

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD CERTIFICATE OF NEED PERMIT**

**APPLICATION**

**JULY 2018 EDITION**

**APPLICABLE TO COUNTY NURSING HOMES ONLY**

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| **TABLE OF CONTENTS**  **SECTION NO. PAGES** | | | |
|  |  | Instructions | ii-iv |
| I. |  | Identification, General Information and Certification | 1-9 |
| II. |  | Project Background, Purpose, and Alternatives | 10-11 |
| III. |  | Project Scope & Size, Utilization and Unfinished/Shell Space | 12-13 |
| IV. |  | Change of Ownership of County-owned Long-Term Care Facilities | 14 |
| V. |  | Availability of Funds | 15 |
| VI. |  | Financial Viability | 16 |
| VII. |  | Economic Feasibility | 17-18 |
| VIII. |  | Safety Net Impact Statement | 19-20 |
| IX. |  | Charity Care Information | 20 |
|  |  | Index of Attachments to the Application | 21 |
|  |  |  |  |

# ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD 525 WEST JEFFERSON STREET, 2nd FLOOR

**SPRINGFIELD, ILLINOIS 62761**

**(217) 782-3516**

**INSTRUCTIONS GENERAL**

* The Application must be completed for all proposed projects that are subject to the permit requirements of the Illinois Health Facilities Planning Act, including those involving establishment, expansion, modernization or discontinuation of a service or facility.
* The person(s) preparing the application for permit are advised to refer to the Planning Act, as well as the rules promulgated there under (77 Ill. Adm. Codes 1100, 1110, 1120 and 1130).
* **This Application does not supersede any of the above-cited rules and requirements that are currently in effect.**
* The application form is organized into several sections, involving information requirements that coincide with the Review Criteria in 77 Ill. Codes 1110 (Processing, Classification Policies and Review Criteria) and 1120 (Financial and Economic Feasibility).
* Questions concerning completion of this form may be directed to the Health Facilities and Services Review Board staff at (217)782-3516.
* Copies of this application form are available on the Health Facilities and Services Review Board Website [www.hfsrb.illinois.gov](http://www.hfsrb.illinois.gov/)

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**SPECIFIC**

* Use this form, as written and formatted.
* Complete and submit **ONLY** those Sections along with the required attachments that are applicable to the type of project proposed.
* **ALL APPLICABLE CRITERIA** for each applicable section must be addressed. **If a criterion is NOT APPLICABLE label as such and state the reason why**.
* For all applications that time and distance are required for a criterion submit copies of all Map-Quest Printouts that indicate the distance and time from the proposed facility or location to the facilities identified**.**
* **ALL PAGES ARE TO BE NUMBERED CONSECUTIVELY BEGINNING WITH PAGE 1 OF THE APPLICATION FOR PERMIT. DO NOT INCLUDE INSTRUCTIONS AS PART OF THE APPLICATION AND OR NUMBERING.**
* Attachments for each Section should be appended after the last page of the application for permit.
* Begin each Attachment on a separate 8 1/2" x 11" sheet of paper and print or type the attachment identification in the lower right-hand corner of each attached page.
* For those criteria that require MapQuest printouts, physician referral letters and attachments, impact letters and documentation of receipt, include as appendices after that last attachment submitted with the application for permit. Label as Appendices 1, 2 etc.
* For all applications that require physician referrals the following must be provided: a summary of the total number of patients by zip code and a summary (number of patients by zip code) for each facility the physician referred patients in the past 12 or 24 months whichever is applicable.
* Information to be considered must be included with the applicable Section attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
* The application must be signed by the authorized representative(s) of each applicant entity.
* Provide an original application and one copy both **unbound**. **Label one copy original** that contains the original signatures **(on the application for permit).**

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| **Failure to follow these requirements WILL result in the application being declared incomplete. In addition, failure to provide certain required information (e.g., not providing a site for the proposed project or having an invalid entity listed as the applicant) may result in the application being declared null and void. Applicants**  **are advised to read Part 1130 with respect to completeness (113.620(d)** |

# ADDITIONAL REQUIREMENTS

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| **FLOOD PLAIN REQUIREMENTS**  Before an application for permit involving construction will be deemed **COMPLETE** the applicant must **attest** that the project **is or is not in a flood plain,** and that the location of the proposed project complies with the Flood Plain Rule under **Illinois Executive Order #2005-5**. |

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| **HISTORIC PRESERVATION REQUIREMENTS**  In accordance with the requirements of the Illinois Historic Resources Preservation Act (IHRP), the Health Facilities Planning Board is required to advise the Historic Preservation Agency of any projects that could affect historic resources. Specifically, the Preservation Act provides for a review by the IHRP Agency to determine if certain projects may impact upon historic resources. Such types of projects include:   1. Projects involving demolition of any structures; or 2. Construction of new buildings; or 3. Modernization of existing buildings.   The applicant must submit the following information to the Illinois Historic Preservation Agency so known or potential cultural resources within the project area can be identified and the project's effects on significant properties can be evaluated:   1. General project description and address; 2. Topographic or metropolitan map showing the general location of the project; 3. Photographs of any standing buildings/structure within the project area; and 4. Addresses for buildings/structures, if present.   The Historic Preservation Agency (HPA) will provide a determination letter concerning the applicability of the Preservation Act. Include the determination letter or comments from the HPA with the submission of the application for permit.  Information concerning the Historic Resources Preservation Act may be obtained by calling (217)782- 4836 or writing Illinois Historic Preservation Agency Preservation Services Division, Old State Capitol,  Springfield, Illinois 67201, |

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| **SAFETY NET IMPACT STATEMENT**  SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**. **SEE SECTION XI** OF THE APPLICATION FOR  PERMIT. |

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| **CHARITY CARE INFORMATION**  CHARITY CARE INFORMATION must be provided for **ALL** projects. **SEE SECTION XII** OF THE APPLICATION FOR PERMIT. |

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| **FEE**  An application processing fee (refer to Part 1130.620(f) for the determination of the fee) must be submitted with most applications. If a fee is applicable, and initial fee of $2,500 MUST be submitted at the same time as submission of the application. **The application will not be declared complete and the review will not be initiated if the processing fee is not submitted.** HFSRB staff will inform applicants of the amount of the fee balance, if any, that must be submitted. **Payment may be by check**  **or money order and must be made payable to the Illinois Department of Public Health**. |

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| **SUBMISSION OF APPLICATION**  **Submit an original and one copy of all Sections** of the application, including all necessary attachments. **The original must contain original signatures in the certification portions of this form.** Submit all copies to:  **ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD**  **525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761** |

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

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

**This Section must be completed for all projects. Facility/Project Identification**

|  |
| --- |
| Facility Name: |
| Street Address: |
| City and Zip Code: |
| County: Health Service Area Health Planning Area: |

**Applicant /Co-Applicant Identification**

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

|  |
| --- |
| Exact Legal Name: |
| Address: |
| Name of Registered Agent: |
| Name of Chief Executive Officer: |
| CEO Address: |
| Telephone Number: |

**Type of Ownership of Applicant/Co-Applicant**

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

**Primary Contact**

[Person to receive all correspondence or inquiries during the review period]

|  |
| --- |
| Name: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

# Additional Contact

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

|  |
| --- |
| Name: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

# Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

|  |
| --- |
| Name: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

# Site Ownership

[Provide this information for each applicable site]

|  |
| --- |
| Exact Legal Name of Site Owner: |
| Address of Site Owner: |
| Street Address or Legal Description of Site:  **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor’s documentation, deed, notarized statement of the corporation**  **attesting to ownership, an option to lease, a letter of intent to lease or a lease**. |
| **APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

|  |
| --- |
| Exact Legal Name: |
| Address: |
| Non-profit Corporation Partnership  For-profit Corporation Governmental  Limited Liability Company Sole Proprietorship Other   * Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. * Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. * **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.** |
| **APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# Organizational Relationships

|  |
| --- |
| Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any  financial contribution. |
| **APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

**Flood Plain Requirements**

[Refer to application instructions.]

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| Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [**www.FEMA.gov**](http://www.fema.gov/)or [**www.illinoisfloodmaps.org.**](http://www.illinoisfloodmaps.org/) **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the  requirements of Illinois Executive Order #2005-5 **(**[**http://www.hfsrb.illinois.gov**](http://www.hfsrb.illinois.gov/)**)**. |
| **APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# Historic Resources Preservation Act Requirements

[Refer to application instructions.]

|  |
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| Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act. |
| **APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# DESCRIPTION OF PROJECT

1. **Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

|  |  |
| --- | --- |
| Part 1110 Classification:  Substantive Non-substantive | Part 1120 Applicability or Classification:  [Check one only.]  Part 1120 Not Applicable Category A Project Category B Project  DHS or DVA Project |

# Narrative Description

|  |
| --- |
| Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal  description of the site. Include the rationale regarding the project's classification as substantive or non-substantive. |

**Project Costs and Sources of Funds**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Project Costs and Sources of Funds** | | | |
| **USE OF FUNDS** | **CLINICAL** | **NONCLINICAL** | **TOTAL** |
| Preplanning Costs |  |  |  |
| Site Survey and Soil Investigation |  |  |  |
| Site Preparation |  |  |  |
| Off Site Work |  |  |  |
| New Construction Contracts |  |  |  |
| Modernization Contracts |  |  |  |
| Contingencies |  |  |  |
| Architectural/Engineering Fees |  |  |  |
| Consulting and Other Fees |  |  |  |
| Movable or Other Equipment (not in construction contracts) |  |  |  |
| Bond Issuance Expense (project related) |  |  |  |
| Net Interest Expense During Construction (project related) |  |  |  |
| Fair Market Value of Leased Space or Equipment |  |  |  |
| Other Costs To Be Capitalized |  |  |  |
| Acquisition of Building or Other Property (excluding land) |  |  |  |
| **TOTAL USES OF FUNDS** |  |  |  |
| **SOURCE OF FUNDS** | **CLINICAL** | **NONCLINICAL** | **TOTAL** |
| Cash and Securities |  |  |  |
| Pledges |  |  |  |
| Gifts and Bequests |  |  |  |
| Bond Issues (project related) |  |  |  |
| Mortgages |  |  |  |
| Leases (fair market value) |  |  |  |
| Governmental Appropriations |  |  |  |
| Grants |  |  |  |
| Other Funds and Sources |  |  |  |
| **TOTAL SOURCES OF FUNDS** |  |  |  |
| **NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** | | | |

# Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

|  |
| --- |
| Land acquisition is related to project Yes No Purchase Price: $  Fair Market Value: $ |
| The project involves the establishment of a new facility or a new category of service Yes No  If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.  Estimated start-up costs and operating deficit cost is $ . |

# Project Status and Completion Schedules

|  |
| --- |
| Indicate the stage of the project’s architectural drawings:  None or not applicable Preliminary  Schematics Final Working |
| Anticipated project completion date (refer to Part 1130.140): |
| Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):  Purchase orders, leases or contracts pertaining to the project have been executed.  Project obligation is contingent upon permit issuance. Provide a copy of the contingent “certification of obligation” document, highlighting any language related to CON Contingencies  Project obligation will occur after permit issuance. |
| **APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

**State Agency Submittals**

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| Are the following submittals up to date as applicable: Cancer Registry  APORS  All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted  All reports regarding outstanding permits  **Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.** |

**Cost Space Requirements**

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Gross Square Feet** | | **Amount of Proposed Total Gross Square Feet**  **That Is:** | | | |
| **Dept. / Area** | **Cost** | **Existing** | **Proposed** | **New**  **Const.** | **Modernized** | **As Is** | **Vacated**  **Space** |
| **REVIEWABLE** |  |  |  |  |  |  |  |
| Medical Surgical |  |  |  |  |  |  |  |
| Intensive Care |  |  |  |  |  |  |  |
| Diagnostic Radiology |  |  |  |  |  |  |  |
| MRI |  |  |  |  |  |  |  |
| Total Clinical |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **NON REVIEWABLE** |  |  |  |  |  |  |  |
| Administrative |  |  |  |  |  |  |  |
| Parking |  |  |  |  |  |  |  |
| Gift Shop |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Total Non-clinical |  |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |  |
| **APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** | | | | | | | |

# Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FACILITY NAME:** | | | **CITY:** | | | |
| **REPORTING PERIOD DATES: From: to:** | | | | | | |
| **Category of Service** | **Authorized Beds** | **Admissions** | | **Patient Days** | **Bed Changes** | **Proposed Beds** |
| Medical/Surgical |  |  | |  |  |  |
| Obstetrics |  |  | |  |  |  |
| Pediatrics |  |  | |  |  |  |
| Intensive Care |  |  | |  |  |  |
| Comprehensive Physical Rehabilitation |  |  | |  |  |  |
| Acute/Chronic Mental Illness |  |  | |  |  |  |
| Neonatal Intensive Care |  |  | |  |  |  |
| General Long Term Care |  |  | |  |  |  |
| Specialized Long Term Care |  |  | |  |  |  |
| Long Term Acute Care |  |  | |  |  |  |
| Other ((identify) |  |  | |  |  |  |
| TOTALS: |  |  | |  |  |  |

# CERTIFICATION

|  |
| --- |
| The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:   * in the case of a corporation, any two of its officers or members of its Board of Directors; * in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist); * in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist); * in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and * in the case of a sole proprietor, the individual that is the proprietor. |
| **This Application for Permit is filed on the behalf of \* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**    SIGNATURE SIGNATURE    PRINTED NAME PRINTED NAME    PRINTED TITLE PRINTED TITLE  Notarization: Notarization:  Subscribed and sworn to before me Subscribed and sworn to before me  this day of this day of    Signature of Notary Signature of Notary  Seal Seal  \*Insert EXACT legal name of the applicant |

# SECTION II – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

# Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

|  |
| --- |
| **BACKGROUND OF APPLICANT**   1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable. 2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility. 3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.    1. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.    2. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.    3. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.    4. A certified listing of each applicant with one or more unsatisfied judgements against him or her.    5. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency. 4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.** 5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data. |
| **APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.** |

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| **PURPOSE OF PROJECT**   1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served. 2. Define the planning area or market area, or other, per the applicant’s definition. 3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.] 4. Cite the sources of the information provided as documentation. 5. Detail how the project will address or improve the previously referenced issues, as well as the population’s health status and well-being. 6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.   For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records. |
| **NOTE: Information regarding the “Purpose of the Project” will be included in the State Agency Report.**  **APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.** |

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| **ALTERNATIVES**   1. Identify **ALL** of the alternatives to the proposed project: Alternative options **must** include:    1. Proposing a project of greater or lesser scope and cost;    2. Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;    3. Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and    4. Provide the reasons why the chosen alternative was selected. 2. Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.** 3. The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available. |
| **APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# SECTION III - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

**PROJECT SERVICES UTILIZATION:**

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SIZE OF PROJECT** | | | | |
| **DEPARTMENT/SERVICE** | **PROPOSED**  **BGSF/DGSF** | **STATE**  **STANDARD** | **DIFFERENCE** | **MET**  **STANDARD?** |
|  |  |  |  |  |

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

READ THE REVIEW CRITERION and provide the following information:

|  |
| --- |
| **SIZE OF PROJECT:**   1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.** 2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::    1. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;    2. The existing facility’s physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;    3. The project involves the conversion of existing space that results in excess square footage.   **Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.** |
| **APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

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

**APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE. APPLICATION FORM.**

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| **UNFINISHED OR SHELL SPACE:**  Provide the following information:   1. Total gross square footage of the proposed shell space; 2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function; 3. Evidence that the shell space is being constructed due to    1. Requirements of governmental or certification agencies; or    2. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space. 4. Provide:    1. Historical utilization for the area for the latest five-year period for which data are available; and    2. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation. |
| **APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

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| **ASSURANCES:**  Submit the following:   1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved. 2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and 3. The anticipated date when the shell space will be completed and placed into operation. |
| **APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# SECTION IV – CHANGE OF OWNERSHIP OF COUNTY-OWNED LONG-TERM CARE FACILITIES

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

**NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.**

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| 1. **Criterion 1110.240(b), Impact Statement**   Read the criterion and provide an impact statement that contains the following information:   * 1. Any change in the number of beds or services currently offered.   2. Who the operating entity will be.   3. The reason for the transaction.   4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.   5. A cost-benefit analysis for the proposed transaction.  1. **Criterion 1110.240(c), Access**   Read the criterion and provide the following:   * 1. The current admission policies for the facilities involved in the proposed transaction.   2. The proposed admission policies for the facilities.   3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.  1. **Criterion 1110.240(d), Health Care System**   Read the criterion and address the following:   * 1. Explain what the impact of the proposed transaction will be on the other area providers.   2. List all of the facilities within the applicant’s health care system and provide the following for each facility.      1. the location (town and street address);      2. the number of beds;      3. a list of services; and      4. the utilization figures for each of those services for the last 12 month period.   3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.   4. Provide time and distance information for the proposed referrals within the system.   5. Explain the organization policy regarding the use of the care system providers over area providers.   6. Explain how duplication of services within the care system will be resolved.   7. Indicate what services the proposed project will make available to the community that are not now available. |
| **APPEND DOCUMENTATION AS ATTACHMENT-19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

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

**Section 1120.120 Availability of Funds − Review Criteria Section 1120.130 Financial Viability − Review Criteria**

**Section 1120.140 Economic Feasibility − Review Criteria, subsection (a)**

**V. 1120.120 - Availability of Funds**

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

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | 1. Cash and Securities − statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:    1. the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and    2. interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion; |  |
|  | b) Pledges − for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience. |
|  | c) Gifts and Bequests − verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts; |
|  | 1. Debt − a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:    1. For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;    2. For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;    3. For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;    4. For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;    5. For any option to lease, a copy of the option, including all terms and conditions. |
|  | e) Governmental Appropriations − a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; |
|  | f) Grants − a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; |
|  | g) All Other Funds and Sources − verification of the amount and type of any other funds that will be used for the project. |
|  |  | **TOTAL FUNDS AVAILABLE** |  |
|  | | | |
| **APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** | | | |

**VI. 1120.130 - Financial Viability**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide Data for Projects Classified as:** | **Category A or Category B (last three years)** | | | **Category B (Projected)** |
| **Enter Historical and/or Projected Years:** |  |  |  |  |
| Current Ratio |  |  |  |  |
| Net Margin Percentage |  |  |  |  |
| Percent Debt to Total Capitalization |  |  |  |  |
| Projected Debt Service Coverage |  |  |  |  |
| Days Cash on Hand |  |  |  |  |
| Cushion Ratio |  |  |  |  |

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

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| **Financial Viability Waiver**  **The applicant is not required to submit financial viability ratios if:**   1. **All of the projects capital expenditures are completely funded through internal sources** 2. **The applicant’s current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent** 3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**   **See Section 1120.130 Financial Waiver for information to be provided** |
| **APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

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| The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.  Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.  2. Variance  Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default. |
| **APPEND DOCUMENTATION AS ATTACHMENT 22, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

# VII. 1120.140 - Economic Feasibility

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

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

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| 1. **Reasonableness of Financing Arrangements**   The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:   * 1. That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or   2. That the total estimated project costs and related costs will be funded in total or in part by borrowing because:      1. 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      2. 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.  1. **Conditions of Debt Financing**   This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:   * 1. That the selected form of debt financing for the project will be at the lowest net cost available;   2. That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;   3. That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.  1. **Reasonableness of Project and Related Costs**   Read the criterion and provide the following:  1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page). |

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| 1. **Projected Operating Costs**   The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.   1. **Total Effect of the Project on Capital Costs**   The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion. |
| **APPEND DOCUMENTATION AS ATTACHMENT -23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

1. **Safety Net Impact Statement**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:**   1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge. 2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant. 3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.   **Safety Net Impact Statements shall also include all of the following:**   1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board. 2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaidpatients. Hospital and non- hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile. 3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.   **A table in the following format must be provided as part of Attachment 43.** | | | | | |
|  | **Safety Net Information per PA 96-0031** | | | |  |
| **CHARITY CARE** | | | |
| **Charity (# of patients)** | **Year** | **Year** | **Year** |
| Inpatient |  |  |  |
| Outpatient |  |  |  |
| **Total** |  |  |  |
| **Charity (cost In dollars)** |  |  |  |
| Inpatient |  |  |  |
| Outpatient |  |  |  |
| **Total** |  |  |  |
| **MEDICAID** | | | |
| **Medicaid (# of patients)** | **Year** | **Year** | **Year** |
| Inpatient |  |  |  |
| Outpatient |  |  |  |
| **Total** |  |  |  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Medicaid (revenue)** |  |  |  |  |
| Inpatient |  |  |  |
| Outpatient |  |  |  |
| **Total** |  |  |  |
|  | | | | | |
| **APPEND DOCUMENTATION AS ATTACHMENT-24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** | | | | | |

1. **Charity Care Information**

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| **Charity Care information MUST be furnished for ALL projects.**   1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue. 2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review. 3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.   **Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.**  **A table in the following format must be provided for all facilities as part of Attachment 44.** |
| **APPEND DOCUMENTATION AS ATTACHMENT-25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INDEX OF ATTACHMENTS**  **ATTACHMENT**  **NO. PAGES** | | | | |
|  | 2 | Site Ownership |  |  |
| 3 | Persons with 5 percent or greater interest in the licensee must be  identified with the % of ownership. |  |
| 4 | Organizational Relationships (Organizational Chart) Certificate of  Good Standing Etc. |  |
| 5 | Flood Plain Requirements |  |
| 6 | Historic Preservation Act Requirements |  |
| 7 | Project and Sources of Funds Itemization |  |
| 8 | Obligation Document if required |  |
| 9 | Cost Space Requirements |  |
| 10 | Discontinuation |  |
| 11 | Background of the Applicant |  |
| 12 | Purpose of the Project |  |
| 13 | Alternatives to the Project |  |
| 14 | Size of the Project |  |
| 15 | Project Service Utilization |  |
| 16 | Unfinished or Shell Space |  |
| 17 | Assurances for Unfinished/Shell Space |  |
| 18 | Chang of Ownership of County-owned Long-Term Care Facilities |  |
|  |  |  |
|  | **Financial and Economic Feasibility:** |  |
| 20 | Availability of Funds |  |
| 21 | Financial Waiver |  |
| 22 | Financial Viability |  |
| 23 | Economic Feasibility |  |
| 24 | Safety Net Impact Statement |  |
| 25 | Charity Care Information |  |