



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: H-12	BOARD MEETING: December 4, 2018	PROJECT NO: 18-035	PROJECT COST:
FACILITY NAME: Morrison Hospital		CITY: Morrison	Original: \$22,500,000
TYPE OF PROJECT: Non-Substantive			HSA: I

PROJECT DESCRIPTION: The Applicant (Morrison Community Hospital District) proposes the modernization of a 25-bed critical access hospital in Morrison, Illinois at a cost of \$22.5 million. The expected completion date is December 31, 2022.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicant (Morrison Community Hospital District) proposes the modernization of a 25-bed critical access hospital in Morrison, Illinois at a cost of \$22.5 million. The expected completion date is December 31, 2022.
- Morrison Community Hospital District is a governmental entity. Morrison Community Hospital is a critical access hospital and is considered a “necessary provider” by the Illinois Department of Public Health. The Hospital participates in the swing bed program. Morrison Community Hospital is located in Whiteside County which has been designated a Health Professional Shortage Area [See requirements of critical access designation and necessary provider status at the end of this report]
- **Note:** The State Board’s gross square footage standards and need criteria were not designed for critical access hospitals. Critical access hospitals by definition are located in rural areas and serve a smaller population. The length of stay at a critical access hospitals is shorter than hospitals located in larger population areas. Additionally, the State Board does not have financial standards for a governmental entity.

WHY THE PROJECT IS BEFORE THE STATE BOARD

- The proposed project is by or on behalf of a health care facility and the cost of the project is in excess of the capital expenditure minimum of \$13,477,931.

PURPOSE OF THE PROJECT:

- The Applicants stated: *“The purpose of the proposed project is to modernize the existing hospital in order to provide a more up-to-date facility with enough space to meet the needs of the planning area population while improving access to modern care. This modernization will allow the applicant to recruit more healthcare professionals to an area which...has a shortage of healthcare personnel. The area is short of doctors, nurses and many other health care professionals.”*

PUBLIC HEARING/COMMENT:

- There was no request for a public hearing. No letters of support and opposition were received by State Board Staff.

SUMMARY:

- The Applicant has addressed a total of 15 criteria and have not met the following:

State Board Standards Not Met	
Criteria	Reasons for Non-compliance
Criterion 1110.120 (a) – Size of the Project	The Applicant does not meet the size requirements for surgery room exceeding the State Board Standard by a total of 19 gross square footage. [See Page 9-10 of this report]
Criterion 1110.120 (b) – Project Service Utilization	The Applicant’s projected utilization does not meet the State Board Standard for medical surgical beds (60%) and emergency department stations. [See Page 10 of this report]
Criterion 1110.120 (e) – Assurances	The Applicant could not justify the number of medical surgical beds or emergency department stations that are being proposed, therefore no assurance was provided. [See Page 10 of this report]

State Board Standards Not Met	
Criterion 1110.120 (d) – Medical Surgical Modernization	The Applicants historical utilization will justify 16 medical surgical beds at the target occupancy of 60% and not the 25 medical surgical beds being proposed. [See Page 12 of this report]
Criterion 1110.270 (c) - Service Modernization	The Applicant’s historical utilization does not warrant the number of medical surgical rooms, the number of emergency department rooms, and the number of surgery rooms. [See Page 13-16 of this report]
Criterion 1120.120 – Availability of Funds	The Applicant is funding this project with bond/mortgage through the United State Department of Agriculture. No assurance that the funding will be available has not been provided as of the date of this report. [See Page 17-18 of this report]
Criterion 1120.140 (c) –Reasonableness of Project Costs.	The Applicant exceeds the new construction and contingency standard by \$3.78 per GSF or a total of \$43,720. [See Page 20-21 of this report]

STATE BOARD STAFF REPORT
Project #18-035
Morrison Community Hospital

APPLICATION CHRONOLOGY/SUMMARY	
Applicants(s)	Morrison Community Hospital District
Facility Name	Morrison Community Hospital
Location	303 N. Jackson Street, Morrison, Illinois
Permit Holder	Morrison Community Hospital District
Operating Entity/Licensee	Morrison Community Hospital District
Owner of Site	Morrison Community Hospital District
Total Gross Square Feet	77,147 GSF
Application Received	September 17, 2018
Application Deemed Complete	September 17, 2018
Financial Commitment Date	December 4, 2020
Anticipated Completion Date	December 31, 2022
Review Period Ends	November 16, 2018
Review Period Extended by the State Board Staff?	No
Can the Applicants request a deferral?	Yes

I. Project Description

The Applicant (Morrison Community Hospital District) proposes the modernization of a 25-bed critical access hospital in Morrison, Illinois at a cost of \$22.5 million. The expected completion date is December 31, 2022.

II. Summary of Findings

- A. State Board Staff finds the proposed project is not in conformance with all relevant provisions of Part 1110.
- B. State Board Staff finds the proposed project is not in conformance with all relevant provisions of Part 1120.

III. General Information

The Applicant is Morrison Community Hospital District. The hospital district was established by referendum and confirmed by order of the court on June 27, 1952 and designated a critical access hospital in August of 2003. The hospital currently has 25 Medical/Surgical Beds, which accommodates both acute care patients and swing-bed patients needing skilled Nursing Services. The 25-bed figure is the size routinely recognized by Medicare and Medicaid as appropriate for a critical access hospital. While fewer beds are allowed, additional beds are not. The hospital is considered a “necessary provider” by the Illinois Department of Public Health.

IV. Health Service Area

Morrison Community Hospital is a 25-bed critical access hospital located in the HSA I Hospital Service Area and the B-03 Hospital Planning Area. Health Service Area I includes the Illinois Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, and Winnebago. The B-03 Hospital Planning Area includes Whiteside County; Lee County Townships of Palmyra, Nelson, Harmon, Hamilton, Dixon, South Dixon, Marion, East Grove, Nachusa, China, Amboy, May, Ashton, Bradford, Lee Center, and Sublette; Carroll County Townships of York, Fairhaven, Wysox, and Elkhorn Grove; Ogle County Townships of Eagle Point, Buffalo, Pine Creek, Woosung, Grand Detour, Oregon, Nashua, Taylor, Pine Rock and Lafayette.

There are two additional hospitals in the B-03 Hospital Planning Area:

- CGH Medical Center, Sterling
- Katherine Shaw Bethea Hospital, Dixon

V. Project Details

The Applicant is proposing to modernize the hospital by constructing two additions to the facility. The proposed project will be done in two phases:

Phase I Emergency Department Addition and Renovations

This phase consists of a single story new addition for the emergency department, and the main entry, registration and expansion space for the surgery department. The new construction also includes a new main entry canopy, a new emergency ambulance canopy and a small canopy at the emergency walk-in entry. There will also be renovation at the first floor for the laboratory, the billing office, surgery reception and circulation. There will also be small new construction addition at the basement level for mechanical infrastructure.

Phase II Med/Surge Nursing Unit addition project will consist of:

This phase will consist of a multi-story addition at the south side of the hospital. This project will also involve renovations to selected existing functional areas. The new construction addition at the second floor will be for new, single patient medical/surgical rooms. The new construction addition at the first floor will be for cardiac rehab, and family clinic provider offices. Renovation of the second floor will include repurposing former patient rooms for new use as nurse station and associated support space. Renovation of the first floor will be for the family clinic provider offices. There will be a new mechanical penthouse for HVAC equipment to serve the new Phase II building addition. The basement space will be used for meeting rooms.

VI. Project Uses and Sources of Funds

The Applicant is funding this project with gifts and bequests in the amount of \$1.5 million and a mortgage/bond issue in the amount of \$21 million.

TABLE ONE
Project Uses and Sources of Funds

Uses of Funds	Reviewable	Non reviewable	Total	% of Total
Preplanning Cost	\$53,571	\$67,685	\$121,256	0.54%
Site Survey and Soil Investigation	\$21,360	\$26,988	\$48,348	0.21%
Site Preparation	\$0	\$2,400,000	\$2,400,000	10.67%
New Construction Costs	\$4,585,700	\$5,266,654	\$9,852,354	43.79%
Modernization Costs	\$1,607,165	\$1,089,940	\$2,697,105	11.99%
Contingencies	\$699,647	\$690,157	\$1,389,804	6.18%
Architectural & Engineering Fees	\$713,374	\$901,325	\$1,614,699	7.18%
Consulting Fees	\$20,064	\$25,350	\$45,414	0.20%
Movable or Other Equipment	\$161,100	\$88,900	\$250,000	1.11%
Net Interest Expense During Construction	\$188,207	\$237,793	\$426,000	1.89%
Other Costs to Capitalized	\$1,614,779	\$2,040,241	\$3,655,020	16.24%
Total Uses of Funds	\$9,664,987	\$12,835,013	\$22,500,000	100.00%
Sources of Funds				
Gifts and Bequests	\$582,700	\$917,300	\$1,500,000	6.67%
Mortgages	\$9,082,287	\$11,917,713	\$21,000,000	93.33%
Total Sources of Funds	\$9,664,987	\$12,835,013	\$22,500,000	100.00%

VI. Background of the Applicants, Purpose of the Project, Safety Net Impact, Alternatives

A) Criterion 1110.110(a) - Background of the Applicant

To address this criterion the applicants must provide a list of all facilities currently owned in the State of Illinois and an attestation documenting that no adverse actions¹ have been taken against any applicant's facility by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities and Services Review Board or a certified listing of adverse action taken against any applicant's facility; and authorization to the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of the application for permit.

1. The Applicant provided the necessary attestation that no adverse action has been taken against any facility owned or operated by the Applicants and authorization allowing the State Board and IDPH access to all information to verify information in the application for permit. [Application for Permit page 50]
2. The Applicant has provided licensure information as required. [Application for Permit page 51]. The Hospital is not accredited.
3. Morrison Community Hospital District is a unit of local government established by referendum and confirmed by order of court entered June 27, 1952, pursuant to what is now called Illinois Hospital District Law. (70 ILCS 910/1 *et seq.*) The District is the owner and the operator of the hospital facility, and there are no individuals or public or private corporations which have any ownership or operational interest in the hospital facility. There is no such thing as a certificate of good standing to be issued or attached, but a copy of the Secretary of State's Certificate of Incorporation has been provided, which recognizes the establishment of the District, by referendum. [Application for Permit pages 32-33]
4. The Applicant provided evidence that they were in compliance with Executive Order #2006-05 that requires *all State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order. State Agencies engaged in planning programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order. The Applicant stated "A portion of the Morris Hospital campus is located in a flood zone. In the past this has affected the campus. A study by Chamlin Associates, Inc. proposed a scope of work to remediate the effects of a 500 year flood. This work has been completed and is*

¹ "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. These actions include, but are not limited to, all Type "A" and Type "AA" violations." (77 IAC 1130.140)

expected to prevent future damage due to flooding.” [See pages 35-36 of the Application for Permit]

5. The proposed location of the facility is in compliance with the Illinois State Agency Historic Resources Preservation Act which requires *all State Agencies in consultation with the Director of Historic Preservation, institute procedures to ensure that State projects consider the preservation and enhancement of both State owned and non-State owned historic resources* (20 ILCS 3420/1). [Application for Permit page 37]

B) Criterion 1110.110(b) – Purpose of the Project

To demonstrate compliance with this criterion the Applicants must document that the project will provide health services that improve the health care or well-being of the market area population to be served. The Applicants shall define the planning area or market area, or other area, per the applicant's definition. The Applicants shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project.

The purpose of the proposed project is to modernize the existing hospital in order to provide a more up-to-date facility with enough space to meet the needs of the planning area population while improving access to modern care. This modernization will allow the applicant to recruit more healthcare professionals to an area which is has a shortage of healthcare personnel. The area is short of doctors, nurses and many other health care professionals. [See Application for Permit page 52]

C) Criterion 1110.110 (c) Safety Net Impact

All health care facilities, with the exception of skilled and intermediate long term care facilities licensed under the Nursing Home Care Act, shall provide a safety net impact statement, which shall be filed with an application for a substantive project (see Section 1110.40). Safety net services are the services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. [20 ILCS 3960/5.4]

This is a non-substantive project. A non-substantive project does not require a Safety Net Impact Statement. Charity Care information was provided as required.

TABLE TWO			
Charity Care Information			
	FY 2015	FY 2016	FY 2017
Net Patient Revenue	\$11,815,286	\$11,839,201	\$13,886,955
Amount of Charity Care (charges)	\$24,174	\$103,901	\$42,238
Cost of Charity Care	\$17,255	\$58,890	\$54,734

D) Criterion 1110.110 (d) - Alternatives to the Proposed Project

To demonstrate compliance with this criterion the Applicants must document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

The applicant considered two alternatives to the proposed project.

Do Nothing

The first alternative was rejected due to the fact that the hospital has several problems which could not be addressed within the existing walls of the hospital. The existing ER is much too small to meet even the basic needs of a modern hospital and has HIPAA problems due to its lack of privacy. Larger rooms are also needed for the Medical Surgical unit, the existing design was developed many years ago and has not been changed to accommodate all of the new equipment currently used to provide optimal patient care. Many of the other departments of the hospital are also undersized and need to be expanded for optimal patient care.

New Facility

The second alternative of constructing a new facility to replace the existing hospital was also rejected due to cost factors. This alternative would more than double (\$51,718,000) the price of the proposed project (\$22,500,000) which is well above the cost the applicant could afford. The space which would result from this alternative would be approximately the same as the proposed project with no appreciable increase in quality or care to the patients.

VII. Project Scope and Size, Utilization and Unfinished/Shell Space

A) Criterion 1110. 120 (a) - Size of Project

To demonstrate compliance with this criterion the Applicant must document that that the physical space proposed for the project is necessary and appropriate. The proposed square footage cannot deviate from the square footage range indicated in Appendix B, or exceed the square footage standard in Appendix B if the standard is a single number, unless square footage can be justified by documenting, as described in subsection (a)(2).

As can be seen in the Table below the Applicant does not meet the State Board's Gross Square Footage Standard for the Surgery Department. The Applicant states that this is due to the constraints of the existing surgical department. The Applicant further states that it is very important that the second surgery room be constructed to insure patient safety and to eliminate the need to by-pass the hospital due to a lack of space to handle more complex cases. The State Board does not have gross square footage standard for Cardio/PT Rehab, Family Clinic and Outpatient Clinic. [At the conclusion of this report is the Cost Space schedule]

TABLE THREE
Size of the Project

Department	Proposed Rooms Units	Proposed	State Board Standard	Met Standard
Emergency	5	4,240	4,500	-260
Surgery	2	5,519	5,500	+19
Diagnostic Radiology		2,038	2,600	-562
X-Ray	1			
CT	1			
Laboratory		2,002		
Medical/Surgical Beds	25	14,468	16,500	-2,032

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION SIZE OF THE PROJECT (77 ILAC 1110.120 (a))

B) Criterion 1110.120(b) - Project Services Utilization

To demonstrate compliance with this criterion the Applicant must document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. All Diagnostic and Treatment utilization numbers are the minimums per unit for establishing more than one unit, except where noted in 77 Ill. Adm. Code 1100. [Part 1110 Appendix B]

The Applicants provided projected information for all services that are being proposed to be modernized by this project at page 59 of the Application for Permit. The Applicant cannot meet the State Board’s Standard for medical surgical beds of 60%, or emergency room visits of 2,000 visits per station. The Applicant is proposing one X-ray unit and one CT unit which are justified by historical utilization.

TABLE FOUR Projected Utilization				
Year	2022	2023	# Justified	
Medical Surgical Beds				
Beds	25	25	16 Beds	
Days	2,950	3,098		
Surgery				
Rooms	2	2	2 Surgery Rooms	
Hours	1,566	1,801		
Emergency Room				
Stations	5	5	2 Rooms	
Visits	2,490	2,739		
Radiology				
Units	2	2	2 units	
Visits	5,255	6,043		

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 document compliance with this criterion the Applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the end of the second year of operation after project completion, the Applicants will meet or exceed the utilization standards specified in Appendix B.

The Applicant is a critical access hospital and the State Board does not have standards specifically for these critical access hospitals and these small hospitals in less populated areas cannot meet the Board's standards designed for hospitals located in more populated areas.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT TO BE IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.120 (e))

VIII. Medical Surgical Beds

A) Criterion 1110.200 (a) – Introduction

This Section applies to projects involving the following categories of hospital bed services: Medical/Surgical; Obstetrics; Pediatrics; and Intensive Care. Applicants proposing to establish, expand or modernize a category of hospital bed service shall comply with the applicable subsections of this Section.

B) Criterion 1110.200 (d) - Category of Service Modernization

- 1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:
 - A) High cost of maintenance;

- B) Non-compliance with licensing or life safety codes;
 - C) Changes in standards of care (e.g., private versus multiple bedrooms); or
 - D) Additional space for diagnostic or therapeutic purposes.
- 2) Documentation shall include the most recent:
- A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and
 - B) The Joint Commission reports.
- 3) Other documentation shall include the following, as applicable to the factors cited in the application:
- A) Copies of maintenance reports
 - B) Copies of citations for life safety code violations; and
 - C) Other pertinent reports and data.
- 4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

The Applicant is designated as a Critical Access hospital with a total of 25 Medical/Surgical beds which are also used as swing beds to serve skilled care patients. The proposed project calls for the construction of new space, immediately adjacent to the existing unit, to house 8 of the 25 beds. This new construction will allow for the modernization of the nurses station and support space for the other 17 beds, while allowing the Applicant to develop larger rooms with more privacy to better serve the acute care needs of the facility's patients. The Applicant's historical utilization justifies 16-beds at the State Board's target occupancy of 60%. The Applicant has not met this criterion.

	2015	2016	2017	State Board Standard
Beds	25	25	25	
Days	4,445	2,993	3,042	60%
Utilization	48.71%	32.80%	33.34%	

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION MEDICAL SURGICAL MODERNIZATION (77 ILAC 1110.200 (d))

IX. Clinical Services Other than Categories of Service

A) Criterion 1110.270 - Introduction

These criteria are applicable only to those projects or components of projects (including major medical equipment), concerning Clinical Service Areas (CSAs) that are not Categories of Service, but for which utilization standards are listed in Appendix B, including:

- A) Surgery
- B) Emergency Services and/or Trauma
- C) Ambulatory Care Services (organized as a service)
- D) Diagnostic and Interventional Radiology/Imaging (by modality)
- E) Therapeutic Radiology
- F) Laboratory
- G) Pharmacy
- H) Occupational Therapy/Physical Therapy
- I) Major Medical Equipment

B) Criterion 1110.270 (c) – Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

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. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

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

The Applicant states that the proposed project is necessary to meet current standards of care by providing larger medical surgical rooms, an expanded emergency department, and upgrading of the surgery department to allow for equipment to accommodate more Ortho procedures.

Emergency Department

The Applicant is proposing to establish a five room Emergency Department to replace the existing three station emergency department in a total of 4,240 GSF. The Applicant's current emergency department has only 795 GSF and does not have private rooms which severely limits the Applicant's ability to insure privacy and meet HIPAA rules. The proposed emergency department will have 3 general purpose rooms, one room large enough to accommodate Trauma patients and one room which will be used for Isolation patients and for Mental Health Patients. The proposed rooms will all be private rooms which will insure patient privacy. It is believed that many times the ambulances make a decision to bypass the applicant facility to take the patient to a more modern facility which can better meet the 'patients' needs. The new facility will allow all types of patients to be treated and triaged at the hospital which will increase the Applicant's workload while providing more expedited treatment to the patients. The outpatient clinic has helped to serve the facilities patients from 8 AM to 8 PM. However, with the shortage of health manpower in this area, the applicant will be reducing those hours from 8AM to 6 PM, which will also increase the workload in the ED. The need for larger rooms is driven by the amount of additional equipment which is needed to treat more complex cases. These cases include trauma, or cardiac patients. Historical utilization will justify two stations and not the five stations being requested.

Emergency Department				
Year	2015	2016	2017	State Board Standard
Rooms	3	3	3	
Visits	2,043	2,105	2,073	2,000

Surgery

The Applicant is proposing to construct space to house one larger operating room while maintaining one existing operating room for a total of two operating rooms. The other existing small operating room will be converted for use as support space for the department. The new operating room will allow the applicant to treat orthopedic cases or other cases requiring more equipment than the existing room can accommodate. It is very important that the second room be constructed to insure patient safety and to eliminate the need to bypass the hospital due to a lack of space to handle more complex cases. Historical utilization will support one operating room and not the two rooms being proposed.

Surgery Department				
Year	2015	2016	2017	State Standard
Operating Rooms	1	1	1	1,500 Hours
Hours	107	174	582	

Diagnostic Radiology/ Imaging

The Diagnostic Imaging Department has one general X-ray unit and one CT scanner. The proposed addition to the department will provide additional support, a waiting area and space for stress testing. Historical utilization will justify the one X-ray unit and one CT scanner being proposed.

Diagnostic Radiology/Imaging				
Year	2015	2016	2017	
X-ray Unit	1	1	1	State Standard
Exams	2,087	2,069	2,313	8,000
CT Unit	1	1	1	State Standard
Exams	598	644	798	7,000

Laboratory

The Applicant is proposing to convert 2,002 GSF of existing space, currently used for Administration and Billing. The laboratory will serve both the inpatient and outpatient departments of the hospital as well as the family and specialty clinics provided at the hospital. The Board does not have a utilization standard for this department.

Laboratory			
Year	2015	2016	2017
Studies	20,887	24,664	24,839

Cardio/PT Rehabilitation

The State Board does not have a utilization standard for this department. Given the projected utilization of the department the proposed space is needed to serve the needs of the patient population of the hospital, and the surrounding area. The rehabilitation department offers inpatient and outpatient therapies to individuals needing physical therapy, speech therapy, and occupational therapy.

Family Clinic/Outpatient Clinic

According to the Applicant over the past two years the Emergency Room and Rural Health Clinic have treated nearly 29,000 patients. The clinic is open 8:00 AM to 8:00 PM 361 days per year. This flexibility of these hours allows our community and surrounding area to utilize primary and urgent care avoiding unnecessary emergency room services. This affords many patients and third party payers with the sufficient cost savings. The clinic provides services for the following:

- General Physical Exams
- DOT Physicals
- Pre-Employment Physicals and Work Comp Injury Evaluations
- Preventive Wellness Screening
- Chronic Disease Management
- Wound Care
- VFC Immunizations
- Allergy Testing
- Dermatology Care
- Laceration Repair
- Incision and Drainage
- Doppler Vascular Pulse Detection
- Spiro meter Screening
- EKG
- EMG
- Echocardiograms

The Applicant's historical utilization does not warrant the number of medical surgical rooms, the number of emergency department rooms, and the number of surgery rooms. The Applicant is not in compliance with this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION CLINICAL SERVICES OTHER THAN CATEGORIES OF SERVICE (77 ILAC 1110.270 (c))

X. Financial Viability

A) Criterion 1120.120 – Availability of Funds

To demonstrate compliance with this criterion the Applicants must document that funds will be available.

The Hospital² is a special taxing district³, which allows it to levy and appropriate property taxes within the taxing district. The Applicant is funding this project with gifts and bequest of \$1.5 million and a mortgage/bond issue of \$21 million. The debt financing will be from the USDA Rural Development Community Facilities Direct Loan program of \$17 million and a USDA Rural Economic Development Guaranteed Loan of \$4 million. As of the date of this report, this financing has not been approved. The Applicant has not met the requirements of this criterion.

² Special purpose districts are most often created to provide services that counties, municipalities, and townships are unable to provide due to financial constraints. Special purpose governments may be divided into two classes – school districts and all others. School districts that provide primary and secondary education have elected governing boards and taxing authority. The majority of other special purpose governments have their own funding mechanisms and are run by managers and governing bodies appointed by the county board. These districts to provide and operate hospital facilities are established by the circuit court on petition of the voters, after local referendum. The board of directors is appointed by the county governing body or the chief executive officer in home rule counties. Hospital districts may issue bonds, levy property taxes, and fix charges for use of facilities and services.

³ The Morrison Community Hospital is a special taxing district which allows it to levy and appropriate property taxes within the taxing district. Tax revenue is recognized as follows:

Property taxes: Property taxes are recognized as a receivable at the time they are levied. Property taxes receivable as of June 30, 2017 represent the uncollected portion of the 2016 levy. Property taxes are certified in December and attached as an enforceable lien on the property as of the preceding January 1. These taxes become due and collectible in June, August, September and November and are collected by the county collector, who in turn remits to the Hospital its respective share. The succeeding year property tax receivable represents an estimate of the 2017 levy, applicable to the fiscal year ended June 30, 2017. Property taxes that are not available for current year operations are shown as deferred inflows of resources on the accompanying statements of net position.

Personal property replacement taxes: The state law mandates that the personal property replacement tax is to be first applied toward payment of the proportionate amount of debt service previously paid from personal property tax levies. After debt service obligations are satisfied, any remaining monies can be used for the general operating purposes of the Hospital. The Hospital recognizes revenue from the personal property replacement tax when it becomes measurable and available. [Source 2017 Audited Financial Statements]

TABLE FIVE
Morrison Community Hospital District
June 30th
Audited

	2017	2016
Cash	\$519,365	\$1,045,054
Current Assets	\$5,961,527	\$5,302,508
Total Assets	\$11,120,006	\$10,756,403
Current Liabilities	\$2,592,929	\$2,226,991
LTD	\$2,805,958	\$2,970,571
Total Liabilities	\$5,398,887	\$5,197,562
Net Patient Revenue	\$13,076,937	\$11,508,609
Total Operating Revenue	\$13,308,700	\$11,690,749
Total Operating Expenses	\$14,378,370	\$12,766,117
Non-Operating Revenue	\$1,204,448	\$1,124,033
Change in Net Position	\$134,778	\$48,665

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION AVAILABILITY OF FUNDS (77 ILAC 1120.120(a))

B) Criterion 1120.130 – Financial Viability

The Applicant did not qualify for the financial waiver⁴ therefore it provided three years of financial viability ratios as required as well as one year of projected information. The State Board does not have financial standards for special purpose districts established to operate a hospital.

⁴Financial Viability Waiver

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

- 1) all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.
- 2) the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA) or its equivalent; or HFSRB NOTE: MBIA Inc. is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.
- 3) the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.

**TABLE SIX
Financial Viability**

Year	2015	2016	2017	2021
Current Ratio	2.3	2.4	2.3	3.35
Net Margin Percentage	3.60%	0.20%	0.80%	2.59%
Percent Debt to Total Capitalization	40.40%	37.80%	35.80%	77.40%
Projected Debt Service	3.4	1.6	1.9	1.64
Days Cash on Hand	35.2	35	13.4	34
Cushion Ratio	3.29	1.97	0.91	1.73

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION FINANCIAL VIABILITY (77 ILAC 1120.130 (b))

XI. Economic Feasibility

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

To demonstrate compliance with this criterion the Applicant must document an “A” or better bond rating or attest to the following

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

The Applicant provided the necessary attestation at page 72 of the Application for Permit that the total estimated project cost and related costs will be funded in part by the borrowing because a portion of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH CRITERION FINANCIAL VIABILITY (77 ILAC 1120.130)

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

To demonstrate compliance with this criterion the Applicants must document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

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

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

The \$21 million bond issue will be at the lowest net cost available. It is the intent of the Applicant to fund the bond issue through the USDA Rural Development Community Facilities Direct Loan⁵ program of \$17 million at 4.875% for 40 years and a USDA Rural Economic Development Guaranteed Loan⁶ of \$4 million at 5.5% with a 30-year term. The Applicant successfully addressed this requirement.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH 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 estimated project costs are reasonable and shall document compliance

Only reviewable/clinical project costs are subject to State Board review. As can be seen from the table below the Applicant did not meet the requirement for new construction and contingency costs. Consulting and Other fees, moveable or other equipment not in the construction contract, net interest during construction, and other costs to be capitalized do not have State Board Standards and were not considered. Contingencies were allocated 74% to new construction and 26% to modernization.

The RS Means Standard for New Construction and Contingency costs is \$378.52 per GSF for a Hospital in Morrison, Illinois inflated by 3% to the midpoint of construction. Modernization and Contingency costs is 70% of new construction and contingency costs.

⁵ USDA Rural Development Community Facilities Direct Loan 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. This program is applicable to rural areas with no more than 20,000 residents. 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: Health care facilities such as hospitals, medical clinics, dental clinics, nursing homes or assisted living facilities. [Source <https://www.rd.usda.gov/programs-services/community-facilities-direct-loan-grant-program>]

⁶ The Rural Economic Development Loan and Grant program provides funding for rural projects through local utility organizations. USDA provides zero-interest loans to local utilities which they, in turn, pass through to local businesses (ultimate recipients) for projects that will create and retain employment in rural areas. The ultimate recipients repay the lending utility directly. The utility is responsible for repayment to USDA. USDA provides grants to local utility organizations which use the funding to establish revolving loan funds (RLF). Loans are made from the revolving loan funds to projects that will create or retain rural jobs. When the revolving loan fund is terminated, the grant is repaid to USDA.

**TABLE SEVEN
RS Means Calculation**

Year	2018	2019	2020	2021	2022	2023
New Construction and Contingencies	\$346.40	\$356.79	\$367.50	\$378.52	\$389.88	\$401.57
Modernization and Contingencies	\$242.48	\$249.75	\$257.25	\$264.96	\$272.91	\$281.10

**TABLE EIGHT
Reasonableness of Project Costs**

	Project Costs		State Board Standard		Difference		Met Standard
	Total \$	%/GSF	Total \$	%/GSF	Total \$	%/GSF	
Preplanning Cost	\$53,571	0.76%	\$126,965.02	1.80%	-\$73,394.02	-1.04%	Yes
Site Survey and Soil Investigation	\$21,360	0.31%	\$344,625.60	5.00%	-\$323,265.60	-4.69%	Yes
New Construction and Contingency Costs	\$5,103,775	\$381.79 GSF	\$5,060,055	\$378.52 GSF	\$43,719.64	\$3.27 GSF	No
Modernization and Contingency Costs	\$1,788,737	\$236.01 GSF	\$2,008,132	\$264.96 GSF	-\$219,394.84	-\$28.95 GSF	Yes
Contingencies	\$699,647	10.15%	\$1,033,877	15.00%	-\$334,229.80	-4.85%	Yes
Architectural & Engineering Fees	\$713,374	10.35%	\$726,470.76	10.54%	-\$13,096.76	-0.19%	Yes
Consulting Fees	\$20,064						
Movable or Other Equipment	\$161,100						
Net Interest Expense During Construction	\$188,207						
Other Costs to Capitalized	\$1,614,779						

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION REASONABLENESS OF PROJECT COSTS (77 ILAC 1120.140 (c))

D) Criterion 1120.140(d) – Projected Direct Operating Costs

To document compliance with this criterion the Applicant must document the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct costs mean the fully allocated costs of salaries, benefits and supplies for the service.

The projected direct operating costs per equivalent patient day for the first year after project completion is \$5,621.83. The State Board does not have a standard for this criterion, therefore the Applicant successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED DIRECT OPERATING COSTS (77 ILAC 1120.140(d))

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

To document compliance with this criterion the Applicants must document the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The capital cost per equivalent patient day for the first full fiscal year after project completion is \$422.80. The State Board does not have a standard for this criterion. Therefore, the Applicant met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS (77 ILAC 1120.140(e))

**TABLE NINE
Cost Space Requirements**

Reviewable	Costs	Existing	Proposed	New Construction	Modern	As Is	Vacated Space
Emergency ⁽³⁾	\$2,162,400	795	4,240	4,240	0	0	0
Surgery	\$1,245,020	3,787	5,519	663	2,021	2,835	
Diagnostic Radiology ⁽³⁾	\$228,960	1,291	2,038	0	848	1,190	
Laboratory ^{(2) (5) (6)}	\$740,740	1,146	2,002	0	2,002	0	
Med/Surg	\$3,017,695	10,953	14,468	3,515	2,121	8,832	
Cardio/PT ⁽¹⁾	\$1,399,740	2,148	3,414	3,414	0	0	
Family Clinic	\$738,110	10,384	11,920	1,536	587	9,797	
Outpatient Clinic	\$0	3,243	3,243	0	0	3,243	
Total Reviewable	\$9,532,665	33,747	46,844	13,368	7,579	25,897	
Non Reviewable							
Administration ⁽⁵⁾	\$653,540	765	1,594	1,594	0	0	138
Registration	\$51,952	138	136	136	0	0	
Billing ⁽⁶⁾	\$267,880	772	792	386	406	0	
Medical Records	\$238,950	668	885	0	885	0	
Cafeteria	\$324,270	774	1,201	0	1,201	0	
Public Waiting Areas	\$256,660	809	626	626	0	0	
Conference	\$979,080	376	2,388	2,388	0	0	376
Support Areas ⁽¹⁾	\$1,202,958	465	3,874	1,377	2,497	0	
Storage ⁽²⁾	\$179,750	0	719	0	719	0	
Mechanical	\$1,872,470	3,844	8,411	4,567	0	3,844	
Stairs/Elevators	\$1,298,797	100	2,952	2,952	0	0	100
Electrical	\$203,697	0	497	497	0	0	
Corridors ⁽⁴⁾	\$2,420,280	2,674	6,228	3,510	2,718	0	
Site Improvement	\$2,400,000						
Canopies	\$617,050						
Total Non-Reviewable	\$12,967,334	11,385	30,303	18,033	8,426	3,844	614
Total	\$22,500,000	45,132	77,147	31,401	16,005	29,741	614

1. Former Cardio/PT space becomes Maintenance and IT space
2. Most of former Lab becomes Storage
3. Former Emergency area becomes diagnostic radiology space
4. Former waiting space becomes corridor
5. Former Administration becomes Lab space
6. Former Billing becomes Lab space

Explanation of critical access and necessary provider status

Morrison Community Hospital is a 25-bed critical access hospital. To be designated a Critical Access Hospital 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 an 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. There are fifty-one (51) CAHs in Illinois.

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