STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO:	BOARD MEETING:	PROJECT NO:	PROJECT COST:
H-12	October 30, 2018	18-029	Original:$24,864,088
FACILITY NAME: Fairfield Memorial Hospital		CITY: Fairfield	
TYPE OF PROJECT: Non-Substantive			HSA: V

PROJECT DESCRIPTION: Fairfield Memorial Hospital Association (the Applicant) proposes a 3-story addition to the existing hospital to modernize the surgery suite and support areas, the long term care unit, the emergency department, urgent care center and add an outpatient clinic at a cost of $24,864,088. The expected completion date is July 1, 2021.
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EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- Fairfield Memorial Hospital Association (the Applicant) proposes a 3-story addition to the existing hospital to modernize the surgery suite and support areas, the long term care unit, the emergency department, urgent care center and add an outpatient clinic at a cost of $24,864,088. The expected completion date is July 1, 2021.
- **State Board Staff Notes** that Fairfield Memorial Hospital is a critical access hospital and has been designated by the Illinois Department of Public Health as a "necessary provider" of health care services in a designated area of the State of Illinois.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project is by or behalf of a heath care facility and is in excess of the capital expenditure minimum threshold of $13,477,931. (20 ILCS 3960/3)
- **The purpose of the Illinois Health Facilities Act** "*This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; and (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs."* [20 ILCS 3960]

PURPOSE OF THE PROJECT:

- The purpose of the project is to improve the health care to residents of Wayne County, White County and Edwards County. There are eight townships in Wayne County, all of White County and all of Edwards County that are classified as Medically Underserved Areas. These areas are within the Applicant's service area and include towns where the Applicant will have clinics at least one day per week. The Applicant is proposing to use the proposed project to help provide additional services to the service area. The Applicant has currently recruited three new surgeons[1] to this area who will come on the hospital's staff in 2019, 2020, and 2021. The hospitals' existing space is not large enough to accommodate the additional patients that would be seen by the new physicians.

PUBLIC HEARING/COMMENT:

- There was no request for a public hearing. No letters of support or opposition was received by State Board staff.

[1] These three surgeons are to begin employment at the Hospital when their residency is completed.

SUMMARY:

- The Applicant addressed a total of 15 criteria and did not meet the following:

Criteria	**Reasons for Non-Compliance**
77 IAC 1110.234 (a) – Size of the Project	The Applicant exceeded the gross square footage standard for emergency department stations by a total 105 GSF and PACU Phase I stations by a total of 730 GSF.
77 IAC 1110.234 (b) – Projected Utilization	As noted in the report, it will take significant growth in the services being modernized for the Applicant to achieve the State Board's target occupancies for long term care services and surgery.
77 IAC 1110.3030 – Clinical Services Other Than Categories of Service	Historical Utilization does not warrant the extent of the modernization being proposed by the Applicant.
77 IAC 1120.120 – Availability of Funds	As with all of projects being funded from governmental sources and pledges there is no indication that the loans will be made or the pledge amount achieved.
77 IAC 1120.130 – Financial Feasibility	The Applicant did not meet all of the financial ratios for the years presented. An explanation is provided at the end of this report. [See discussion at the end of this report]

Fairfield Memorial Hospital
STATE BOARD STAFF REPORT
Project #18-029

APPLICATION/CHRONOLOGY	
Applicant	Fairfield Memorial Hospital Association
Facility Name	Fairfield Memorial Hospital
Location	303 N.W. 11st Street, Fairfield, Illinois
Permit Holder	Fairfield Memorial Hospital Association
Operating Entity/Licensee	Fairfield Memorial Hospital Association
Owner of Site	Fairfield Memorial Hospital Association
Gross Square Feet	71,405 GSF
Application Received	August 22, 2018
Application Deemed Complete	August 28, 2018
Financial Commitment Date	October 30, 2020
Anticipated Completion Date	July 1, 2021
Review Period Extended by the State Board Staff?	No
Can the Applicant request a deferral?	Yes

I. Project Description

Fairfield Memorial Hospital Association (the Applicant) proposes a 3-story addition to the existing hospital to modernize the surgery suite and support areas, the long term care unit, the emergency department, urgent care center and add an outpatient clinic at a cost of $24,864,088. The expected completion date is July 1, 2021.

II. Summary of Findings

A. The State Board Staff finds the proposed project is not in conformance with all relevant provisions of Part 1110.

B. The State Board Staff finds the proposed project is not in conformance with all relevant provisions of Part 1120.

III. General Information

The Applicant is Fairfield Memorial Hospital Association. Fairfield Memorial Hospital Association (the Hospital) is a critical access hospital with 25-bed acute care beds located in Fairfield, Illinois. The Hospital provides inpatient, outpatient, urgent and emergency care services and home health services for residents in and around Wayne County Illinois. The Hospital also owns and operates Horizon Health Care, a certified rural health clinic. This project is a non-substantive project subject to a Part 1110 and Part 1120 review. Financial commitment will occur after permit issuance.

As can be seen by the Table below over the past five years (2012-2016) the Applicant's payor source has been approximately 50% Medicare, 21.3% Medicaid, 23.2% private insurance, 3% private pay and 2.5% charity care.

TABLE ONE
Fairfield Memorial Hospital Utilization/Payor Source

	Existing	2012	2013	2014	2015	2016	
Medical Surgical	21 beds	68.40%	49.20%	44.60%	44.30%	34.60%	
Intensive Care	4 beds	40.30%	46.60%	8.20%	37.90%	5.5%	
Long Term Care	30 beds	63.40%	62.60%	62.00%	55.60%	65.80%	
Surgery	3 rooms	33.62%	27.64%	24.41%	44.62%	43.07%	
Emergency Department	5 beds	99.34%	100.33%	91.73%	100.81%	101.62%	
	2012	2013	2014	2015	2016	Total	%
Medicare Patients	17,208	19,481	15,457	16,929	14,080	83,155	49.96%
Medicaid Patients	9,487	7,016	4,341	9,596	5,050	35,490	21.32%
Other Public	0	0	102	0	90	192	0.12%
Private Insurance	10,021	9,591	6,522	11,643	753	38,530	23.15%
Private Pay	1,182	1,761	809	824	431	5,007	3.01%
Charity Care	884	1,333	1,097	0	765	4,079	2.45%
Total						166,453	100.00%

IV. Critical Access Hospital

Fairfield Memorial Hospital is a 25-bed critical access hospital. To be designated a Critical Access Hospital (CAH), a hospital must meet the following criteria:

- Be located in a state that has established a State Flex Program;
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, a CAH may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less (excluding beds that are within distinct part units [DPU]); and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR prior to January 1, 2006 were State certified as a "necessary provider" of health care services to residents in the area.

Congress passed the Medicare Rural Hospital Flexibility Grant Program/original balanced budget act in 1997, the critical access hospital program was created and rural hospitals could convert to CAH status if they could meet the thirty-five (35) miles or greater definition. Subsequently, CMS/Congress learned that most small hospitals were located less than thirty-five (35) miles from another facility, especially in the Midwest, so they passed the necessary provider provision in 1999 as part the Balanced Budget Refinement Act. The necessary provider provision allowed the states to determine their own criteria to become a CAH and also had to develop a plan for implementing the CAH program, called the Rural Health Plan, which then had to be approved by CMS. Illinois' plan was approved by CMS in May 1999.

Since all Illinois small rural hospitals are less than thirty-five (35) miles from another hospital (regardless of state lines,) each Illinois hospital applying for CAH status had to be approved by IDPH as a "necessary provider" of health care services for its community. All small hospitals had to first be located in a state or federal designated area and then meet one of the following criteria to be designated as a necessary provider:

- In a health professional shortage area (HPSA); or
- In a state physician shortage area (PSA);
- In a county where there was a greater percentage of residents 65 years or older than the state average; or
- In a county where there was a greater percentage of residents 200% or more of the federal poverty level than the state average.

The original IDPH plan for implementation of the CAH program (Rural Health Plan) was approved by CMS in May 1999. The plan was updated in 2009. Congress passed the Medicare Modernization Act in 2005 which discontinued the "necessary provider" program for the states, grandfathered all the CAHs approved under the "necessary provider" provision, and changed the criteria for CAH conversion to thirty-five (35) miles or greater by any type of road and fifteen (15) miles or greater by secondary road. Federal criteria for conversion to CAH status required a hospital to be part of a network and in Illinois, the hospital were approved based on the hospital being part of an EMS network. There were fifty-two (52) hospitals approved as a "necessary provider" critical access hospital prior to December 31, 2005. White County Hospital closed in December 2005. Thus, now there are fifty-one (51) CAHs in Illinois. [Source: IDPH Center for Rural Health and Illinois Critical Access Hospital Network]

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

V. Health Service Area/Health Planning Area

Fairfield Memorial Hospital is located in the HSA V Health Service Area and the F-03 Hospital Planning Area. The F-03 Hospital Planning Area includes Crawford, Lawrence, Richland, Wabash, and Edwards Counties; Jasper County Townships of Hunt City, Willow Hill, Ste. Marie, Fox, and Grandville; Clay County Townships of Louisville, Songer, Xenia, Oskaloosa, Hoosier, Harter, Stanford, Pixley, and Clay City; Wayne County Townships of Orchard Keith, Garden Hill, Berry, Bedford, Lamard, Indian Prairie, Zif, Elm River, Jasper, Mount Erie, Massilion, Leech, Barnhill and Grover. There are six hospitals in the F-03 Hospital Planning Area (See Table below).

TABLE TWO
Facilities within the F-03 Hospital Planning Area

Facility	City	Beds
Carle Richland Memorial Hospital	Olney	61
Clay County Hospital	Flora	20
Crawford Memorial Hospital	Robinson	21
Fairfield Memorial Hospital	Fairfield	21
Lawrence County Memorial Hospital	Lawrenceville	25
Wabash General Hospital District	Carmel	25

VI. Project Details

The proposed project calls for the construction of a 3-story addition to the existing hospital building. The first floor of the new addition will house a new Emergency Department; a new 4-room Urgent Care Center; a new Central Sterile Supply department, and two new operating rooms with the related surgical support area. The second floor will house a new outpatient clinic with 24 exam rooms, and X-ray unit dedicated for clinic use; and office space for visiting doctors as well as the new physicians who have been recruited to the hospital and who will be coming on staff in the next 2-3 years. The third floor will house a replacement 30-bed skilled nursing unit which is currently located on the third floor of the existing hospital building. Existing space on the first floor will be remodeled to house 16 outpatient prep and holding rooms for the surgical department; 4 PACU rooms (for Stage 1 Recovery patients after surgery); and one endoscopy room. Some surgical support space will also be located in this area and 2 existing operating rooms will continue to be utilized as is. The third floor of the existing hospital building will be vacated by the skilled nursing unit and that space will be used to house laundry and general storage. This space will be used as is with no capital expenditures planned.

VII. Project Costs

The Applicant is funding this project with pledges of $3,000,000 a USDA Bond Anticipation Note of $19,864,089 and a USDA Loan of $2,000,000.

TABLE THREE [(1)]
Project Uses and Sources of Funds

	Reviewable	Non-Reviewable	Total	% of Total
Preplanning Costs	$289,339	$73,559	$362,898	1.46%
Site Survey and Soil Investigation	$38,270	$9,730	$48,000	0.19%
Site Preparation	$469,809	$119,441	$589,250	2.37%
New Construction Contract	$10,998,898	$2,796,283	$13,795,181	55.48%
Modernization Contracts	$2,789,490	$709,181	$3,498,671	14.07%
Contingencies	$0	$0	$0	0.00%
Architectural/Engineering Fees	$1,114,625	$283,375	$1,398,000	5.62%
Consulting and Other Fees	$43,852	$11,149	$55,001	0.22%
Movable or Other Equipment (not in construction	$2,391,900	$608,100	$3,000,000	12.07%
Bond Issuance Expense (project related)	$341,213	$86,748	$427,961	1.72%
Net Interest Expense During Construction	$1,267,011	$322,115	$1,589,126	6.39%
Other Cost& To Be Capitalized	$79,730	$20,270	$100,000	0.40%
Total Uses of Funds	$19,824,137	$5,039,951	$24,864,088	100.00%
SOURCE OF FUNDS				
Pledges	$2,391,900	$608,100	$3,000,000	12.07%
USDA 2019 Bond Anticipation Note	$15,837,638	$4,026,451	$19,864,089	79.89%
USDA REDLG Loan	$1,594,600	$405,400	$2,000,000	8.04%
TOTAL SOURCES OF FUNDS	$19,824,137	$5,039,951	$24,864,088	100.00%

1. Itemization of these costs can be found at pages 40-42 of the Application for Permit.

VIII. Background of the Applicant, Purpose of the Project, Safety Net Impact Statement, Alternative to the Project

A) Criterion 1110.110 (b) (1) (3) Background of the Applicants

To demonstrate compliance with this criterion the applicants must document any adverse action taken against the applicants in the three (3) years prior to the filing of the application for permit; a listing of all health care facilities owned and operated by the applicants, and authorization allowing the State Board and the Illinois Department of Public Health access to any documentation to verify information in the application for permit. An adverse action is defined as "*a disciplinary action taken by IDPH, CMMS, or any other State or federal agency against a person or entity that owns or operates or owns and operates a licensed or Medicare or Medicaid certified healthcare facility in the State of Illinois* [77 IAC 1130.140 – Definitions]."

1. There has been no adverse action[2] taken against any facility owned and/or operated by the Applicant during the three (3) years prior to the filing of the application. Authorization permitting HFSRB

[2] "Adverse Action" means a disciplinary action taken by IDPH, CMMS, or any other State or federal agency against a person or entity that owns or operates or owns and operates a licensed or Medicare or Medicaid certified healthcare facility in the State of Illinois. These actions include, but are not limited to, all Type "A" and Type "AA" violations. As defined in Section 1-129 of the Nursing Home Care Act [210 ILCS 45], *"Type 'A' violation" means a violation of* the Nursing Home Care *Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that risk of death or serious mental or physical harm to a resident will result therefrom or has resulted in actual physical or mental harm to a resident.* As defined in Section 1-128.5 of the Nursing

and Illinois Department of Public Health access to any documents necessary to verify information that have been submitted with the application for permit was provided as required.

2. A Certificate of Good Standing from the State of Illinois has been provided which verifies that the corporation actually exists, has paid all its statutory dues, has met all filing requirements and, therefore, is authorized to transact business in that state.
3. The Applicant attests that the proposed expansion and modernization project will not be in a flood plain area and that the hospital lies outside the 500 year flood plain zone. The applicants are in compliance with Executive Order # 2006-5.
4. The Illinois Historic Preservation Agency have provided a letter stating that the properties effected by the modernization are in compliance with section 106 of the National Historic Preservation Act of 1966. [Additional information submitted September 14, 2018]
5. The Applicant has provided evidence of site ownership at page 25 of the Application for Permit.
6. The Applicant has submitted all reports required by the HFSRB and the Illinois Department of Public Health as well as licensure and Joint Accreditation.

B) Criterion 1110.120 (b) – Purpose of the Project

To demonstrate compliance with this criterion the Applicant must identify the problems to be addressed by the proposed project, define the planning or market area, and how the proposed project will address the problems identified.

The proposed project's purpose is to improve the availability of care to the residents of the service area and improve the health status of the area by providing additional physicians in a modem facility in which to practice. The proposed project is being undertaken in order to improve the health care to residents of Wayne County, White County and Edwards County. Eight townships in Wayne County; all of White County and all of Edwards County are classified as Medically Underserved Areas. These areas are within the Applicant's service area and include towns where the Applicant will have clinics at least one day per week. The Applicant provided historic admission data for patients by date of admission, county, city, and zip code at pages 56-71 of the Application for Permit.

C) Criterion 1110.110 (c) – Safety Net Impact Statement

This project is considered a non-substantive project and a safety net impact statement is not required. The Applicant did provide a safety net impact statement at pages 117-122 of the Application for Permit. Charity care information is provided below.

TABLE FOUR
Charity Care

	FY2015	FY2016	FY2017
Net Patient Revenue	$27,127,241	$27,788,161	$28,139,255
Charity Care Charges	$837,006	$1,001,541	$797,142
Charity Care at cost	$259,472	$310,478	$247,114
% of Charity Care at Cost to Net Revenue	0.96%	1.12%	0.88%

Home Care Act, *a "Type AA violation" means a violation of* the *Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility that proximately caused a resident's death.* [210 ILCS 45/1-129]

D) Criterion 1110.110 – Alternatives to the Project

To demonstrate compliance with this criterion the Applicant must document <u>All</u> alternatives that were considered.

The Applicant considered two alternatives to the proposed project:

1. Do Nothing
2. Establish a new hospital

The first alternative was rejected because it would not address the issues which are the basis of the proposed project. The do nothing alternative would not provide for additional space and the modernization of existing space to support the new physicians who have been recruited to improve the availability of health care to the residents of the identified service area.

The second alternative was rejected because of the cost of establishing a new hospital. The Applicant estimated the cost of the new hospital would be at the very least twice the proposed project.

IX. <u>Size of the Project, Projected Utilization, Assurance</u>

A) Criterion 1110.120 (a) - Size of the Project

To demonstrate compliance with this criterion the Applicant must document that the size of the project is in conformance with the requirements in Part 1110 Appendix B.

The Applicants exceed the State Board standard for emergency room stations by 105 GSF and PACU Phase I recovery rooms by 730 GSF.

TABLE FIVE
Size of the Project

	Number of Rooms/Station/beds	Proposed GSF	State Standard		Difference
			Room/Station	Total	
Surgery	4 rooms	7,830	2,750	11,000	-3,170
Surgery Prep	16 stations	5,600	400	6,400	-800
PACU	4 stations	1,450	180	720	730
Endoscopy	1room	715	1,100	1,100	-385
Skilled Care Nursing	30 beds	16,191	570	17,100	-909
Emergency Department	9 stations	8,205	900	8,100	105
Urgent Care		1,616			
Outpatient Clinic		13,468	No Standard		
Central Sterile Supply		1,054			

STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT MEET THE REQUIREMENTS OF CRITERION SIZE OF THE PROJECT (77 ILAC 1110.120 (a))

B) Criterion 1110.120 (b) – Projected Utilization

To demonstrate compliance with this criterion the Applicants must document that the services proposed will meet or exceed the State Board Standards published in Part 1110. Appendix B.

The Applicant is proposing the modernization of four services in which the State Board has utilization standard (see Table below).

TABLE SIX
Historical Utilization

	Existing	Proposed	2012	2013	2014	2015	2016	Avg.	CAGR
Long Term Care (1)	30 beds	30 beds	6,942	6,855	6,789	6,088	7,205	6,776	0.75%
Surgery (2)	3 rooms	4 rooms	1,513	1,244	1,099	2,008	1,939	1,560	5.08%
Emergency Department (3)	5 stations	9 stations	9,934	10,033	9,173	10,081	10,162	9,877	0.45%
Endoscopy (Gastro) (4)	1 room		310	268	298.56	550.8	311.74	348	0.11%

1. Long term care/patient days
2. Surgery utilization/hours
3. Emergency Department utilization/visits
4. Endoscopy number of hours
5. CAGR = Compounded Annual Growth = (CY2016/CY2012)^(1/5)-1

Long Term Care

The 30-bed long term care unit has had over the past five years (2012-2016) an average daily census of 19 patients or approximately 62% utilization. As shown in the table above there has been an approximate 1% growth in the number of patient days over this 5-year period. The Applicant's projected occupancy rate is 87% for 2021 and 93% for 2022 which is when all three of the applicant's new surgeons will be on staff. The State Occupancy Standard for long term care service is 90%. To achieve target occupancy the number of days would need to increase at a rate of 4.9% annually.

According to the Applicant the 30-bed unit's historical utilization has not achieved the target occupancy due to several different factors. There is an insufficient number of physicians in the planning area. The existing unit has some four bed rooms which share a single bathroom which limits the patients who can share the room which on several occasions required the Applicant to not allow admissions to this unit. The small number of total beds makes it difficult to maintain 90% occupancy especially given the shorter length of stay general associated with hospital based SNF units especially units in Critical Access Hospitals since they serve a higher percentage of short stay patients than other SNF units.

Surgery

The Applicant currently has three operating rooms and are proposing to add a fourth operating room as part of this modernization project. The Applicant has averaged approximately 1,200 hours of surgeries per year over the past five years (2012-2016) which would justify one room. As can be seen by the table above the Applicant has had an average annual increase in surgery hours of 5.08% over the five year period (2012-2016). The Applicant has recruited 3 new physicians to the

hospital to all begin working by 2022. Two of these physicians are general surgeons and one is an orthopedic surgeon. The hospital now has only a consulting orthopedic surgeon one day per week and he does not currently provide surgical procedures at the hospital. The new orthopedic surgeon will perform his surgical procedures at the hospital. The Applicant is projecting 4,613 hours of surgery by 2021 and a 2022 volume of 5,177 hours of surgery which would be a 16.7% increase in surgery hours from 2016.

Emergency Department

The Applicant currently has 5 stations and is proposing nine stations as part of this modernization. The Applicant has averaged 9,900 visits over the five year period in their emergency department which justifies the 5 stations at the State Board Standard of 2,000 visits per station per year. The Applicant has stated of the nine stations two are designated for mental illness patients including Drug Abuse patients and one station is for SANE patients (Sexual Abuse Nursing Evaluation) as required by state law. The Applicant is projecting a workload for 2022 of 9,185 total visits which justifies 5 stations based upon the State Standard of 2,000 visits per ED station. While the Applicant is proposing six rooms beyond the three dedicated rooms, it is the Applicant's expectation that the number of ED visits will continue to grow in this planning area as outpatient clinics they are proposing to establish in communities (Cisne, Greyville, and Canni) that do not have hospitals are completed.

Endoscopy (Gastro)

The Applicant is proposing one room to perform their endoscopy procedures. Currently the Applicant does not have a dedicated procedure room for his specialty. Outpatient gastro procedures have been performed in the existing surgery rooms and have average approximately 348 procedures per year which would justify the one room being requested.

Surgery Prep and PACU

The Applicant is proposing 16 surgery prep stations and four PACU stations for the four surgery rooms and one procedure room for a total of 20 stations. The State Board allows four stations per operating/procedure room. Therefore, the number of recovery rooms being proposed is in compliance with State Board Requirements.

Urgent Care

The Applicant established this four bed urgent care center in 2017. The urgent care center will be located adjacent to the emergency department. The establishment of this unit allowed for the ED staff to better triage the patients in order for them to receive care in a timely fashion. 4,770 patients were seen in the first year with the Applicant expecting the volume to increase over the next several years. The State Board does not have a standard for this service.

Outpatient Clinic

The Applicant is proposing outpatient clinical space for both staff physicians and four physicians who travel to the clinic on a regular but not daily basis from other larger hospitals in the surrounding area. The new clinic area will house two new general surgeons, an orthopedic surgeon, a pain clinic, a urologist, an ENT physician, and a podiatrist. The clinic will also have

some expansion capability for additional specialists to serve the facilities on a limited schedule. The space for the urologist, the podiatrist and the ENT will be rented to those physicians with the billing primarily provided by outside resources. The general surgeon who will be the first one to arrive has a projected volume of 830 visits the first year and 1,210 visits the second year. The orthopedic surgeon will have a projected volume of 2,700 visits the first year and 3,300 visits the second year. It is important to know that he will be the only orthopedic surgeon in the area, and he will be recruiting a Physicians assist or a nurse practitioner to assist in his practice. There is no State Standard for this department.

Central Sterile Supply

This department will be located adjacent to the Surgery Department and the Emergency Department in new construction. This space includes the sterilization equipment for sterilizing surgical instruments and packs, as well as space for storingthe supplies within the sterile confines of the Surgery Department, while still providing quick access to the needs of the ED. There are no State Standards for this department. The applicant believes that the proposed department will meet all of the hospital needs.

Summary

Based upon the historical utilization at the hospital it does not appear that the proposed modernization of the long term care unit will meet target occupancy. It will take a growth of 4.6% compounded annually by 2022 for the 30-bed unit to be at the target occupancy of 90%. In addition to reach target occupancy for the four operating rooms the surgery hours would have to increase by 15.6% compounded annually and the number of surgery cases by 11% to justify the four surgery rooms by 2022.

If the State Board accepts the three dedicated stations in the emergency department as reasonable the Applicant's current workload will justify the six stations being proposed. The one procedure room for endoscopy procedures is justified by the current workload. The remaining areas being modernized do not have a State Board Standard.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT MEET THE REQUIREMENTS OF CRITERION PROJECTED UTILIZATION (77 ILAC 1110.120 (b))

C) Criterion 1110.120 (e) - Assurances

To demonstrate compliance with this criterion the Applicant must attest that the proposed project will achieve target occupancy within two years after project completion.

In additional information the Applicant provided the necessary attestation.

X. Clinical Services Other than Categories of Service

A) Criterion 1110.270 (c)- Service Modernization

2. Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

C. If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

The Applicant is modernizing services that are considered clinical services other than categories of service. These include surgery and Phase I and Phase II recovery stations and the emergency department. Long term care service is considered a hospital based long term care unit and is considered a category of service by rule.

The Applicant last modernized the Surgery and Emergency Department as well as support areas in 1998, and as the care model has changed, the Applicants believe it is necessary to expand these services to meet the needs of the physicians hired and the needs of the patients of its service area.

The Applicant has stated the modernization is necessary to accommodate the additional demand they believe will be achieved by the hiring of additional physicians to provide care to the medically underserved areas that comprise much of the hospital service area. As can be seen by the discussion at Criterion 1110.120 (b) the historical utilization does not warrant the extent of the modernization being proposed by Applicant. The Applicant has not met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT MEET THE REQUIREMENTS OF CRITERION CLINICAL SERVICES OTHER THAN CATEGORIES OF SERVICE (77 ILAC 1110.270 (c) (2))

XI. Financial Viability

A) Criterion 1120.120 – Availability of Funds

To demonstrate compliance with this criterion the Applicant must demonstrate that resources are available.

The Applicant is funding this project with pledges of $3,000,000 a USDA Bond Anticipation Note of $19,864,089 and a USDA Loan of $2,000,000. The Applicant will receive two loans from the USDA. First is a USDA Rural Development Community Facilities Direct Loan for $19,864,000 loan at 4.25% interest rate (estimate) and a 40 year amortization period. The second loan is a USDA Rural Economic Development Loan at $2 million (Max, with a 0% interest rate and a 10 year term with no deferral period).

[3]No documentation has been provided that indicates that the resources are currently available to the fund the proposed project. The Applicant has not met the requirements of this criterion.

Fairfield Memorial Hospital Audited Financial Statements June 30		
	2017	2016
Cash	$571,648	$235,156
Current Assets	$1,515,655	$1,694,541
PPE	$3,904,534	$5,998,430
Total Assets	$24,311,535	$25,775,734
Current Liabilities	$2,997,190	$4,478,134
LTD	$5,621,324	$6,132,327
Net Assets	$15,380,346	$14,749,269
Net Patient Revenue	$28,392,655	$27,788,161
Total Revenue	$29,393,302	$28,422,641
Operating Income	$543,148	-$473,898
Increase in Net Assets	$662,120	-$142,326

STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT MEET THE REQUIREMENTS OF CRITERION AVAILABILITY OF FUNDS (77 ILAC 1120.120)

B) Criterion 1120.130 – Financially Viability

To demonstrate compliance with this criterion the Applicant must demonstrate that they are financially viable.

The Applicant provided three years of historical financial ratios and the projected ratios for the first year after project completion. As can be seen at the end of this report the Applicant does not meet all of the financial ratios for all years considered. An explanation of the differences from the State Board Standards are provided at pages 91-93 of the Application for Permit.

[3] Bond anticipation notes are short-term debt securities issued by the USDA to fund a new project. These notes are issued in anticipation of long-term financing which when issued is used to retire or pay off the Notes. The Rural Economic Development Loan (REDL) and Grant (REDG) programs provide funding to rural projects through local utility organizations.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT MEET THE REQUIREMENTS OF CRITERION FINANCIAL VIABILITY (77 ILAC 1120.130)

XII. Economic Feasibility

A) Criterion 1120.140(a) – Reasonableness of Project Financing

To demonstrate compliance with this criterion the Applicant must attest that debt financing is necessary to maintain the cash and equivalents of the hospital be retained in order to maintain a current ratio of at least 2.0.

The Applicant provided the necessary attestation at page 107 of the Application for Permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT MEETS THE REQUIREMENTS OF CRITERION REASONABLENESS OF PROJECT FINANCING (77 ILAC 1120.140(a))

B) Criterion 1120.140(b) – Terms of Debt Financing

To demonstrate compliance with this criterion the Applicant must attest that the debt financing will be at the lowest cost available.

The Applicant provided the necessary attestation at page 109 of the Application for Permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT MEETS THE REQUIREMENTS OF CRITERION TERMS OF DEBT FINANCING (77 ILAC 1120.140(b)

C) Criterion 1120.140(c) – Reasonableness of Project Costs

To demonstrate compliance with this criterion the Applicant must document that the project is in conformance with the State Board Standard as stated in Part 1120 Appendix A.

The Applicant is proposing 42,965 in reviewable gross square footage for new construction and 11,380 GSF of modernization. The State Board Standard for new construction is $379 inflated by 3% to the midpoint of construction and the modernization Standard is 70% of the new construction standard. The Applicant has met all of the requirements of the State Board. The State Board does not have standards for movable of other equipment, consulting fees, bond issuance expense, net interest expense and other costs to be capitalized.

TABLE SEVEN
Reasonableness of Project Costs

	Project Costs		State Board Standard		Difference		Met Standard?
Preplanning Costs	$289,339	1.79%	$291,245	1.80	-$1,906	-.01%	Yes
Site Survey and Soil Investigation & Site Preparation	$508,079	3.68%	$689,419	5.00%	-$181,340	-1.32%	Yes
New Construction Contract	$10,998,898	$256.00	$16,282,876	$379%	-$5,238,398	-$122.99	Yes
Modernization Contracts	$2,789,490	$245.12	$3,019,114	$265	-$229,624	-$19.88	Yes
Architectural/Engineering Fees	$1,114,625	8.08%	$1,243,713	9.02%	-$129,088	-.94%	Yes

STATE BOARD STAFF FINDS THE PROPOSED PROJECT MEETS THE REQUIREMENTS OF CRITERION REASONABLENESS OF PROJECT COSTS (77 ILAC 1120.140(c)

D) Criterion 1120.140(d) – Direct Operating Costs

To demonstrate compliance with this criterion the Applicant must document the direct operating costs per equivalent patient day for the first year after project completion.

The projected operating cost per equivalent patient day for 2021 is $1,807.74 and for 2022 is $1,857.60.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT MEETS THE REQUIREMENTS OF CRITERION DIRECT OPERATING COSTS (77 ILAC 1120.140 (d))

E) Criterion 1120.140(d) – Effect of the Project on Capital Costs

To demonstrate compliance with this criterion the Applicant must document the capital costs per equivalent patient day for the first year after project completion.

The capital cost per equivalent patient day for 2021 is $63.33 and for 2022 is $186.37.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT MEETS THE REQUIREMENTS OF CRITERION EFFECT OF THE PROJECT ON CAPITAL COSTS (77 ILAC 1120.140(e))

TABLE EIGHT
Financial Ratios

		State Standard	FY2015	FY2016	FY2017	FY2018	FY2021
Current Ratio	Current Assets / Current Liabilities	1.5	1.5	1.64	2.41	1.04	2.15
Net Margin %	Net Income / Net Patient Revenue	3.00%	3.00%	0.50%	2.25%	1.26%	2.60%
Total Debt to Capitalization	LTD / LTD + Equity	<80%	33%	33%	30%	28%	58%
Projected Debt Service Coverage	NI + Dep + Interest+ Amort / Principle + Interest	>1.75	2.78	1.81	2.63	2.758	2.763
Days Cash on Hand	Cash + Investments + Board Designated Funds/ Operating Expense - Dep/ 365 days	>45	23	19	19	45.56	41.02
Cushion Ratio	Cash + Investments + Board Designated Funds/ Operating Expense - Dep	>3	1.71	1.53	1.56	4.47	2.53

Explanation of the Ratios (provided by Applicant**)**

Current Ratio

The Current Ratio does not include assets whose use is limited. Fairfield Memorial had $1,172,379 in Board Designated funds during 2015 and $1,125,861 in 2016. While these funds require the Hospital CEO approval prior to spending funds, these are not restricted for any purpose, and can be used to pay current liabilities as needed. Second, accrued liabilities third party reimbursement, was an estimate of the amount the Hospital owed to Medicare, when filing the 2015 and 2016 Cost Report. The hospital accrues monthly based on past history and expected monies either owed to, or owed from Medicare. In 2015, $297,222 was booked, which was substantially higher than the $3,497 actually owed to Medicare, as shown in the final Summary Settlement Worksheet. In 2016, $315,000 was booked as a liability to Medicare, which was slightly higher than the actual amount owed of $266,712, per the Summary Settlement Worksheet. Were the Hospital to have included the Board Designated funds in the current ratio, and used the actual amount owed to Medicare instead of an estimate based on history, the current ratio for 2015 would have been 2.04, and 1.91 in 2016. All past years except 2016, and all projected years meet the required 2.0 current ratio. 2016 was an anomaly, and should not be used to determine projected financial viability.

Net Margin Percentage

Fairfield Memorial Hospital is a not for profit critical access hospital, and as such, operates on a low net margin percentages. In support of its mission, the Hospital voluntarily provides care to patients at less than the established charges for patients who meet the charity care criteria. The hospital provided $310,478 of charity cost in 2016, and $247,114 in 2017, which impacts the net margin percentage. In addition the Hospital provides services to other medically indigent patients under certain government reimbursement programs. Such programs pay the Hospital less than established charges, and in the case of Medicaid, less than cost. Approximately 52% and 55% of net patient service revenues are from participation in Medicare and Illinois Medicaid for the years ending 2017and 2016, respectively. The services to these patients also directly impact the Net Margin Percentage. Therefore, Fairfield Memorial Hospital's Net Margin Percentage is lower than the 3.0%, due to the Hospital providing a wide range of services to the poor, uninsured and underinsured individuals in the community.

Projected Debt to Total Capitalization

The hospital was not able to raise the needed funds, other than with debt. The hospital has borrowed funds for projects in the past, and has quickly been able to drop this percentage. 2021 is when the projected is expected to be completed, and as such, will have the highest debt service coverage. The hospital expects that based on projected financial operations, and making the minimum required payments on the issued debt, that this percentage will be at the required percentage of 50%, within 4 years of the projects' completion. Fairfield Memorial intends to pay more than the minimum payment on its current debt, which should reduce the time it will take to reach the targeted percentage.

Projected Debt Service Coverage

All past years except 2016, and all projected years meet the required 2.50 debt service ratio. 2016 was an anomaly, and should not be used to determine projected financial viability.

Days Cash on Hand

The State of Illinois, paying both Medicaid and State of Illinois employees' insurance claims, is a significant payor for Fairfield Memorial Hospital. During the past 3 historical years shown on the ratios, the Hospital has had cash flow issues due to the State of Illinois owing Fairfield Memorial in excess of $4,000,000. This has had a significant impact on the Hospital's cash. If the amounts owed by the State of Illinois to Fairfield Memorial in 2015, 2016, and 2017 were added to the Hospital's operating cash, days cash on hand would be 78, 72, and 73 respectively. Projected 2021 days is 41, due to several factors. The hospital will be paying cash for the necessary orthopedic surgical equipment, estimated at over 1.5 million, needed when our new Orthopedic Surgeon joins the hospital in 2021. This is not included in the current project, and will not be financed, either through a lease or direct loan. Were the equipment not purchased with cash, Days cash on hand would be 57 days. In addition, the 2021 projection takes into account, that the hospital could spend additional cash up to $1 million dollars on items relating to the project, including additional supplies, minor equipment, needed for the renovated areas. This cash will not have been replenished by 2021. The hospital projects days' cash on hand to be 75 days by 2024, based on the additional revenue generated by the new physicians, which will be employed by Fairfield Memorial.

Cushion Ratio

The State of Illinois, paying both Medicaid and State of Illinois employees' insurance claims, is a significant payor for Fairfield Memorial Hospital. During the past 3 historical years shown on the ratios, the Hospital has had cash flow issues due to the State of Illinois owing Fairfield Memorial in excess of $4,000,000. This has had a significant imp;,ct on the Hospital's cash. If the amounts owed by the State of Illinois to Fairfield Memorial in 2015, 2016, and 2017 were added to the Hospital's operating cash cushion would have been 6.0, for each of these years. During 2018, this ratio improved 4.47, with the State paying a portion of the amounts owed to Fairfield. However, Fairfield used a significant portion to pay off older accounts payable. If the State had paid all of the funds owed to Fairfield, older than 90 days, the 2018 ratio would have been 7.0. The projected 2021 Cushion Ratio is 2.53, due to several factors. The hospital will be paying cash for the necessary orthopedic surgical equipment, estimated at over 1.5 million, needed when our new Orthopedic Surgeon joins the hospital in 2021. This is not included in the current project, and will not be financed, either through a lease or direct loan. Were the equipment not purchased with cash, Cushion Ratio would be 3.5. The Hospital anticipates the Cushion Ratio to be 6.0, by 2024.

Ownership, Management and General Information

ADMINISTRATOR NAME:	Katherine Bunting
ADMINSTRATOR PHONE:	618-847-8333
OWNERSHIP:	Fairfield Memorial Hospital Association
OPERATOR:	Fairfield Memorial Hospital Association
MANAGEMENT:	Not for Profit Corporation (Not Church-R
CERTIFICATION:	Critical Access Hospital
FACILITY DESIGNATION:	General Hospital
ADDRESS	N.W. 11th Street **CITY:** Fairfield **COUNTY:** Wayne County

Patients by Race

White	99.9%
Black	0.1%
American Indian	0.0%
Asian	0.0%
Hawaiian/ Pacific	0.0%
Unknown	0.0%

Patients by Ethnicity

Hispanic or Latino:	0.0%
Not Hispanic or Latino:	100.0%
Unknown:	0.0%

IDPH Number:	0679
HPA	F-03
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2016	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	21	21	21	629	1,858	804	4.2	7.3	34.6	34.6
0-14 Years				*5*	*14*					
15-44 Years				*63*	*195*					
45-64 Years				*150*	*444*					
65-74 Years				*146*	*378*					
75 Years +				*265*	*827*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	4	4	4	39	62	18	2.1	0.2	5.5	5.5
Direct Admission				*29*	*42*					
Transfers - Not included in Facility Admissions				*10*	*20*					
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	30	25	25	121	7,220	0	59.7	19.7	65.8	78.9
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		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	**55**			**779**	**9,140**	**822**	**12.8**	**27.2**	**49.5**	

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	**64.5%**	**12.9%**	**0.5%**	**19.1%**	**0.6%**	**2.3%**	
	415	83	3	123	4	15	**643**
Outpatients	**66.5%**	**24.3%**	**0.4%**	**3.1%**	**2.1%**	**3.7%**	
	13665	4987	87	630	427	750	**20,546**

Financial Year Reported: 7/1/2015 *to* 6/30/2016

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**68.4%**	**3.6%**	**0.9%**	**19.4%**	**7.6%**	**100.0%**	
	3,953,739	210,279	50,635	1,123,210	440,253	5,778,116	46,572
Outpatient Revenue ($)	**32.9%**	**8.7%**	**1.3%**	**49.9%**	**7.1%**	**100.0%**	
	7,616,908	2,021,532	305,174	11,546,334	1,631,554	23,121,502	263,906

Total Charity Care Expense
310,478

Total Charity Care as % of Net Revenue
1.1%

Birthing Data

Number of Total Births:	1
Number of Live Births:	1
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	12,677
Outpatient Studies	122,553
Studies Performed Under Contract	0

Organ Transplantation

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

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	2	2	145	790	287.6	1014	1301.6	2.0	1.3
Gastroenterology	0	0	1	1	30	748	12.79	298.95	311.74	0.4	0.4
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	5	57	9.97	183.59	193.56	2.0	3.2
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	137	0	85.72	85.72	0.0	0.6
Orthopedic	0	0	0	0	0	5	0	4.46	4.46	0.0	0.9
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	3	3	2.93	2.05	4.98	1.0	0.7
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	0	62	0	36.18	36.18	0.0	0.6
Totals	**0**	**0**	**3**	**3**	**183**	**1802**	**313.29**	**1624.95**	**1938.24**	**1.7**	**0.9**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 3 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilzation

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	0	0	0	0	0	0	0	0.0	0.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	2	2	0	637	0	191	191	0.0	0.3
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	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
	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**	**Level 2**
	(Not Answered)	Not Answered
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		2,922
Patients Admitted from Trauma		114
Emergency Service Type:		Basic
Number of Emergency Room Stations		5
Persons Treated by Emergency Services:		7,240
Patients Admitted from Emergency:		795
Total ED Visits (Emergency+Trauma):		**10,162**

Free-Standing Emergency Center

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

Outpatient Service Data

Total Outpatient Visits	**68,560**
Outpatient Visits at the Hospital/ Campus:	68,560
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 Labs	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	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	2	0	585	7,616	0
Nuclear Medicine	0	1	0	0	700
Mammography	0	1	0	4,267	0
Ultrasound	1	0	4	1,377	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	164	3,128	0
Magnetic Resonance Imaging	0	1	0	0	628

Therapeutic Equipment	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	0	0	0
Image Guided Rad Therapy			0
Intensity Modulated Rad Thrpy			0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2016 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

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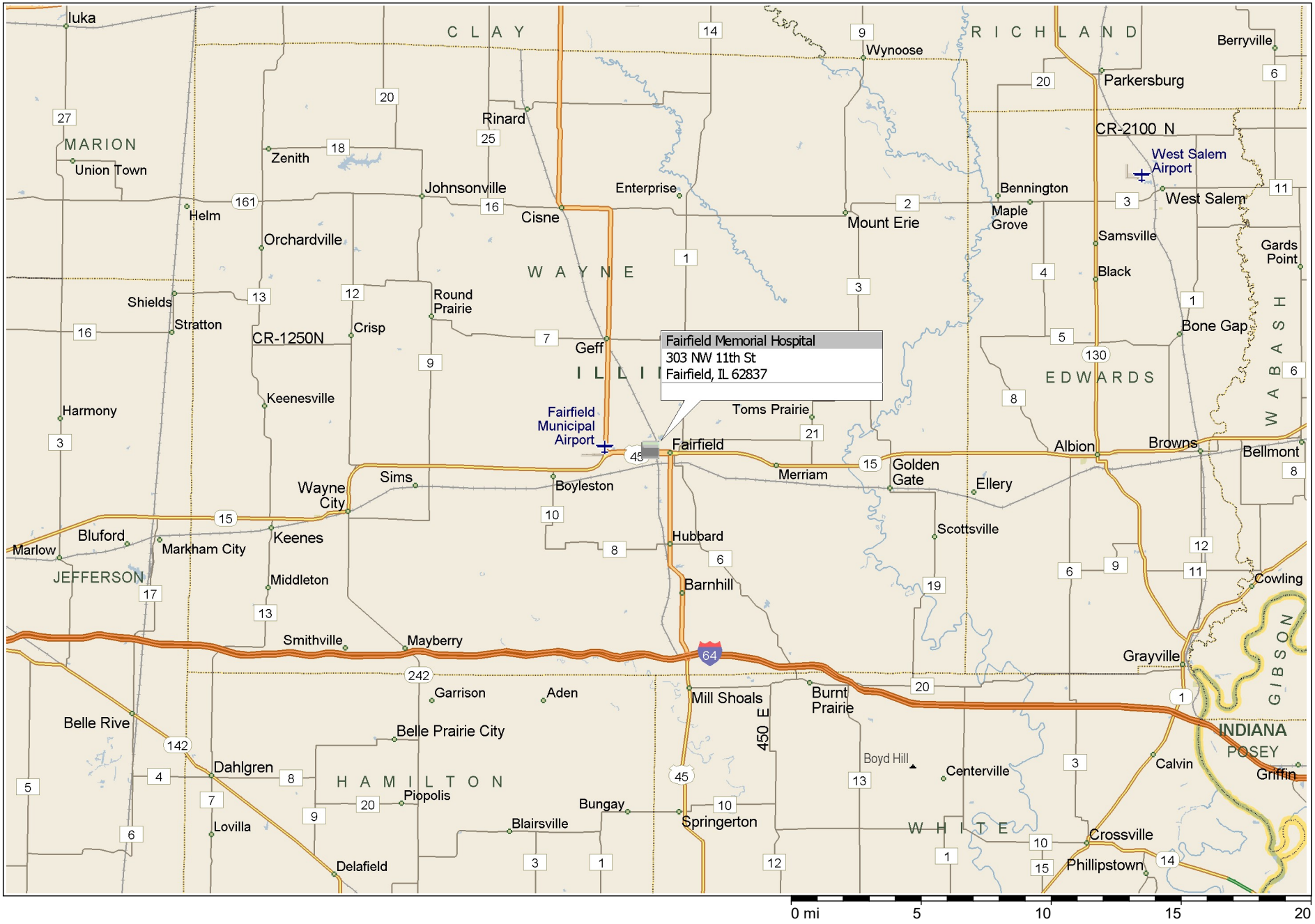

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