



Ferrell Hospital

1201 Pine Street | Eldorado, IL 62930 | P: 618-273-3361 | F: 618-273-2571

February 8, 2017

VIA OVERNIGHT DELIVERY
RETURN RECEIPT REQUESTED

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

RECEIVED

FEB 09 2017

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Re: HFSRB Clarifying Information
Intent to Deny Determination, January 24, 2017
Ferrell Hospital Modernization Project 16-048

Dear Ms. Avery,

This submission is intended to clarify information contained in our original permit application, dated November 4, 2016, subsequent information filings as requested by the HFSRB staff, as well as information in the Project file and posted on the Board's project web-site, the State Board Report dated January 10, 2017, related public participation testimony, as well as Ferrell Hospital's testimony before the Review Board on January 24, 2017. This letter also responds to Review Board Member concerns expressed at the Review Board meeting and contained in excerpts from the meeting transcripts.

At the January 24th Board meeting, the motion to approve the project received a 4 to 1 vote, with three members absent, resulting in an Intent-to-Deny and the notification letter dated January 25, 2017. Our subsequent response letter dated February 2, 2017 indicated our intent to appear again before the Review Board and also provided notification we anticipated submitting the information included with this letter. We respectfully request an expedited review of this material in order to appear at the Board's next meeting on March 14, 2017, so as to not delay commencement of the project and to allow us to more quickly submit our formal application for funding to the U. S. Department of Agriculture as addressed below.

Our clarifying material is structured as follows:

- A. Review Board Member issues / concerns
- B. Critical Access Hospital (CAH) reimbursement / funding status
- C. Projected Utilization / projections
- D. SBR non-compliance determinations
- E. Post-Review Board meeting responses.

A. Review Board Member Issue / Concerns

Two concerns were indicated and each will be clarified herein.

1. Non-compliance determinations in the SBR.
2. Critical Access Hospital reimbursement and funding status given concerns with changes in the healthcare laws (assumed to be the ACA).

B. Critical Access Hospital (CAH) reimbursement and funding status

One apparent concern relates to whether or not CAHs will potentially be decertified by CMS given the criteria under which they were established and/or whether their reimbursement methodology will be adversely modified impacting their financial viability, in particular, given the anticipated changes to the ACA legislation (“Obamacare”).

Ferrell was designated a “necessary provider of health services” in 2002 and, on February 13, 2003, CMS designated Ferrell Hospital as a CAH. We believe the support for Critical Access Hospitals will continue under the new Administration in Washington and we understand that our Illinois U.S. Senators have expressed their strong and continuing support for Critical Access Hospitals.

Additionally, we requested Health Care Futures, one of our outside planning consultants, to conduct additional research on this issue as it relates to CAHs. Their comments are briefly summarized below with additional information provided in the attached letter (See Attachment A).

Critical Access Hospitals such as Ferrell Hospital today represent approximately 30 percent of the hospitals in the United States. In terms of cost to the health care system, CAHs

represent just over two percent of the overall CMS budget on an annual basis. CAH categories were established by Congress in 1997 in response to a number of hospitals closing and rural communities losing access to hospital and ambulatory care. Congress saw the importance of providing support for smaller hospitals like Ferrell back in 1997 and Congress and CMS have continued to support CAHs for 20 years now. Changes that may emanate from Congress relative to the ACA in the view of: our advisors; many other experts in the industry; the American Hospital Association; and, large numbers of Congressmen should have minimal negative impact on reimbursements to necessary community hospitals such as Ferrell. It should be noted that various Congressmen continue to pursue legislations to reduce the administrative (and thus cost) burden on CAHs. For example, the Rural Hospital and Provider Equity Act of 2016 (introduced in September 2016) calls for easing the burden on CAHs by eliminating a requirement for a physician to certify a patient will be able to be discharged or transferred within 96 hours. Legislative enhancements to CAHs such as this would assist CAHs in meeting the demands of the community. Thus, we believe CAHs, while clearly subject to any replacement of the ACA, will continue to be supported with reimbursement that allows CAHs to maintain care in the local community.

C. Projected Utilization / Assurances (Criterion 1110.234 (e))

As noted in the project related SBR prepared by HFSRB staff ... "it is difficult for a critical access hospital to meet the State Board utilization standards because of its rural location and small population the critical access hospital is serving".

We concur with this observation, but further wish to clarify our projections and the material presented to the Review Board in our January 24th testimony.

The underlying Permit Application is based on a very conservative projection methodology predicated on the patients Ferrell currently serves, as well as the Hospital's current market / service area, market share, while considering an aging population. We based the permit application projections on the patients and market currently served so as to not overestimate utilization. Our strategic and facility planning was based solely on providing healthcare services which meet the needs of our patients. We had two major planning goals:

- First, to modernize our facility in response to service and documented code, licensing and CoP deficiencies necessary to improve patient care quality.
- Second, to provide facilities in the safest and most contemporary environment.

Our conservative methodology did not include the recapture of significant planning areas. If considered, we believe we would be able to meet target utilization in all departments. Our co-applicant, Deaconess Regional Healthcare Network, Illinois, is a component of the Deaconess Health System, Evansville, Indiana. Deaconess currently provides significant services to Southeastern Illinois, including: affiliations with three CAHs; serving as a resource hospital to four EMS services; serving as a State of Illinois Level II Trauma Center for adult and pediatric care; chairing the Region 5 Trauma System; and, managing one CAH. However, many patients from Ferrell's Illinois service area out-migrate to Deaconess in Indiana for specialized care. As testified by Jared Florence, President of Deaconess Regional Healthcare Network of Illinois, during our formal testimony before the Board, Deaconess anticipates, through their ACO, to have more patients treated locally in Illinois. In fact, all southeastern Illinois hospitals located within Deaconess' service area have been offered the opportunity to participate and partner in the ACO and Deaconess' population health strategies which embrace the Triple Aim strategy. This strategy focuses on cost reduction, increased patient satisfaction and improved quality. Currently, Deaconess has over 120,000 lives under a value based contract and is actively managing the population health and costs for these patients. Ferrell Hospital's modernization program will facilitate Deaconess' efforts as more patients will have access to improved specialty, outpatient and inpatient care close to home, as opposed to costly transport to Indiana, improving the overall health of the communities served by Ferrell Hospital. Through these efforts, we expect our future utilization to exceed current conservative projections.

In 2015, our hospital had about 2500 patient days. The Review Board's latest Inventory shows that our planning area lost over 8,000 patient days from local residents leaving the planning area for other Illinois hospitals. In addition to those leaving the planning area, we have a large number of residents leaving the State. The Deaconess hospital in Evansville, Indiana, alone has 1300 admissions a year from our planning area. Additionally, there are

currently no hospital or emergency department services in White and Gallatin Counties, causing patients to depend heavily on Deaconess Hospital for services. Deaconess, however, is working with us to help keep as many of these patients as possible in our Eldorado facility. Our partnership with Deaconess along with this modernization project will help to provide necessary hospital and emergency care within Southeastern Illinois, enabling patients access to care closer to home. Deaconess knows that it is better for these patients to be treated close to home, and that is what we are working towards together.

Deaconess is supporting and encouraging our efforts to keep Illinois patients in Illinois as Deaconess believes that by partnering with Critical Access Hospitals in Illinois, more care can be given to patients in the right place (the local hospital), at the right time and at a lower cost. Those efforts include: assisting with physician recruitment of Deaconess' family practice residents for Ferrell Hospital; access to Deaconess' robust information system as well as their Marketing, Facility Planning and other expertise that Ferrell is not able to employ on its own.

If we capture just a fraction of the out-migration from our planning area and from the State, we can meet target utilization in our 25-bed unit.

D. SBR Non-Compliance Determinations

As noted in the SBR, the applicants received non-compliance determinations in the following areas.¹

1. Project Size (Criterion 1110.234 (a))

Only three (3) of thirteen (13) departments exceed the State Board's square footage standards in Part 1110, Appendix B. These are the Endoscopy area and the Phase I and II recovery beds. The remainder of the departments are under the Board's sq. ft. Standards and are in compliance. Those departments with space below the Board standards approximate 14,584 gsf below what could be developed. In other words,

¹ Some Review Board members commented on the proposed project size and related non-compliance determinations. These comments appear to relate to space, certain ancillary rooms, and the number of M/S beds. Based on the unapproved Review Board meeting transcript, it appears our testimony satisfactorily addressed Board member concerns in these areas. However, to ensure full understanding we offer the above clarifications.

this additional 14,584 gsf area could be added to the project and still meet State Board criteria.

Those areas over the Standards approximate a total 1,285 gsf (Note: There is a calculation error impacting the Phase II recovery bed excess area on Table Seven of the SBR) or less than 1 percent of the project's total sq. ft. Taken in aggregate, considering both the gsf under the standards (14,584 gsf) and the calculated excess gsf (1,285 gsf), the difference is 13,299 gsf below the Board Standards.

The primary reason for the "excess" gsf in select areas is to meet Medicare CoP criteria and IDPH Licensing requirements such as providing the facilities necessary to support family access to recovery room beds. We believe the space is adequately sized, in aggregate and our proposed Project is the most cost effective given our planning efforts and alternatives considered.

2. Projected Utilization and Clinical Service Areas (Criterion 1110.234 and .3030)

Twenty One (21) clinical service areas (CSA's), other than a Category of Service, are proposed in the modernization project; of these, 9 have associated Review Board evaluation criteria. Only three CSA's received non-compliance determinations ... the number of General Radiology units, the number of Operating Rooms, and the proposed number of Emergency Department Stations. The rationale for including each in our proposed project follows:

A. General Radiology Units

Imaging is a critical ancillary service. Two (2) general radiology units are proposed or one (1) more than justified under Board criteria. The rationale for the two (units) is to be able to provide continuous service to our inpatient, outpatient, and emergency patients if one unit is down for repair or preventative maintenance.

B. Surgery Rooms

Two (2) surgery rooms are proposed. The second room is requested to ensure a sterile environment if one is contaminated due to an infected case, as well as to provide back-up surgical capabilities in a disaster situation similar to the 2012 leap-day tornado when Harrisburg Medical Center was damaged and Ferrell Hospital served as a primary treatment site as noted in our January 24, 2017 testimony. A modernized surgical suite will also assist in recruiting and retaining surgeons to our medically underserved area (MSA).

C. Emergency Room Stations

Eight (8) emergency department (ED) stations are proposed for the modernization project whereas historical average utilization justifies four (4) based on Review Board criteria. The requested station complement is based on ensuring timely patient care times during frequently peak utilization in that the ED functions as a walk-in clinic during certain times of the day and on weekends, let alone needing stations to accommodate peak seasonal periods, such as, during the flu season. Adequate ED facilities improve timely access to care, in particular, to our elderly population.

3. Assurances (Criterion 1110.234(e))

The SBR notes that utilization data in the CON application did not show state standards satisfied by the second year of operation for some departments, although most departments would meet the standards. (See Table Eight on page 18 of the SBR.) The SBR further notes that "it is difficult for a critical access hospital to meet the State Board Utilization Standards because of its rural location and the small population the critical access hospital is serving." (SBR at 19.) As addressed above, we utilized conservative assumptions in making these utilization projections that did not include any recapture of outmigration, much of which is going to the Deaconess facility in Evansville, Indiana, and Deaconess is working with us to help keep these Illinois patients in Illinois through a number of the initiatives discussed above.

If we capture just a fraction of the out-migration from our planning area and from the State, we can meet target utilization in the four departments indicated in the SBR.

We are doing, and will continue to do, everything we can to improve utilization to meet target utilization in a way that does not adversely impact other planning area facilities.

4. M/S Bed Modernization (Criterion 1110.3030)

Average historical bed utilization justifies 14 M/S beds when taking into account observation bed days, swing bed utilization, and inpatient days (2,866 bed days; 2015 AHQ data). The modernization project proposes to develop 15 new private rooms while maintaining 10 beds in existing patient rooms. The project proposes a total 25 M/S beds, our current approved CON bed size, to accommodate historic peak census periods which, on any given day, could be 14 M/S patients, 6 swing bed patients, and 2 to 3 observation patients in 2015 (see related AHQ profile) without taking into consideration the potential to recapture out-migration trends as described above which, if they occur as contemplated, will increase our utilization.

5. Fund Availability

As noted in the project record, the USDA has encouraged Ferrell to submit a loan application for project funding and refinancing an existing USDA loan. However, a CON Permit is required to do so, it is a “chicken and egg” circumstance in this situation. Hence, the need for a valid CON permit. (See information from the USDA below and Attachment B)

- As indicated on the USDA’s website in response to frequently asked questions regarding additional requirements for obtaining a loan, the USDA states, “Applicants must have legal authority to borrow money, obtain security, repay loans, construct, operate, and maintain the proposed facilities.”
- Additionally, as indicated in the USDA’s Community Facilities Infrastructure Toolkit, published January 2016, the USDA recognizes that organizations may need to complete a Certificate of Need prior to proceeding with the project. The material continues to state that if a

CON is needed, “the Project Team will need to complete a formal checklist of procedures involving data analysis aimed at identifying the actual needs and actual capacity of the project. This process should be engaged as part of the concept development phase in order to facilitate reasonable project estimates.”

- USDA loan applicants are required to attach their obtained Certificate of Need, if a CON is required by state law (See Attachment B, Application for Loan Guarantee, item 31).

6. Financial Feasibility

As noted in the SBR, and posted on the Review Board project website, EideBailey has attested to the fact the Hospital is financially viable and the proposed project is financially feasible, even though certain Review Board financial ratios are not met.

E. Post-Review Board Meeting Responses

During the entire HFSRB process there has been only one organization opposing the proposed Ferrell Hospital modernization program in contrast to the strong local community and multi-county public support voiced for the modernization project as evidenced by permit application support letters and the public participation testimony on January 24th. Subsequent to the January 24, 2017 Intent-to-Deny, several relevant circumstances have occurred to further indicate community support as well as unanticipated support by the opposition.

1. The Harrisburg Daily Register on its January 25, 2017 opinion page, in the “Our Opinion” segment, made several observations:
 - a. “ ... Overall, Southern Illinois doesn’t have the level of available healthcare other parts of the State enjoy.”
 - b. “ ... we believe, overall, that allowing Ferrell Hospital to expand its services is good for Saline County and Southern Illinois as a whole”; and, in conclusion, the editorial opinion states,

- c. “We also believe the healthcare landscape is better with Ferrell Hospital continuing to be a vibrant player in the medical marketplace. Ultimately, it’s about serving the residents. We hope the Facilities Board sees that.”
2. In a posted letter addressed to the “Citizens and Patients that we serve”, subsequent to the January 24, 2017 intent-to-deny determination by the Review Board, Mr. Rodney D. Smith, President and CEO, Harrisburg Medical Center apparently stepped back from the written opposition posted on the HFSRB Project website and contradicted both his written opposition letter and HFSRB public participation testimony by stating:
 - a. “Harrisburg Medical Center has no opposition to Ferrell Hospital improving their facility and upgrading it.”
 - b. “ ... we actually work cooperatively (with Ferrell) on projects to serve our area.”
 - c. “Harrisburg Medical Center’s (sic) ... will ... do the right things to serve our patients and community.”

Summary

We trust the clarifying information will assist the Review Board in its determination and look forward to appearing before you on March 14th, notwithstanding a potentially longer review period, up to 60 days, based on this submittal.

Please contact me if additional information or clarification is required. I can be reached at 618-273-3361 ext. 150 or by e-mail at acoleman@ferrellhosp.org.

Sincerely,


Alisa Coleman, CEO
Ferrell Hospital

CC: Mr. Mike Constantino, Supervisor, Project Review Section

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Clarifying Information Submission
February 8, 2017
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Attachments: Attachment A: Consultant letter, CAH findings
Attachment B: USDA requirements re valid CON



February 7, 2017

Ms. Alisa Coleman
CEO Ferrell Hospital
1201 Pine St.
Eldorado, IL 62930

Re: Ferrell Hospital Project 16-048

Dear Alisa:

This letter serves to provide our conclusion relative to Critical Access Hospitals (CAH) and future funding implications under the Affordable Care Act (ACA) or changes/replacement of the ACA.

The CAH designation was created by Congress in the 1997 Balanced Budget Act in response to a large number of rural hospital closures in the 1980s and 1990s. CAH's are a separate provider type having their own respective Conditions of Participation (CoP) for Medicare certification as well as a separate Medicare payment methodology implemented through the Center for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS).

Following up on comments concerning CAH funding, we respectfully submit that, from our research, there is no tangible indication that current legislation will result in changes for CAH funding and, furthermore, believe this concern is not applicable to this project. CAHs are too vital in providing accessible healthcare in rural America. Some important background on CAHs follows.

- The approximate 1,330 CAHs represent about 30 percent of US hospitals.
- The estimated allocation to Critical Access Hospitals approximates only 2 percent of CMS' total 2017 Budget.
- CAH employees approximate 275,000 FTEs in the USA.
- CAHs, on the average, have 22,000 Emergency Department visits a day.

Attachment A

Re: Ferrell Hospital Project 16-048

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- CAHs are responsible for treating approximately 38 Million outpatients and 800,000 inpatients, or approximately 2,200 inpatients per day.

We strongly believe that it is unlikely CAHs will be adversely impacted by Federal legislation anytime soon. Since 2012, the federal budget has repeatedly proposed reducing CAH reimbursement from 101 percent to 100 percent of reasonable costs and modifying distance requirements for CAH designation. These proposed budget cuts have, year after year, been met with opposition and, accordingly, have not come to fruition. In prior budget proposals, opposition to these Budget cuts affecting essential providers was expressed by members of Congress, including Representative Kuster (New Hampshire), who stated, in part, that the modification to the distance requirement for CAH designation was the most troubling part of the President's Budget Proposal as this modification did not have the research or rationale to support the proposed policy change. Moreover, Senators from nineteen states wrote to President Obama in support of CAHs, opposing these budget proposals. Additionally, the American Hospital Association has steadfastly opposed these proposals and continues to emphasize the importance of Critical Access Hospitals and its support for these providers.

There has been a lot of Legislative actions introduced to reduce the regulatory burden placed on CAHs over the past years. Proposed legislation includes the Rural Hospital and Provider Equity Act of 2016, S. 3435, introduced in September 2016, which is a bi-partisan bill that, in part, seeks to remove the 96-hour condition of payment rule (requiring CAH physicians to certify that a patient may reasonably be expected to be discharged/transferred within 96 hours of admission) for CAHs and proposes to extend the exemption of the direct supervision policy for outpatient therapeutic service through 2017. The Rural Hospital Regulatory Relief Act of 2016, H.R. 5164, introduced in May 2016, seeks to provide permanent extension of the exemption of the direct supervision policy for outpatient therapeutic services. While both Bills have only been introduced to date, they serve as examples of continual legislative support to reduce regulatory burdens on Critical Access Hospitals.

Furthermore, Illinois Congressmen have indicated support for CAHs. Most recently, Senator Durbin met with hospital executives, including four CAH CEOs, to discuss potential implications of a possible ACA repeal. Senator Durbin indicated his support to protect patients



Attachment A

Re: Ferrell Hospital Project 16-048

February 7, 2017

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and providers such as Critical Access Hospitals. In 2015, Representative Shimkus co-sponsored The Critical Access Hospital Relief Act of 2015, H.R. 169, which proposed to alleviate the 96-hour mandate.

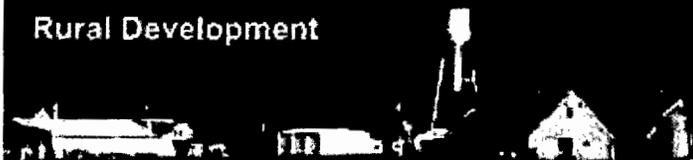
Despite the unknown surrounding the Affordable Care Act in the wake of new Administration, should Healthcare policies revert in some capacity to pre-ACA measures it is unlikely support and funding for Critical Access Hospitals will be eliminated as these providers, which are vital to providing healthcare in rural America, have been steadfastly supported throughout the years and will likely continue to be supported as outlined above.

Thank you,
Health Care Futures L.P.



Edward J. McGrath
Partner





Community Facilities Direct Loan & Grant

What does this program do?

This program provides affordable funding to develop essential community facilities in rural areas. An essential community facility is defined as a facility that provides an essential service to the local community for the orderly development of the community in a primarily rural area, and does not include private, commercial or business undertakings.

Who may apply for this program?

Eligible borrowers include:

- Public bodies
- Community-based nonprofit corporations
- Federally recognized Tribes

What is an eligible area?

Rural areas including cities, villages, townships and towns including Federally Recognized Tribal Lands with no more than 20,000 residents according to the latest **U.S. Census Data** are eligible for this program.

How may funds be used?

Funds can be used to purchase, construct, and/or improve essential community facilities, purchase equipment and pay related project expenses.

Examples of essential community facilities include:

- Healthcare facilities such as hospitals, medical clinics, dental clinics, nursing homes or assisted living facilities
- Public facilities such as town halls, courthouses, airport hangars or street improvements
- Community support services such as child care centers, community centers, fairgrounds or transitional housing
- Public safety services such as fire departments, police stations, prisons, police vehicles, fire trucks, public works vehicles or equipment
- Educational services such as museums, libraries or private schools
- Utility services such as telemedicine or distance learning equipment
- Local food systems such as community gardens, food pantries, community kitchens, food banks, food hubs or greenhouses

For a complete list see Code of Federal Regulations 7 CFR, Part 1942.17(d) for loans; **7 CFR, Part 3570.62** for grants.

What kinds of funding are available?

- Low interest direct loans
- Grants
- A combination of the two above, as well as our **loan guarantee program**. These may be combined with commercial financing to finance one project if all eligibility and feasibility requirements are met.

What are the funding priorities?

Priority point system based on population, median household income

- Small communities with a population of 5,500 or less
- Low-income communities having a median household income below 80% of the state nonmetropolitan median household income.

What are the terms?

Funding is provided through a competitive process.

Direct Loan:

- Loan repayment terms may not be longer than the useful life of the facility, state statutes, the applicant's authority, or a maximum of 40 years, whichever is less.
- Interest rates are set by Rural Development, contact us for details and current rates.
- Once the loan is approved, the interest rate is fixed for the entire term of the loan, and is determined by the median household income of the service area.
- There are no pre-payment penalties.
- Contact us for details and current interest rates applicable for your project.

Community Facilities Direct Loan & Grant

What are the terms? (continued)

Grant Approval:

Grant funds must be available. Applicant must be eligible for grant assistance, which is provided on a graduated scale with smaller communities with the lowest median household income being eligible for projects with a higher proportion of grant funds. Grant assistance is limited to the following percentages of eligible project costs:

Maximum of 75 percent when the proposed project is:

- Located in a rural community having a population of 5,000 or fewer; and
- The median household income of the proposed service area is below the higher of the poverty line or 60 percent of the State nonmetropolitan median household income.

Maximum of 55 percent when the proposed project is:

- Located in a rural community having a population of 12,000 or fewer; and
- The median household income of the proposed service area is below the higher of the poverty line or 70 percent of the State nonmetropolitan median household income.

Maximum of 35 percent when the proposed project is:

- Located in a rural community having a population of 20,000 or fewer; and
- The median household income of the proposed service area is below the higher of the poverty line or 80 percent of the State nonmetropolitan median household income.

Maximum of 15 percent when the proposed project is:

- Located in a rural community having a population of 20,000 or fewer; and
- The median household income of the proposed service area is below the higher of the poverty line or 90 percent of the State nonmetropolitan median household income. The proposed project must meet both percentage criteria. Grants are further limited.

Are there additional requirements?

- Applicants must have legal authority to borrow money, obtain security, repay loans, construct, operate, and maintain the proposed facilities
- Applicants must be unable to finance the project from their own resources and/or through commercial credit at reasonable rates and terms
- Facilities must serve rural area where they are/will be located
- Project must demonstrate substantial community support
- Environmental review must be completed/acceptable

How do we get started?

Contact your **local offices** to discuss your specific project. Applications are accepted year round

Who can answer questions?

Contact our **local office** that serves your area.

What governs this program?

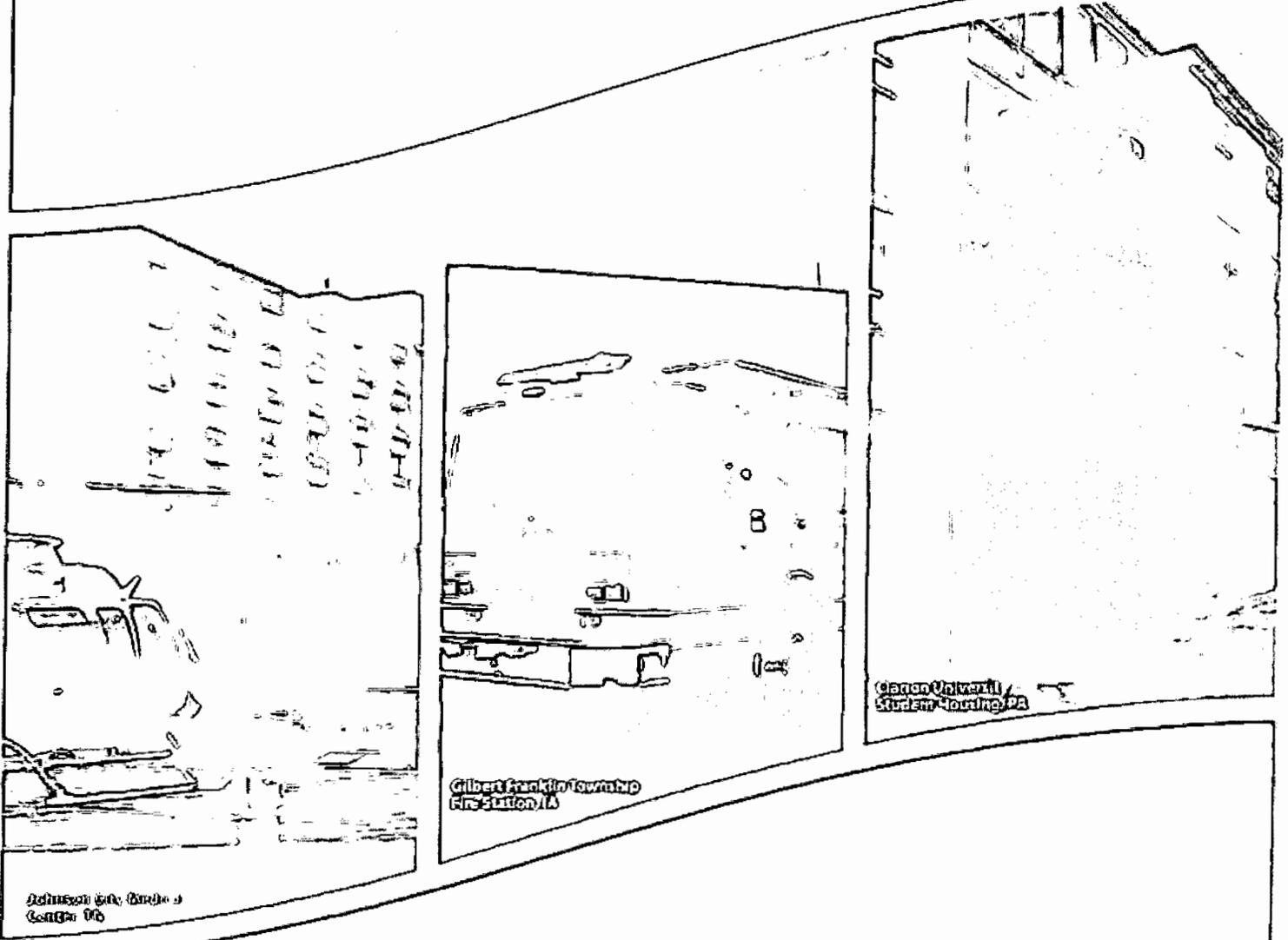
- Direct Loan: 7 CFR Part 1942, Subpart A
- Grant: 7 CFR Part 3570, Subpart A

Attachment B



United States
Department of
Agriculture

Rural Development



JANUARY 2016

Introduction

This *Community Facilities Infrastructure Toolkit* can be used as a guide to help organizations and community leaders better understand the complex process that is required to successfully develop and construct a new facility. The Toolkit outlines the major capacity, credit, and logistical challenges that particularly confront America's small towns and rural areas.

The *Community Facilities Infrastructure Toolkit* is designed to apply broadly across organizations regardless of project type or finance sources—including conventional bank loans, bond financing, or state and federal grant and lending programs. The U.S. Department of Agriculture's (USDA) Rural Development Community Facilities programs particularly applies to the types of projects discussed in the Toolkit, which provides useful recommendations for rural communities seeking financial support from USDA Rural Development.

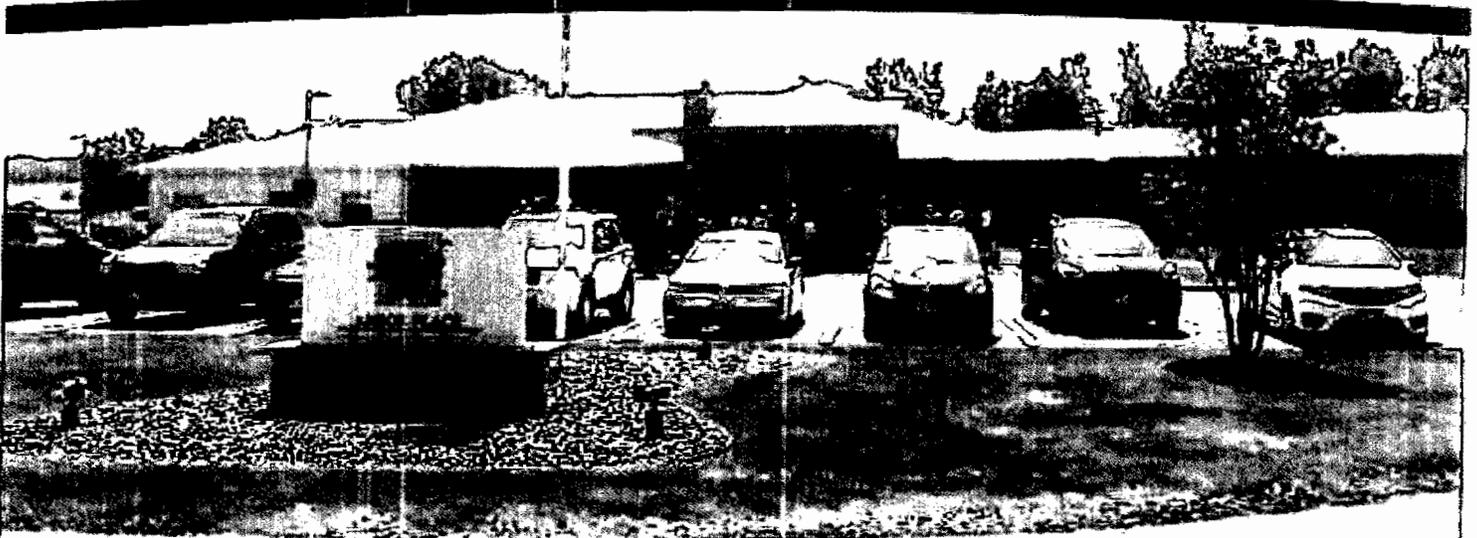
The Community Facilities programs apply a public-private partnership model consisting of the private community organization, private lender, and the USDA to catalyze rural development

throughout the country. The programs provide direct loans and loan guarantees to numerous projects in several categories: healthcare, public facilities, community support, public safety, educational services, utility services, and food systems. Rural communities with populations under 20,000 are eligible for the program. Contact your local USDA Rural Development office to learn more.

The *Community Facilities Infrastructure Toolkit* contains sections on concept development, planning, designing, environmental compliance, finance, and construction. These sections are ordered roughly chronologically, although some elements of the project process may run concurrently. Organizations are encouraged to review the entire Toolkit and to consult with experienced professionals and your local USDA Rural Development staff before proceeding deeply into the project process.

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Certificate of Need²

Organizations undertaking healthcare projects may need to complete a Certificate of Need (CON) program before proceeding with the project. The CON program, which varies by state in terms of applicability and process, is designed to prevent over-buying of equipment and over-building of facilities. If applicable, the Project Team will need to complete a formal checklist of procedures involving data analysis aimed at identifying the actual needs and actual capacity of the project. This process should be engaged as part of the concept development phase in order to facilitate reasonable project estimates.

The Communication Plan

During the concept development phase, the Steering Committee should seek the input of community stakeholders regarding the community facility project. Most organizations will eventually seek financing from the public directly (e.g., through contributions) or indirectly (e.g., through state or federal financing), and the community is therefore entitled to participate in the planning process. Projects will also benefit from open communication with the public, either by receiving useful ideas or by avoiding potential disagreements or criticism. Organizations should always be well-prepared when engaging with external stakeholders. A communication plan is therefore necessary.

Communication Partners

The first step in the development of a communication plan is to identify the internal and external stakeholders that are appropriate to engage in project development. The following list defines many of the individuals and groups that may be appropriate to include in the plan:

- Existing and target clientele;
- Industry regulators;
- Local politicians;
- Neighborhood groups or societies;
- Organization and project investors;

- Organization staff and Board of Directors; and
- Potential funders and consultants (if not formally engaged in review process).

As the communication plan is developed, the Steering Committee should decide if certain stakeholders require special outreach efforts. For example, the types of meetings and outreach extended to local elected officials may be very different than those extended to existing clientele. The goal of outreach efforts to elected officials may surround a specific event or expectation for funding, whereas the goal of outreach efforts to existing clientele may be to mitigate fears regarding change or to assess opportunities to provide (or sell) additional services.

Outgoing Message

The message to stakeholders should be consistent, concise, and positive. If different components of the Project Team are presenting different ideas, or cannot readily articulate aspects of the project, then public support and participation may be more difficult to attain. Certainly, a negative message from the Project Team can have significant repercussions for the project's status in the community. In order to maintain a strong message, the communication plan should focus on purpose and need, benefits and costs, and transparency.

² American Health Planning Association. (2014). CON Web Sites & Contacts. Retrieved from: http://www.ahpanet.org/websites_copn.html

Attachment B

Form RD 4279-1
(Rev. 11-06)

Position 3

UNITED STATES DEPARTMENT OF AGRICULTURE
RURAL DEVELOPMENT

FORM APPROVED
OMB No. 0570-0017
OMB No. 0570-0050

APPLICATION FOR LOAN GUARANTEE
(Business and Industry and Section 9006 Program)

Section 1001 of Title 18, United States Code provides: "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined under this title or imprisoned not more than five years or both."

CERTIFICATION: Information contained below and in attached exhibits is true and complete to my best knowledge. (Misrepresentation of material facts may be the basis for denial of credit by the United States Department of Agriculture ("USDA").)

PART A: Completed By Borrower

1. AMOUNT OF LOAN \$ _____		2. NAME OF BORROWER		3. ADDRESS (Include Zip Code)	
4. CONTACT PERSON		5. TELEPHONE NUMBER (Include Area Code)		6. TAX ID # OR SOCIAL SECURITY # FOR INDIVIDUALS	
7. PROJECT LOCATION (Town/City)		8. POPULATION	9. COUNTY	10. TYPE OF BORROWER <input type="checkbox"/> Proprietorship <input type="checkbox"/> Cooperative <input type="checkbox"/> Partnership <input type="checkbox"/> Indian Tribe <input type="checkbox"/> Corporation <input type="checkbox"/> Political Subdivision	11. SIC CODE
12. DATE BUSINESS ESTABLISHED		13. FRANCHISE <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, attach a copy of franchise agreement)</i>			
14. a. THIS PROJECT IS <input type="checkbox"/> An expansion <input type="checkbox"/> New Business <input type="checkbox"/> Refinancing <input type="checkbox"/> Transfer of ownership <input type="checkbox"/> Other b. JOBS Created _____ Saved _____		15. IF BORROWER IS AN INDIVIDUAL <i>(Item 10 checked proprietorship)</i> A. IS HE OR SHE A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO B. MARITAL STATUS - <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried		16. HAS BORROWER OR RELATED INDIVIDUAL EVER BEEN IN RECEIVERSHIP OR BANKRUPTCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

17. SCHEDULE OF INSTALLMENT DEBTS, CONTRACTS, NOTES AND MORTGAGES PAYABLE CORRELATED TO LATEST BALANCE SHEET DATED _____, INDICATE WITH ASTERISK (*) DEBTS TO BE REPAYED WITH PROPOSED USDA GUARANTEED LOAN IF APPLICABLE. (*Attach additional sheet if necessary.)

CREDITOR	ORIGINAL LOAN AMOUNT	LOAN BALANCE	DATE OF LOAN	INTEREST RATE	MATURITY DATE	M - MONTHLY Q - QUARTERLY A - ANNUAL PAY	CURRENT? Y - YES N - NO	SECURITY

18. For Existing Businesses Only - Aging of accounts receivable, correlated to latest balance sheet dated _____, typical selling terms are:
 30 Days or Less, 60 Days or Less, 90 Days or Less, Other (Specify) _____
 30 Days or Less \$ _____ 61 to 90 Days \$ _____
 31 Days to 60 Days \$ _____ Over 90 Days \$ _____

19. PROFESSIONAL SERVICE FEES FOR ENGINEERS, ARCHITECTS, LAWYERS, ACCOUNTANTS, LOAN PACKAGERS, APPRAISERS, PROVIDED IN THE PREPARATION OF THIS APPLICATION (SUBJECT TO USDA APPROVAL)

NAME	SERVICE	FEE/COMPENSATION	SOURCE OF FUNDING

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0570-0017. The time required to complete this information collection is estimated to average 4 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Attachment B

20. PROVIDE INFORMATION BELOW ON KEY PEOPLE (PROPRIETOR, PARTNERS, OFFICERS, DIRECTORS, KEYS EMPLOYEES AND STOCKHOLDERS WITH 20% OR MORE INTEREST IN THE BUSINESS). ALSO INCLUDE PERSONS OR CORPORATION THAT WILL GUARANTEE LOAN. (*Optional, used for monitoring purposes only.)

NAME AND POSITION	RACE	SEX	U.S. CITIZEN YES OR NO	ANNUAL COMPENSATION	% OF OWNERSHIP	OUTSIDE NET WORTH	PERSONAL/ CORPORATE GUARANTEE YES OR NO

ATTACH THE FOLLOWING IF NOT ALREADY SUBMITTED:

- 21. ATTACH BUSINESS PLAN that should as a minimum include description of business or project, management experience, products or services, proposed use of funds, community benefits, type and number of jobs, availability of labor or raw materials or supplies, names of any corporate parents, affiliates, subsidiaries and describe relationship, including products, ownership between borrower, parent, affiliates, etc..
- 22. "Certification of Non-Relocation and Market Capacity Information Report," Form 4279-2. (*Not applicable to Section 9006 Program*).
- 23. State Clearinghouse comments or recommendations.
- 24. For companies listed on major stock exchanges and or subject to the Securities and Exchange Commission regulations, a copy of Form 10-K; Annual Report Pursuant to Section 13 or 15D of the Act of 1934."
- 25. "Request for Environmental Information," Form RD 1940-20, and attachments. (*If applicable*)
- 26. Independent Feasibility Study. (*if applicable, see RD Instruction 4279-B, for Section 9006 Program, see §4280.128(b)(1)(vii).*)
- 27. Architectural or Engineering Plans. (*if applicable*)
- 28. Cost estimates and forecasts of contingency funds to cover cost increases or project changes.
- 29. Financial Statements; a) At least 3 years historical income statements and balance sheets (if an existing business), including parents, affiliate and subsidiary firms, Annual Audits if available; b) Current (not more than 90 days old) balance sheet and profit and loss statement (if an existing business); c) Pro-forma balance sheet (at startup); d) 2 years of projections: income statements, balance sheets and cash flow statements supported by a list of assumptions (monthly first year, quarterly for 2nd year). For the Section 9006 program, instead of complying with this item, comply with the requirements in §4280.128.
- 30. Record of any pending or final regulatory or legal (civil or criminal) action against the business, parent, affiliate, proposal guarantors, subsidiaries, principal stockholders, officers and directors.
- 31. If a health care facility, a "Certificate of Need" (*if required by state law*).
- 32. Current personal (not more than 60 days old) and corporate (not more than 90 days old) financial statements on guarantors in Item 20, above.
- 33. Technical Report (Section 9006 Program only; see §4280.128(b)(1)(vi) or §4280.128(c)(1)(ii), as applicable.

By my signature, I certify that I have read the General Borrower Certifications contained in this application. My signature represents my agreement to comply with the limitations outlined in the General Borrower Certifications.

CORPORATE SEAL

BORROWER SIGNATURE

ATTEST _____

BY _____

TITLE _____

TITLE _____

DATE _____