEM	SCOPE ASSUMPTIONS	LOW	MID	HIGH
01	Demolish 1950's portion	Does not include asbestos abatement	$60,000	$69,000	$80,000
02	Build new ED & OR Wing	Assumed to go where 1950's building was demolished.	$2,465,000	$2,900,000	$3,335,000
03	Renovate for Pat Rooms and Imaging	Imaging to go in wing with current OR Pat Rooms to be reconfigured and updated	$2,975,000	$3,500,000	$4,025,000
04	New Infrastructure Units for renovation	New HVAC for the existing facility to be renovated.	$170,000	$200,000	$230,000
05	Build new Entrance, Clinic & Admin	2-story Business Occupancy built as a new wing	$2,125,000	$2,500,000	$2,875,000
06	New Entrance Parking & Hardscapes		$680,000	$800,000	$920,000

Upgrades to existing areas not to be fully renovated					
07	Repoint mortar at masonry walls		$25,500	$30,000	$34,500
08	Repaint building		$4,250	$5,000	$5,750
09	Replace roof & aluminum flashing	Includes demo of old roof, flashing replacement, etc.	$71,038	$99,453	$127,868
10	ADA Compliance revisions	This could fluctuate wildly	$10,000	$105,000	$200,000
11	Potential mold and asbestos abatement	Assumes recent clinic was abated already Cost could fluctuate wildly	$650,000	$1,125,000	$1,600,000
12	Fully sprinkler building		$70,469	$86,382	$102,294

GRAND TOTALS		
[illegible]	[illegible]	[illegible]
$9,306,257	$11,419,834	$13,535,412

NOTE: This estimate is only for construction costs. Additional costs such as professional fees, equipment, financing, etc. is not included.

	COST ITEM	SCOPE / ASSUMPTIONS	Low	Mid	High
01	Add Lightning Protection		$ 29,500	$ 34,950	$ 40,400
02	Replace windows w/ aluminum frame		$ 20,000	$ 40,000	$ 60,000
03	Repoint mortar at masonry walls		$ 30,000	$ 52,500	$ 75,000
04	Repaint building		$ 14,000	$ 19,000	$ 24,000
05	Upgrade floor finishes		$ 300,000	$ 500,000	$ 700,000
06	Upgrade wall finishes		$ 67,000	$ 113,500	$ 160,000
07	Upgrade ceiling finishes		$ 174,000	$ 494,500	$ 815,000
08	Upgrade casework		$ 70,000	$ 85,000	$ 100,000
09	Replace/Upgrade exterior signage		$ 8,000	$ 16,000	$ 24,000
	COST ITEM	**SCOPE / ASSUMPTIONS**	**Low**	**Mid**	**High**
10	Replace/Upgrade interior signage	Assumes recent clinic will not be upgraded	$ 10,000	$ 25,000	$ 40,000
11	Resurface/Restripe parking lots		$ 8,500	$ 13,750	$ 19,000
12	Replace roof and aluminum flashing (repair leaks)		$ 200,000	$ 325,000	$ 450,000

13	Repair concrete ramps, curbs, sidewalk, etc.		$ 5,000	$ 15,000	$ 25,000
14	ADA compliance revisions throughout	Cost could fluctuate wildly	$ 10,000	$ 65,000	$ 120,000
15	Potential mold and asbestos abatement	Cost could fluctuate wildly	$ 650,000	$ 1,125,000	$ 1,600,000
16	Fully sprinkler building		$ 275,000	$ 337,500	$ 400,000
17	Replace MEP equipment		$ 450,000	$ 600,000	$ 750,000
18	Upgrade elec. to meet codes		$ 150,000	$ 325,000	$ 500,000

GRAND TOTALS		
Low Est.	Mid Est.	High Est.
$ 2,471,000	$ 4,186,700	$ 5,902,400

NOTE: This estimate is only for construction costs. Additional costs such as professional fees, equipment, financing, etc. is not included.

Section III. Background, Purpose of the Project, and Alternatives

ALTERNATIVES

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

Alternative options must include:

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

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

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

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

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

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

Section III. Background, Purpose of the Project, and Alternatives

Alternatives

Ferrell Hospital is a health care facility that has not seen any major renovations or modernizations since 1973. Assessments of the current state of Ferrell Hospital date back to March of 2006, in which multiple deficiencies throughout the facility were identified. These deficiencies, which can be identified in criterion 1110.530 (e) (1); (2) & (3) in Section VII – Specific Service Review Criteria, will be addressed in the proposed alternative. In the recent years it has become evident to the Applicant's leadership that the facility is due for a modernization and expansion.
After examining the current state of Ferrell Hospital, the administration considered multiple options, which are listed in order of the Applicant's preference.

1. Modernization of the existing facility and introduction of Chemotherapy Services
2. Modernization of the facility on a lesser scale.
3. Pursue a merger or Joint Venture.
4. Close the facility.

Ferrell Hospital's leadership deemed that a complete modernization of the facility would be the best option in order to not only correct the deficiencies, but to ensure that the Hospital is prepared to deliver high quality care for decades to come.

1) Identify all of the alternatives to the proposed project.

- *Propose a project of greater or lesser scope and cost.*

Ferrell Hospital developed two Alternative modernization projects to address the deficiencies and shortcomings of the current facility as documented by the IDPH and others. "Option 1," in which positions the larger project, includes the modernization of the:

- Emergency Department – 2 Cardiac Trauma Rooms and 6 Intermediate Treatment Rooms.
- Imaging Department – 1 CT, 1 Nuclear Medicine, 2 X-Ray, 1 Mammogram, 1 Bone Density, 1 Ultrasound.
- Registration.
- Lab.
- Phlebotomy.
- Surgery Department – 2 Operating Rooms and 1 Minor Procedure Room.
- Post-Anesthesia Care Unit.
- Ambulatory Care Unit.
- Central Sterile.
- Cafeteria.
- Lobby, Waiting, and Entry Canopy.

Once complete, the modernization of the departments listed above would result in an addition of approximately 36,000 square feet. The shortcomings of this project would include the Inpatient wing and Physical Therapy unit of the facility not being fully addressed and modernized to improve satisfaction. Chemotherapy services would not be incorporated. The modernizations of

staff spaces would not be addressed; those spaces include Material Management, Environmental Services, Plant Ops, Staff Training Room, Human Resources, Medical Records, Information Technology, and administration.

The shortcomings of this "Option 1", in comparisons to the proposed "Option 2" project includes the following:

1. The proposed project includes the addition of Oncology Infusion Bays and Pharmacy modifications to allow Ferrell Hospital to provide Chemotherapy Services for Breast, Colon, Lung, and Prostate Cancer patients. Ferrell Hospital resides in a Medically Underserved Area and wishes to further increase the scope of care provided to the community, an Alternative of "Option 1" would not allow Ferrell Hospital the capability to serve its community.
2. Recently, Ferrell Hospital partnered with Deaconess Illinois, the Co-Applicant. This partnership has granted the Applicant access to Physicians with Specialties new to Ferrell Hospital. "Option 1" will not allow for Ferrell Hospital to provide the resources and space necessary for the new Physicians and their programs to provide enhanced care.
3. The proposed project of "Option 1" will not allow Ferrell Hospital to further utilize their access to the associated Purchasing Alliance, which will improve operating costs resulting in incremental funds for the proposed project.
4. Due to financing rates being near historic lows allowing the financing of the "Option 2" project, additional Specialty care to be provided at Ferrell Hospital, and Chemotherapy services being added to the services Ferrell Hospital provides, the "Option 1" Alternative will not provide long-term or short-term financial benefits over the proposed project.
5. The "Option 1" Alternative does not include a full modernization of the Medical/Surgical and Physical Therapy units of the Hospital, which will be addressed in the proposed project. As well, the modernizations of staff spaces including Material Management, Environmental Services, Plant Ops, Staff Training Room, Human Resources, Medical Records, Information Technology, and administration.
6. The "Option 2" will allow for a more consolidated facility arranged in a manner that will allow for a more effective and efficient operation, while simultaneously decreasing foot traffic throughout the Hospital and improving the experience and safety of any patient, visitor, or staff. The proposed Alternative of "Option 1" will not as effectively address these documented deficiencies within the existing Hospital.

The departments of the hospital listed prior in this proposed Alternative are addressed in the larger, more expansive project. The cost of "Option 1" would be approximately $24,000,000; which includes financing costs. As previously mentioned, this option does not imply that there will be any short or long-term financial benefits over the proposed project if Ferrell Hospital were to pursue this Alternative.

- *Pursuing a joint venture or similar arrangement with one or more providers.*

Throughout 2013 and 2014, Deaconess moderated a discussion between Ferrell Hospital and Harrisburg Medical Center regarding merging and constructing a new centrally-located facility. In 2014 the respective governing boards did not see a path toward a merger, even with the assistance of Deaconess Illinois. Again in 2016, under new Ferrell Hospital leadership, the furtherance of discussions regarding merging services or facilitating more substantive discussions between Ferrell Hospital and Harrisburg Medical Center did not result in either hospital agreeing to a plan to move forward with a formal proposal. As a result, no formal plans for a new hospital were developed. It is difficult to conclude what the cost a new combined

hospital would be on the two communities. It is likely a new Greenfield hospital cost would be in the range of $40 to $50 million, which exceeds Ferrell Hospital's proposed renovations of $37,353,666.

- *Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project.*

Historically Ferrell Hospital has taken pride in being a local, independent health care provider. The Contribution Agreement between Deaconess Illinois and Ferrell Hospital allows for the independent decision making to remain with the local Board of directors. Ferrell Hospital maintains transfer agreements with Harrisburg Medical Center, Herrin Hospital, Deaconess Hospital, and others as required by the Critical Access Hospital regulations so that patients can be stabilized and transferred to higher levels of care. Other hospitals the Applicant transfers patients to are included in Exhibit 13, Attachment 1.

- *Vacate the market.*

Another alternative for Ferrell Hospital would be to close its facility and vacate the market. This alternative was not chosen for a multitude of reasons that included:

1. It would have an adverse effect on the quality of life for patients without the ability to travel.
2. Inability of the next closest hospital to have excess capacity to handle additional patient volumes, particularly for emergencies.
3. The economic impact that Hospital has on the local communities would add to the unemployment rate, ability to recruit, and maintain local businesses in and around the Primary Service Area.
4. Currently Ferrell is capable of producing a positive net income.

Ferrell Hospital's designation as a Critical Access Hospital is reason enough to exclude vacating the market as a reasonable alternative. Vacating a market would leave a large region of South-East Illinois facing a lack of healthcare providers and would force an aging community to travel for care. Ferrell Hospital takes pride in being a local, independent healthcare provider for a rural, medically underserved community. Ferrell Hospital for the prior Fiscal Year 3/31/16 reported $3,307,699 in Long-Term Debt, Net of Current Maturities. If Ferrell Hospital were to cease operations these debts would still have to be paid, with the costs of demolition and clean up totaling to approximately $2,368,112 the price of vacating the market amounts to approximately $5.7M. As well, Ferrell Hospital has historically operated with revenue in excess of expenses, therefore adding to the local economies, maintaining 200 healthcare jobs and allowing for the continuation of providing healthcare services to the local communities.

- *Provide the reasons why the chosen alternative was selected.*

Ferrell Hospital chose to go forward with "Option 2" the project that would result in the more expansive modernization of Ferrell Hospital that also includes the addition of Chemotherapy services. Rationale for why Ferrell Hospital decided to follow through with "Option 2" includes the following:

1. The relationship with Deaconess Illinois has afforded Ferrell Hospital with additional resources such as:

a. Access to Informational Technology to take advantage of the Meaningful Use incentives and being enrolled in the Next Gen Medicare Accountable Care Organization.
b. Access to the Purchasing Alliance to purchase supplies at a much lower cost.
c. Management services that provide onsite expertise in healthcare management and fiscal oversight.
d. The ability to recruit needed physicians from the Deaconess Family Practice Residency Program and access to specialists from Deaconess interested in expanding their scope to Ferrell's Service Areas.

2. Interest rates for financing being near historic lows.
3. The Applicant's status as a 340-B hospital that receives substantial discounts on the purchase of most drugs.
4. The cost-reimbursement associated with the designation as a Critical Access Hospital allows for a majority of the costs to be covered associated with this project
5. The ability to address the deficiencies associated with the facility, and
6. Allow for these issues to be addressed and allow for continued growth through a comprehensive and thoughtful expansion plan.
7. Additional new services can be added and continued for General Surgery, Endoscopy, Chemotherapy and additional physicians.

Ferrell Hospital's designation as a Critical Access Hospital allows for reimbursement for inpatient and outpatient services provided to Medicare patients. Cost based reimbursement provides significant financial advantages to Ferrell Hospital which allows payment at 101% of allowable costs on all of the Medicaid patients served. However, since sequestration, currently Ferrell only receives 99% reimbursement for allowable costs associated with Medicare patients.

Ferrell Hospital currently faces code deficiencies within their building that will be addressed. Anything less than the full modernization plan continues to leave fragmented and unorganized space that is not conducive to modern patient care. During the modernization of Ferrell Hospital, services will be consolidated and arranged in a manner that allows for a more productive workforce, as well as a better environment and throughput for the patient. The contemporary rooms that will come as a result of the modernization, paired with less traffic through the patient corridors will allow for a better experience for the patient and add to the security and safety of staff, patients and visitors.

Ferrell Hospital resides within a Medically Underserved Area (MUA). The addition of Chemotherapy services, coupled with expanded Surgery and Emergency Departments at Ferrell Hospital will help to better address the medical needs of the community Ferrell Hospital serves. From both a long-term and short-term financial benefits perspective it appears that going forward with the selected alternative, modernization project is the best option. Ferrell Hospital's 340-B designation will assist with the purchase of Chemotherapy drugs provided to patients. The complete project will allow for repurposing vacated spaces within Ferrell Hospital that will house non-clinical functions that will be more strategically located to improve productivity and accessibility to staff those services.

The size of the proposed project, "Option 2", will be approximately 88,375 square feet, with a project cost of $37,353,666.

Ferrell Hospital Transfer Log						
Zip Code	Date	Destination	Location	Diagnosis	MD Transferring	Specialty
62984	1/4/2014	Carbondale Memorial	Carbondale, IL	Acute Cholecystitis	Partridge	Family Practice
62946	1/5/2014	Deaconess	Evansville, IN	M.I.	Svoboda	Family Practice
62930	1/7/2014	Deaconess	Evansville, IN	CHF	Bledig	Family Practice
62821	1/24/2014	Deaconess	Evansville, IN	CHF/Pneumonia	Bledig	Family Practice
62930	1/25/2014	St Francis Cape Girardeau	Cape Girardeau, MO	CHF	Bledig	Family Practice
62930	1/25/2014	Deaconess	Evansville, IN	Further Evaluation	Oldham	Family Practice
62930	1/26/2014	Deaconess	Evansville, IN	CBD Obstruction	Partridge	Family Practice
62984	1/29/2014	Deaconess	Evansville, IN	Bradycardia	Oldham	Family Practice
62984	2/6/2014	Deaconess	Evansville, IN	GI Bleed	Bledig	Family Practice
62821	2/12/2014	Deaconess	Evansville, IN	Hypoxia/Pneumonia	Oldham	Family Practice
62869	2/13/2014	Deaconess	Evansville, IN	Spider bite/Leukocystosis	Partridge	Family Practice
62917	2/18/2014	Carbondale Memorial	Carbondale, IL	Pneumonia	Abdo	General Surgery
62946	2/22/2014	Deaconess	Evansville, IN	Sepsis/ARF	Partridge	Family Practice
62817	2/23/2014	St. Mary's Evansville	Evansville, IN	ACS/CHF	Partridge	Family Practice
62867	2/24/2014	Deaconess	Evansville, IN	Pneumonia	Partridge	Family Practice
62930	2/24/2014	Deaconess	Evansville, IN	Pneumonia/Resp Failure	Partridge	Family Practice
62930	2/27/2014	Deaconess	Evansville, IN	SBO	Partridge	Family Practice
62930	3/3/2014	Deaconess	Evansville, IN	NSTEMI	Oldham	Family Practice
62930	3/3/2014	Deaconess	Evansville, IN	Pneumonia	Oldham	Family Practice
62817	3/6/2014	Deaconess	Evansville, IN	Resp Failure	Petersen	Family Practice
62930	3/21/2014	Deaconess	Evansville, IN	MRSA Septicemia	Partridge	Family Practice
62930	3/24/2014	Deaconess	Evansville, IN	M.I.	Partridge	Family Practice
62869	3/26/2014	Deaconess	Evansville, IN	A Fib	Svoboda	Family Practice
62934	4/16/2014	Deaconess	Evansville, IN	Acute Cholecystitis	Oldham	Family Practice
62821	4/18/2014	Deaconess	Evansville, IN	CHF/Cirrhosis	Bledig	Family Practice
62930	4/27/2014	Deaconess	Evansville, IN	M.I.	Partridge	Family Practice
62934	4/28/2014	Carbondale Memorial	Carbondale, IL	Cardiac Ischemia	Bledig	Family Practice
62930	5/1/2014	Deaconess	Evansville, IN	Grand Mal Seizure	Partridge	Family Practice
62930	5/6/2014	St Mary's Evansville	Evansville, IN	Metastatic Lung Mass	Bledig	Family Practice
62930	5/14/2014	Deaconess	Evansville, IN	Bacterial Pneu/Resp Failure	Partridge	Family Practice
62984	5/15/2014	Deaconess	Evansville, IN	Pneumonia	Partridge	Family Practice
62869	5/16/2014	Deaconess	Evansville, IN	M.I.	Partridge	Family Practice
62935	5/19/2014	Carbondale Memorial	Carbondale, IL	M.I.	Partridge	Family Practice
62930	5/24/2014	Deaconess	Evansville, IN	Acute Cholecystitis	Partridge	Family Practice
62946	6/3/2014	Deaconess	Evansville, IN	Cecal Mass	Oldham	Family Practice
62934	6/11/2014	Carbondale Memorial	Carbondale, IL	M.I.	Partridge	Family Practice
62979	6/14/2014	Deaconess	Evansville, IN	Gastric Ulcer/Gastroenteritis	Svoboda	Family Practice
62930	6/17/2014	Deaconess	Evansville, IN	DVT	Bledig	Family Practice
62930	6/17/2014	Deaconess	Evansville, IN	Pneumonia/Hypoxia	Oldham	Family Practice
62930	6/19/2014	Mulberry Center	Harrisburg, IL	Psych	Blain	Family Practice
62930	6/21/2014	Carbondale Memorial	Carbondale, IL	M.I.	Svoboda	Family Practice
62954	6/21/2014	Deaconess	Evansville, IN	Renal Failure	Partridge	Family Practice
62930	6/21/2014	Deaconess	Evansville, IN	Avulsion laceration	Oldham	Family Practice
62930	6/23/2014	Deaconess	Evansville, IN	ACS	Partridge	Family Practice
62930	6/27/2014	Deaconess	Evansville, IN	UTI/Bladder Mass	Partridge	Family Practice
62928	7/7/2014	Deaconess	Evansville, IN	Sick Sinus Syndrome	Partridge	Family Practice
62869	7/11/2014	Deaconess	Evansville, IN	M.I.	Svoboda	Family Practice
62984	7/12/2014	Deaconess	Evansville, IN	Acute Cholangitis	Oldham	Family Practice
62930	7/14/2014	Hospice Evansville	Evansville, IN	Prostate CA	Oldham	Family Practice
62946	7/17/2014	St Mary's Evansville	Evansville, IN	Acute Diverticulitis	Partridge	Family Practice
62817	7/25/2014	Deaconess	Evansville, IN	Acute Renal Failure	Partridge	Family Practice
62869	7/28/2014	Deaconess	Evansville, IN	Chest Pain	Svoboda	Family Practice
62946	7/28/2014	Barnes Jewish	St. Louis, MO	Discitis/Osteomyelitis	Oldham	Family Practice
62943	7/28/2014	Western Baptist	Paducah, KY	Chest Pain	Partridge	Family Practice
62930	7/29/2014	Deaconess	Evansville, IN	NSTEMI	Oldham	Family Practice
62930	8/6/2014	Deaconess	Evansville, IN	Acute back pain	Bledig	Family Practice
62979	8/7/2014	Deaconess	Evansville, IN	Septicemia	Oldham	Family Practice
62979	8/20/2014	Deaconess	Evansville, IN	SVT	Svoboda	Family Practice
62930	8/25/2014	Marion VA	Marion, IL	Lacunar Infarct	Partridge	Family Practice
62871	8/31/2014	Mulberry Center	Harrisburg, IL	Psych	Svoboda	Family Practice
62930	9/3/2014	Deaconess	Evansville, IN	ARF/Fluid Overload	Partridge	Family Practice
62930	9/3/2014	Deaconess	Evansville, IN	M.I.	Partridge	Family Practice
62946	9/4/2014	Carbondale Memorial	Carbondale, IL	Acute M.I	Partridge	Family Practice
62935	9/20/2014	Carbondale Memorial	Carbondale, IL	CHF	Bledig	Family Practice
62930	9/27/2014	Deaconess	Evansville, IN	NSTEMI	Oldham	Family Practice
62869	10/4/2014	Deaconess	Evansville, IN	NSTEMI	Svoboda	Family Practice
62934	10/10/2014	Deaconess	Evansville, IN	SBO	Oldham	Family Practice
62979	10/13/2014	Deaconess	Evansville, IN	Chest Pain	Svoboda	Family Practice
62984	10/13/2014	Carbondale Memorial	Carbondale, IL	Chest Pain	Svoboda	Family Practice
62946	10/13/2014	Carbondale Memorial	Carbondale, IL	Chest Pain	Abdo	General Surgery
62930	10/14/2014	Deaconess	Evansville, IN	CKD/Dehydration	Abdo	General Surgery

Zip Code	Date	Destination	Location	Diagnosis	MD Transferring	Specialty
62930	10/19/2014	Barnes Jewish	St. Louis, MO	Acute CHF	Bledig	Family Practice
62930	10/21/2014	Deaconess	Evansville, IN	Hypertension	Bledig	Family Practice
62946	10/29/2014	Mulberry Center	Harrisburg, IL	Psych	Bledig	Family Practice
62930	11/3/2014	Mulberry Center	Harrisburg, IL	Psych	Abdo	General Surgery
62954	11/4/2014	Deaconess	Evansville, IN	Intractable Headache	Partridge	Family Practice
62817	11/7/2014	Deaconess	Evansville, IN	Infectious Tenosynovitis	Oldham	Family Practice
62979	11/8/2014	Deaconess	Evansville, IN	GI Bleed	Bledig	Family Practice
62869	11/13/2014	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62867	11/17/2014	Mulberry Center	Harrisburg, IL	Psych	Svoboda	Family Practice
62930	11/21/2014	Deaconess	Evansville, IN	Distal SBO	Oldham	Family Practice
62984	11/24/2014	Deaconess	Evansville, IN	M.I.	Bledig	Family Practice
62930	11/25/2014	Mulberry Center	Harrisburg, IL	Psych	Oldham	Family Practice
62869	11/29/2014	Deaconess	Evansville, IN	Septic Shock	Bledig	Family Practice
62930	12/2/2014	Mulberry Center	Harrisburg, IL	Psych	Oldham	Family Practice
62867	12/5/2014	Deaconess	Evansville, IN	Ileus	Bledig	Family Practice
62979	12/5/2014	Deaconess	Evansville, IN	Infected Decubitus	Partridge	Family Practice
62977	12/10/2014	Mulberry Center	Harrisburg, IL	psych	Bledig	Family Practice
62930	12/26/2014	Carbondale Memorial	Carbondale, IL	M.I.	Oldham	Family Practice
62930	12/27/2014	Deaconess	Evansville, IN	Cardiac Arrest	Oldham	Family Practice
62984	12/27/2014	Deaconess	Evansville, IN	Hyperglycemia	Oldham	Family Practice
62930	12/29/2014	Deaconess	Evansville, IN	Intractable Abd Pain	Partridge	Family Practice
62930	1/3/2015	Richland Memorial	Olney, IL	Psych	Oldham	Family Practice
62984	1/6/2015	Carbondale Memorial	Carbondale, IL	M.I.	Svoboda	Family Practice
62930	1/9/2015	Deaconess	Evansville, IN	Septic Arthritis	Partridge	Family Practice
62817	1/13/2015	Deaconess	Evansville, IN	Pneumonia/Resp Failure	Oldham	Family Practice
67124	1/19/2015	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62930	1/23/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62930	2/4/2015	Deaconess	Evansville, IN	Altered LOC	Partridge	Family Practice
63869	2/5/2015	Barnes Jewish	St. Louis, MO	Cirrhosis/GI Bleed	Partridge	Family Practice
62930	2/13/2015	St Mary's Evansville	Evansville, IN	Acute surgical abdomen	Bledig	Family Practice
62867	2/18/2015	Vantage Point	Fayetteville, AR	Rehab/Detox	Oldham	Family Practice
62930	2/20/2015	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62930	2/22/2015	Deaconess	Evansville, IN	Acute Resp Failure	Partridge	Family Practice
62984	2/26/2016	Deaconess	Evansville, IN	Severe C Diff	Oldham	Family Practice
62930	2/26/2015	Deaconess	Evansville, IN	Pulmonary Rehab	Partridge	Family Practice
62930	3/11/2015	Deaconess	Evansville, IN	Rehab	Oldham	Family Practice
62930	3/13/2015	Deaconess	Evansville, IN	Rehab	Oldham	Family Practice
62817	3/13/2015	Harrisburg Medical Center	Harrisburg, IL	Acute appendicitis	Partridge	Family Practice
62869	3/18/2015	Harsha	Terre Haute, IN	Psych	Partridge	Family Practice
62930	3/19/2015	Deaconess	Evansville, IN	CHF	Bledig	Family Practice
62930	3/26/2015	Deaconess	Evansville, IN	Chest Pain	Rudisel	Emergency Medicine/Hospitalist
62946	3/26/2015	Deaconess	Evansville, IN	Septicemia	Bledig	Family Practice
62930	3/26/2015	Carbondale Memorial	Carbondale, IL	Chest Pain	Bledig	Family Practice
62930	3/30/2015	Deaconess	Evansville, IN	Acute Resp Failure	Oldham	Family Practice
62930	4/6/2015	Deaconess	Evansville, IN	Severe Colitis	Oldham	Family Practice
62930	4/12/2015	Deaconess	Evansville, IN	Bowel Perforation	Bledig	Family Practice
62946	4/12/2015	Deaconess	Evansville, IN	Pyelonephritis	Oldham	Family Practice
62930	4/13/2015	Deaconess	Evansville, IN	Resp Failure	Oldham	Family Practice
62869	4/22/2015	Deaconess	Evansville, IN	Small Bowel Obstruction	Partridge	Family Practice
62930	4/22/2015	Carbondale Memorial	Carbondale, IL	Chest Pain	Partridge	Family Practice
62984	4/23/2015	Southeastern Hosp	Cape Girardeau, MO	Psych	Partridge	Family Practice
62930	4/24/2015	Herrin Hospital	Herrin, IL	Hempotysis/Pneumonia	Bledig	Family Practice
62930	4/27/2015	Deaconess	Evansville, IN	Chest Pain	Bledig	Family Practice
62930	4/29/2015	Deaconess	Evansville, IN	A Fib	Bledig	Family Practice
62984	5/4/2016	Deaconess	Evansville, IN	R Neck Mass	Oldham	Family Practice
62954	5/6/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62984	5/13/2015	Mulberry Center	Harrisburg, IL	Psych	Blain	Family Practice
62930	5/17/2015	Deaconess	Evansville, IN	Metastatic CA	Bledig	Family Practice
62930	5/20/2015	Mulberry Center	Harrisburg, IL	Psych	Partridge	Family Practice
62930	5/27/2015	Deaconess	Evansville, IN	Afib/TEE	Partridge	Family Practice
62946	5/27/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62930	5/29/2015	Deaconess	Evansville, IN	Vasculitis	Oldham	Family Practice
62930	6/1/2015	Carbondale Memorial	Carbondale, IL	CHF	Partridge	Family Practice
62930	6/2/2015	Carbondale Memorial	Carbondale, IL	Chest Pain	Bledig	Family Practice
62946	6/6/2015	Deaconess	Evansville, IN	Chest Pain	Bledig	Family Practice
62930	6/9/2015	Mulberry Center	Harrisburg, IL	Psych	Partridge	Family Practice
62930	6/18/2015	Deaconess	Evansville, IN	Bacteremia	Oldham	Family Practice
62930	6/26/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62935	7/6/2015	Deaconess	Evansville, IN	Hyperglycemia	Partridge	Family Practice
62821	7/7/2015	Heartland Regional	Marion, IL	Abd Pain	Partridge	Family Practice
62946	7/8/2015	Mulberry Center	Harrisburg, IL	Psych	Oldham	Family Practice
62930	7/10/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice

Zip Code	Date	Destination	Location	Diagnosis	MD Transferring	Specialty
62930	7/11/2015	Deaconess	Evansville, IN	COPD	Bledig	Family Practice
62930	7/11/2015	Deaconess	Evansville, IN	COPD	Bledig	Family Practice
63869	7/11/2015	Barnes Jewish	St. Louis, MO	Hepatic Encephalopathy	Partridge	Family Practice
62821	7/14/2015	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62946	7/15/2015	Deaconess	Evansville, IN	DVT	Partridge	Family Practice
62869	7/16/2015	Deaconess	Evansville, IN	Liver Failure	Jackson	Family Practice
62930	7/16/2015	Deaconess	Evansville, IN	ARF	Bledig	Family Practice
62930	7/18/2015	Deaconess	Evansville, IN	CVA	Oldham	Family Practice
62930	7/19/2015	St Mary's Evansville	Evansville, IN	Gastroenteritis	Partridge	Family Practice
62930	7/21/2015	Deaconess	Evansville, IN	Diverticulitis	Partridge	Family Practice
62965	7/24/2015	Deaconess	Evansville, IN	Impacted Humerus Fx	Partridge	Family Practice
62959	8/5/2015	Carbondale Memorial	Carbondale, IL	CHF	Bledig	Family Practice
62867	8/6/2015	Deaconess	Evansville, IN	CHF	Partridge	Family Practice
62984	8/6/2015	Deaconess	Evansville, IN	Cellulitis	Partridge	Family Practice
62930	8/11/2015	Carbondale Memorial	Carbondale, IL	A Fib	Bledig	Family Practice
62931	8/19/2015	Deaconess	Evansville, IN	Syncope	Partridge	Family Practice
62930	8/20/2015	Richland Memorial	Olney, IL	Psych	Jackson	Family Practice
62930	8/21/2015	Deaconess	Evansville, IN	Bradycardia	Bledig	Family Practice
62817	9/2/2015	Good Samaritan MT Vernon	Mt. Vernon, IL	Pneumonia	Partridge	Family Practice
62984	9/10/2015	Carbondale Memorial	Carbondale, IL	M.I.	Oldham	Family Practice
62917	9/17/2015	St Mary's Evansville	Evansville, IN	Jaundice/Hepatitis	Partridge	Family Practice
62930	9/24/2015	Deaconess	Evansville, IN	Abd Pain	Partridge	Family Practice
62917	9/24/2015	Herrin Hospital	Herrin, IL	GI Bleed	Partridge	Family Practice
62821	10/1/2015	Deaconess	Evansville, IN	Sepsis	Oldham	Family Practice
62821	10/2/2015	St Johns Springfield	Springfield, IL	Psych	Adams	Emergency Medicine/Hospitalist
62817	10/5/2015	Deaconess	Evansville, IN	Chest Pain	Bledig	Family Practice
62930	10/5/2015	Deaconess	Evansville, IN	Chest Pain	Sobko	Emergency Medicine/Hospitalist
62930	10/6/2015	Deaconess	Evansville, IN	Sepsis	Jackson	Family Practice
62930	10/7/2015	Deaconess	Evansville, IN	Cellulitis/Sepsis	Oldham	Family Practice
62869	10/7/2015	Deaconess	Evansville, IN	Encephalopathy	Partridge	Family Practice
62869	10/16/2015	Deaconess	Evansville, IN	A Flutter	Partridge	Family Practice
62946	10/24/2015	Carbondale Memorial	Carbondale, IL	CHF	Partridge	Family Practice
62930	10/28/2015	Choate	Anna, IL	Psych	Oldham	Family Practice
62930	11/12/2015	McFarland	Springfield, IL	Psych	Partridge	Family Practice
62934	11/13/2015	Deaconess	Evansville, IN	NSTEMI	Jackson	Family Practice
62931	11/17/2015	Carbondale Memorial	Carbondale, IL	Acute Pancreatitis	Partridge	Family Practice
62930	11/17/2015	Deaconess	Evansville, IN	CVA	Oldham	Family Practice
62930	11/21/2015	HealthSouth Evansville	Evansville, IN	Rehab	Oldham	Family Practice
302832	12/1/2015	Deaconess	Evansville, IN	Chest Pain	Britt	Family Practice
62930	12/8/2015	Harsha	Terre Haute, IN	Psych	Bledig	Family Practice
62967	12/9/2015	Herrin Hospital	Herrin, IL	CHF	Partridge	Family Practice
62930	12/19/2015	Deaconess	Evansville, IN	Cardiac Ischemia	Partridge	Family Practice
62930	12/19/2015	Carbondale Memorial	Carbondale, IL	GI Bleed	Adams	Emergency Medicine/Hospitalist
62930	12/23/2015	Deaconess	Evansville, IN	NSTEMI	Oldham	Family Practice
62984	12/23/2015	Deaconess	Evansville, IN	SBO	Partridge	Family Practice
62871	12/31/2015	Deaconess	Evansville, IN	Sepsis	Bledig	Family Practice
62869	1/3/2016	Deaconess	Evansville, IN	Abd Pain	Partridge	Family Practice
62930	1/7/2016	St Mary's Evansville	Evansville, IN	Infection of Pacemaker	Bledig	Family Practice
62930	1/24/2016	Deaconess	Evansville, IN	Resp Failure	Tariq	Emergency Medicine/Hospitalist
62859	1/29/2016	St Mary's Decatur	Decatur, IL	Psych	Bledig	Family Practice
62930	2/1/2016	Deaconess	Evansville, IN	Overdose	Rudisel	Emergency Medicine/Hospitalist
62979	2/1/2016	Deaconess	Evansville, IN	Cardiac	Bledig	Family Practice
62930	2/4/2016	Mulberry Center	Harrisburg, IL	Psych	Oldham	Family Practice
62930	2/8/2016	Deaconess	Evansville, IN	MRSA Pneumonia	Bledig	Family Practice
62930	2/9/2016	Deaconess	Evansville, IN	CHF	Oldham	Family Practice
62930	2/15/2016	Good Samaritan MT Vernon	Mt. Vernon, IL	Resp Distress	Jackson	Family Practice
62859	2/23/2016	Deaconess	Evansville, IN	A Fib	Oldham	Family Practice
62930	2/29/2016	Deaconess	Evansville, IN	GI Bleed	Rudisel	Emergency Medicine/Hospitalist
62946	2/29/2016	Barnes Jewish	St. Louis, MO	PE	Partridge	Family Practice
62930	3/1/2016	Deaconess	Evansville, IN	Hypercapnia	Sobko	Emergency Medicine/Hospitalist
62984	3/3/2016	Deaconess	Evansville, IN	CHF	Oldham	Family Practice
62930	3/3/2016	Deaconess	Evansville, IN	Pneumonia	Oldham	Family Practice
62871	3/4/2016	Deaconess	Evansville, IN	Heart Failure	Partridge	Family Practice
62930	3/7/2016	Deaconess	Evansville, IN	Abd Pain	Oldham	Family Practice
62930	3/8/2016	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62979	3/11/2016	Lincoln Prarie	Springfield, IL	Psych	Jackson	Family Practice
62930	3/18/2016	Deaconess	Evansville, IN	Abd Pain	Partridge	Family Practice
62946	3/21/2016	Carbondale Memorial	Carbondale, IL	Chest Pain	Partridge	Family Practice
62930	3/24/2016	Herrin Hospital	Herrin, IL	Gangrene	Partridge	Family Practice
62930	3/24/2016	Lincoln Prarie	Springfield, IL	Psych	Jackson	Family Practice
62930	3/25/2016	Mulberry Center	Harrisburg, IL	Psych	Abdo	General Surgery
62979	3/25/2016	West Ridge Medical Ctr	Cedar Rapids, IA	Rehab	Partridge	Family Practice

Zip Code	Date	Destination	Location	Diagnosis	MD Transferring	Specialty
62946	3/28/2016	Deaconess	Evansville, IN	Hydronephrosis	Jackson	Family Practice
62930	4/5/2016	Carbondale Memorial	Carbondale, IL	M.I.	Sobko	Emergency Medicine/Hospitalist
62869	4/12/2016	Good Samaritan MT Vernon	Mt. Vernon, IL	Incarcerated Hernia	Adams	Emergency Medicine/Hospitalist
62930	4/12/2016	Deaconess	Evansville, IN	Pneumonia	Oldham	Family Practice
62930	4/13/2016	Deaconess	Evansville, IN	Biliary Colic	Oldham	Family Practice
62930	4/14/2016	Good Samaritan MT Vernon	Mt. Vernon, IL	Abd Mass	Bledig	Family Practice
34606	4/17/2016	Carbondale Memorial	Carbondale, IL	M.I.	Tariq	Emergency Medicine/Hospitalist
62979	4/17/2016	Lincoln Prarie	Springfield, IL	Psych	Oldham	Family Practice
62977	4/18/2016	Deaconess	Evansville, IN	MVA	Adams	Family Practice
62930	4/21/2016	Cross pointe	Evansville, IN	Psych	Bledig	Family Practice
62930	4/26/2016	Deaconess	Evansville, IN	Seizures	Bledig	Family Practice
62935	4/28/2016	Lincoln Prarie	Springfield, IL	Psych	Oldham	Family Practice
62984	4/29/2016	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62930	5/4/2016	Deaconess	Evansville, IN	Chest Pain	Partridge	Family Practice
62930	5/8/2016	Deaconess	Evansville, IN	GI Bleed	Tariq	Emergency Medicine/Hospitalist
62859	5/16/2016	Deaconess	Evansville, IN	Chest Pain	Oldham	Family Practice
62935	5/16/2016	Deaconess	Evansville, IN	Pneumonia	Bledig	Family Practice
62930	5/18/2016	Deaconess	Evansville, IN	Neck Swelling	Jackson	Family Practice
62934	5/25/2016	Carbondale Memorial	Carbondale, IL	Chest Pain	Partridge	Family Practice
62930	5/25/2016	Deaconess	Evansville, IN	Hip Fracture	Adams	Emergency Medicine/Hospitalist
62821	5/26/2016	Deaconess	Evansville, IN	CVA	Sanchez	Emergency Medicine/Hospitalist
62930	6/1/2016	Vantage Point	Fayetteville, AR	Rehab/Detox	Oldham	Family Practice
62867	6/7/2016	Deaconess	Evansville, IN	Chest Pain	Sanchez	Emergency Medicine/Hospitalist
62930	6/8/2016	Heartland Regional	Marion, IL	Fracture	Oldham	Family Practice
62935	6/8/2016	VA Marion	Marion, IL	Hospice Care	Partridge	Family Practice
62821	6/13/2016	Deaconess	Evansville, IN	COPD Exac	Oldham	Family Practice
62930	6/21/2016	Mulberry Center	Harrisburg, IL	Psych	Oldham	Family Practice
62930	6/22/2016	Deaconess	Evansville, IN	OVT	Bledig	Family Practice
62946	6/25/2016	Southeast Mo Hospital	Cape Girardeau, MO	Psych	Partridge	Family Practice
62917	6/26/2016	Barnes Jewish	St. Louis, MO	Colon Resection	Abdo	General Surgery
62984	6/28/2016	Deaconess	Evansville, IN	Pneumonia/COPD	Partridge	Family Practice
62946	6/30/2016	Carbondale Memorial	Carbondale, IL	Acute Cholecystitis	Partridge	Family Practice
62979	7/5/2016	Deaconess	Evansville, IN	Pancytopenia	Jackson	Family Practice

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?**

Section IV. Project Size, Utilization, and Unfinished/Shell Space

Ferrell Hospital Program Narrative

Ferrell Hospital Community Foundation, d.b.a. Ferrell Hospital proposes to expand and modernize its current facility located at 1201 Pine Street in Eldorado, Illinois. Eldorado is a rural community located in Saline County. Saline County is designated by the U.S. Department of Health and Human Services as a Medically Underserved Area (MUA). The county is also designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA).

Ferrell Hospital is a 25-bed facility that received Critical Access Hospital designation in 2003. The plan for the Project includes the renovation of the existing space and the expansion of the facility, while still remaining a 25-bed facility and retaining the designation as a Critical Access Hospital.

In 1925, Ferrell Hospital began as a small hospital on the 2nd floor of a business building, Ferrell Hospital then moved into its own building in 1928. Since then, Ferrell Hospital has undergone two major renovations; one occurring in 1958 and the second in 1973. Part of the Project will include the demolition of the original 1928 building. The work plan for the Project identifies that the hospital will continue normal operations as the renovations and additions take place on campus.

The proposed project will consist of 55,008 square feet of new space and 17,370 square feet of re-modernized spaces. New spaces will be developed for an emergency department, diagnostic imaging, front lobby and waiting area, exterior front canopy, registration, lab, phlebotomy, cafeteria, surgery department, post-anesthesia care unit, ambulatory care unit, central sterile unit and an addition for chemotherapy services. The Project will also correct and adjust facility deficiencies as identified in past facility assessments. Upon completion, total hospital square footage will consist of 88,000 square feet.

The work plan for the Project identified that the hospital will continue normal operations as renovations and additions take place on campus. Ferrell Hospital has not undergone major renovations in over 40 years and as a result, the facility is in need of modernization in order to continue to provide quality services in a safe environment. Areas re-modernized will include non-clinical areas such as business office functions, health information, accounting, human resources and personnel files, information technology and administration. In addition, demolition of the original building, constructed in 1928, is included in the scope of the project. The Project's new construction and re-modernization is substantive and will exceed total capital expenditures greater than the total capital expenditure minimum. The projected total costs of the Project are $37,353,666.

Size of Project

Ferrell Hospital is a Critical Access Hospital and therefore a large portion of the services they provide are outpatient-related. This, combined with the fact that they are subject to large shifts in utilization due to their size, suggests that the applicable State Agency guidelines may not be directly applicable.

After the proposed modernization of the facility Ferrell Hospital will total 88,375 square feet. Once the modernization of Ferrell Hospital is complete 56,630 square feet, or approximately 64%, of the facility will be dedicated to clinical functions.

A listing of all clinical departments/services with State standards for review is seen below.

Size of Project							
Department/Service	Proposed BGSF/DGSF	Existing Units	Proposed Units	State Standard/Unit	State Standard	Difference	Met Standard?
Medical/Surgical	12,785	25	25	660	16,500	3,715	Yes
Emergency Department	5,371	4	8	900	7,200	1,829	Yes
Nuclear Medicine	400	1	1	1,600	1,600	1,200	Yes
CT Scan	500	1	1	1,800	1,800	1,300	Yes
Ultrasound	120	1	1	900	900	780	Yes
Mammography	91	1	1	900	900	809	Yes
General Radiology	620	2	2	1,300	2,600	1,980	Yes
Surgical Operating Suite	3,860	1	2	2,750	5,500	1,640	Yes
Endoscopy	1,357	1	1	1,100	1,100	(257)	No
Post Anesthesia Recovery Phase I (PACU)	1,197	4	4	180	720	(477)	No
Post Anesthesia Recovery Phase II	1,351	2	2	400	800	(551)	No

A listing of all clinical department/services with no State standards for review are seen below.

Size of Project				
Department/Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
Diagnostic Imaging	1,680	N/A	N/A	N/A
Surgical Preparation	1,135	N/A	N/A	N/A
Inpatient Physical Therapy	680	N/A	N/A	N/A
Laboratory with Draw Station	1,278	N/A	N/A	N/A
Pharmacy	1,225	N/A	N/A	N/A
Pain Management	818	N/A	N/A	N/A
Central Sterile Processing	1,250	N/A	N/A	N/A
Rural Health Clinic	18,100	N/A	N/A	N/A
Oncology Infusion Area	1,750	N/A	N/A	N/A
Pre-Admission Services (Draw Station)	422	N/A	N/A	N/A
Respiratory Therapy	640	N/A	N/A	N/A

CLINICAL

Medical/Surgical

The Applicant proposes 12,785 square feet for 25 Medical/Surgical beds. The State standards for review allocate a range of 500-660 square feet per bed, in which Ferrell Hospital proposes 511.4 square feet per bed. To fit this criteria Ferrell Hospital's Medical / Surgical unit must have a total square footage of 12,500 to 16,500 – Which the proposed Medical/Surgical department does meet the State standards. Ferrell Hospital is proposing 20 key rooms for the 25 Medical/Surgical beds. Of these 20 key rooms 15 will be private, single-bed rooms and 5 key rooms will be 2-bed rooms. As part of the modernization of Ferrell Hospital 9,075 square feet of the proposed Medical/Surgical department will be new construction, 840 square feet will be modernized, and 2,870 square feet will be left as is. The expansion of the Medical/Surgical department is necessary to ensure that all patients receive the privacy they need while undergoing care at Ferrell Hospital.

The average daily census at Ferrell Hospital for Fiscal Year 2016 is currently 7.1, with spikes in utilization reaching the upper teens. The State standards for Medical/Surgical utilization are not met. By 2021 Ferrell Hospital's average daily census is projected to be 9.6, which assuming the volatile utilization will result in a daily census often reaching the mid-to-upper teens. Ferrell Hospital would like to, when possible, provide each patient with their own private room to ensure higher quality of care.

Emergency Department

The Applicant proposes 5,371 square feet for the Emergency Department with 8 key rooms. The Applicant proposes an Emergency Department with a total of 8 stations. To meet the Board standards for size, the Emergency Department must be no more than 7,200 square feet. The proposed project is within the State standards. All 5,371 square feet of the proposed Emergency Department will be new construction as the current Emergency Department will be demolished as part of the modernization process.

For Fiscal Year 2016 the Applicant's Emergency Department saw 6,931 visits, with this number anticipated to climb to 8,201 by 2021. While the Applicant only meets the State standards for 4 Emergency Department key rooms the Emergency Department is prone to swings in utilization in the same way the daily census at Ferrell Hospital is.

Central Sterile Supply

The Applicant proposes 1,250 square feet for Central Sterile Supply. There are no State standards for Central Sterile Supply. All 1,250 square feet of the proposed Central Sterile Supply will be new construction as the current Central Sterile Supply will be demolished as part of the modernization process.

Nuclear Medicine

The Applicant proposes 400 square feet for 1 Nuclear Medicine unit. The State standards for review indicate 1,600 square feet per recovery station. The proposed Nuclear Medicine unit fits within the State standards. The Nuclear Medicine key room will be entirely new construction. With the Nuclear Medicine projected to see 150 visits in 2021 the Applicant meets the State standard for review as they are only proposing 1 key room.

CT Scan

The Applicant proposes 500 square feet for 1 CT Scan unit. The State standards for review indicate 1,800 square feet per recovery station, in which the proposed project meets the State standards. The CT Scan key room will be entirely new construction. With the CT Scan projected to see 2,869 visits in 2021 the Applicant meets the State standard for review as they are only proposing 1 key room.

Ultrasound

The Applicant proposes 120 square feet for 1 Ultrasound unit. The State standards for review indicate 900 square feet per recovery station, in which the proposed project meets the State standards. The current Ultrasound key room will have its 220 square feet vacated and the 120 square feet proposed for the unit will be entirely new construction. With the Ultrasound projected to see 1,271 visits in 2021 the Applicant meets the State standard for review as they are only proposing 1 key room.

Mammography

The Applicant proposes 91 square feet for Mammography. The State standards for review indicate 900 square feet per recovery station, in which the proposed project meets the state standards. With Mammography projected to see 400 visits in 2021 the Applicant meets the State standard for review as they are only proposing 1 key room.

General Radiology

The Applicant proposes 620 square feet for 2 General Radiology units. The State standards for review indicate 1,300 square feet per recovery station, in which the proposed project meets the state standards. The proposed General Radiology unit fits within the State standards. All 612 square feet of the current key room for General Radiology will be removed, and the entire General Radiology unit will be new construction. With Ferrell Hospital proposing 2 General Radiology key rooms, and with projected utilization of 6,298 procedures, the State standards for General Radiology utilization (8,000 procedures/unit) will not be met.

Diagnostic Imaging

The Applicant proposes a Diagnostic Imaging department with a total square footage of 1,680 square feet. The Diagnostic Imaging department currently stands at 900 square feet, all of which will be demolished to make space for 1,680 square feet of new construction.

Laboratory with Draw Station

The Applicant proposes 1,278 square feet for the Laboratory with Draw Station. There are no State standards for the Laboratory with Draw Station. The Laboratory with Draw Station currently stands at 797 square feet, all of which will be demolished to make space for 1,357 square feet of new construction. Projected Laboratory utilization for 2021 is 78,672.

Pharmacy

The Applicant proposes 1,225 square feet for the Pharmacy. There are no State standards for Pharmacy. The Pharmacy currently stands at 516 square feet, all of which will be demolished to make space for 1,225 square feet of new construction. Projected Laboratory utilization for 2021 is 278,662.

Oncology Infusion Area

The Applicant proposes 1,750 square feet for the Oncology Infusion Area. Ferrell Hospital proposes 4 Infusion Stations, resulting in 437.5 square feet/station. There are no State standards for Infusion Stations. The new Oncology Infusion Area will be developed utilizing 1,250 square feet in new construction, as well as modernizing 500 square feet of the current facility for the Oncology Infusion Area. Projected Oncology Infusion utilization for 2021 is 272.

Rural Health Clinic and Physician Offices

The Applicant proposes 18,100 square feet for this combined hospital-based physician office area. There are no State standards for Physician Offices. As part of the modernization of Ferrell Hospital 8,410 square feet of the proposed Rural Health Clinic and Physician Offices will be new construction, 6,254 square feet will be modernized, and 8,476 square feet will be left as is. Projected Rural Health Clinic utilization for 2021 is 37,006.

Inpatient Physical Therapy

The Applicant proposes 680 square feet of new construction for the Inpatient Physical Therapy. There are no State standards for Inpatient Physical Therapy. Projected Rural Health Clinic utilization for 2021 is 37,006.

Respiratory Therapy

The Applicant proposes a total of 640 square feet for Respiratory Therapy. There are no State standards for Respiratory Therapy. The Respiratory Therapy key room currently stands at 300 square feet, all of which will be demolished to make space for 640 square feet of new construction. Projected Respiratory Therapy utilization for 2021 is 10,931.

Pain Management

The Applicant proposes a total of 818 square feet of new construction for Pain Management. There are no State standards for Pain Management. Projected Pain Management utilization for 2021 is 1,312.

Surgical Operating Suite

The Applicant proposes 3,860 square feet for 2 Surgical Operating Suites. The State standards mandate no more than 2,750 square feet per Operating Room. Ferrell Hospital proposes 2 Operating Rooms for a total of 1,930 square feet per Operating Room, which meets the Review Board standards. The Surgical Operating Suite key room currently stands at 973 square feet, all of which will be demolished to make space for 3,860 square feet of new construction for 2 Surgical Operating Suites. The projected utilization of Surgical Operating Suites at Ferrell Hospital is 999 hours in 2021, which as Ferrell Hospital proposes 2 key rooms, does not meet the criteria of 1,500 hours.

Endoscopy Suite

The Applicant proposes a total of 1,357 square feet for 1 Endoscopy Suite. The State standards mandate no more than 1,100 square feet per Operating Room, which the proposed Endoscopy Suite does not meet the State standards. The Endoscopy Suite key room currently stands at 330 square feet, all of which will be demolished to make space for 1,357 square feet of new construction. While the Endoscopy Suite is not being modernized, other parts of the facility are, which in turn affects the sizing of the Endoscopy Suite. As Ferrell Hospital is currently designed patient travel from the Endoscopy Suite to the PACU unit requires the patients and staff both to take corridors that are not in the direct route of travel as the current corridors of Ferrell Hospital are too narrow for staff to travel a patient on a bed.

Surgical Preparation

The Applicant proposes a total of 1,135 square feet of new construction for Surgical Preparation. There are no State standards for Surgical Preparation.

Post Anesthesia Recovery Phase I (PACU)

The Applicant proposes a total 1,197 square feet for 4 Post Anesthesia Recovery Phase I units. The State standards for review indicate 180 square feet per recovery station. The Applicant exceeds the State standards of 720 square feet for the proposed Post Anesthesia Recovery Phase I (PACU) department. The Post Anesthesia Recovery Phase I (PACU) key rooms currently stands at 320 square feet, all of which will be demolished to make space for 1,197 square feet of new construction.

Post Anesthesia Recovery Phase II

The Applicant proposes a total of 1,351 square feet of new construction for Post Anesthesia Recovery Phase II. The State standards for review indicate 400 square feet per recovery station.

The Applicant exceeds the State standards of 800 square feet for the proposed Post Anesthesia Recovery Phase II department.

Pre-Admission Services (Draw Station)

The Applicant proposes a total 422 square feet for Pre-Admission Services (Draw Station). There are no State standards for Pre-Admission Services (Draw Station). The Pre-Admission Services (Draw Station) currently stands at 300 square feet, all of which will be demolished to make space for 422 square feet of new construction for the new Pre-Admission Services (Draw Station).

NON-CLINICAL

Registration

The Applicant proposes a total of 2,720 square feet for Registration. There are no State standards for Respiratory Therapy

Chapel

The Applicant proposes a total of 190 square feet for the Chapel. There are no State standards for the Chapel.

Lobby / Public Space

The Applicant proposes a total of 3,882 square feet for the Lobby / Public Space. There are no State standards for the Lobby / Public Space.

Ambulance Vestibule

The Applicant proposes a total of 90 square feet for the Ambulance Vestibule. There are no State standards for the Ambulance Vestibule.

Materials Management

The Applicant proposes a total of 1,442 square feet for Materials Management. There are no State standards for Materials Management.

Circulation / Building Gross

The Applicant proposes a total of 6,175 square feet for Circulation / Building Gross. There are no State standards for Circulation / Building Gross.

Health Information Management

The Applicant proposes a total of 915 square feet for Health Information Management. There are no State standards for Health Information Management.

Administration

The Applicant proposes a total of 3,098 square feet for Administration. There are no State standards for Administration.

Waiting / Dining

The Applicant proposes a total of 3,980 square feet for Waiting / Dining. There are no State standards for Waiting / Dining.

Gift Shop

The Applicant proposes a total of 506 square feet for the Gift Shop. There are no State standards for the Gift Shop.

Kitchen

The Applicant proposes a total of 1,850 square feet for the Kitchen. There are no State standards for the Kitchen.

Information Management (IT)

The Applicant proposes a total of 1,315 square feet for Information Management. There are no state Standards for the Information Management.

Plant Operations

The Applicant proposes a total of 300 square feet for Plant Operations. There are no State standards for the Plant Operations.

Environmental Services

The Applicant proposes a total of 350 square feet for Environmental Services. There are no State standards for the Environmental Services.

Conference Rooms

The Applicant proposes a total of 1,100 square feet for Conference Rooms. There are no State standards for the Conference Rooms.

Human Resources

The Applicant proposes a total of 506 square feet for Human Resources. There are no state standards for the Human Resources.

Mechanical / Electrical

The Applicant proposes a total of 3,130 square feet for Mechanical / Electrical. There are no State standards for the Mechanical / Electrical.

Housekeeping

The Applicant proposes a total of 300 square feet for Housekeeping. There are no State standards for the Housekeeping.

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

Section IV – Project Scope, Utilization, and Unfinished/Shell Space

Project Services Utilization

The Applicant proposes a total of 10 departments/services of which the Board has set standards for. All of the following proposed department/service already exist at Ferrell Hospital:

- Medical/Surgical
- Radiology
- Mammography
- Ultrasound
- CT Scan
- Nuclear Medicine
- Surgery
- CT Scan
- MRI
- Emergency Department

The historical utilization, projected utilization, and State standards for all departments or services that have State standards for review can be seen below.

Utilization								
	Historical Utilization		Projected Utilization		Existing Units	Proposed Units	State Guideline	Met Standard
Dept./Service	2014	2016	2020	2021				
Medical/Surgical	2,510	2,615	3,296	3,492	25	25	80% occupancy	No
General Radiology	5,900	6,011	6,239	6,298	2	2	8,000 procedures	No
Mammography	707	613	429	400	1	1	5,000 visits	Yes
Ultrasound	1,221	1,235	1,263	1,271	1	1	3,100 visits	Yes
CT Scan	1,947	2,175	2,714	2,869	1	1	7,000 visits	Yes
Nuclear Medicine	180	171	154	150	1	1	2,000 visits	Yes
Surgery (Hours)*	663	475	883	999	1	2	1,500 hrs/OR	No
MRI	480	550	722	773	1	1	2,500 procedures	Yes
Emergency Department	6,480	6,931	7,929	8,201	4	8	2,000 visits/station	No

**Historical Utilization is for Calendar Years 2013 and 2015, respectively.*

The historical utilization, projected utilization, and State standards for all departments or services that do not have State standards for review can be seen below.

Utilization						
	Historical Utilization		Projected Years		State	Met
Dept./Service	2014	2016	2020	2021	Guideline	Standard
Laboratory	74,211	75,459	78,018	78,672	N/A	N/A
Outpatient EKG, Holter, EEG	1,741	1,744	1,750	1,752	N/A	N/A
Respiratory Therapy	16,166	14,456	11,560	10,931	N/A	N/A
Cardiopulmonary Rehab	1,182	1,248	1,318	1,336	N/A	N/A
Physical Therapy	8,585	8,617	8,681	8,698	N/A	N/A
Occupational Therapy	4,621	4,316	3,765	3,639	N/A	N/A
Pharmacy	131,671	257,400	274,273	278,662	N/A	N/A
Rural Health Clinic	18,804	26,162	34,526	37,006	N/A	N/A
Pain Management	-	656	1,312	1,312	N/A	N/A
Oncology Infusion	-	-	60	60	N/A	N/A

Medical/Surgical Category of Service

Ferrell Hospital's projected utilization for Medical/Surgical was derived using data and projections reported by the Illinois Department of Public Health. The projections include the annual Inventory Report, in which 2013 utilization data and 2018 projected utilization for Planning Area F-05 is included in. Use rates by age cohort are incorporated into this data as well, and were used for in calculating the projected Medical/Surgical utilization.

From the IDPH projected patient days by age a compound annual growth rate was calculated for each age cohort. Using the CAGR rate developed for each age cohort, the population was projected out to 2021. Applying the IDPH use rates for each age cohort in Planning Area F-05 for the 2021 population the total patient admissions for Planning Area F-05 were developed. From the same Inventory data reported by the IDPH is was concluded that Ferrell Hospital was drawing 22.5% of the admissions in Planning Area F-05. The ALOS from the same IDPH inventory data was applied to these admissions to determine the patient days.

Ferrell Hospital's projected occupancy does not meet the State standards – However, Ferrell Hospital already is licensed for 25 Medical/Surgical beds and does not wish to reduce their bed count. Ferrell Hospital's average daily census is volatile and fluctuates often – even outside the peak months. On August 16th & 18th of Ferrell Hospital's Fiscal Year 2016 the census at the hospital reached 14. During peak months Ferrell Hospital's daily census often hovers around 15, with the Applicant reaching a census of 18 on March 2nd. The Applicant recorded an ADC of 7.16 for FY 2016, yet had peak utilization reaching ~2.5 the ADC, and often recorded a daily census over double the ADC. With Ferrell Hospital projected to have an ADC of 9.56 in FY 2021, the recent trends regarding volatility of the ADC suggest that the 25 Medical/Surgical beds are necessary.

The proposed project includes the Medical/Surgical department utilizing existing space, modernizing portions of the current facility, and utilizing new construction to add additional space to the Medical/Surgical department.

General Radiology

General Radiology growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of .9% was applied. While the Applicant does not meet the State standards for 2 General Radiology units, the 2 proposed General Radiology units are necessary to provide services at Ferrell Hospital. Potential down-time of a unit due to maintenance would limit the healthcare services to the community the Applicant serves. As well, General Radiology services are often scheduled ahead of time by the patient, and therefore Ferrell Hospital would like to limit scheduling conflicts to ensure convenient and accessible care for their patients.

The General Radiology functional area will be vacated in its entirety. As a result all 620 square feet that will comprise the 2 General Radiology key rooms will be new construction.

Mammography

Mammography growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the

Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of -6.9% was applied. The proposed Mammography unit meets the State standards for review.

The Mammography functional area will be vacated in its entirety. As a result all 91 square feet that will comprise the Mammography key room will be new construction.

Ultrasound

Ultrasound growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of .6% was applied. The proposed Ultrasound unit meets the State standards for review.

The Ultrasound functional area will be vacated in its entirety. As a result all 120 square feet that will comprise the Mammography key room will be new construction.

CT Scan

CT Scan growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of 5.7% was applied. The proposed CT Scan unit meets the State standards for review.
The CT Scan functional area will be vacated in its entirety. As a result all 500 square feet that will comprise the CT Scan key room will be new construction.

Nuclear Medicine

Nuclear Medicine growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of -2.5% was applied. The proposed Nuclear Medicine unit meets the State standards for review.

All 400 square feet that will comprise the Nuclear Medicine key room will be new construction.

Surgery

Ferrell Hospital for Calendar Year 2015 had a total of 475 surgery hours. The Applicant only employed one general surgeon working at a .725 FTE status throughout 2015. In May 2016 two more general surgeons joined the Ferrell Hospital staff. The cumulative FTE status of these three physicians is 1.525. Using the .725 FTE productivity in 2015 with the 475 hours it was determined that 1.0 FTE could generate 655 surgery hours at Ferrell Hospital. At 1.525 FTE, this productivity could increase to 999 hours. Ferrell Hospital may not meet the State standards, but with three general surgeons helping to drive demand the Applicant does not want to allow potential scheduling conflicts prevent patients who are seeking care to travel further for care, especially since many of the patients that will be seeking surgery services from Ferrell Hospital will be older and lacking the mobility to travel for care.

The Surgical Operating Suite functional area will be vacated in its entirety. As a result all 500 square feet that will comprise the 2 Surgical Operating Suite key rooms will be new construction.

MRI

MRI growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's MRI utilization to project future utilization. Through 2021 an annual growth rate of 7.0% was applied. The proposed MRI unit meets the State standards for review.

Emergency Department

Emergency Department growth was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Radiology utilization to project future utilization. Through 2021 an annual growth rate of 3.4% was applied. The Applicant, per the Board's standards, qualifies for 4 Emergency Department stations, but is proposing a total of 8 units. During situations that require immediate care, time is more than invaluable. Ferrell Hospital's designation as a Critical Access Hospital implies that there are limited health care resources in the immediate area. Ferrell Hospital proposes the current Emergency Department to ensure that no patient in need of immediate care is not given the care they need in a timely manner.

The Emergency Department functional area will be vacated in its entirety. As a result all 5,371 square feet that will comprise the 2 Surgical Operating Suite key rooms will be new construction.

Laboratory

Laboratory utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Laboratory utilization to project future utilization. Through 2021 an annual growth rate of 0.8% was applied. There are no State standards for utilization of Laboratory services.

The Laboratory functional area will be vacated in its entirety. As a result all 1,278 square feet that Laboratory will comprise of will be new construction.

Outpatient EKG, Holter, EEG

Outpatient EKG, Holter, EEG utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Outpatient EKG, Holter, EEG utilization to project future utilization. Through 2021 an annual growth rate of 0.1% was applied. There are no State standards for utilization of Outpatient EKG, Holter, EEG services.

Respiratory Therapy

Respiratory Therapy utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Respiratory Therapy utilization to project future utilization. Through 2021 an annual growth rate of -5.4% was applied. There are no State standards for utilization of Respiratory Therapy.

The Respiratory Therapy functional area will be vacated in its entirety. As a result all 640 square feet that will comprise the Respiratory Therapy key rooms will be new construction.

Cardiopulmonary Rehab

Cardiopulmonary Rehab utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Cardiopulmonary Rehab utilization to project future utilization. Through 2021 an annual growth rate of 1.4% was applied, which is half of the compound annual growth rate between FY 2014 and FY 2016. There are no State standards for utilization of Cardiopulmonary Rehab.

Physical Therapy

Physical Therapy utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Physical Therapy utilization to project future utilization. Through 2021 an annual growth rate of 0.2% was applied. There are no State standards for utilization of Physical Therapy.

The Physical Therapy functional area will be vacated in its entirety. As a result all 680 square feet that will comprise the Physical Therapy key room will be new construction.

Occupational Therapy

Occupational Therapy utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. Compound annual growth rate was applied to the Applicant's Occupational Therapy utilization to project future utilization. Through 2021 an annual growth rate of -3.4% was applied. There are no State standards for utilization of Occupational Therapy.

Pharmacy

Pharmacy utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. A calculation using the Applicant's historical utilization for Fiscal Year 2014 through 2016 determined the annual growth rate to be 39.8% - This growth at the Pharmacy would not be sustainable. Through 2021 an annual growth rate of 1.6%, which is much more in line with the growth of other services at Ferrell Hospital, was applied. There are no State standards for utilization of the Pharmacy.

The Pharmacy functional area will be vacated in its entirety. As a result all 1,225 square feet that will comprise the Physical Therapy key room will be new construction.

Rural Health Clinic

Rural Health Clinic utilization was projected using Ferrell Hospital internal data from Fiscal Year 3/31/14 through Fiscal Year 3/31/16. A calculation using the Applicant's historical utilization for Fiscal Year 2014 through 2016 determined the annual growth rate to be 18.0% - This growth at the Rural Health Clinic would not be sustainable, so an annual growth rate of

40% of the 18.0% compound annual growth rate was applied to the Applicant's Rural Health Clinic utilization to project future utilization. Through 2021 an annual growth rate of 7.2% was applied. There are no State standards for utilization of the Rural Health Clinic.

The Rural Health Clinic will keep 8,476 of its 18,100 proposed square feet as is. 6,254 square feet of the existing facility will be modernized and 3,370 square feet will be new construction.

Pain Management

Ferrell Hospital recently began providing Pain Management services for the last six months of their previous Fiscal Year. During this span Ferrell Hospital recorded 656 visits. Annualizing the 6 months of Pain Management visits results in annual utilization of 1,312.

The Pain Management functional area will be added as a result of 818 square feet.

Oncology Infusion

To determine potential utilization of Chemotherapy services at Ferrell Hospital incidence rates, which were adjusted to the Primary Service Area of Ferrell Hospital were determined. Ferrell Hospital will provide services for four types of cancer: Colon, Lung, Breast, and Prostate.

Cancer Incidence Rates (per 100,000)		
Cancer	Rate	Adjusted
Colon	41.0	12.6
Lung	57.3	17.6
Breast (Female)	125.0	19.5
Prostate (Male)	129.4	19.5

Primary Service Area Population		
Population	2021	% of 100,000
Female	15,608	15.6%
Male	15,099	15.1%
Total	30,707	30.7%

Incidence data was utilized was reported by the National Cancer Institute (Attachment 15, Exhibit 2).

Utilizing annual visits per patient data provided by Deaconess Health System and assuming a 14.2% Market Share Ferrell Hospital, which is less than what is indicated in the Medical/Surgical projections, results in a projected 60 Chemotherapy visits annually.

Projected Primary Service Area Chemotherapy Utilization					
Cancer	Adjusted Incidence Rate	Utilization/Incident	Annual Utilization	Market Share %	Ferrell Hospital Utilization
Colon	12.6	12	151	14.2%	21
Lung	17.6	6	106	14.2%	15
Breast (Female)	19.5	4.5	88	14.2%	12
Prostate (Male)	19.5	4	78	14.2%	12

The proposed Oncology Infusion Area will total 1,750 square feet – 500 square feet will be modernized from the current facility while the remaining 1,250 square feet will be new construction.

Ferrell Hospital Historical Utilization^ (Fiscal Year March 31)					
Service	2012	2013	2014	2015	2016
Acute Care					
Admissions	875	881	693	642	639
Patient Days	-	-	2,194	2,142	2,075
Swing Beds					
Admissions	51	45	47	74	65
Patient Days	-	-	316	516	540
Subtotal					
Admissions	926	926	740	716	704
Patient Days	2,938	2,736	2,510	2,658	2,615
Observation Patients	-	-	453	396	499
Days	-	-	400	394	395
Emergency Visits	7,096	7,398	6,480	6,783	6,931
# Admitted to AC	500	464	329	330	330
# Admitted to Observation	-	-	374	538	400
Laboratory Tests					
Inpatient	970	953	760	751	731
Outpatient	20,614	18,350	15,770	15,527	15,026
Inpatient Tests	11,992	11,683	9,889	9,025	8,812
Outpatient Tests	77,658	71,008	64,322	64,218	66,647
Ancillary Registrations	-	-	15,926	15,252	15,137
Surgery					
Inpatient	14	21	39	31	17
Endoscopy			6	28	12
Other			3	3	5
Outpatient	602	575	502	509	720
Endoscopy			66	338	345
Other			16	158	386
Total Endscopies	498	455	398	366	357
Radiology Tests					
Total Inpatient	707	662	563	503	505
Total Outpatient	6,432	6,007	5,337	5,299	5,506
Mammography	1,566	960	707	580	613
Computerized Tomography	2,119	2,116	1,947	2,052	2,175
Nuclear Medicine	300	249	180	137	171
MRI	561	612	480	588	550
Ultrasound	1,657	1,525	1,221	1,231	1,235
Stress Echo	10	17	20	15	14
Industrial Black Lung	-	-	144	200	54
Physical Therapy*					
Inpatient	360	431	238	77	27
Units	551	728	445	151	73
Swingbed	-	-	234	348	321
Units	-	-	564	817	714
Outpatient	4,289	3,097	2,684	1,850	2,695
Units	9,974	8,373	7,576	5,203	7,830
Occupational Therapy*					
Inpatient	34	8	12	229	424
Units	26	21	31	506	978
Swingbed	-	-	158	413	468
Units	-	-	432	1,022	1,201
Outpatient	235	105	1,414	1,850	779
Units	440	314	4,158	5,203	2,137

^All Utilization Data is from Ferrell Hospital's internal reports.

*Physical Therapy and Occupational Therapy's Swing bed 2012-2013 utilization is consildated

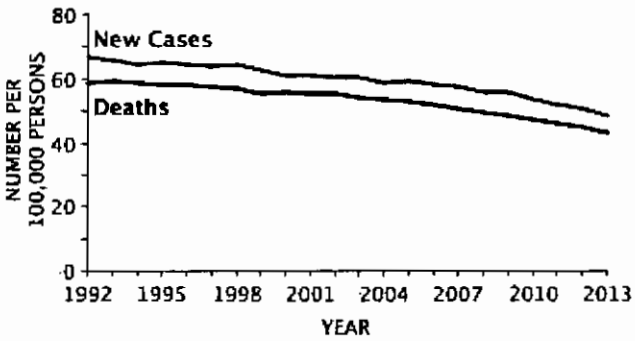
NATIONAL CANCER INSTITUTE
Surveillance, Epidemiology, and End Results Program

SEER Stat Fact Sheets: Lung and Bronchus Cancer

Statistics at a Glance

At a Glance

Estimated New Cases in 2016	224,390
% of All New Cancer Cases	13.3%
Estimated Deaths in 2016	158,080
% of All Cancer Deaths	26.5%



Percent Surviving 5 Years

17.7%

2006–2012

Number of New Cases and Deaths per 100,000: The number of new cases of lung and bronchus cancer was 57.3 per 100,000 men and women per year. The number of deaths was 46.0 per 100,000 men and women per year. These rates are age-adjusted and based on 2009–2013 cases and deaths.

Lifetime Risk of Developing Cancer: Approximately 6.5 percent of men and women will be diagnosed with lung and bronchus cancer at some point during their lifetime, based on 2011–2013 data.

Prevalence of This Cancer: In 2013, there were an estimated 415,707 people living with lung and bronchus cancer in the United States.

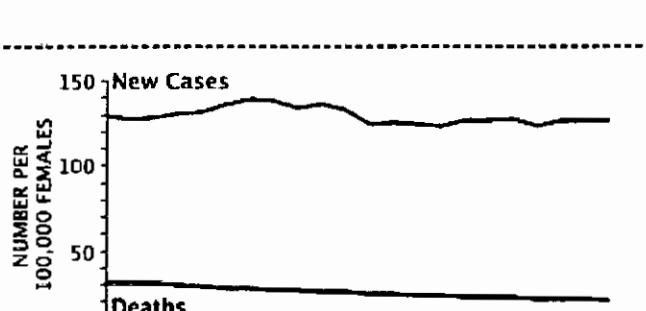
NATIONAL CANCER INSTITUTE
Surveillance, Epidemiology, and End Results Program

SEER Stat Fact Sheets: Female Breast Cancer

Statistics at a Glance

At a Glance

Estimated New Cases in 2016	246,660
% of All New Cancer Cases	14.6%
Estimated Deaths in 2016	40,450
% of All Cancer Deaths	6.8%



Percent Surviving 5 Years

89.7%

2006–2012

Number of New Cases and Deaths per 100,000: The number of new cases of female breast cancer was 125.0 per 100,000 women per year. The number of deaths was 21.5 per 100,000 women per year. These rates are age-adjusted and based on 2009–2013 cases and deaths.

Lifetime Risk of Developing Cancer: Approximately 12.4 percent of women will be diagnosed with female breast cancer at some point during their lifetime, based on 2011–2013 data.

Prevalence of This Cancer: In 2013, there were an estimated 3,053,450 women living with female breast cancer in the United States.

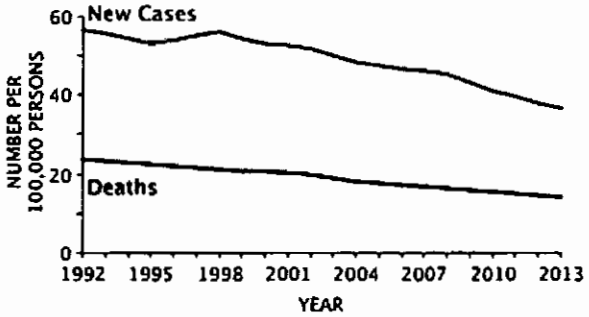
NATIONAL CANCER INSTITUTE
Surveillance, Epidemiology, and End Results Program

SEER Stat Fact Sheets: Colon and Rectum Cancer

Statistics at a Glance

At a Glance

Estimated New Cases in 2016	134,490
% of All New Cancer Cases	8.0%
Estimated Deaths in 2016	49,190
% of All Cancer Deaths	8.3%



Percent Surviving 5 Years

65.1%

2006-2012

Number of New Cases and Deaths per 100,000: The number of new cases of colon and rectum cancer was 41.0 per 100,000 men and women per year. The number of deaths was 15.1 per 100,000 men and women per year. These rates are age-adjusted and based on 2009-2013 cases and deaths.

Lifetime Risk of Developing Cancer: Approximately 4.4 percent of men and women will be diagnosed with colon and rectum cancer at some point during their lifetime, based on 2011-2013 data.

Prevalence of This Cancer: In 2013, there were an estimated 1,177,556 people living with colon and rectum cancer in the United States.

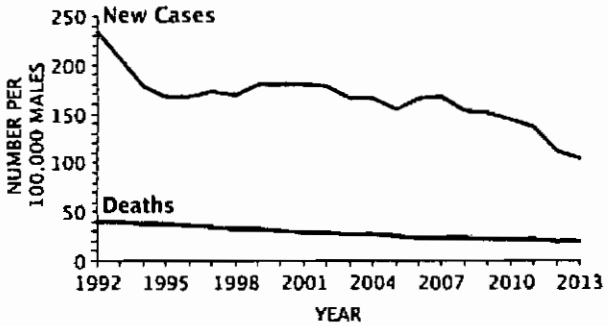
NATIONAL CANCER INSTITUTE
Surveillance, Epidemiology, and End Results Program

SEER Stat Fact Sheets: Prostate Cancer

Statistics at a Glance

At a Glance

Estimated New Cases in 2016	180,890
% of All New Cancer Cases	10.7%
Estimated Deaths in 2016	26,120
% of All Cancer Deaths	4.4%



Percent Surviving 5 Years

98.9%

2006-2012

Number of New Cases and Deaths per 100,000: The number of new cases of prostate cancer was 129.4 per 100,000 men per year. The number of deaths was 20.7 per 100,000 men per year. These rates are age-adjusted and based on 2009-2013 cases and deaths.

Lifetime Risk of Developing Cancer: Approximately 12.9 percent of men will be diagnosed with prostate cancer at some point during their lifetime, based on 2011-2013 data.

Prevalence of This Cancer: In 2013, there were an estimated 2,850,139 men living with prostate cancer in the United States.

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

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

1. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:
2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ **Medical/Surgical**	**25**	**25**
☐ **Obstetric**		
☐ **Pediatric**		
☐ **Intensive Care**		

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

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

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(3) -	Documentation Related to Cited Problems			X
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	X

Section VII – Service Specific Review Criteria

Medical/Surgical

Ferrell Hospital proposes the modernization of Ferrell Hospital's Medical/Surgical authorized beds through the construction of a new addition to the hospital. Ferrell Hospital does not propose to add to their 25 Medical/Surgical beds, but to place 15 of the authorized beds within their own private room. The project is necessary as the current Ferrell Hospital patient rooms have deteriorated and have multiple code and safety deficiencies, which include the patient rooms within the facility lack the current code mandated complement of medical gases and emergency power outlets. These deficiencies can be found in Attachment 12, Exhibits 2 & 3.

Criterion 1110.530 (a)(4) Introduction.

Ferrell Hospital is not proposing to change their bed count, which is currently 25. Ferrell Hospital is proposing the modernization and expansion of the inpatient wing to feature more private rooms. The Applicant proposes a total of 15 private rooms with 5 rooms that will each have 2 Medical/Surgical authorized beds in them. As the Applicant proposes a modernization project the establishment and expansion criteria do not apply. The modernization criteria that apply to this project include: 1110.530(b)(1) & (3); (e) (1) & (2) & (3) (4) and (g).

Over the previous 5 fiscal years Ferrell Hospital's utilization has declined.

Ferrell Hospital Historical Inpatient Utilization (Fiscal Year 3/31)					
	2012	2013	2014	2015	2016
Admissions	926	926	740	716	704
Patient Days	2,938	2,736	2,510	2,658	2,615
Average Daily Census	8.0	7.5	6.9	7.3	7.2

This decline in utilization is due to multiple circumstances. Recent healthcare trends have pushed for more hospitals, including Ferrell Hospital, to provide more outpatient services and keep patients for an extended time only if it is absolutely necessary. The drop in admissions, yet increase in patient days from 2014 to 2016 suggest this. The population of the community that Ferrell Hospital serves is slowly declining. However, the population that is remaining in the Primary Service Area is rapidly aging and will be continuing to seek care locally.

Swing Bed utilization at Ferrell Hospital has been rapidly increasing; in Fiscal Year 2014 Ferrell Hospital saw Swing Beds utilized for a total of 316 days, this number increased 71% to 540 patient days for Fiscal Year 2016. Over the three Fiscal Years Ferrell Hospital has seen an annual growth of 30.7% for Swing Beds. As the population continues to age Swing Bed utilization at Ferrell Hospital are anticipated to continue to climb, furthering the necessity of 25 Medical/Surgical beds at Ferrell Hospital.

To determine Ferrell Hospital's projected inpatient utilization both population and utilization projections from the Illinois Department of Public Health were applied to Ferrell Hospital. IDPH most recent available inventory data is for 2013 utilization, which then projects out to 2018 utilization for Planning Area F-05. From the IDPH projected patient days by age a compound annual growth rate was calculated for each age cohort. Using the CAGR rate developed for each age cohort the population was projected out to 2021. Applying the IDPH use rates for each age

cohort in Planning Area F-05 for the 2021 population the total patient admissions for Planning Area F-05 were developed. From the same data it was concluded that Ferrell Hospital was drawing 22.5% of the admissions. Therefore, 22.5% of admissions for each age cohort were allocated to Ferrell Hospital. The ALOS from the same IDPH inventory data was applied to these admissions to determine the patient days. The projected inpatient utilization following the aforementioned steps for Ferrell Hospital can be seen below.

Ferrell Hospital's 2021 Projected Inpatient Utilization			
	Admissions	Days	Average Daily Census
0-14	9	35	0.1
15-44	71	275	0.8
45-64	160	616	1.7
65-74	159	613	1.7
75+	508	1,954	5.4
Total	907	3,492	9.6

Criterion 1110.530 (b)(1)(3) Background of Applicant.

As demonstrated in Attachment 11, the Applicant meets all criterion pertaining to the Background of Applicant. Copies of the licensing administered to Ferrell Hospital Community Foundation from the Illinois Department of Public Health can be found in Attachment 11-B. Reviews of the Hospital completed by Johnson Johnson Crabtree Architects and Adams Group can be found in Attachment 12, Exhibits 2 & 3.

Alisa Coleman, CEO of Ferrell Hospital, confirmed that no adverse actions have taken place against Ferrell Hospital Community Foundation over the three prior years. The notarized letter confirming this can be found following Section VII – Service Specific Review Criteria.

As Ferrell Hospital Community Foundation is a community-based, tax-exempt entity with no adverse actions over the three prior years, criterion (b) (1) & (2) are not applicable.

Criterion 1110.530 (c)(1) Planning Area Need – 77 Ill. Adm. Code 1100

While this criterion is not applicable as the Applicant is proposing a project that will modernize / replace an existing category of service and does not propose to expand the Hospitals bed capacity it should be noted that this project will allow Ferrell Hospital to continue to provide local access to the community it serves. Ferrell Hospital does not wish to reduce their bed count as influx of patients can occur, and with the community continuing to age, these influxes in admissions can become more volatile during the colder months of the year. On March 2nd, 2016 Ferrell Hospital recorded a daily census of 18; on both January 19th and February 29th of the same year Ferrell Hospital recorded a daily census of 15. It is not unreasonable to conclude that these volatile influxes of patients, given the projected demographics of the community, can become more and more common in the next 5-10 years. The Applicant prides itself on being a local community-based provider, and would keep the transferring of patients to other facilities to a minimum.

Criterion 1110.530 (c)(2) Planning Area Need - Service to Planning Area Residents.

Ferrell Hospital received their designation as a Critical Access Hospital in March of 2003 and since then the Hospital has always emphasized being a local, independent provider that provides quality care to the rural community of Eldorado and the surrounding communities. As noted in both the Program Narrative and Attachment 12 within this Certificate of Need, the primary purpose of the project is to improve to Ferrell Hospital facility in order to better fulfill the health care related needs of the local community. Saline County is designated as a Medically Underserved Area by the Health Resources and Services Administration (Attachment 20, Exhibit 2).

According to COMPdata for Calendar Year 2015 Ferrell Hospital had 610 discharges. Of these 610 Discharges, 372 (61.0%) came from within Saline County. The break-out of discharges by Saline County zip code can be seen below. Saline County is just one of six counties that reside within Planning Area F-05.

Ferrell Hospital's Calendar Year 2015 Saline County Discharges		
Zip Code/City	#	% of Tot.
62930 - Eldorado	269	44.1%
62946 - Harrisburg	52	8.5%
62935 - Galatia	18	3.0%
62917 - Carrier Milles	14	2.3%
62977 - Raleigh	14	2.3%
62965 - Muddy	5	0.8%
Saline County Totol	372	61.0%
Other	238	39.0%
Total	610	100.0%

Source: CY 2015 COMPdata.

Of the 610 discharges from Ferrell Hospital in CY 2015, 588, or 96.4%, of the patients originated in Planning Area F-05. Tbe CY 2015 patient origin for Ferrell Hospital can be found in Attachment 20, exhibit 2.

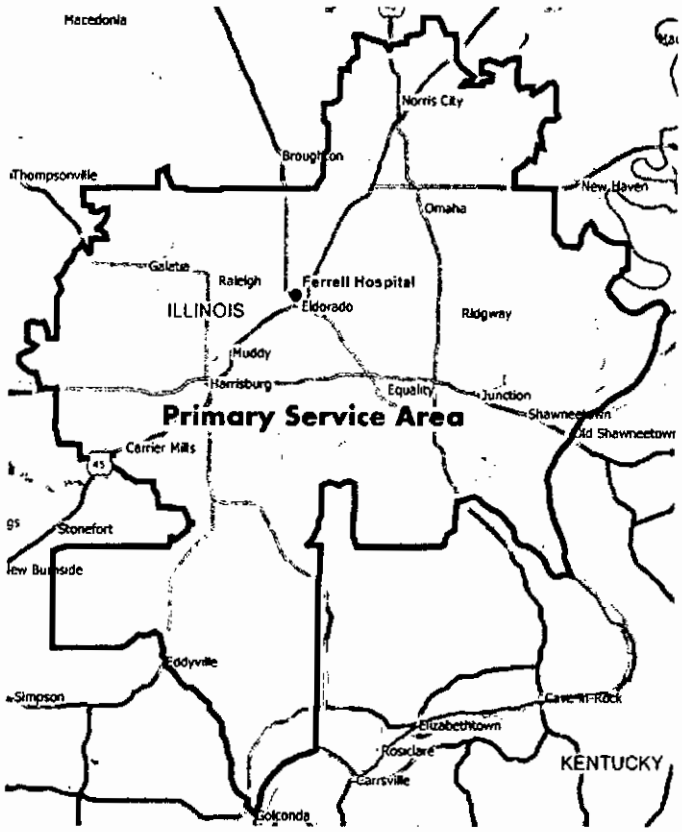
The community Ferrell Hospital serves is continuing to age, which can be seen in *Criterion 1100.530 (c)(4) Planning Area Need – Service Demand.* By 2021, it is anticipated that 22.7% of Ferrell Hospital's Primary Service Area will be over the age of 65. As this population continues to age and tbeir mobility becomes more limited it is crucial that Ferrell Hospital remains accessible to the local community. Removing the community's local health care provider could be the difference in elderly patients receiving the care they need.

Criterion 1110.530 (c)(3) Planning Area Need – Service Demand – Establishment of Category of Service.

Ferrell Hospital is not proposing to establish a new category of service, therefore this criterion is not applicable.

Criterion 1110.530 (c)(4) Planning Area Need – Service Demand.

Ferrell Hospital's Primary Service Area encompasses a 12 zip code area that includes, but is not limited to, the communities of Eldorado, Harrisburg, Shawneetown, Norris City, Ridgeway, Equality, Galatia, Raleigh, Carrier Milles, Junction, Omaha, and Muddy. Harrisburg Medical Center in Harrisburg, Illinois is the only other hospital that resides within the Primary Service Area. The Primary Service Area can be seen below.



Source: Maptitude.

For Calendar Year 2015 Ferrell Hospital had a total of 610 inpatient discharges. 517, or 84.8%, of these discharges originated in the Service Area defined above. A break-out of the Primary Service Area's discharges by zip codes can be seen below.

Ferrell Hospital's Primary Service Area Discharges			
		CY 2015 Discharges	
Zip & City Name	County	#	% of Tot.
62930 - Eldorado	Saline	269	44.1%
62946 - Harrisburg	Saline	52	8.5%
62984 - Shawneetown	Gallatin	39	6.4%
62869 - Norris City	White	36	5.9%
62979 - Ridgway	Gallatin	32	5.2%
62934 - Equality	Gallatin	23	3.8%
62935 - Galatia	Saline	18	3.0%
62917 - Raleigh	Saline	14	2.3%
62977 - Carrier Milles	Saline	14	2.3%
62954 - Junction	Gallatin	9	1.5%
62871 - Omaha	Gallatin	6	1.0%
62965 - Muddy	Saline	5	0.8%
PSA Total		517	84.8%
Outside of PSA total		93	15.2%
Total		610	100.0%

Source: CY 2015 COMPdata.

In 2016 there are approximately 31,300 people residing in the previously defined Primary Service Area. Through 2021 the population is projected to decline to approximately 30,700 people, with an anticipated compound annual growth rate expected to be approximately -0.4%.

Note that Zip code 62965 – Muddy's population statistics are not reported in Nielsen Pop-Facts. The United States Census Bureau estimates that Zip Code 62965 has a population of 69 as of 2013.

Ferrell Hospital's Service Area Population by Zip Code					
	Population				
	2016		2021		
Zip Code & City Name	#	% of Tot.	#	% of Tot.	CAGR
62930 - Eldorado	6,133	19.6%	6,022	19.6%	-0.4%
62946 - Harrisburg	12,620	40.3%	12,384	40.3%	-0.4%
62984 - Shawneetown	1,583	5.1%	1,498	4.9%	-1.1%
62869 - Norris City	2,734	8.7%	2,734	8.9%	0.0%
62979 - Ridgway	1,102	3.5%	1,049	3.4%	-1.0%
62934 - Equality	877	2.8%	837	2.7%	-0.9%
62935 - Galatia	1,918	6.1%	1,895	6.2%	-0.2%
62977 - Raleigh	664	2.1%	665	2.2%	0.0%
62917 - Carrier Milles	2,517	8.0%	2,475	8.1%	-0.3%
62954 - Junction	564	1.8%	533	1.7%	-1.1%
62871 - Omaha	634	2.0%	615	2.0%	-0.6%
Total	31,346	100.0%	30,707	100.0%	-0.4%

Source: Nielsen Pop-Facts.

Despite the decline in population, the Primary Service Area's 65+ population will continue to grow.

Ferrell Hospital's Service Area Population by Age					
	Population				
	2016		2021		
Age	#	% of Tot.	#	% of Tot.	CAGR
00-17	6,751	21.5%	6,554	21.3%	-0.6%
18-44	9,749	31.1%	9,448	30.8%	-0.6%
45-64	8,413	26.8%	7,727	25.2%	-1.7%
65+	6,433	20.5%	6,978	22.7%	1.6%
Total	31,346	100.0%	30,707	100.0%	-0.4%

Source: Nielsen Pop-Facts.

As seen above, 22.7% of the projected Primary Service Area population will be 65 years of age or older. This is a much higher number when compared to the 13.0% of the national population that is 65 or older. Ferrell Hospital has historically emphasized being a local community-based provider and as this population continues to age it is becoming apparent that the local population will lean on Ferrell Hospital for care more than ever.

As the population continues to age it is important that the older demographic has convenient, accessible care. In 2015 only 33.5% of discharges originating in Eldorado's zip code 62930 went to Ferrell Hospital for care.

Eldorado, Illinois - All Discharges						
	CY 2013		CY 2014		CY 2015	
Hospital	#	% of Tot.	#	% of Tot.	#	% of Tot.
Ferrell Hospital	320	42.0%	262	34.2%	269	33.5%
Harrisburg Medical	149	19.6%	217	28.4%	223	27.7%
Memorial Hospital - Carbondale	127	16.7%	129	16.9%	141	17.5%
Heartland Regional Med.	92	12.1%	70	9.2%	93	11.6%
Herrin Hospital	41	5.4%	45	5.9%	45	5.6%
Other	33	4.3%	42	5.5%	33	4.1%
Total	762	100.0%	765	100.0%	804	100.0%

Source: CY 2013, 2014 & 2015 COMPdata.

As noted above, over 1/3rd of the discharges originating within the Eldorado community are leaving the Primary Service Area for their care. As well, only 33.5% of Eldorado's 2015 discharges utilized Ferrell Hospital for care, which is approximately a 25% decline from 42.0% in 2013. The modernization of the Ferrell Hospital campus will give the facility a more contemporary feel, one which may entice the more able-bodied members of the community to stay in the community for their care.

There are only four hospitals that are within a 45 minute travel time of Ferrell Hospital.

							MapQuest	
Facility	Beds	CAH	Administrator	Address	Municipality	Zip Code	Miles	Minutes
Ferrell Hospital	25	Yes	Alisa Coleman	1201 Pine St.	Eldorado	62930	-	-
Harrisburg Medical Center	64	No	Rodney D. Smith	100 Doctor Warren Tuttle Dr.	Harrisburg	62946	8.8	13
Hamilton Memorial Hospital District	25	Yes	Greg Sims	611 S Marshall Ave.	McLeansboro	62859	20.9	23
Franklin Hospital District	25	Yes	Hervey E. Davis	201 Bailey Lane	Benton	62812	32.1	40
Heartland Regional Medical Center	92	No	James Flynn	3333 W Deyoung	Marion	62959	34.2	41

Neither Herrin Hospital nor Memorial Hospital – Carbondale are within a 45 minute drive time of Ferrell Hospital. It takes approximately one hour to drive from Ferrell Hospital to Memorial Hospital in Carbondale, Illinois and approximately 50 minutes to drive to Herrin Hospital from Ferrell Hospital. The lack of accessible options for healthcare is problematic for the aging population, a demographic that may not be able to travel the previously mentioned distances for care. As seen, Ferrell Hospital in Eldorado is the only convenient option for care for many of the community's residents.

Criterion 1110.530 (e) Category of Service Modernization.

1) Please refer to Attachment 20, Exhibit 2, for the IDPH Centers for Medicare and Medicaid Services inspection reports and Attachment 12, Exhibit 1 for the infrastructure analysis completed by DEJA.

2) Please refer to Attachment 20, Exhibit 2 for the IDPH Centers for Medicare and Medicaid Services inspection reports.

3) Please refer to Attachment 12, Exhibit 1 for the infrastructure analysis completed by DEJA.

4) Occupancy – Ferrell Hospital internal data.

Based on 25 Medical/Surgical Beds		
Year	Without Swing Beds	With Swing Beds
2014	27.5%	24.0%
2015	29.1%	23.5%
2016	28.7%	22.7%

Criterion 1110.530 (f) Staffing Availability.

Ferrell Hospital already has the necessary staff to attend to the 25 medical/surgical beds provided at the Hospital.

Criterion 1110.530 (g) Performance Requirements.

The Applicant does not propose a new medical/surgical category of service. The Applicant proposes to modernize the current services within the hospital that has 25 authorized medical/surgical beds. Ferrell Hospital does not reside within a Metropolitan Statistical Area (MSA), therefore this criterion is not applicable.

Shortage Designation

Find Shortage Areas

Health Professional Shortage Areas (HPSAs)

Medically Underserved Areas and Populations (MUAs/Ps)

Governor's Designation of Shortage Areas for Rural Health Clinics

Frequently Asked Questions

Negotiated Rulemaking Committee

Improving Transparency in Auto-HPSA Scoring Webinar

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Auto-HPSA Facilities

Contact: SDB@hrsa.gov or 301-594-5168

Medically Underserved Areas/Populations

Share

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)

Health Professional Shortage Area or Medically Underserved Area/Population?

What Does That Mean?

Dictionary of MUA/P Words, Acronyms and Codes

(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 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 2a 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: Ration 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 MUA/Ps.

Revised June, 1995

U.S. Department of Health & Human Services

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HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/25/2016

State: Illinois
County: Saline County
Discipline: Primary Care
Metro: All
Status: Designated
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Saline County	165	I17999171W	Low Income - Saline County	Primary Care	HPSA Population	2	16	Designated	07/09/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Saline County	165		Saline	Primary Care	Single County			Designated	07/09/2013

1 Page Size: 20 01 items in 01 pages

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

CERTIFIED MAIL
RETURN RECEIPT REQUESTED **7015 1660 0000 4182 2047**

April 22, 2016

Alisa Coleman, Administrator
Ferrell Hospital Community Foundations
1201 Pine Street
Eldorado, IL 62930

Dear Ms. Coleman:

The Illinois Department of Public Health conducted a Medicare Recertification survey at Ferrell Hospital Community Foundations on April 14, 2016 which included both health surveillance and a life safety code survey for the Condition of Participation for Critical Access Hospitals. The survey found your hospital was not in compliance with the following Medicare Condition of Participation for Critical Access Hospitals:

- 42 CFR 485.41 Physical Environment

In addition, a number of deficiencies were found in other Medicare requirements. Enclosed is a complete listing of all deficiencies cited on the April 14, 2016 survey.

The Condition of Participation which is not met must be corrected within 45 days of the survey exit date, in this case by **May 29, 2016.** If you believe your Critical Access Hospital will be able to come into compliance by the 45th day, you should submit an allegation of compliance and plan of correction (PoC) that addresses all of the deficiencies cited at the April 14, 2016 survey(s). **Your PoC for the C Tags (Conditions of Participation Critical Access Hospitals) should be sent to IDPH, 525 W. Jefferson, 4th Floor, Springfield, Illinois 62761: Attention Ginnie Pribble, Field Supervisor.**

Your plan of correction for all life safety code deficiencies (K tags) should be sent to Henry Kowalenko, Division Chief, IDPH, Division of Life Safety and Construction, 525 West Jefferson Street, 4th Floor, Springfield, IL 62761. Your plan of correction should be submitted within ten (10) calendar days of the receipt of this letter by your office. If we accept your allegation of compliance, and it is within the 45 day timeframe, IDPH will return for a revisit with 45 days of the survey exit date to determine compliance with the Condition of Participation indicated above. Failure on your part to meet these requirements will result in our recommendation to CMS that termination action be effectuated effective July 14, 2016.

PROTECTING HEALTH, IMPROVING LIVES

Please note that a PoC must meet the following criteria: (1) Clearly states the specific nature of the corrective actions for each deficiency along with supporting documentation. (2) Sets reasonable completion dates for all deficiencies prior to the termination date along with interim dates for any phases or intermediate steps. (3) Describes how your plan/action will prevent recurrence, (4) Describes the title of the person(s) who will be responsible for implementing and monitoring the plan for future compliance with the regulations and (5) Evidence that the facility has incorporated systemic efforts into its quality assessment and performance improvement program. A response to each deficiency on the CMS-2567 is required and the right side of the CMS-2567 must be used to document your plan for corrective action. The PoC must be signed and dated on the bottom of the first page of the CMS-2567 by the authorized official at your Critical Access Hospital. Additional documentation may be attached to the CMS-2567, when necessary. If a deficiency has been corrected since the survey, this should be indicated on the form along with the date of correction and the corrective action.

If you have any questions regarding this matter, please me at 217-782-0381.

Sincerely yours,

Karen Senger RN

Karen Senger RN BSN
Supervisor of Central Office Operations
Division of Health Care Facilities and Programs

Enclosure: Form CMS-2567, Statement of Deficiencies

Cc: Ginnie Pribble, Health Care Facilities and Programs Springfield
Jody Gudgel, Division of Life Safety and Construction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	141324	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERRELL HOSPITAL COMMUNITY FOUNDATIONS	1201 PINE STREET ELDORADO, IL 62930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS A recertification survey for health standards was conducted on 4/11/16-4/14/16. The facility was not in compliance with standards for Critical Access Hospital (CAH), 42 CFR 485, as evidenced by: Abbreviations: CAH-Critical Access Hospital CPR-Cardiopulmonary Resuscitation CNO-Chief Nursing Officer CRNA-Certified Registered Nurse Anesthesist ED-Emergency Department E#-Employee OR-Operating Room PACU-Post Anesthesia Care Unit Pt-Patien RN-Registered Nurse SNF-Skilled Nursing Facility The Life Safety Code portion of the Re-Certification Survey was conducted on April 13 - 14, 2016. Due to the number, severity, and variety of deficiencies observed during the survey walk-through, the requirements of 42 CFR Subpart 485.623, Physical Plant and Environment, are NOT MET.	C 000	Ferrell Hospital Community Foundation recognizes the opportunity identified in the survey to improve the life safety code meaures within the facility to enhance the safety for our patients, staff, visitors and facility.	04/15/16
C 220	485.623 PHYSICAL PLANT AND ENVIRONMENT Physical Plant and Environment This CONDITION is not met as evidenced by: Based on observation during the survey	C 220	Please see attached Life Safety Corrective Action Plan that was mailed in on 05/03/16 to address tags C220 and C231. (See Attachment Q)	05/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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C 220	Continued From page 1 walk-through, staff interview, and document review during the Life Safety Code portion of a Re-Certification Survey conducted on April 13 - 14, 2016, the surveyor finds that the facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the number, severity, and variety of Life Safety Code deficiencies that were found. Also see C0231.	C 220		
C 231	466.623(d)(1) LIFE SAFETY FROM FIRE- NFPA Except as otherwise provided in this section-- (i) the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.	C 231	Please see attached Life Safety Corrective Action Plan that was mailed in on 05/03/16 to address tags C220 and C231. (See Attachment Q)	05/17/16

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C 231	Continued From page 2 (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH. After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients. This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, staff interview, and document review during the Life Safety Code portion of a Re-Certification Survey conducted on April 13 - 14, 2016, the surveyor finds that the facility does not comply with the applicable provisions of the 2000 Edition of the NFPA 101 Life Safety Code. See the Life Safety Code deficiencies identified with K-Tags.	C 231		
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, document review and staff interview, it was determined the CAH failed to ensure all staff in the surgery department followed policies to prevent the possibility of	C 278	Ferrell Hospital has identified the deficiencies noted under C278;485.635(a)(3)(vi) Patient Care Policies. The plan of correction will be as follows:	

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C 278	Continued From page 3 transmission of infection, potentially affecting all patients receiving surgical services. Findings include: 1. A tour of the surgery department and observation of surgical procedures was conducted with the Surgical Director (E #3) on 4/12/16 at 9:00 AM. During the observation of the surgical procedure for Pt #5 the following was observed: CRNA (E #4) was observed wearing a watch and a ring on the right index finger. E#4 was wearing scrub top and pants with another hospital logo. E#4 licked bare fingers while reviewing pages of Pt #5's surgical record, then proceeded to prepare medications without hand hygiene and /or donning gloves. E# 4's cell phone buzzed during the procedure. E#4 removed it from front pocket, viewed the phone, returned phone to pocket then proceeded with patient care. E#4 did not perform hand hygiene after handling the phone. Due to Pt #5 exhibiting decreasing oxygen saturation during the procedure, E#4 inserted a nasal airway after 2 unsuccessful attempts. E#4 did not wear gloves or complete hand hygiene prior to or between attempts at insertion. Fluids from the nasal passage were observed, along with topical anesthetic. 2. The CAH policy titled "Attire of Personnel in the Surgical Suite" dated 09/03 was reviewed on 4/12/16 at 11:30 AM. The policy indicates under I. POLICY, "The OR is considered to be a controlled environment therefore; all persons entering this area will be required to wear surgical clothing as provided by this facility." The policy titled "Infection Control" dated 07/15 was reviewed on 4/12/16 at 11:45 AM. The	C 278	1. The OR Director, Rita Etienne placed a can of Eco Lab Quik-Care hand foam on the Anesthesia Cart on 4/19/16. The CRNAs were instructed to utilize hand foam between any movements away from patient. Re-Education was provided to the CRNAs regarding proper PPE protocol which includes wearing of gloves when coming into contact with any surgical patient. 2. Rita Etienne, OR Director will be re-educating all surgical staff on PPE protocols in OR May staff meeting. 3. Alisa Coleman, CEO spoke to Randy Wientjes, Owner of Metro Anesthesia Services, on April 13, 2016 regarding the noted deficiencies. A letter followed addressing the issues related to Infection Control and failure to follow the Policies and Procedures of Ferrell Hospital. (See Attachment A) 4. Rita Etienne, OR Director, spoke to Mr. Wientjes on 4/19/2016 and asked that a CRNA Orientation Checklist be implemented and will be placed in providers' credential file. Mr. Wientjes was asked to provide an educational checklist that the verified education was provided to all CRNAs practicing at Ferrell Hospital.	04/18/16

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C 278	Continued From page 4 policy indicates under III RESPONSIBILITY, " All OR and PACU personnel will perform patient care activities in a manner that decreased the possibility of cross contamination." Under V. PROCEDURE, 2.6 Anesthesia personnel should wear disposable gloves when touching the patient's mucous membranes (intubation, suctioning, extubation etc). Standard precautions will be observed at all times. Under 12.3 Gloves shall be used when handling or touching any item that comes into contact with the patient's respiratory tract." 3. On 4/12/16 at 8:30 AM, an interview was conducted with the RN Surgery Director (E#3). E #3 was asked if staff are allowed to wear jewelry into the OR area (restricted). E#3 provided the policy and stated," It is a known policy jewelry is not to be worn. We follow AORN (Association of periOperative Registered Nurses) standards." E#3 agreed the observations during the OR procedure indicated infection control policies and standards were not being followed.	C 278	5. Rita Etienne, OR Director has initiated a Process Improvement for observing 10 surgical cases per week to ensure that all surgical staff is maintaining appropriate PPE Protocol for the Surgery Department. Rita is scheduled to report her findings to the Process Improvement . Quality Meeting on May 12th at 12 Noon. (See PI Quality Committee Meeting Agenda Attachment B) 6. Rita Etienne has updated the OR Allire Policy to reflect AORN standards regarding the wearing of jewelry in the OR. This policy will go to Policy Sub-Committee on May 17, 2016. See policy and Policy Sub-Committee agenda. (Attachment C&D)	
C 298	485.635(d)(2) NURSING SERVICES A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH. This STANDARD is not met as evidenced by: Based on document review and staff interview, it was determined in 1 of 4 (Pt #19) patient with wounds, the nurse failed to notify the physician of a Stage II open ulcer. This failure has the potential to affect all patients with skin breakdown.	C 298	C298- Ferrell Hospital has identified the deficiencies noted under C298 485.635 (d)(2) Nursing Services. The Plan of Correction will be as follows: 1. Sarah Hendrix, In-Patient Director is currently working with Brent Volkert, Informatics Specialist to build a check box on the EMR Anatomical Man stating" Physician Notified" and "Orders Received." Sarah informed her nursing staff in the Med-Surg/ER Staff meeting on May 4th, that we will be making the additional changes to the Anatomical Man, Wound Documentation. (See Staff Meeting Minutes, Attachment E)	05/24/16

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C 298	Continued From page 5 Findings include: 1. The policy revision date 10/14, titled "Pressure Ulcer" was reviewed on 4/14/16 at 2:30 PM. The policy indicates under "V. PROCEDURE, 15.0 Notify the physician when other interventions are needed. 16.0 Notify physician if redness persists in an area or if an open area is noted on skin. Obtain physician's order for definitive pressure ulcer care." 2. The clinical record of Pt #19 was reviewed on 4/14/16 at 1:30 PM. Pt #19 was admitted to the CAH on 2/16/16 with diagnoses of dehydration and upper respiratory infection. Documentation in the initial nursing assessment of 2/16/16 indicated Pt #19 arrived from the SNF with a Stage II decubitus ulcer of the coccyx. There is no documentation to indicate the nurse notified the physician of the open ulcer and no orders for treatment were obtained. 3. On 4/14/16 at 2:00 PM, an interview was conducted with the Inpatient Director (E#2). E#2 reviewed the record of Pt #19 and agreed there was no report to the physician and no orders for treatment.	C 298	2. Sarah Hendrix, In- Patient Director has initiated a Process Improvement; monitoring 100% of all patients with wounds. Sarah is scheduled to report her findings to the Process Improvement Quality Committee Meeting on May 12th at 12 Noon. (See PI Quality Committee Meeting Agenda Attachment F) 3. Rita Etienne, OR Manager has her wound certification. Rita will be providing education on proper staging, proper dressing change procedures, appropriate dressings and communication with physicians to all of the nursing staff during the Annual Skills lab scheduled the week of May 23rd. (See Attached Annual Nursing Skills Lab Agenda, Attachment G) 4. Sarah Hendrix, In-Patient Director has implemented a Wound Log for the Med-Surg Department. The Log will consist of patient name, patient number, date of pictures, MD notified, initials of RN who received the MD orders. (See Wound Tracking Log Attachment H)	
C 304	485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode,	C 304	C304-Ferrell Hospital has identified the deficiencies noted under 485.638(a)(4)(i) Record Systems The plan of correction will be as followed:	04/26/16

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C 304	Continued From page 6 disposition, and instructions to the patient; This STANDARD is not met as evidenced by: A. Based on document review and staff interview, it was determined in 2 of 13 (Pt #2, #4) clinical records reviewed, the CAH failed to ensure history and physicals were completed within the required timeframe. This has the potential to affect all patients receiving services. Findings include: 1. The CAH Rules and Regulations revised 12/2015 was reviewed on 4/13/16. The Rules and Regulations under "Section 2: Medical Records 4. ...A complete history and physical examination shall be recorded within twenty-four (24) hours of admission...". 2. The clinical record of Pt #2 was reviewed on 4/11/16 at 2:30 PM. Pt #2 was admitted on 4/9/16 with diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The history and physical was not completed by the physician until 4/11/16, over the 24 hour timeframe. 3. The clinical record of Pt #4 was reviewed on 4/11/16 at 2:45 PM. Pt #4 was admitted on 4/9/16 with diagnosis of altered mental status. The history and physical was not completed by the physician until 4/11/16, over the 24 hour timeframe. 4. On 4/11/16 at 3:00 PM, an interview was conducted with the Inpatient Director (E #2). E #2 reviewed the history and physicals for Pt # 2 and Pt #4. E# 2 verified the history and	C 304	1. H&P Time a. On Tuesday, April 26th, Alisa Coleman, CEO educated the Medical Staff on the required timeline of completing the History and Physicals. Alisa handed a copy of the CMS guidelines stating the required timeframe. (See Med Staff Agenda, Med Staff Meeting Minutes and copy of CMS Education; Attachments I, J & K) b. The policy titled Medical Records was submitted to the Policy Sub-Committee on May 3rd with revisions of stating the required time frames of completing H&Ps and what actions would be initiated if non-compliance is noted. The policy was approved by committee and will be forwarded to Quality Council, Med Staff Committee, and the Governing Board for final approval. (See Medical Records Policy & Policy Subcommittee Agenda Attachment L & M)	

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	141324	A. BUILDING _____ B. WING _____	04/14/2016

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C 304	Continued From page 7 physicals were not completed within the 24 hour timeframe. B. Based on document review and staff interview, it was determined in 2 of 2 (Pt #5, #6) surgical records reviewed, the CAH failed to ensure the post-operative anesthesia follow-up was timed, potentially affecting all patients receiving surgical services. Findings include: 1. The CAH Rules and Regulations revised 12/2015 was reviewed on 4/13/16. The Rules and Regulations under, "Section 2: Medical Records 8. CLINICAL ENTRIES. All clinical entries in the patient's records shall be accurately dated, timed and authenticated and legible...". 2. The clinical record of Pt #5 was reviewed on 4/13/16. Pt #5 was admitted on 4/12/16 for inguinal hernia repair. The "Post-Op Anesthesia Follow-Up" did not indicate a time of follow-up assesement. 3. The clinical record of Pt #6 was reviewed on 4/13/16. Pt #6 was admitted on 4/12/16 for a colonoscopy. The "Post-Op Anesthesia Follow-Up" did not indicate a time of follow-up assessment. 4. On 4/13/16 at 11:00 AM, an interview was conducted with the Surgical Director.(E #3). E #3 reviewed the "Post-Op Anesthesia Follow-Up" of Pt #5 and #6. E #3 stated, there is no time documented and it should have been". C. Based on document review and staff	C 304	2. CRNA Documentation: a. Rita Etienne, OR Director informed Randy Wientjes, Director/Owner of CRNA group, on 4/19/16 that he would need to provide a statement stating that all CRNA staff have been educated on proper documentation on all patient records. b. Rita Etienne, OR Director has initiated a Process Improvement for auditing 100% of all CRNA charts for 3 months. Rita will report to the Process Improvement Quality Committee on Thursday May 12th at 12 Noon. (See PI Quality Committee Meeting agenda, Attachment N)	

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C 304	Continued From page 8 Interview it was determined in 3 of 5 (Pt #13, #17, #18) ED transferring records reviewed, the CAH failed to ensure the transfer records were complete. Findings include: 1. The CAH policy revision date, 11/07, titled, "Transfer to Other Health Facilities" was reviewed on 4/14/16. The policy under "8.0 Documentation on the Authorization for Transfer form 8.2 Section 1 Certify that either: 8.2.1.1 No emergency medical condition exists, sign and date the form and stop there....8.3 Section 2 (check one) 8.3.1 The patient requests transfer...8.4 Section 3 8.4.1 Unstable patients must have section A-E....". 2. The clinical record of Pt #13 was reviewed on 4/13/16 at 2:00 PM. Pt # 13 was admitted to the ED with chief complaint psychiatric evaluation. Pt #13 was transferred to psychiatric hospital for inpatient care. The "AUTHORIZATION FOR TRANSFER" was not completed in Section 1, Section 2 or Section 3. 3. The clinical record of Pt # 17 was reviewed on 4/14/16 at 9:30 AM. Pt # 17 was admitted to the ED with chief complaint of suicidal ideation and alcohol intoxication. Pt #17 was transferred to psychiatric hospital for inpatient care. The "AUTHORIZATION FOR TRANSFER" was not completed in Section 2. 4. The clinical record of Pt # 18 was reviewed on 4/14/16 at 10:00 AM. Pt #18 was admitted to the ED with chief complaint of seizure activity. Pt #18 was transferred to an inpatient hospital. The	C 304	3. Emergency Room Authorization to Transfer Form: a. Midge Beal, ER Manager provided education in the Med-Surg-ER staff meeting on May 4th regarding the proper process of filling out the form. Midge showed an example of an incomplete form as well as a properly completed form. (See Med-Surg –ER staff meeting Minutes Attachment O) b. Midge Beal, ER Manager has initiated a Process Improvement; monitoring 100% of all Transfer Charts. Midge is scheduled to report to the Process Improvement Quality Committee Meeting on Thursday, May 12that 12 noon. (See PI Quality Committee Meeting agenda, Attachment P) c. Midge Beal, ER Manager has created individualized staff report cards covering all of the Process Improvements she is working on in the department. Midge will add to the report card properly completing the Authorization to Transfer Form to the list. These report cards have improved the awareness of the staff, assisted with improving documentation and improved the overall accountability.	

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C 304	Continued From page 9 "AUTHORIZATION FOR TRANSFER" was not completed in Section 3. 5. On 4/14/16 at 11:00 AM, an interview was conducted with the Chief Nursing Officer (E # 1). E #1 reviewed the ED transfer forms of Pt # 13, #17, and # 18. E# 1 verified the transfer forms were not completed per policy.	C 304		

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K 000	INITIAL COMMENTS On April 13 - 14, 2016, the Life Safety portion of a Re-Certification Survey was conducted. The surveyor was accompanied during the survey walk-through by the following provider representatives: Chief Financial Officer (CFO) Director of Facilities (DF) The facility consists of multiple buildings, both on-site and off-site. The buildings are described as follows: 1. Ferrell Hospital Community Foundation (Main Building), constructed in 1973, was observed to be of Type I (322) construction. The facility was observed to be partially covered by an automatic sprinkler system. The facility was surveyed as an existing health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 19. 2. The Ferrell Hospital Clinic, also constructed in 1973. The building was observed to contain no health care occupancies, was observed to be separated from all health care occupancies by minimum 2 hour fire rated construction, and had no egress paths for health care occupancies passing through it. The Clinic was excluded from the survey walk-through. 3. Therapy Services, housing outpatient physical therapy and rehabilitation functions, located at 1200 Pine Street, Eldorado, Illinois. Unless otherwise noted, those code sections listed herein that do not include a reference to a	K 000	Ferrell Hospital recognized this opportunityidentified in the survey to improve the life safety code measures within the facility to enhance the safety for our patients, staff, visitors and facility.	04/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 2 Findings include: While accompanied by the CFO and DF, the surveyor observed pipe or other penetrations in exit access corridor walls that are not sealed against the passage of smoke as required by 19.3.6.2.2. and 8.2.4.4.1. Locations observed include (all coaxial cables penetrating the wall above the room door): A. April 13, 2016 at 1:18 PM: Patient Sleeping Room 114. B. April 13, 2016 at 1:20 PM: Patient Sleeping Room 117. C. April 13, 2016 at 1:48 PM: Patient Sleeping Room 147.	K 017	(Continued from Page 2) 3. The monitoring procedures established to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and in compliance with regulatory requirements: A policy was created which will be used to monitor any contractor which may risk penetration of smoke barriers. The policy will be presented to the Policy and Procedure Committee for approval on May 3, 2016. See attached policy (Attachment C).	
K 026	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, not all designated or required smoke barrier walls are constructed or maintained as minimum 30 minute fire rated assemblies. These deficiencies could affect any patients, staff, or visitors in the building by allowing smoke to pass between smoke compartments.	K 025	K025 NFPA 101Life Safety Code Standard Ferrell Hospital recognized the opportunity identified in the survey to improve the smoke barriers within the facility to enhance the safety for our patients, staff, visitors and facility. 1. The plan of correcting the specific deficiency cited: The Facilities Director was also informed of void penetrations created during the installation of new coaxial cables by an outside contractor. On April 15, 2016, the Facilities Director and Maintenance staff identified coaxial sleeves at the open end of the sleeve, above the cross-corridor doors in patient sleeping room 106 and a smoke barrier wall adjacent to the Emergency Department. Other areas where coaxial cables were installed were inspected and all areas were identified and marked for penetration. See attached pictures (Attachment D) 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All areas with penetrations were identified and any penetration above the cross-corridor doors in smoke barrier walls that were not sealed against the passage of smoke were filled with SpecSeal Firestop Putty.	05/03/2016

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K 025	Continued From page 3 Findings include: On April 13, 2016, while accompanied by the CFO and DF, the surveyor observed penetrations (coaxial cables not sealed at both the joint between the wall and the cable sleeve and at the open end of the sleeve) above the cross-corridor doors in smoke barrier walls that are not sealed against the passage of smoke, as required by 19.3.7.3. and 8.3.6.1. A. 1:25 PM: Smoke barrier wall adjacent to patient Sleeping Room 106. B. 1:42 PM: Smoke barrier wall adjacent to Emergency Department.	K 025	3. The monitoring procedures established to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and in compliance with regulatory requirements: A contractor checklist was developed that would require validation that all smoke barriers are sealed and that all coaxial sleeves are closed in accordance with 19.3.7.3 and 8.3.6.1. that will provide a seal against the passage of smoke. See attached checklist (Attachment E).	
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, staff interview, and document review, not all emergency lighting is properly maintained. This deficiency could affect any patients, staff, or visitors in the building because the failure of the emergency lighting could prevent them from safely exiting the building under fire conditions. Findings include: A. On April 14, 2016 at 9:30 AM, during a review of the facility's building systems test records and while accompanied by the CFO and DF, the surveyor determined that battery-powered emergency lights are not tested	K 046	K046 NFPA 101 Life Safety Code Standard Ferrell Hospital recognizes the opportunity identified in the survey to improve the performance of battery testing of the emergency lighting within and outside the facility to enhance the safety for our patients, staff, visitors and facility 1. The plan for correcting the specific deficiency cited: The Facilities Director was made aware of the ninety-minute battery back-up light testing required yearly under 7.9.18.2.9.1, 19.2.9.1 and 7.9.3. The required time frame was not met as evidenced by the documentation. After review, the policy related to emergency lighting was revised to include the annual ninety minute testing requirement. The policy will be presented to the Policy and Procedure Committee on May 3, 2016. See attached policy revision (Attachment F). 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: A log book was created on April 15, 2016 to document annual testing of the Emergency Lighting. The ninety-minute annual test was performed on	05/03/2016

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K 046	Continued From page 4 for a period of 1-1/2 hours at least once each year as required by 7.9.3.	K 046		
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, staff interview, and document review, not all exit lighting is properly maintained. This deficiency could affect any patients, staff, or visitors in the building by preventing them from safely exiting the building under fire conditions. Findings include: On April 14, 2016 at 9:35 AM, during a review of the facility's building systems test records and while accompanied by the CFO and DF, the surveyor determined that battery-powered exit lights are not tested for a period of 1-1/2 hours at least once each year as required by 7.10.9.2. and 7.9.3.	K 047	K047 NPFA 101 Life Safety Code Standard Ferrell Hospital recognizes the opportunity identified in the survey to maintain the performance of continuous illumination also served by the emergency lighting system to enhance the safety for our patients, staff, visitors and facility. 1. The plan for correcting the specific deficiency cited: The Facilities Director was made aware of the need to provide continuous illumination under section 7.10 .9.2 and 7.9.3 by way of testing the battery back lighting system. The checklist for maintenance rounding did not include the ninety-minute test. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Facilities Director has included the ninety-minute testing on the Maintenance Monthly Report. The Maintenance Staff have received training on testing and documenting the testing of the emergency lighting system. See the attached in-service and attendance of training session. (Attachment H).	05/03/2016
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning	K 050		

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K 060	Continued From page 5 and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and staff interview, fire drills are not held at varying times and varying conditions. This deficeincy could affect any patients, staff, or visitors in the building because the staff may not be properly prepared for a fire emergency. Findings include: On April 14, 2016 at 9:30 AM, during a review of the facility's building systems test records and while accompanied by the CFO and DF, the surveyor determined that fire drills are not conducted at varying times as required by 19.7.1.2. During the calendar years 2015 and 2016, fire drills for the following quarters/shifts were conducted at the similar times listed: A. First Shift: 1. September 18, 2015: 2:55 PM. 2. November 30,, 2016: 3:26 PM. 3. March 29, 2016: 3:26 PM. B. Second Shift: 1. September 17, 2015: 10:25 PM. 2. November 30, 2015: 11:50 PM.	K 060	1. The plan of correcting the specific deficiency cited: The Facilities Director has been delegated the responsibility of planning and conducting drills as outlined in 18.7.1.2, 19.7.1.2. The Facilities Director recognizes that regular announced and unannounced fire drills serve to familiarize facility personnel with the signals and emergency action required under varied conditions. The Life Safety Inspection revealed an opportunity to improve the safety of the environment through performing drills and performing simulations of emergency fire conditions at unexpected times. The Facilities Director and Safety Chairperson will develop a monthly fire drill plan that will include designated times for each shift and will include weekends at various times. The Safety Committee will receive quarterly reports of the previous drill and will discuss any improvement opportunities. The evaluation of the fire drills will be added to the Safety Committee's Monthly Agenda. See Safety Agenda. (Attachment J) 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Facilities Director will re-educate and inform new employees during the May Employee Round Table Meeting to be held on May 10th and 11th of the fire drill requirement. See the Employee Round Table and New Emmployee Orientation Safety Agendas. (Attachment K)	

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K 050	Continued From page 6 3. March 28, 2016: 11:00 AM.	K 050		
K 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observation during the survey walk-through and staff interview, not all medical gas piping systems are installed and maintained as required. This deficiency could affect any patients in the cited area because the medical gas system could become compromised. Findings include: On April 13, 2016 at 12:30 PM, while accompanied by the CFO and DF, the surveyor observed that the Medical Gas Alarm Panel located on the south wall of the Nurses' Station indicated, via an illuminated warning signal, that the oxygen secondary liquid level was low. During an interview held at that time and location, the DF stated that the panel was not functioning properly. The panel is not properly alerting the facility to problems with the medical gas system in accordance with NFPA 99 1999 4-3.1.2.2(a).	K 077	K077 NFPA 101Life Safety Code Standard Ferrell Hospital recognizes that appropriate medical gas monitoring is an integral part of ongoing readiness in providing a safe environment for our patients, staff and visitors. 1. The plan of correction correcting the specific deficiency cited: The Facilities Director recognizes that having proper maintenance of gas piping systems is required. The Facilities Director was made aware that the Medical Gas Alarm Panel was not properly alerting the staff of problems related to the medical gas systym according to NFPA 99 1999 4-3.1.2.2(a). 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Facilities Director contacted the Linde Group, the medical gas vendor, and it was determined the equipment is no longer serviced by them. Maintenance staff determined that e faulty board was the reason for the warning signal for a low reading for the oxygen secondary liquid level. A new board was ordered on 04/22/2016 and will be installed by 05/17/2016.	05/17/2016
K 104	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 &	K 104		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 104	Continued From page 7 NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, not all duct penetrations at smoke barriers are protected against the passage of smoke. This deficiency could affect any patients, staff, or visitors in the building by permitting smoke to pass between smoke compartments. Findings include: On April 13, 2016 at 1:40 PM, while accompanied by the CFO and DF, the surveyor observed a duct penetrating the designated smoke barrier wall, at the north side of the Emergency Department Office, which is not equipped with a smoke damper as required by 19.3.7.3. and 8.3.5.1.	K 104	K104 NFPA 101 Life Safety Code Standard Ferrell Hospital recognizes the opportunity identified in the survey to improve the smoke barriers within the facility to enhance the safety for our patients, staff, visitors and facility. 1. The plan of correction correcting the specific deficiency cited: The Facilities Director recognized that a deficiency could affect any patients, staff or visitors in the building by permitting smoke to pass between smoke compartments. All duct penetrations at smoke barriers were not protected against the passage of smoke in accordance to 18/19.3.5 and 18.3.7.3 and 19.3.7.3. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Facilities Director investigated the duct penetration as noted by the surveyor. It was determined that the exhaust duct located near the Emergency Department was no longer required and was removed on	05/03/2016
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, document review, and staff interview, the facility is not in compliance with a series of Life Safety and other code requirements that are not documented under other K-Tags. Findings include: A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	141324	A. BUILDING 01 - MAIN BUILDING B. WING	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERRELL HOSPITAL COMMUNITY FOUNDATIONS	1201 PINE STREET ELDORADO, IL 62930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			K130 NFDA 101 Miscellaneous	05/03/2016
K 130	Continued From page 8 shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses.	K 130	3. The monitoring procedures established to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and in compliance with regulatory requirements: A daily checklist will be completed to monitor the hallways for obstruction. See the narrative for the interim life safety code measures taken. (Attachment O)	
			K145 NFDA Life Safety Code Standard	05/17/2016
K 145	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation during the survey walk-through and staff interview, the facility's electrical system is not divided into the critical branch, life safety branch, and the emergency system. These deficiencies could affect any patients being treated in the facility's patient care areas because the Essential Electrical System (EES) could become compromised. Findings include: On April 13, 2016 at 12:45 PM, while accompanied by the CFO and DF, the surveyor observed that the electrical receptacles at the patient headwall in Patient Sleeping Room 114 are not labeled or color coded to demonstrate that each patient are area is provided with electrical receptacles served by at least two	K 145	Ferrell Hospital recognizes the opportunity identified in the survey to improve knowledge, compliance and monitoring of the Life Safety Code requirements related to the electrical system to enhance the safety for our patients, staff, visitors and facility. 1. The plan of correcting the deficiency cited: The electrical receptacles at the patient headwall in Patient Sleeping Room 114 was not categorized into critical branch, life safety branch or emergency system. It is recognized that this could affect any patient being treated because the Essential Electrical System could become compromised. See pictures (Attachment P) 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Facilities Director and Maintenance Staff labeled all receptacles according to which panel and electrical branch each receptacle was assigned. Staff members will have options should emergency power be required. 3. The monitoring procedures established to insure that the plan of correction is effective and the specific deficiency cited remains corrected and in compliance with regulatory requirements: The Facilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	141324	A. BUILDING 01 - MAIN BUILDING B. WING	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRELL HOSPITAL COMMUNITY FOUNDATIONS	1201 PINE STREET ELDORADO, IL 62930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 145	Continued From page 9 separate transfer switches as required by NFPA 70 199 617-18(a) and 617-19(a). During an interview held at that time and location, the DF confirmed that all patient care areas are similar.	K 146	(Continued from Page 13) Director will educate staff members during Employee Round Table Meetings and provide Department Directors with a guide to provide education during orientation to new staff members regarding the identification of alternate circuits to use in case of an emergency power outage or faulty switch. See Employee Round Table Agenda. (Attachment Q)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	141324	A. BUILDING 02 - THERAPY SERVICES B. WING	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERRELL HOSPITAL COMMUNITY FOUNDATIONS	1201 PINE STREET ELDORADO, IL 62930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS On April 14, 2016 , the Life Safety portion of a Re-Certification Survey was conducted at the Therapy Services Building in Eldorado, Illinois The building, housing outpatient physical therapy and rehabilitation functions and constructed in 2008, was identified by provider representatives as being of Type V (000) construction and to not be covered by an automatic sprinkler system. The building was surveyed as a new business occupancy under the 2000 Edition of the NFPA 101 Life Safety Code. No deficiencies were observed during the survey walk-through.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K6P321 Facility ID: IL140XV If continuation sheet Page 1 of 1

Ferrell Hospital
DEACONESS ILLINOIS PARTNER

1201 Pine Street | Eldorado, IL 62930

September 28, 2016

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

Re: Ferrell Hospital – Assurances, Section 1130.234 e) 1)

Dear Ms. Avery:

This letter provides the Illinois Health Facilities and Services Review Board with assurances regarding our application to expand and modernize key clinical services at Ferrell Hospital.

We hereby state that it is our understanding, based upon information available to us at this time, that by the second year of operation after project completion, Ferrell Hospital reasonably expects to operate all clinical services included in this application for which there are utilization targets at the State Agency utilization specified in 77 Ill. Adm. Code 1110 Appendix B.

Sincerely,

Alisa Coleman

Alisa Coleman, CEO

Notarization
Subscribed and sworn before me
on this 28 th day of September 2016

Signature of Notary Beth Ann Cooley

Seal

Official Seal
Beth Ann Cooley
Notary Public State of Illinois
My Commission Expires 08/01/2020

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
Emergency Department	4	8
Central Supply Processing	1	1
Nuclear Medicine	1	1
Ultrasound	1	1
Laboratory with Draw Station	1	1
Mammography	1	1
General Radiology	2	2
Post-Anesthesia Care Unit Phase I (PACU)	4	4
Post-Anesthesia Care Unit Phase II	2	2
Surgical Operating Suite	1	1
Physical Therapy	1	1
Pharmacy	1	1
Rural Health Clinic	10	14
Oncology Infusion	-	4

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

Section VII. Service Specific Review Criteria

Clinical Service Areas Other than Categories of Service.

The Applicant proposes the modernization of the following Clinical Service Areas that are not Categories of Service. The following Clinical Service Areas currently exist at Ferrell Hospital.

- Emergency Department
- Central Supply Processing
- Nuclear Medicine
- Ultrasound
- Laboratory with Draw Station
- Mammography
- CT Scan
- General Radiology
- Post Anesthesia Recovery Phase I (PACU)
- Post Anesthesia Recovery Phase II
- Surgical Operating Suite
- Physical Therapy
- Pharmacy
- Rural Health Clinic
- Oncology Infusion

All of the Clinical Service Areas listed above are services that are already provided at Ferrell Hospital, excluding Oncology Infusion. The Applicant proposed a modernization project that will include modernization of the Clinical Service Areas.

77 Ill. Adm. Code 1110. Appendix B contains a utilization and square footage standard for General Radiology, Mammography, Ultrasound, CT Scan, Nuclear Medicine, Emergency Department, Endoscopy, Post Anesthesia Recovery Phase I (PACU), and Post Anesthesia Recovery Phase II – all of which are included in this project.

Criterion 1110.3030 (b) Background of Applicant.

The proposed project meets Criterion 1110.3030 (b) Background of Applicant. This criterion is demonstrated in Attachment 11.

Criterion 1110.3030 (c) Need Determination – Establishment.

The Applicant proposes the addition of Oncology Infusion services. Ferrell Hospital continues to provide quality healthcare to the members of the community it serves and currently the community Ferrell Hospital serves does not have immediate access to Oncology Infusion Services. As noted in Attachment 20, Exhibit 1 Ferrell Hospital resides in a Medically Underserved Area by the Health Resources and Services Administration. The Applicant understands that comfort and accessibility during Chemotherapy treatments are very important to patients, and is why Ferrell Hospital wishes to add Chemotherapy services.

The Oncology Infusion Department does not have State standards for review.

The following chart identifies historic and projected utilization for the first two years of operation for Oncology Infusion services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Oncology Infusion	-	-	60	60

The Applicant proposes 1,750 square feet for the Oncology Infusion services, which will feature 4 units for services. Oncology Infusion services would be primarily served during business hours. The 4 units will allow for flexibility in patient scheduling to receive their services.

Criterion 1110.3030 (d) Service Modernization.

- *Nuclear Medicine.*

The following chart identifies the State Guidelines for Nuclear Medicine.

Clinical Service Area	State Guidelines
Nuclear Medicine	2,000 visits/unit 1,600 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for Nuclear Medicine.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Nuclear Medicine	137	171	154	150

The projected utilization is based on a -2.5% compound annual growth rate from FY 2014 to FY 2016. Ferrell Hospital wishes to modernize the Nuclear Medicine key room. Currently Nuclear Medicine shares space with other Imaging services. Nuclear Medicine services, post-modernization, will have 400 square feet designated for the service, which meets the State standards.

Nuclear Medicine services will be relocated as they are currently not located in an effective area of the Hospital. Post-modernization of Ferrell Hospital the Imaging Department, which includes Nuclear Medicine services, will be located between the Emergency Department and the Surgical Suites. Nuclear Medicine services will be located next to the Laboratory as well.

- *Emergency Department.*

The following chart identifies the State Guidelines for the Emergency Department.

Clinical Service Area	State Guidelines
Emergency Department	2,000 visits/unit 900 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for the Emergency Department.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Emergency Department	6,783	6,931	7,929	8,201

The projected utilization is based on a 3.4% compound annual growth rate from FY 2014 through FY 2016. The Emergency Department, per the State standards, meets the utilization standards for 4 units. The Applicant is proposing an 8 unit, 5,371 square foot Emergency Department. The proposed Emergency Department does not meet the State standards for utilization, but does meet the standards for size.

With the modernization of Ferrell Hospital the Emergency Department will have clear separation from the rest of the facility, which it currently does not have. The current Emergency Department only has direct ambulatory access through the Ambulance Ramp entrance, which can pose a safety hazard for patients and visitors. With the modernization of the Emergency Department there will be a designated ambulatory access point for any foot traffic.

- *Ultrasound.*

The following chart identifies the State Guidelines for Ultrasound services.

Clinical Service Area	State Guidelines
Ultrasound	3,100 visits/unit 900 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for Ultrasound services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Ultrasound	1,231	1,235	1,263	1,271

The projected utilization is based on a 0.6% compound annual growth rate from FY 2014 through FY 2016. The Applicant, whom is proposing 1 Ultrasound Key Room, meets the State standards for review. The proposed Ultrasound unit will be 120 square feet, also meeting the State standards.

- *CT Scan.*

The following chart identifies State Guidelines for CT Scan.

Clinical Service Area	State Guidelines
CT Scan	7,000 visits/unit 1,800 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for CT Scan services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
CT Scan	1,947	2,175	2,714	2,689

The projected utilization is based on a 5.7% compound annual growth rate from FY 2014 through FY 2016. The Applicant, whom is proposing 1 CT Scan Key Room, meets the State standards for both utilization and square feet. The proposed CT Scan unit will be 500 square feet.

- *Mammography.*

The following chart identifies State Guidelines for Mammography services.

Clinical Service Area	State Guidelines
Mammography	5,000 visits/unit 900 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for Mammography services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Mammography	580	613	461	429

The projected utilization is based on a -6.9% compound annual growth rate from FY 2014 through FY 2016. Mammography utilization at Ferrell Hospital may be declining, but the State standards for utilization are met as the Applicant is only proposing 1 Mammography Key Room. The proposed unit will be 91 square feet, also meeting the State standards for review.

- *General Radiology*

The following chart identifies State Guidelines for General Radiology services.

Clinical Service Area	State Guidelines
General Radiology	8,000 procedures/unit 1,300 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for General Radiology services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
General Radiology	5,802	6,011	6,239	6,298

The projected utilization is based on a 0.9% compound annual growth rate from FY 2014 through FY 2016. General Radiology utilization is projected to continue to incline, but will not meet the State standards for review. The Applicant still proposes two General Radiology key units in order to continue providing General Radiology services if a unit were to be undergoing maintenance. The 2 Key Rooms proposed for General Radiology total 620 square feet, meeting the State standards of 1,300 square feet per unit.

- *Surgical Operating Suite*

The following chart identifies State Guidelines for Surgical services.

Clinical Service Area	State Guidelines
Surgical Operating Suite	1,500 hours/unit 2,750 DGSF/unit

The following chart identifies historic utilization and projected utilization for the first two years of operation for Surgical Operating Suite services.

	Historic Years		Projected Years	
Clinical Service Areas	CY 2014	CY 2015	FY 2020	FY 2021
Surgical Operating Suite	546	475	883	999

The projected utilization is adjusted on an FTE-basis. In May 2016 Ferrell Hospital added two additional General Surgeons. The Applicant proposes two Key Rooms for Surgical services, but only meets the State standards for one. Ferrell Hospital wishes to build both Key Rooms to be ready for increased utilization beyond 2021, as well as allowing for more patient flexibility in scheduling Surgical services. The current Surgical Operating Suite currently features multiple clinical deficiencies that will be corrected during the modernization of the Clinical Service Area.

These deficiencies include:

- The current Surgery Department is inefficient in its layout, and is not separated from the Medical/Surgical patient wing.
- The corridors leading to the Operating Room are currently too narrow for proper patient transport. As a result patients must be taken through more public corridors to reach the recovery units.

3,860 square feet is proposed as part of the project, which meets the State standards for review of 2,750 square feet per unit.

- *Physical Therapy*

Physical Therapy services do not have State standards for review.

The following chart identifies historic utilization and projected utilization for the first two years of operation for Physical Therapy services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Physical Therapy	6,171	8,617	8,681	8,698

The Applicant proposes 680 square feet for their Physical Therapy services.

The proposed Physical Therapy unit will be located adjacent to the Medical/Surgical wing of the Hospital, allowing for convenient patient transport. Ferrell Hospital currently provides Physical Therapy services.

- *Pharmacy*

The Pharmacy department does not have State standards for review.

The following chart identifies historic and projected utilization for the first two years of operation for Pharmacy services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Pharmacy	131,671	257,400	274,273	278,662

The Applicant proposes 1,225 square feet for the Pharmacy, which will be positioned adjacent to the PACU unit and Medical/Surgical department. This will allow for the Ferrell Hospital staff to be more efficient when providing services to patients.

- *Laboratory with Draw Station*

The Laboratory with Draw Station does not have State standards for review.

The following chart identifies historic and projected utilization for the first two years of operation for Laboratory services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Laboratory	73,243	75,459	78,018	78,672

The Applicant proposes 1,278 square feet for the Laboratory with Draw Station. This department will be placed across the corridor from both the Surgery Department and the Imaging Department, for accessibility purposes.

- *Rural Health Clinic*

The Rural Health Clinic does not have State standards for review.

The following chart identifies historic and projected utilization for the first two years of operation for Rural Health Clinic services.

	Historic Years		Projected Years	
Clinical Service Areas	FY 2015	FY 2016	FY 2020	FY 2021
Rural Health Clinic	23,181	26,162	34,526	37,006

The Applicant proposes 18,100 square feet for the Rural Health Clinic. There will be 14 pods within the Rural Health Clinic.

- *Post Anesthesia Recovery Phase I (PACU)*

The following chart identifies State Guidelines for the Post Anesthesia Recovery Phase I (PACU).

Clinical Service Area	State Guidelines
Post Anesthesia Recovery Phase I (PACU)	180 DGSF/unit

Ferrell Hospital proposes 1,197 square feet for their Post Anesthesia Recovery Phase I (PACU) department, which will feature 4 units. Ferrell Hospital does not meet the State standards for size, but it not proposing an expansion of the unit. The excess of square footage is the result of modernizing the current facility.

- *Post Anesthesia Recovery Phase II*

The following chart identifies State Guidelines for the Post Anesthesia Recovery Phase II.

Clinical Service Area	State Guidelines
Post Anesthesia Recovery Phase II	400 DGSF/unit

Ferrell Hospital proposes 1,351 square feet for their Post Anesthesia Recovery Phase I (PACU) department, which will feature 2 units. Ferrell Hospital does not meet the State standards for size, but it not proposing an expansion of the unit. The excess of square footage is the result of modernizing the current facility.

Ferrell Hospital
DEACONESS ILLINOIS PARTNER
1201 Pine Street | Eldorado, IL 62930

September 28, 2016

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

Re: Ferrell Hospital – Assurances, Section 1130.234 e) 1)

Dear Ms. Avery:

This letter provides the Illinois Health Facilities and Services Review Board with assurances regarding our application to expand and modernize key clinical services at Ferrell Hospital.

We hereby state that it is our understanding, based upon information available to us at this time, that by the second year of operation after project completion, Ferrell Hospital reasonably expects to operate all clinical services included in this application for which there are utilization targets at the State Agency utilization specified in 77 Ill. Adm. Code 1110 Appendix B.

Sincerely,

Alisa Coleman

Alisa Coleman, CEO

Notarization
Subscribed and sworn before me
on this 28 th day of September, 2016

Signature of Notary Beth Ann Cooley

Seal

Official Seal
Beth Ann Cooley
Notary Public State of Illinois
My Commission Expires 08/01/2020

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

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

VIII. - 1120.120 - Availability of Funds

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

_____	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;
$510,000 _____	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;
$36,843,666 _____	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.
$37,353,666	**TOTAL FUNDS AVAILABLE**	

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

1. **"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.

Section IX. Financial Viability

USDA Funding

The U.S. Department of Agriculture is favorably inclined to finance the proposed project, but will not approve an application for funding until the Certificate of Need determination is made. Confirmation that the U.S. Department of Agriculture is aware, and interested in, funding the Ferrell Hospital modernization project can be seen in Attachment 37, Exhibit 1.

U.S. DEPARTMENT OF AGRICULTURE

NOTICE OF PREAPPLICATION REVIEW ACTION

From: **USDA, Rural Development**

Agency Number: 07
Preapplication #: _____
Date: 10-17-2016

To: Alisa Coleman, CEO
Ferrell Hospital Community Foundation
1201 Pine Street
Eldorado, IL 62930

1. We have reviewed your preapplication for Federal assistance under 10.766 and have determined that your proposal is:

   X eligible for funding by this agency and can compete with similar applications from other applicants.
   _____ eligible but does not have the priority necessary for further consideration at this time.
   _____ not eligible for funding by this agency.

2. Therefore, we suggest that you:
   X file a formal application with us before December 31, 2016.
   _____ file an application with _____ (Suggested Federal agency).
   _____ find other means of funding this project.

3. Based upon the funds available for this program over the last two fiscal years and the number of applications reviewed, or pending, we anticipate that funds for which you are competing will be available after _____.

4. You requested **$36,135,000.00** Federal funding in your preapplication form, and we:
   X are agreeable to consideration of approximately this amount in the formal application.
   _____ will need to analyze the amount requested in more detail.

5. A preapplication conference will be X necessary ___not necessary. Please contact this office to set up a time and place.

6. Enclosures: _____ Forms _____Instructions _____ Other (specify) _____

7. Other remarks: **See Attached**

Signature	Title	Date
Leeann Denny	**Area Specialist**	10-17-2016
USDA, Rural Development	**Marion Area Office**	**(618) 993-5396**
Address 502 Comfort Drive Marion, IL 62959		

Note: This form will be used by Federal agencies to inform applicants of the results of a review of their preapplication request for Federal assistance. When the review cannot be performed within 45 days, the applicant shall be informed by letter as to when the review will be completed. When Federal agencies determine that the proposal is not eligible for Federal assistance, specific reasons should be provided in Item 7 Other Remarks.

Form AD 622 (12-72)

USDA

United States Department of Agriculture

October 17, 2016

ATTACHMENT TO AD-622

Ferrell Hospital Community Foundation
New building
CF LOAN - $36,135,135

Rural Development has reviewed Ferrell Hospital's pre-application for Federal Assistance for a Community Facility Loan (CF Loan) to build a new facility.

We are of the opinion this is a worthy project and would consider a loan of approximately $36,135,135.

The offer is subject to the availability of FY 2017 direct loan funding. The project may require either private loan or a guaranteed CF loan leveraged funds or other outside grant funds.

Due to the size and scope of the project, a feasibility study per CF guidelines will be required. This will need to be an examined forecast with applicable CPA opinion letter.

A detailed Preliminary Architectural Report per RD Instruction 1942, guide 6 is required.

Rural Development will not be able to refinance their existing debt.

OGC will need to review the Management Agreement and possibly other agreements between Ferrell Hospital and Deaconess Health Systems.

The preliminary architectural report, architectural services agreement and environmental assessment should be completed and submitted to this office as soon as possible. The environmental assessment must be completed and any required public notices given and the architectural report and cost estimate approved before a letter of conditions can be issued.

You are reminded of the requirement to hold a public meeting before funds can be obligated.

You are advised against taking any actions or incurring any obligations, which would either limit the range of alternatives to be considered, or which would have an adverse effect on the environment.

Please call me to set up a meeting for the application conference.

Leeann Denny
Area Specialist

cc: CP Section, Champaign
Area Director, Marion

Rural Development • Marion Area Office
502 Comfort Dr. • Marion, IL 62959
Voice (618) 993-5396 • Fax (855) 833-9898
TTY (217) 403-6240

IX. **1120.130 - Financial Viability**

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

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

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	FY 2014	FY 2015	FY 2016	FY 2022
Current Ratio	.98	1.21	1.48	3.33
Net Margin Percentage	4.34%	4.83%	5.30%	0.33%
Percent Debt to Total Capitalization	2542.07%	417.60%	167.72%	769.18%
Projected Debt Service Coverage	2.52	2.29	1.97	2.05
Days Cash on Hand	11.71	12.20	21.90	84.09
Cushion Ratio	0.90	0.76	1.06	2.85

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.

Ferrell Hospital - Viability Ratios*	Audited Financial Statements			Forecast
*All numbers in (000s)	3/31/2014	3/31/2015	3/31/2016	3/31/2022
Current Ratio				
Total Current Assets	3,798	3,498	3,607	9,599
Total Current Liabilities	3,868	2,885	2,441	2,884
Current Ratio	**0.98**	**1.21**	**1.48**	**3.33**
Net Margin Percentage				
Net Income	702	768	931	87
Net Operating Revenues	16,190	15,913	17,576	26,004
Net Margin Percentage	**4.34%**	**4.83%**	**5.30%**	**0.33%**
Percent Debt to Total Capitalization				
Current maturities of long-term debt	335	638	719	570
Long-term debt, less current maturities	3,351	3,325	3,308	33,974
Total long-term debt	3,686	3,963	4,027	34,544
Unrestricted net assets	145	949	2,401	4,491
Percent Debt to Total Capitalization	**2542.07%**	**417.60%**	**167.72%**	**769.18%**
Projected Debt Service Coverage				
Net Income	702	768	931	87
Depreciation and Amortization	466	508	636	2,446
Interest	176	205	214	1,350
	1,344	1,481	1,781	3,883
Principal paid on long-term debt	358	441	691	548
Interest	176	205	214	1,350
	534	646	905	1,898
Projected Debt Service Coverage	**2.52**	**2.29**	**1.97**	**2.05**
Days Cash on Hand				
Cash and Cash Equivalents	213	247	206	4,653
Board Designated	269	242	754	754
	482	489	960	5,407
Operating Expense	15,488	15,144	16,634	25,917
Depreciation and Amortization	466	508	636	2,446
	15,022	14,636	15,998	23,471
Days	365	365	365	365
	41	40	44	64
Days Cash on Hand	**11.71**	**12.20**	**21.90**	**84.09**
Cushion Ratio				
Cash and Cash Equivalents	213	247	206	4,653
Board Designated	269	242	753	754
	482	489	959	5,407
Principal Payments on Long-Term Debt	358	441	691	548
Interest	176	205	214	1,350
Cushion Ratio	**0.90**	**0.76**	**1.06**	**2.85**

Ferrell Hospital
Forecasted Balance Sheets

	Audited 3/31/2016	Forecasted 3/31/2017	Forecasted 3/31/2018	Forecasted 3/31/2019	Forecasted 3/31/2020	Forecasted 3/31/2021	Forecasted 3/31/2022
Assets							
Current Assets							
Cash and Cash Equivalents	$ 206,243	$ 108,000	$ 53,000	$ 1,538,000	$ 2,165,000	$ 3,331,000	$ 4,653,000
Patient Accounts Receivable, Net	2,498,095	2,732,000	2,839,000	2,962,000	3,490,000	3,601,000	3,716,000
Other Receivables	437,037	437,000	437,000	437,000	437,000	437,000	437,000
Inventories	236,524	244,000	254,000	264,000	320,000	332,000	344,000
Prepaid Expenses	402,513	410,000	417,000	425,000	433,000	441,000	449,000
Total Current Assets	3,780,413	3,931,000	4,000,000	5,626,000	6,845,000	8,142,000	9,599,000
Assets Whose Use Is Limited							
Debt Reserve Funds	561,036	225,000	225,000	225,000	411,000	597,000	783,000
Project Fund	-	-	19,268,000	-	-	-	-
Board Designated	753,505	754,000	754,000	754,000	754,000	754,000	754,000
Total Assets Whose Use Is Limited	1,314,541	979,000	20,247,000	979,000	1,165,000	1,351,000	1,537,000
Property and Equipment, Net	3,054,723	3,331,000	16,363,000	34,829,000	32,848,000	30,829,000	28,833,000
Other Assets	-	-	1,509,000	1,509,000	1,466,000	1,423,000	1,380,000
Total Assets	$ 8,149,676	$ 8,241,000	$ 42,119,000	$ 42,943,000	$ 42,324,000	$ 41,745,000	$ 41,349,000
Liabilities and Net Assets							
Current Liabilities							
Current Maturities of Long-Term Debt	$ 719,097	$ 135,000	$ 115,000	$ 583,000	$ 563,000	$ 549,000	$ 570,000
Accounts Payable	551,682	570,000	591,000	612,000	712,000	736,000	761,000
Accrued Payroll and Related Expenses	990,789	1,166,000	1,201,000	1,247,000	1,295,000	1,334,000	1,374,000
Estimated Third-Party Payor Settlements Payable	179,338	179,000	179,000	179,000	179,000	179,000	179,000
Total Current Liabilities	2,440,905	2,050,000	2,086,000	2,621,000	2,749,000	2,798,000	2,884,000
Long-Term Debt, Less Current Maturities	3,307,700	3,174,000	36,238,000	35,655,000	35,092,000	34,543,000	33,974,000
Total Liabilities	5,748,605	5,224,000	38,324,000	38,276,000	37,841,000	37,341,000	36,858,000
Net Assets - Unrestricted	2,401,072	3,017,000	3,795,000	4,667,000	4,483,000	4,404,000	4,491,000
Total Liabilities and Net Assets	$ 8,149,676	$ 8,241,000	$ 42,119,000	$ 42,943,000	$ 42,324,000	$ 41,745,000	$ 41,349,000

Ferrell Hospital
Forecasted Statements of Operations and Changes in Net Assets

	Audited 3/31/2016	Forecasted 3/31/2017	Forecasted 3/31/2018	Forecasted 3/31/2019	Forecasted 3/31/2020	Forecasted 3/31/2021	Forecasted 3/31/2022
Unrestricted Revenues, Gains and Other Support							
Patient Service Revenue (net of contractual allowances and discounts)	$ 17,721,489	$ 19,445,000	$ 20,232,000	$ 21,130,000	$ 24,878,000	$ 25,707,000	$ 26,565,000
Provision for Bad Debts	(877,280)	(978,000)	(1,041,000)	(1,108,000)	(1,288,000)	(1,364,000)	(1,447,000)
Net Patient Service Revenue, Less Provision for Bad Debts	16,844,210	18,467,000	19,191,000	20,022,000	23,590,000	24,343,000	25,118,000
Other Revenue	720,261	744,000	770,000	797,000	825,000	855,000	886,000
Total Unrestricted Revenues, Gains, and Support	17,564,471	19,211,000	19,961,000	20,819,000	24,415,000	25,198,000	26,004,000
Expenses							
Salaries and Wages	7,564,263	8,991,000	9,260,000	9,611,000	9,975,000	10,275,000	10,583,000
Employee Benefits	1,476,548	1,851,000	1,702,000	1,769,000	1,838,000	1,895,000	1,954,000
Professional Fees	1,306,944	1,341,000	1,376,000	1,412,000	1,448,000	1,486,000	1,525,000
Utilities	236,629	246,000	255,000	265,000	275,000	285,000	296,000
Repairs and Maintenance	198,750	204,000	209,000	215,000	220,000	226,000	232,000
Drugs and Pharmaceuticals	613,811	682,000	736,000	795,000	1,833,000	1,902,000	1,977,000
Supplies and Other	4,371,416	4,558,000	4,712,000	4,874,000	5,042,000	5,219,000	5,404,000
Depreciation and Amortization	506,153	620,000	696,000	775,000	2,431,000	2,469,000	2,446,000
Interest and Amortization	213,933	157,000	91,000	84,000	1,389,000	1,371,000	1,350,000
Insurance	143,495	145,000	146,000	147,000	148,000	149,000	150,000
Total Expenses	16,631,943	18,595,000	19,183,000	19,947,000	24,599,000	25,277,000	25,917,000
Operating Income (Loss)	932,528	616,000	778,000	872,000	(184,000)	(79,000)	87,000
Other Income							
Gain on Property Taxes	(1,902)	-	-	-	-	-	-
Interest Income	7,830	-	-	-	-	-	-
Unrestricted Donations	4,036	-	-	-	-	-	-
Other Income, Net	9,964	-	-	-	-	-	-
Revenues in Excess of (Less Than) Expenses	942,492	616,000	778,000	872,000	(184,000)	(79,000)	87,000
Grants Received for Property and Equipment	510,000	-	-	-	-	-	-
Change in Unrestricted Net Assets	1,452,492	616,000	778,000	872,000	(184,000)	(79,000)	87,000
Unrestricted Net Assets - Beginning of Year	948,580	2,401,000	3,017,000	3,795,000	4,667,000	4,483,000	4,404,000
Unrestricted Net Assets - End of Year	$ 2,401,072	$ 3,017,000	$ 3,795,000	$ 4,667,000	$ 4,483,000	$ 4,404,000	$ 4,491,000

Ferrell Hospital
Forecasted Statements of Cash Flows

	Audited 3/31/2016	Forecasted 3/31/2017	Forecasted 3/31/2018	Forecasted 3/31/2019	Forecasted 3/31/2020	Forecasted 3/31/2021	Forecasted 3/31/2022
Cash Flows from Operating Activities							
Change in Net Assets	$ 1,452,492	$ 616,000	$ 778,000	$ 872,000	$ (184,000)	$ (79,000)	$ 87,000
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities							
Depreciation and Amortization	506,153	620,000	696,000	775,000	2,431,000	2,469,000	2,446,000
Amortization of Deferred Financing Costs	-	-	-	-	43,000	43,000	43,000
Grants Received for Property and Equipment	(510,000)	-	-	-	-	-	-
Provision for Bad Debts	877,280	978,000	1,041,000	1,108,000	1,286,000	1,364,000	1,447,000
(Increase) Decrease in:							
Patient Receivables	(790,599)	(1,213,000)	(1,148,000)	(1,231,000)	(1,814,000)	(1,475,000)	(1,562,000)
Other Current Assets	(188,483)	(15,000)	(17,000)	(18,000)	(84,000)	(20,000)	(20,000)
Increase (Decrease) in:							
Accounts Payable and Accrued Expenses	128,654	194,000	56,000	67,000	148,000	63,000	65,000
Estimated Third-Party Payor Settlements	(653,819)	-	-	-	-	-	-
Net Cash Provided by Operating Activities	821,678	1,180,000	1,406,000	1,573,000	1,846,000	2,365,000	2,506,000
Cash Flows from Investing Activities							
Purchase of Property and Equipment	(229,147)	(896,000)	(13,728,000)	(19,241,000)	(450,000)	(450,000)	(450,000)
Change in Assets Limited as to Use	(848,645)	336,000	(19,268,000)	19,268,000	(186,000)	(186,000)	(186,000)
Net Cash Used by Investing Activities	(1,077,792)	(560,000)	(32,996,000)	27,000	(636,000)	(636,000)	(636,000)
Cash Flows from Financing Activities							
Payment of Debt Issuance Costs	-	-	(1,509,000)	-	-	-	-
Proceeds from Issuance of Long-Term Debt	398,400	-	36,135,000	-	-	-	-
Refinance of Long-Term Debt	-	-	(2,956,000)	-	-	-	-
Principal Payments on Long-Term Debt	(691,305)	(718,000)	(135,000)	(115,000)	(583,000)	(563,000)	(548,000)
Grants Received for Property and Equipment	510,000	-	-	-	-	-	-
Net Cash Provided (Used) by Financing Activities	215,095	(718,000)	31,535,000	(115,000)	(583,000)	(563,000)	(548,000)
Increase (Decrease) in Cash and Cash Equivalents	(41,019)	(98,000)	(55,000)	1,485,000	627,000	1,166,000	1,322,000
Cash and Cash Equivalents at Beginning of Year	247,262	206,000	108,000	53,000	1,538,000	2,165,000	3,331,000
Cash and Cash Equivalents at End of Year	$ 206,243	$ 108,000	$ 53,000	$ 1,538,000	$ 2,165,000	$ 3,331,000	$ 4,653,000
Supplemental Disclosure of Cash Flow Information							
Cash Payments for Interest	$ 213,933	$ 157,000	$ 920,000	$ 913,000	$ 1,346,000	$ 1,328,000	$ 1,307,000
Capital Lease Obligations Incurred for Equipment	$ 358,509	$ -	$ -	$ -	$ -	$ -	$ -

Ferrell Hospital
Forecasted Schedule of Debt Service Coverage and Financial Ratios

	Audited 3/31/2016	Forecasted 3/31/2017	Forecasted 3/31/2018	Forecasted 3/31/2019	Forecasted 3/31/2020	Forecasted 3/31/2021	Forecasted 3/31/2022
Income Available for Debt Service:							
Operating Income (Loss)	$ 932,528	$ 616,000	$ 778,000	$ 872,000	$ (184,000)	$ (79,000)	$ 87,000
Add Back:							
Depreciation and Amortization	506,153	620,000	696,000	775,000	2,431,000	2,469,000	2,446,000
Interest and Amortization	213,933	157,000	91,000	84,000	1,389,000	1,371,000	1,350,000
Total Income Available for Debt Service	$ 1,652,614	$ 1,393,000	$ 1,565,000	$ 1,731,000	$ 3,636,000	$ 3,761,000	$ 3,883,000
Debt Service:							
Principal Payments	$ 891,305	$ 718,000	$ 135,000	$ 115,000	$ 583,000	$ 583,000	$ 548,000
Interest Payments	213,933	157,000	920,000	913,000	1,346,000	1,328,000	1,307,000
Less: Project Funded Capitalized Interest	-	-	(829,000)	(829,000)	-	-	-
Total Debt Service	$ 905,238	$ 875,000	$ 226,000	$ 199,000	$ 1,929,000	$ 1,891,000	$ 1,855,000
Debt Service Coverage Ratio (Times)	1.83	1.59	6.92	8.70	1.88	1.99	2.09
Debt Service as Percentage of Net Patient Revenue	5.37%	4.74%	1.18%	0.99%	8.18%	7.77%	7.39%
Operating Margin	5.31%	3.21%	3.90%	4.19%	-0.75%	-0.31%	0.33%
Operating EBITDA	1,652,614	1,393,000	1,565,000	1,731,000	3,636,000	3,761,000	3,883,000
Operating EBITDA Margin	9.41%	7.25%	7.84%	8.31%	14.99%	14.93%	14.93%
Days Cash on Hand - (Operating Funds Only)	5	2	1	29	36	53	72
Days Cash on Hand - (Including Board Designated Funds)	22	18	16	44	48	65	84

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

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

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

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

Cost and Gross Square Feet by Department or Service									
Department	A	B	C	D	E	F	G	H	Total Cost
	Cost/Square Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	
	New	Mod.	New	Circ.*	Mod.	Circ.*	(A x C)	(B x E)	(G+H)
Clinical									
Emergency Department	$ 356.85	$ -	5,371	1,700	-	-	$ 1,916,644	$ -	$ 1,916,644
Diagnostic Imaging	$ 381.41	$ -	1,680	500	-	-	$ 640,775	$ -	$ 640,775
CT Scan	$ 381.41	$ -	500	-	-	-	$ 190,707	$ -	$ 190,707
General Radiology	$ 381.41	$ -	620	-	-	-	$ 236,477	$ -	$ 236,477
Ultrasound	$ 381.41	$ -	120	-	-	-	$ 45,770	$ -	$ 45,770
Mammography	$ 381.41	$ -	91	-	-	-	$ 34,709	$ -	$ 34,709
Nuclear Medicine	$ 381.41	$ -	400	-	-	-	$ 152,566	$ -	$ 152,566
Surgical Operating Suite	$ 360.19	$ -	3,860	985	-	-	$ 1,390,319	$ -	$ 1,390,319
Surgical Preparation	$ 360.19	$ -	1,135	240	-	-	$ 408,811	$ -	$ 408,811
Post Anesthesia Recovery Phase I (PACU)	$ 360.19	$ -	1,197	300	-	-	$ 431,143	$ -	$ 431,143
Post Anesthesia Recovery Phase II	$ 360.19	$ -	1,351	250	-	-	$ 486,612	$ -	$ 486,612
Inpatient Physical Therapy	$ 317.24	$ -	680	-	-	-	$ 215,723	$ -	$ 215,723
Medical / Surgical	$ 373.26	$ 193.55	9,075	2,300	840	275	$ 3,387,317	$ 162,578	$ 3,549,896
Mobile Technology Port (MRI)	$ -	$ -	-	-	-	-	$ -	$ -	$ -
Endoscopy	$ 333.56	$ -	1,357	290	-	-	$ 452,641	$ -	$ 452,641
Laboratory	$ 342.25	$ -	1,278	350	-	-	$ 437,401	$ -	$ 437,401
Pharmacy	$ 279.30	$ -	1,225	180	-	-	$ 342,147	$ -	$ 342,147
Pain Management	$ 317.24	$ -	818	200	-	-	$ 259,502	$ -	$ 259,502
Central Sterile Processing	$ 326.51	$ -	1,250	130	-	-	$ 408,133	$ -	$ 408,133
Rural Health Clinic	$ 204.55	$ 72.83	3,370	511	6,254	1,715	$ 689,338	$ 455,474	$ 1,144,812
Oncology Infusion Area	$ 317.24	$ 149.96	1,250	320	500	180	$ 396,551	$ 74,980	$ 471,530
Pre-Admission Services (Draw Station)	$ 321.06	$ -	422	60	-	-	$ 135,486	$ -	$ 135,486
Respiratory Therapy	$ 317.24	$ -	640	-	-	-	$ 203,034	$ -	$ 203,034
Clinical / Average Cost / Sq. Ft.	$ 342.52	$ 138.78					$ 584,628	$ 231,011	$ 616,129
Clinical Contingency/ Sq. Ft.	$ 34.13	$ 13.69					$ 1,286,181	$ 103,955	$ 1,390,135
Clinical Subtotal	**$ 375.38**	**$ 104.95**	**37,690**	**8,316**	**7,594**	**2,170**	**$ 14,147,986**	**$ 796,987**	**$ 14,944,973**
Non-Clinical									
Registration	$ 268.76	$ 171.83	1,920	200	800	-	$ 516,028	$ 137,464	$ 653,492
Chapel	$ 268.76	$ -	190	-	-	-	$ 51,065	$ -	$ 51,065
Lobby / Public Space	$ 268.76	$ 126.23	3,382	1,776	500	100	$ 908,963	$ 63,115	$ 972,077
Ambulance Vestibule	$ 268.76	$ -	90	-	-	-	$ 24,189	$ -	$ 24,189
Maintenance	$ -	$ -	-	-	-	-	$ -	$ -	$ -
Materials Management	$ -	$ 75.00	-	-	1,442	-	$ -	$ 108,150	$ 108,150
Circulation / Building Gross	$ 268.76	$ -	3,450	-	-	-	$ 927,239	$ -	$ 927,239
Health Information Management	$ -	$ 45.00	-	-	915	-	$ -	$ 41,175	$ 41,175
Administration	$ -	$ 130.95	-	-	3,098	475	$ -	$ 405,687	$ 405,687
Waiting / Dining	$ 330.15	$ -	3,980	-	-	-	$ 1,314,010	$ -	$ 1,314,010
Gift Shop	$ 356.08	$ -	506	-	-	-	$ 180,176	$ -	$ 180,176
Kitchen	$ 330.15	$ -	1,850	-	-	-	$ 610,783	$ -	$ 610,783
Information Management (IT)	$ -	$ 45.00	-	-	315	-	$ -	$ 14,175	$ 14,175
Plant Operations	$ -	$ 45.00	-	-	300	-	$ -	$ 13,500	$ 13,500
Environmental Services	$ -	$ 138.47	-	-	350	-	$ -	$ 48,464	$ 48,464
Conference Room	$ -	$ 45.00	-	-	1,100	-	$ -	$ 49,500	$ 49,500
Human Resources	$ -	$ 45.00	-	-	506	-	$ -	$ 22,770	$ 22,770
Mechanical / Electrical	$ 208.01	$ 45.00	1,950	-	150	-	$ 405,615	$ 6,750	$ 412,365
Storage	$ -	$ -	-	-	-	-	$ -	$ -	$ -
Housekeeping	$ -	$ 138.47	-	-	300	-	$ -	$ 41,541	$ 41,541
Demolition	$ 139.77	$ -	16,457	-	-	-	$ 2,300,237	$ 67,875	$ 2,368,112
Non-Clinical Cost / Sq. Ft.							$ 7,238,305	$ 1,020,166	$ 8,258,471
Non-Clinical Contingency/ Sq. Ft.	$ 41.80	$ 15.65					$ 723,830	$ 153,025	$ 876,855
Non-Clinical Average Cost / Sq. Ft.	$ 285.36	$ 87.58					$ 1,316,055	$ 145,738	$ 825,847
Total with Contingency/Average Cost/Sq. Ft.	**$ 309.38**	**$ 113.42**	**71,465**	**10,292**	**17,370**	**2,745**	**$ 22,110,121**	**$ 1,970,178**	**$ 24,080,299**

Section X. Economic Feasibility

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.

The direct annual operating costs for Fiscal Year 2022, as indicated in Attachment 38, Exhibit 1 are $17,941,000. This total includes Salaries and Wages ($10,583,000), Employee Benefits ($1,954,000), and Supplies and Other ($5,404,000).

	Fiscal Year 2022 (000's)
Salaries and Wages	$10,583
Employee Benefits	$1,954
Supplies and Other	$5,404
Estimated Direct Operating Costs	$17,941
Inpatient Gross Revenue	$13,640
Total Revenue	$26,004
Patient Days	3,570
Equivalent Patient days	19,881
Estimated Direct Operating costs per Equivalent Patient Day	$ 902

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.

The annual capital costs for Fiscal Year 2022, as indicated in Attachment 38, Exhibit 1 are $636,000. This total includes Purchase of Property and Equipment ($450,000) and Change In Assets Limited as to Use ($186,000).

	Fiscal Year 2022 (000's)
Purchase of Property and Equipment	$450
Change in Assets Limited as to Use	$186
Estimated Direct Capital Costs	$636
Inpatient Gross Revenue	$13,640
Total Revenue	$26,004
Patient Days	3,570
Equivalent Patient days	19,881
Estimated Direct Capital costs per Equivalent Patient Day	$ 32

Section X. Economic Feasibility

USDA Funding

The U.S. Department of Agriculture is favorably inclined to finance the proposed project, but will not approve an application for funding until the Certificate of Need determination is made. Confirmation that the U.S. Department of Agriculture is aware, and interested in, funding the Ferrell Hospital modernization project can be seen in Attachment 39, Exhibit 1. As demonstrated in Attachment 39, Exhibit 2 Ferrell Hospital sought out the debt financing alternative that would be the lowest cost option.

U.S. DEPARTMENT OF AGRICULTURE

NOTICE OF PREAPPLICATION REVIEW ACTION

From: **USDA, Rural Development**

Agency Number: 07
Preapplication #: _____
Date: 10-17-2016

To: Alisa Coleman, CEO
Ferrell Hospital Community Foundation
1201 Pine Street
Eldorado, IL 62930

1. We have reviewed your preapplication for Federal assistance under 10.766 and have determined that your proposal is:

   X eligible for funding by this agency and can compete with similar applications from other applicants.
   _____ eligible but does not have the priority necessary for further consideration at this time.
   _____ not eligible for funding by this agency.

2. Therefore, we suggest that you:
   X file a formal application with us before December 31, 2016.
   _____ file an application with _____ (Suggested Federal agency).
   _____ find other means of funding this project.

3. Based upon the funds available for this program over the last two fiscal years and the number of applications reviewed, or pending, we anticipate that funds for which you are competing will be available after _____.

4. You requested **$36,135,000.00** Federal funding in your preapplication form, and we:
   X are agreeable to consideration of approximately this amount in the formal application.
   _____ will need to analyze the amount requested in more detail.

5. A preapplication conference will be X necessary ___not necessary. Please contact this office to set up a time and place.

6. Enclosures: _____ Forms _____Instructions _____ Other (specify) _____

7. Other remarks: **See Attached**

Signature	Title	Date
Leeann Denny	**Area Specialist**	10-17-2016
USDA, Rural Development	**Marion Area Office**	**(618) 993-5396**
Address 502 Comfort Drive Marion, IL 62959		

Note: This form will be used by Federal agencies to inform applicants of the results of a review of their preapplication request for Federal assistance. When the review cannot be performed within 45 days, the applicant shall be informed by letter as to when the review will be completed. When Federal agencies determine that the proposal is not eligible for Federal assistance, specific reasons should be provided in Item 7 Other Remarks.

Form AD 622 (12-72)

USDA

United States Department of Agriculture

October 17, 2016

ATTACHMENT TO AD-622

Ferrell Hospital Community Foundation
New building
CF LOAN - $36,135,135

Rural Development has reviewed Ferrell Hospital's pre-application for Federal Assistance for a Community Facility Loan (CF Loan) to build a new facility.

We are of the opinion this is a worthy project and would consider a loan of approximately $36,135,135.

The offer is subject to the availability of FY 2017 direct loan funding. The project may require either private loan or a guaranteed CF loan leveraged funds or other outside grant funds.

Due to the size and scope of the project, a feasibility study per CF guidelines will be required. This will need to be an examined forecast with applicable CPA opinion letter.

A detailed Preliminary Architectural Report per RD Instruction 1942, guide 6 is required.

Rural Development will not be able to refinance their existing debt.

OGC will need to review the Management Agreement and possibly other agreements between Ferrell Hospital and Deaconess Health Systems.

The preliminary architectural report, architectural services agreement and environmental assessment should be completed and submitted to this office as soon as possible. The environmental assessment must be completed and any required public notices given and the architectural report and cost estimate approved before a letter of conditions can be issued.

You are reminded of the requirement to hold a public meeting before funds can be obligated.

You are advised against taking any actions or incurring any obligations, which would either limit the range of alternatives to be considered, or which would have an adverse effect on the environment.

Please call me to set up a meeting for the application conference.

Leeann Denny
Area Specialist

cc: CP Section, Champaign
Area Director, Marion

Rural Development • Marion Area Office
502 Comfort Dr. • Marion, IL 62959
Voice (618) 993-5396 • Fax (855) 833-9898
TTY (217) 403-6240

Ferrell Hospital

1201 Pine Street | Eldorado, IL 62930 | P: 618-273-3361 | F: 618-273-2571

October 31, 2016

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

RE: Ferrell Hospital Community Foundation d.b.a. Ferrell Hospital

Dear Ms. Avery:

This letter will serve to inform you of our intent to secure financing of our project through the USDA Community Facilities division of the USDA. This is the lowest cost option available to Ferrell Hospital

Sincerely,

Alisa Coleman

Alisa Coleman, CEO

Notarization
Subscribed and swom before me
On this 31 st day of October, 2016

Signature of Notary R Robison

Seal:

"OFFICIAL SEAL"
R. ROBISON
Notary Public, State of Illinois
My Commission Expires: 9/11/2017

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2013**	**2014**	**2015**
Inpatient	17	7	6
Outpatient	801	207	208
Total	**818**	**213**	**214**
Charity (cost in dollars)			
Inpatient	$218,155	$7,171	$56,283
Outpatient	$650,987	$172,103	$178,230
Total	**$869,142**	**$179,274**	**$234,515**
MEDICAID			
Medicaid (# of patients)	**2013**	**2014**	**2015**
Inpatient	112	126	122
Outpatient	2,912	7,681	7,471
Total	3,024	7,807	7,593
Medicaid (revenue)			
Inpatient	$425,571	$282,284	$456,663
Outpatient	$2,527,810	$1,192,049	$2,692,740
Total	**$2,953,381**	**$1,474,333**	**$3,149,403**

Section XI. Safety Net Impact Statement

Ferrell Hospital Community Foundation, which does business as Ferrell Hospital, proposes to modernize their current campus at 1201 Pine Street in Eldorado, Illinois. The 25-bed Critical Access Hospital does not propose to increase their licensed beds, but rather to modernize their existing services, address code and safety issues, and update the facility. The Applicant provides healthcare services that are essential to their patients within the Service Area.

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

The current population within Ferrell Hospital's Service Area is aging and has limited access to locally based hospital facilities asides from Ferrell Hospital. If modernization to the Ferrell Hospital facility is not approved, the hospital will continue to provide existing services; no service discontinuation is proposed. However, modernization of the current facility will allow Ferrell Hospital to provide quality care in a more contemporary facility.

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.

Ferrell Hospital is a Critical Access Hospital, and, as a result, is located distant from other community hospitals in the region. The majority of the care Ferrell Hospital provides is to the population of the immediate surrounding community. The patients expected to use the services provided by Ferrell Hospital are all local community residents that see Ferrell Hospital as their hometown healthcare provider. Therefore, the proposed modernization project is not expected to have any impact on another provider's ability to provide safety net services. Ferrell Hospital will continue to provide, as it does today, safety net service to its community and Service Area.

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.

Not applicable, no service discontinuation is anticipated. The Applicant proposes a modernization project.

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			
	FY 2014	**FY 2015**	**FY 2016**
Net Patient Revenue	**$16,580,217**	**$16,347,058**	**$17,721,488**
Amount of Charity Care (charges)	$795,000	$235,000	$322,000
Cost of Charity Care	$329,000	$95,000	$148,000

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

FERRELL HOSPITAL COMMUNITY FOUNDATION

FINANCIAL STATEMENTS

YEARS ENDED MARCH 31, 2016 AND 2015

FERRELL HOSPITAL COMMUNITY FOUNDATION
TABLE OF CONTENTS
YEARS ENDED MARCH 31, 2016 AND 2015

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Ferrell Hospital Community Foundation
Eldorado, Illinois

Report on the Financial Statements

We have audited the accompanying financial statements of Ferrell Hospital Community Foundation (an Illinois not-for-profit corporation), which comprise the balance sheets as of March 31, 2016 and 2015 and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Board of Directors
Ferrell Hospital Community Foundation

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Ferrell Hospital Community Foundation as of March 31, 2016 and 2015, and the results of its operations and changes in its net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated July 29, 2016, on our consideration of Ferrell Hospital Community Foundation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Ferrell Hospital Community Foundation's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
July 29, 2016

FERRELL HOSPITAL COMMUNITY FOUNDATION
BALANCE SHEETS
MARCH 31, 2016 AND 2015

	2016	2015
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 206,242	$ 247,262
Patient Accounts Receivable, Net	2,598,190	2,584,776
Other Receivables	336,942	303,485
Inventories	236,525	240,091
Prepaid Expenses	228,639	122,903
Total Current Assets	3,606,538	3,498,517
ASSETS WHOSE USE IS LIMITED		
Debt Reserve Funds	224,873	223,425
Project Funds	336,162	-
Board Designated	753,505	242,471
Total Assets Limited as to Use	1,314,540	465,896
PROPERTY AND EQUIPMENT, Net	3,228,599	3,177,333
OTHER ASSETS	-	17,000
Total Assets	$ 8,149,677	$ 7,158,746
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Current Maturities of Long-Term Debt	$ 719,099	$ 638,272
Accounts Payable	551,682	606,970
Accrued Payroll and Related Expenses	990,791	795,744
Accrued Other Expenses	-	11,104
Estimated Third-Party Payor Settlements Payable	179,336	833,155
Total Current Liabilities	2,440,908	2,885,245
LONG-TERM DEBT, Less Current Maturities	3,307,699	3,324,921
Total Liabilities	5,748,607	6,210,166
NET ASSETS		
Unrestricted Net Assets	2,401,070	948,580
Total Liabilities and Net Assets	$ 8,149,677	$ 7,158,746

See accompanying Notes to Financial Statements.

FERRELL HOSPITAL COMMUNITY FOUNDATION
STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED MARCH 31, 2016 AND 2015

	2016	2015
UNRESTRICTED REVENUES, GAINS AND OTHER SUPPORT		
Patient Service Revenue (Net of Contractual Allowances and Discounts)	$ 17,721,488	$ 16,347,058
Provision for Bad Debts	(877,280)	(1,071,491)
Net Patient Service Revenue, Less Provision for Bad Debts	16,844,208	15,275,567
Other Revenue	720,260	637,251
Total Unrestricted Revenues, Gains and Other Support	17,564,468	15,912,818
EXPENSES		
Salaries and Wages	7,564,261	6,813,052
Employee Benefits	1,476,548	1,371,176
Professional Fees	1,306,944	1,207,283
Utilities	236,630	216,510
Repairs and Maintenance	196,782	196,734
Drugs and Pharmaceuticals	613,811	617,979
Supplies and Other	4,245,855	3,892,141
Depreciation and Amortization	635,584	508,271
Interest	213,933	205,025
Insurance	143,496	116,186
Total Expenses	16,633,844	15,144,357
OPERATING INCOME	930,624	768,461
OTHER INCOME		
Gain on Property Taxes	-	21,601
Interest Income	7,830	13,047
Unrestricted Donations	4,036	403
Total Other Income	11,866	35,051
EXCESS OF REVENUE OVER EXPENSES	942,490	803,512
Contribution from Management Service Provider	510,000	-
CHANGE IN UNRESTRICTED NET ASSETS	1,452,490	803,512
Unrestricted Net Assets - Beginning of the Year	948,580	145,068
UNRESTRICTED NET ASSETS - END OF THE YEAR	$ 2,401,070	$ 948,580

See accompanying Notes to Financial Statements.

FERRELL HOSPITAL COMMUNITY FOUNDATION
STATEMENTS OF CASH FLOWS
YEARS ENDED MARCH 31, 2016 AND 2015

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ 1,452,490	$ 803,512
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	635,584	472,727
Contribution from Management Service Provider	(510,000)	-
Provision for Bad Debts	877,280	1,071,491
(Increase) Decrease in:		
Patient Receivables	(890,694)	(673,995)
Other Current Assets	(118,627)	(45,653)
Increase (Decrease) in:		
Accounts Payable and Accrued Expenses	128,655	(784,867)
Estimated Third-Party Payor Settlements	(653,819)	(57,688)
Net Cash Provided by Operating Activities	920,869	785,527
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Property and Equipment	(328,341)	(611,210)
Change in Assets Limited as to Use	(848,644)	26,139
Net Cash Used by Investing Activities	(1,176,985)	(585,071)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds From Issuance of Long-Term Debt	396,400	275,000
Principal Payments on Long-Term Debt	(691,304)	(441,487)
Contribution from Management Service Provider	510,000	-
Net Cash Provided (Used) by Financing Activities	215,096	(166,487)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(41,020)	33,969
Cash and Cash Equivalents at Beginning of Year	247,262	213,293
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 206,242	$ 247,262
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash Payments for Interest	$ 213,933	$ 205,025
Capital Lease Obligations Incurred for Equipment	$ 358,509	$ -
Line of Credit Conversion to Term Note	$ -	$ 443,783

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Ferrell Hospital Community Foundation (the Hospital) is a 25-bed acute care facility located in Eldorado, Illinois. The purpose of the Hospital is to provide inpatient, outpatient, emergency care and other healthcare services to all persons needing such services, including providing services free or at a reduced fee to those persons otherwise financially unable to obtain such services. Admitting physicians are primarily practitioners in the local area.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use.

Patient Accounts Receivable

The Hospital reports patient accounts receivable for services rendered at net realizable amounts from third-party payors, patients and others. The Hospital provides an allowance for doubtful accounts based upon a review of outstanding receivables, historical collection information and existing economic conditions. As a service to the patient, the Hospital bills third-party payors directly and bills the patient when the patient's liability is determined. Accounts are considered delinquent and subsequently written off as bad debts based on individual credit evaluation and specific circumstances of the account after 120 days. At March 31, 2016 and 2015, the allowance for uncollectible accounts was approximately $637,000 and $627,000, respectively.

The Hospital's allowance for doubtful accounts for self-pay patients was an average of 80 percent of self-pay accounts receivable as of March 31, 2016 and 2015. In addition, the Hospital's self-pay write-offs decreased approximately $194,000 to $877,000 for fiscal year 2016 from $1,071,000 for fiscal year 2015.

Inventories

Inventories are stated at the lower of cost, determined using the first-in, first-out method, or net realizable value.

Assets Limited as to Use

Assets limited as to use include assets set aside by the board of directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. Assets limited as to use also include assets that have been set aside in accordance with loan agreements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is recorded over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Property and equipment acquisitions over $5,000 having a useful life of one year or more are capitalized.

Depreciation is computed using the straight-line method over the following estimated useful lives:

Land Improvements	15 years
Building and Improvements	5 to 40 years
Equipment	3 to 10 years

Gifts of long-lived assets such as land, buildings or equipment are reported as additions to unrestricted net assets, and are excluded from deficit of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used.

Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Charity Care

The Hospital provides care without charge to patients meeting certain criteria under its charity care policy. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as net patient service revenue.

Electronic Health Record Incentive Payments

As discussed in Note 6, the Hospital received funds under the Electronic Health Records (EHR) Incentive Program during 2016 and 2015. The Hospital recognizes revenue at the completion of the EHR reporting period and all meaningful use objectives and any other specific grant requirements that are applicable, e.g., electronic transmission of quality measures to CMS in the second and subsequent payment years are met.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Operating Revenues and Expenses

The Hospital's statement of operations and changes in net assets distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services - the Hospital's principal activity. Non-exchange revenues, including investment income, grants and contributions received for purposes other than capital asset acquisition and from management service provider, are reported as non-operating revenues. Operating expenses are all expenses incurred to provide health care services.

Grants and Contributions

From time to time, the Hospital receives grants and contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are restricted to a specific operating purpose are reported as other-operating revenues. Amounts restricted to capital acquisitions are reported after non-operating revenues and expenses.

Excess of Revenues over Expenses

The statement of operations includes excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, consistent with industry practice, include permanent transfers of assets to and from affiliates for other than goods and services and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

The Hospital applies the income tax standard for uncertain tax positions. This standard clarifies the accounting for uncertainty in income taxes recognized in an organization's financial statements in accordance with the income tax standard. This standard prescribes recognition and measurement of tax positions taken or expected to be taken on a tax return that are not certain to be realized.

The Hospital's income tax returns are subject to review and examination by federal, state, and local authorities. The Hospital is not aware of any activities that would jeopardize its tax-exempt status and is not aware of any activities that are subject to tax on unrelated business income or excise or other taxes.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Reclassifications

Certain reclassifications were made to the 2015 information in order to conform to the 2016 financial statement presentation. Such reclassifications had no effect on net assets or the change in net assets.

Subsequent Events

In preparing these financial statements, the Hospital has evaluated events and transactions for potential recognition or disclosure through July 29, 2016, the date the financial statements were available for issuance.

NOTE 2 NET PATIENT SERVICE REVENUE

The Hospital has agreements with third party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third party payors follows:

Medicare

The Hospital is designated as a critical access hospital. This designation provides for most inpatient and outpatient services to be reimbursed on a cost basis methodology. The Hospital has one clinic which is designated as a rural health clinic, which is also reimbursed on a cost basis methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been finalized by the Medicare fiscal intermediary through March 31, 2013.

Medicaid

Inpatient and substantially all outpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates. The state of Illinois has previously enacted legislation that provides for a hospital assessment program intended to qualify for federal matching funds under the Illinois Medicaid program.

Under the hospital assessment program, each hospital is assessed tax based on that hospital's adjusted gross revenue. The legislation provides that none of the assessment funds are to be collected and no additional Medicaid payments are to be paid until the program receives the required federal government approval through CMS.

In addition, the State of Illinois passed legislation in State Fiscal Year 2012 that expanded the Hospital Assessment Program by providing additional Hospital Access Improvement Payments to qualifying hospitals, also referred to Enhanced Hospital Assessment. CMS approved the program on October 1, 2013 with a retroactive effective date of June 10, 2012.

NOTE 2 NET PATIENT SERVICE REVENUE (CONTINUED)

Medicaid (Continued)

In 2014 the Centers for Medicare and Medicaid Services (CMS) approved an additional supplemental payment to Illinois' hospitals for services provided to newly eligible Medicaid beneficiaries under the Affordable Care Act. The supplemental payment to hospitals was retroactive to March 1, 2014. The assessments are effective until June 30, 2018 to align with the transition periods of both rate reform and the ACA Medicaid expansion payments.

The effects of the programs in the statements of operations for the years ended March 31, 2016 and 2015 are as follows:

	2016	2015
Additional Medicaid Payments Included in Net Patient Service Revenue	$ 2,532,876	$ 2,351,379
Taxes Assessed and Included in Supplies and Others	$ 386,255	$ 378,593

These additional reimbursement programs represented approximately 15% of the Hospital's net patient revenue for the years ended March 31, 2016 and 2015, respectively. The programs are subject to future modification through legislative action, specifically related to Medicaid reform initiatives that are ongoing with the State of Illinois. Given the impact of these programs on the Hospital's net patient service revenue, dependency on these programs is a significant concentration of revenue risk for the Hospital.

Other

The Hospital has also entered into payment agreements with Blue Cross and other commercial insurance carriers. The basis for reimbursement under these agreements includes discounts from established charges and prospectively determined rates.

Uninsured

For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, an increased portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Approximately 61% and 64% of net patient service revenues are from participation in the Medicare and state-sponsored Medicaid programs for the years ended March 31, 2016 and 2015, respectively. The 2016 net patient service revenue increased approximately $39,000 while the 2015 net patient service revenue decreased approximately $124,000, due to prior year retroactive adjustments in excess of amounts previously estimated.

NOTE 2 NET PATIENT SERVICE REVENUE (CONTINUED)

Net patient service revenue recognized for the years ended March 31, 2016 and 2015 are as follows:

	2016	2015
Net Patient Service Revenue (Net of Contractual Allowances and Discounts) from:		
Government and Third Party Payors	$ 17,181,580	$ 15,258,427
Uninsured Patients	539,908	1,088,631
	17,721,488	16,347,058
Provision for Bad Debts	(877,280)	(1,071,491)
Net Patient Service Revenue, Less Provision for Bad Debts	$ 16,844,208	$ 15,275,567

NOTE 3 PROPERTY AND EQUIPMENT

A summary of property and equipment at March 31, 2016 and 2015 is as follows:

	2016	2015
Land and Land Improvements	$ 224,697	$ 203,997
Buildings and Improvements	2,992,816	3,133,652
Fixed and Movable Equipment	5,225,581	4,504,744
Construction in Progress	92,217	11,568
	8,535,311	7,853,961
Less: Accumulated Depreciation	(5,306,712)	(4,676,628)
Net Property and Equipment	$ 3,228,599	$ 3,177,333

Construction in progress as of March 31, 2016 consists of various updates, renovation projects and development costs associated with long-range facility project expected to be completed in future years.

NOTE 4 LINE OF CREDIT

The Hospital maintains a line of credit with a local bank (the Bank) with a borrowing base of $750,000. Interest on advances under this borrowing arrangement is 5.75% and the line of credit agreement terminates December 11, 2016. As of March 31, 2016 and 2015 the Hospital had an outstanding balance on the line of credit of $-0-. The line of credit is collateralized by all contract rights to accounts and general intangibles.

During 2015, the Hospital and the Bank entered into a three year term note agreement for the 2014 outstanding balance of the line of credit in the amount of $443,783, as discussed in Note 5.

NOTE 5 LONG-TERM DEBT

A summary of long-term debt at March 31, 2016 and 2015 follows:

Description	2016	2015
2005 U.S.D.A. Rural Development Note Payable, interest 4.5% per annum, payable in monthly installments of $17,923 beginning March 2005 through 2025	$ 1,585,778	$ 1,725,839
Note Payable to Bank, variable interest rate, payable in monthly installments of approximately $12,000 beginning March 2005 through 2025	1,117,790	1,222,686
2012 U.S.D.A. Rural Health Clinic Note Payable, interest 3.375% per annum, payable in monthly installments of $1,148 beginning September 2012 through 2032	173,911	181,671
Legence Bank Note Payable, interest rate 5.75% per annum, payable in monthly installments of $12,188 beginning March 2015 through 2017	130,268	264,762
Converted Note Payable, interest rate 5.75% per annum, payable in monthly installments of approximately $12,500 beginning in July of 2014 through 2017	181,283	331,283
2015 U.S.D.A. Rural Development Note Payable, interest 3.250% per annum, payable in monthly installments of $1,852 beginning November 2015 through 2035	322,127	-
Note Payable to First Southern Bank, interest 2.850% per annum, payable in monthly installments of $859 beginning July 2015 through 2020	41,990	-
Note Payable to First Southern Bank, interest 2.850% per annum, payable in monthly installments of $401 beginning June 2015 through 2020	19,241	-
Capital lease obligations for equipment with monthly payments ranging from $541 to $5,843, various rates of interest from 3% to 9% and expiring in years through 2021	454,410	236,952
Total Long-Term Debt	4,026,798	3,963,193
Less: Current Maturities	(719,099)	(638,272)
Long-Term Debt, Net of Current Maturities	$ 3,307,699	$ 3,324,921

NOTE 5 LONG-TERM DEBT (CONTINUED)

2005 U.S.D.A. Rural Development Note Payable

In March of 2005 the U.S.D.A Rural Development note payables (the 2005 U.S.D.A note) were issued in the original amount of $2,831,400 to finance the purchase of the Hospital's facilities. All contract rights to accounts receivable and general intangibles as well as equipment and furniture of the facility are pledged as security for the loan.

Note Payable to Bank

In March of 2005 the Hospital authorized a note payable to a local bank in the original amount of $2,012,000. The note financed the purchase of the Hospital's facilities as well as certain other necessary costs related to the financed facility. The note is guaranteed by U.S.D.A Rural Development. The loan agreement contains numerous quarterly covenants pertaining to measures of financial performance. The Hospital was out of compliance with certain financial performance covenants as of March 31, 2016 and 2015. The Hospital has received waivers from the bank related to the respective covenant in violation through the year ended March 31, 2017.

2012 U.S.D.A. Rural Health Clinic Note Payable

In June of 2012, the 2012 U.S.D.A Rural Health Clinic note payable was issued in the original amount of $200,000 to finance a portion of the cost of acquiring and construction a physician clinic within the Hospital campus. All contract rights to accounts receivable and general intangibles as well as equipment and furniture of the facility are pledged as security for the loan.

Legence Bank Note Payable

In January of 2015 the Hospital authorized a note payable to Legence Bank in the original amount of $275,000. The note is collateralized by the property, plant and equipment of the Hospital.

Converted Note Payable

In June of 2014 the Hospital converted outstanding line of credit balance of $443,783 to a term note. All contract rights to accounts receivable and general intangibles as well as equipment and furniture of the facility are pledged as security for the note.

2015 U.S.D.A. Rural Development Note Payable

In November of 2015, the 2015 U.S.D.A Rural Development note payable was issued in the original amount of $326,000 to finance costs associated with the construction of a new roof at the Hospital. All contract rights to accounts receivable and general intangibles as well as equipment and furniture of the facility are pledged as security for the loan.

First Southern Bank Notes Payable

In June and July of 2015 the Hospital authorized two notes payable to First Southern Bank in the original amounts of $48,000 and $22,400, respectively. Both notes are collateralized by the property, plant and equipment of the Hospital.

NOTE 5 LONG-TERM DEBT (CONTINUED)

Debt Reserve Funds

The Loan Resolution Security Agreement for the 2005 U.S.D.A. note requires the Hospital to deposit $1,800 each month into a reserve account. These deposits are required until $218,000 has been accumulated in the account. The Loan Resolution Security Agreement for the 2012 U.S.D.A note requires the Hospital to deposit $114 each month into a reserve account. These deposits are required until $13,776 has been accumulated in the account. The reserve funds can only be expended for specific purposes as outlined in the Security Agreement. Accordingly, these funds are included in assets whose use is limited in the financial statements. As of March 31, 2016 and 2015, the reserve accounts had a balance of $224,873 and $223,425, respectively.

Capital Lease Obligation

Capital lease obligation includes the following property under capital lease:

	2016	2015
Equipment	$ 887,337	$ 506,128
Less: Accumulated Depreciation	(445,360)	(332,097)
Total	$ 441,977	$ 174,031
Depreciation Expense	$ 113,263	$ 101,226

Future Maturities

Scheduled principal repayments on long-term debt are as follows:

Year Ending December 31,	Note Payable	Capital Lease Obligations
2017	$ 569,145	$ 175,357
2018	331,269	137,969
2019	311,822	109,949
2020	324,138	58,508
2021	326,379	34,272
Thereafter	1,709,635	-
Total	$ 3,572,388	516,055
Less: Amount Representing Interest on Obligation Under Capital Lease		(61,645)
Total		$ 454,410

NOTE 6 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

The Electronic Health Record (EHR) incentive program was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. These Acts provided for incentive payments under both the Medicare and Medicaid programs to eligible hospitals that demonstrate meaningful use of certified EHR technology. The incentive payment for Critical Access Hospitals related to Medicare is made based on the cost of acquiring and implementing the certified EHR system. The Medicaid incentive payments are made based on a statutory formula and are contingent on the Hospital continuing to meet the escalating meaningful use criteria. For the first payment year, the Hospital must attest, subject to an audit, that it met the meaningful use criteria for a continuous 90-day period.

The Hospital demonstrated meaningful use with Medicare in the year ended March 31, 2014 and Medicaid in the year ended March 31, 2013. The Hospital continues to demonstrate meaningful use through the year ended March 31, 2016. Medicaid paid the Hospital over the three year model of 50%, 40%, 10% with the final payment of $86,910 recognized in the year ended March 31, 2015. Medicare and Medicaid amounts were recognized as other operating revenues in the statements of operations and changes in net assets.

The final amount of these payments will be based on information from the Hospital's Medicare cost reports and an audit of the submitted costs by the Hospital's fiscal intermediary. Events could occur that would cause the final payments to differ materially upon final settlement.

NOTE 7 EMPLOYEE BENEFIT PLAN

The Hospital has a qualified deferred compensation plan under Section 401(k) of the Internal Revenue Code. The plan covers substantially all employees over age 18 with one or more years of employment. The Hospital contributes 50% of each eligible employee's contribution, not to exceed 2.5% of compensation. Plan provisions and contributions are established by the Hospital's Board of Directors. For the years ended March 31, 2016 and 2015, the Hospital contributed approximately $70,000 and $72,000, respectively, to the deferred compensation plan.

NOTE 8 UNCOMPENSATED CARE AND COMMUNITY BENEFIT

In support of its mission, the Hospital voluntarily provides care to patients that meet the Hospital's charity care criteria. The Hospital has a Hospital Assistance Plan (HAP) that provides for the subsidy and or forgiveness of patient balances for services. Under the presumption of eligibility criteria a patient is included in the HAP if they are covered under a government assistance plan such as Women, Infants and Children Nutrition Program, Supplemental Nutrition Assistance Program, Illinois Free Lunch and Breakfast Program, and other named programs. The hospital requires the completion of appropriate forms and obtains requisite signatures to document its processes.

NOTE 8 UNCOMPENSATED CARE AND COMMUNITY BENEFIT (CONTINUED)

Patients not eligible under the presumption of eligibility provisions must complete an application process and fulfill eligibility criteria in order to have their accounts covered under the HAP.

In addition, the Hospital provides services to other medically indigent patients under certain government-reimbursed public aid programs. Such programs pay providers amounts which are less than established charges for the services provided to the recipients and many times the payments are less than the cost of rendering the services provided.

Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue. Charges excluded from revenue under the Hospital's charity care policy were approximately $322,000 and $235,000 for the years ended March 31, 2016 and 2015, respectively.

For the years ended March 31, 2016 and 2015, management has estimated the cost of charity as $129,000 and $95,000, respectively. The cost of charity care is estimated using the Hospital's overall cost to charge ratios.

In addition, the Hospital also commits significant time and resources to endeavors and critical services which meet otherwise unfilled community needs. Many of these activities are sponsored with the knowledge that they will not be self-supporting or financially viable.

NOTE 9 FUNCTIONAL EXPENSES

The Hospital provides health care services to residents within its geographic location. Expenses related to providing these services by functional class for the years ended March 31, 2016 and 2015 are estimated to be:

	2016	2015
Health Care Services	$ 16,338,127	$ 14,856,071
General and Administrative	295,717	288,286
Total Expenses	$ 16,633,844	$ 15,144,357

NOTE 10 SIGNIFICANT CONCENTRATIONS AND CREDIT RISK

Patient Accounts Receivable

The Hospital grants credit without collateral to its patients, most of who are area residents and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at March 31, 2016 and 2015 is:

	2016	2015
Medicare	23 %	24 %
Medicaid	28	48
Commercial Insurance	32	16
Self Pay	17	12
Total	100 %	100 %

FDIC Coverage

The Hospital maintains cash balances at several financial institutions. FDIC insurance coverage per depositor account is $250,000. At times, cash balances may have been in excess of insured limits.

Risk Management

The Hospital is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; injuries to employees; and natural disasters.

NOTE 11 COMMITMENTS AND CONTINGENCIES

Medical Malpractice Insurance Coverage and Claims

The Hospital has joined together with other providers of health care services to form the Illinois Provider Trust and a risk pool self-insurance trust program organized under Illinois Statutes for the purpose of providing general and professional liability. The Hospital pays annual premiums to the pools for its general liability torts, medical malpractice and employee injuries insurance coverage. The pools' governing agreements specify that the pools will be self-sustaining through member premiums and will reinsure through commercial carriers for claims in excess of specified stop-loss amounts.

The Hospital purchases medical malpractice insurance as described above on a claims made, fixed premium basis. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate cost of the incidents. Based upon the Hospital's experience, no such accrual has been made. It is reasonably possible that this estimate could change materially in the near term.

NOTE 11 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Litigation

In the normal course of business, the Hospital is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in areas not covered by the Hospital's insurance program (discussed elsewhere in these notes); for example, allegations regarding performance of contracts. The Hospital evaluates such allegations by conducting investigations to determine the validity of each potential claim. Litigation based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Healthcare Legislation and Regulation

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers.

Violation of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Hospital is in substantial compliance with fraud and abuse as well as other applicable government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations is subject to government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Operating Leases

The Hospital leases equipment and office space under non-cancelable operating lease agreements expiring through 2019. Total expense for the operating leases amounted to approximately $36,000 and $56,000 for the years ended March 31, 2016 and 2015, respectively.

The following is a schedule by year of future minimum lease payments under the operating leases as of March 31, 2016, that have an initial or remaining lease term in excess of one year:

Year Ending December 31,	Operating Lease Obligations
2017	$ 15,000
2018	15,000
2019	7,500
Total	$ 37,500

NOTE 12 MANAGEMENT AGREEMENTS

On December 29, 2015, the Hospital terminated the management agreement which went into effect March 13, 2014 and subsequently entered into another Management agreement effective January 1, 2016. Management services provided to the Hospital consist of management personnel including a CEO and CFO, facility planning, strategic planning, recruiting, and several other support and oversight services. The initial term of the agreement is for a five year period, which can be extended beyond the initial five year period if so desired. The agreement can be terminated by either party with a one hundred eighty day notice without recourse subsequent to the initial five year term of the agreement. If the agreement is terminated by the Hospital within the initial five year term, the Hospital will be accessed a penalty in the amount of $500,000 to be payable to the management service organization. The Hospital will reimburse the management service provider the actual cost of providing the management services on a monthly basis. For the years ended March 31, 2016 and 2015, management fees incurred were $120,000 and $104,163, respectively.

For the year ended March 31, 2016, the management service organization of the Hospital made a one-time contribution in the amount of $510,000 in support of the Hospital's mission.

NOTE 13 PROPERTY TAX

The Hospital incorporated in 2005, and was therefore not grandfathered into the property tax exemption in the State of Illinois (the State). At that time in the State, non-profit hospitals were not determined to be exempt from property tax and this decision was being appealed at the State level. During the period of 2006 through 2012 the Hospital was paying property tax uncontested which approximated $690,000. In 2012 the decision from the State Appeals Court determined non-profit hospitals to be exempt from property tax assessments. Pursuant to a Non-homestead Property Tax Exemption Certificate, dated July 5, 2013, issued to the Hospital by the Illinois Department of Revenue, which approved the exemption of the Hospital's property for the 2006 assessment year. As a result the Hospital requested a refund of all paid taxes from 2006 through 2012. The Hospital received approximately $0 and $26,000 in property tax refunds for the years ended March 31, 2016 and 2015, respectively. As of March 31, 2016 and 2015, the Hospital has estimated approximately $564,000 as a receivable, however this amount has not been recognized in the financial statements as the timing and consistency of collection is uncertain.

NOTE 14 OPERATING ENVIROMENT

For As discussed in Notes 2 and 8 the Hospital provides a significant amount of services to under-insured and uninsured patients. The Hospital receives additional funding from the state sponsored Medicaid programs related to the patient population.

Through ongoing strategic initiatives focused on reducing costs and increasing revenues, the Hospital has improved financial performance in recent history. As discussed in Note 2 of the financial statements, a significant risk for the Hospital is in the legislative impact to the programs that supplement the Hospital's revenues, due to the significant amount of unreimbursed and under-reimbursed care provided by the Hospital. However, with the assistance provided through these state Medicaid programs and management's continued focus, the Hospital's financial performance has improved.

In addition to the continued support from the state Medicaid program supplementing the reimbursement of the Hospital's provided care, Management has identified several operational and environmental factors which they expect will continue to positively and materially impact the operations and cash flows of the Hospital in the near term.

- The Hospital continues to seek doctors for the medical staff in anticipation of replacement, or in addition to, its retirement minded physicians. Such new physicians are expected to add significant additional revenue.

- Ferrell is continuing its practice of instituting price increases on a regular and precise basis.

- The Hospital's management agreement is designed to provide for additional sources of revenue and reduction of costs over a long period of time. Immediate plans include increased patient volume in physical, occupational, speech and cardiopulmonary rehab. Surgical volume is being sought through the addition of additional provider availability. The management service provider is also providing support through the capital planning of potential new facility.

Through these items as well as other future plans management believes the Hospital's ability to continue to provide impactful services to the community is sustainable for the foreseeable future. One area of specific concern that management continues to monitor for relates to the impact of payment reform that is currently occurring over the next several years in both Federal and State levels of government.

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

Board of Directors
Ferrell Hospital Community Foundation
Eldorado, Illinois

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Ferrell Hospital Community Foundation(the Hospital), which comprise the balance sheet as of March 31, 2016, and the related statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated July 29, 2016.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Board of Directors
Ferrell Hospital Community Foundation

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

St. Louis, Missouri
July 29, 2016

FERRELL HOSPITAL COMMUNITY FOUNDATION
SCHEDULE OF FINDINGS AND RESPONSES
YEAR ENDED MARCH 31, 2016

Material Weaknesses

NONE