ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

CERTIFICATE OF NEED PERMIT APPLICATION

SEPTEMBER 2026 EDITION

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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 projects that are subject to the requirements of the Health Facilities Planning Act (the Act), including those involving the establishment, expansion, modernization and certain discontinuations of a service or facility.
- Persons preparing the application are advised to refer to the Act and the rules (77 Ill. Adm. Code 1100, 1110, 1120 and 1130) for more information.
- The application does not supersede the Act or any of the above-cited rules and requirements.
- The application is organized into sections, with information requirements that coincide to Review Criteria in 77 Ill. Adm. Code 1110 (Processing, Classification Policies and Review Criteria) and 77 Ill. Adm. Code 1120 (Health Facilities and Services Financial and Economic Feasibility).
- Questions concerning this form may be directed to staff at 217-782-3516 or dph.hfsrb@illinois.gov.
- Copies of the application are available on the Health Facilities and Services Review Board's Website Certificate of Need (CON) Program & Applications.

SPECIFIC

- Use the Application as written and formatted.
- Complete and submit only those Sections along with the attachments that are applicable to the project.
- All criteria for each applicable section must be addressed. If a criterion is not applicable, label it as such and state the reason why.
- Applications where time and distance documentation is required, submit copies of all travel radius printouts that coincide with the distance determinations in 77 Ill. Adm. Code 1100.510(d). Independent travel studies may be submitted in addition to the above information in accordance with 77 Ill. Adm. Code 1100.510(e).
- All pages must be numbered consecutively beginning with Page 1 of the application. Do not include instructions as part of the application or in numbering the pages in the application.
- Unless stated, attachments should be appended after the last page of the application.
- 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.
- Materials such as maps, travel studies, referral letters, impact letters, document as appendices after the last attachment. Follow the ATTACHMENT numbers of each criterion. Label appendices as Attachment-1, Attachment-1A, Attachment-1B, Attachment-2, Attachment-2A, Attachment-2B, etc.
- For applications that require physician referrals, provide: 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 to in the past 12 or 24 months, as applicable. Referral letters must be notarized.
- Information to be considered must be included with the applicable attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
- Articles/Studies etc. that are referenced in the Application must be provided with the application.
- The application must be signed by the authorized representative(s) of each applicant entity. For electronically filed applications, signatures may be electronic, but a copy of the electronic certification must follow the signature pages.
- Applications may be submitted electronically to dph.hfsrb@illinois.gov. If submitting paper copies, provide an original application and one copy, both unbound. Label the copy that contains the original signatures "Original"

Failure to follow these requirements will result in the application being incomplete. Also, failure to provide required information (e.g., not providing a site for the project or having an invalid entity listed as the applicant) may result in the application being null and void. Applicants should review 77 Ill. Adm. Code 1130.620(b)(3) regarding completeness.

ADDITIONAL REQUIREMENTS

FLOOD PLAIN REQUIREMENTS
Before an application involving construction will be deemed complete, the applicant must fulfil **SECTION XI** and attest the project is or is not in a flood plain and that the location of the project complies with the Flood Plain Rule under Illinois Executive Order #2006-5.

HISTORIC PRESERVATION REQUIREMENTS
In accordance with the Historic Preservation Act [20 ILCS 3405], HFSRB must advise the Illinois Department of Natural Resources (IDNR) of projects that could affect historic resources. Specifically, the Historic Preservation Act provides for a review by IDNR to determine if projects may impact on historic resources. Types of projects include:

1. Demolition of any structures; or
2. Construction of new buildings; or
3. Modernization of existing buildings.

The applicant must submit the following information to IDNR so that known or potential cultural resources within the project 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.

IDNR will provide a determination letter concerning the applicability of the Historic Preservation Act. Include the determination letter or comments from IDNR with the application.

Information on the Historic Preservation Act may be obtained by contacting IDNR at 217-782-4836, going to this website: Preserve History - Preservation, or writing to: Illinois Department of Natural Resources, State Historic Preservation Office, One Natural Resources Way, Springfield, Illinois 62702-1271

SAFETY NET IMPACT STATEMENT
A safety net impact statement must be submitted for all substantive and discontinuation projects. See Section X of the application.

CHARITY CARE INFORMATION
Charity care information must be provided for all projects. See Section XI of the application.

FEE
A processing fee (see 77 Ill. Adm. Code 1130.230) must be submitted with most applications. If a fee is applicable, an initial fee of $5,000 must be submitted with the application. HFSRB staff will inform the applicant of the amount of the fee balance, if any, that must be submitted. The application will not be deemed complete, and a review will not be initiated until the entire fee is submitted. Fee payment may be made by check or money order payable to the Illinois Department of Public Health.

APPLICATION SUBMISSION
Applications may be submitted electronically or by mail in accordance with the specific rules above. All fees associated with applications and requests must be mailed. No action will be taken on applications until all applicable payments are received. Submit all copies to:

Dph.hfsrb@illinois.gov
or
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(s) (provide for each applicant (see 77 Ill. Adm. Code 1130.220))

Exact Legal Name:
Street Address:
City and Zip Code:
Name of Registered Agent:
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer:
CEO Street Address:
CEO City and Zip Code:
CEO Telephone Number:

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company (LLC)	☐	Sole Proprietorship	☐	Other _____

- Corporations and LLCs must provide a certificate of good standing from the Illinois Secretary of State.
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS <u>ATTACHMENT 1</u> AFTER THE LAST PAGE OF THE APPLICATION.

Primary Contact [person to receive ALL correspondence or inquiries]

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

Additional Contact [person who is also authorized to discuss the application]

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

Post Permit Contact [person to receive all correspondence after 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, Legal Description of the Site: Proof of ownership or control of the site must be provided. Examples are property tax statements, 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 AFTER THE LAST PAGE OF THE APPLICATION.

Operating Identity/Licensee [provide for each applicable facility and insert after this page]

Exact Legal Name:					
Address:					
☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company (LLC)	☐	Sole Proprietorship	☐	Other _____

- Corporations & LLCs must provide a Certificate of Good Standing from the Illinois Secretary of State.
- 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% or greater interest in the licensee must be identified with the percentage of ownership.

APPEND DOCUMENTATION AS ATTACHMENT 3 AFTER THE LAST PAGE OF THE APPLICATION.

Organizational Relationships

For each applicant, provide an organizational chart containing the name and relationship of any person or entity who is related (as defined in 77 Ill. Adm. Code 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 AFTER THE LAST PAGE OF THE APPLICATION.

Flood Plain Requirements [refer to application instructions]

Provide documentation that the project complies with the requirements of Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition, provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 Executive Order Number 06-05. **NOTE:** A Special Flood Hazard Area and 500-Year Floodplain Determination Form has been added after this application, which must be completed to deem a project complete.
APPEND DOCUMENTATION AS ATTACHMENT 5 AFTER THE LAST PAGE OF THE APPLICATION.

Historic Resources Preservation Act Requirements [refer to application instructions]

Provide documentation regarding compliance with the requirements of the Illinois State Agency Historic Resources Preservation Act [20 ILCS 3420]. Information can be found at Preserve History - Preservation
APPEND DOCUMENTATION AS ATTACHMENT 6 AFTER THE LAST PAGE OF THE APPLICATION.

DESCRIPTION OF PROJECT

1. Project Classification [Check those applicable - refer to 77 Ill. Adm. Code1110.20 and 1120.20(b)]

Part 1110 Classification :

☐ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative of the project. Explain **WHAT** is to be done in **HFSRB defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description. Include the rationale regarding the project's classification as substantive or non-substantive. If the narrative is longer than the space available, it must be placed as a labeled attachment (Attachment Narrative Description).

Project Costs and Sources of Funds

Complete the following table listing all costs associated with the project (see 77 Ill. Adm. Code 1120.110). 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 (see 77 Ill. Adm. Code 1130.140) of the component must be included in the project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column. Note, the use and sources of funds must be equal.

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**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**	**NON-CLINICAL**	**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			
ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AS ATTACHMENT 7 AFTER THE LAST PAGE OF THE APPLICATION.			

Related Project Costs
Provide the following information, as applicable, regarding 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 77 Ill. Adm. Code 1100.

Estimated start-up costs and operating deficit cost are $ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued, provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Project completion date (see 77 Ill. Adm. Code 1130.140): _____

Indicate the following with respect to project expenditures or to financial commitments (see 77 Ill. Adm. Code 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8 AFTER THE LAST PAGE OF THE APPLICATION.

State Agency Submittals (see 77 Ill. Adm. Code 1130.620(b)(3)(H), 77 Ill. Adm. Code 840.110(d), 77 Ill. Adm. Code 840.115(i), 77 Ill. Adm Code 840.210(a))

Are the following submittals up to date as applicable?

☐ Cancer Registry
☐ Adverse Pregnancy Outcomes Reporting System (APORS)
☐ All requests such as IDPH Questionnaires and Annual Bed Reports have been submitted
☐ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application being deemed incomplete.

Cost Space Requirements

Provide, in the following format, the Departmental Gross Square Feet (DGSF) or the Building Gross Square Feet (BGSF) and associated 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 departments or area's portion of the surrounding circulation space. Explain the use of any vacated space.

Non-clinical Service Area: ***means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; components in patient care unit used as educational space, consultation and touchdown rooms, and on-call; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Non-clinical service area does not include health and fitness centers, areas in a patient care unit, or areas that are required by Department licensing standards, including life safety code regulations, such as hallways and other interdependent components to a clinical area.*** **[20 ILCS 3960/3]**

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

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 the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is 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 representatives of the applicant entity. Authorized representatives 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 manager 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 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 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 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: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
_____	_____
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this application https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm**

Criterion 77 Ill. Adm. Code 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS (see 77 Ill. Adm. Code 1110.290(a))

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of a facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the districts in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall be made at least 30 days prior to filing of the application.**
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action (see 77 Ill. Adm. Code 1110.290(b) for examples)).

IMPACT ON ACCESS (see 77 Ill. Adm. Code 1110.290(c))

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's service area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the geographic service area.

APPEND DOCUMENTATION AS ATTACHMENT 10 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION III. BACKGROUND, PURPOSE, AND ALTERNATIVES

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

77 Ill. Adm. Code 1110.110(a) – Background of the Applicant

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 (see 77 Ill. Adm. Code 1110.110(a)(2)(A)).

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 (see 77 Ill. Adm. Code 1110.110(a)(2)(B)).

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.

    a. 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 (see 77 Ill. Adm. Code 1110.110(a)(2)(C)).

    b. 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 (see 77 Ill. Adm. Code 1110.110(a)(2)(D)).

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude (see 77 Ill. Adm. Code 1110.110(a)(2)(F)).

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her (see 77 Ill. Adm. Code 1110.110(a)(2)(G)).

    e. 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 (see 77 Ill. Adm. Code 1110.110(a)2)(I)).

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** (see 77 Ill. Adm. Code 1110.110(a)(2)(J)).

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 that the information was 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 can submit amendments to previously submitted information, as needed, to update and/or clarify data (see 77 Ill. Adm. Code 1110.110(a)(3)).

APPEND DOCUMENTATION AS ATTACHMENT 11 AFTER THE LAST PAGE OF THE APPLICATION. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 77 Ill. Adm. Code 1110.110 (b) & (d)

PURPOSE OF PROJECT (see 77 Ill. Adm. Code 1110.110(b))

1. Document that the project will provide health services that improve the health care or well-being of the service area population to be served.

2. Define the planning area or service area, or other relevant area, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.

4. Cite the sources of the 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 the age and condition of the project site, as well as regulatory citations, if any. For equipment to be replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12 AFTER THE LAST PAGE OF THE APPLICATION. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES (see 77 Adm. Code 1110.110(d))

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

   Alternative options **must** include:

   A) Proposing a project of greater or lesser scope and cost (see 77 Ill. Adm. Code 1110.110(d)(1)(A)).

   B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes (see 77 Ill. Adm. Code 1110.110(d)(1)(B)).

   C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project (see 77 Ill. Adm. Code 1110.110(d)(1)(C)); and

   D) Provide the reasons why the chosen alternative was selected (see 77 Ill. Adm. Code 1110.110(d)(1)(D)).

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 (see 77 Ill Adm. Code 1110.110(d)(2)).

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available (see 77 Ill. Adm. Code 1110.110(d)(3)).

APPEND DOCUMENTATION AS ATTACHMENT 13 AFTER THE LAST PAGE OF THE APPLICATION.

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

Read the review criterion and provide the following information:

SIZE OF PROJECT (see 77 Ill. Adm. Code 1110.120(a))

1. Document that the amount of physical space proposed for the project is necessary and not excessive. This must be a narrative, and it shall include the basis used for determining the space and the methodology applied.

2. If the gross square footage exceeds the BGSF/DGSF standards in 77 Ill. Adm. Code 1110.Appendix B, justify the discrepancy by documenting one of the following:

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

   c. The project involves the conversion of existing space that results in excess square footage.

   d. Additional space is mandated by governmental or certification agency requirements that were not in existence when 77 Ill. Adm. Code 1110.Appendix B standards were adopted.

Provide a narrative for any discrepancies. A table must be provided in the following format with Attachment 14.

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

APPEND DOCUMENTATION AS ATTACHMENT 14 AFTER THE LAST PAGE OF THE APPLICATION.

PROJECT SERVICES UTILIZATION (see 77 Ill. Adm. Code 1110.120(b))

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 77 Ill. Adm. Code 1110.Appendix B. A narrative of the rationale that supports the projections must be provided.

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

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

APPEND DOCUMENTATION AS ATTACHMENT 15 AFTER THE LAST PAGE OF THE APPLICATION.

UNFINISHED OR SHELL SPACE (see 77 Ill. Adm. Code 1110.120(d))

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. Anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.

3. Evidence that the shell space is being constructed due to:

    a. Requirements of governmental or certification agencies; or

    b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:

    a. Historical utilization for the area for the latest five-year period for which data is available; and

    b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16 AFTER THE LAST PAGE OF THE APPLICATION.

ASSURANCES (see 77 Ill. Adm. Code 1110.120(e))

Provide 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 threshold 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 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION V. - MASTER DESIGN AND RELATED PROJECTS

This Section is applicable only to proposed master design and related projects.

Criterion 77 Ill. Adm. Code 1110.130(a) – General Review Criteria for Master Design and Related Projects

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities.

2. How the services proposed in future projects will improve access to planning area residents.

3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed.

4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that willresult in the transfer of patients to the applicant's facility.

Criterion 77 III. Adm. Code 1110.130(b) - Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed and document the improvement in access for each service proposed. Provide the following:

1. The anticipated completion date(s) for the future construction or modernization projects; and

2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:

   a. limitation on government funded or charity patients that are expected to continue.

   b. restrictive admission policies of existing planning area health care facilities are expected to continue.

   c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.

3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:

   a. historical service/beds utilization levels.
   b. projected trends in utilization (include the rationale and projection assumptions used in such projections).
   c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and anticipated changes in delivery of the service due to changes in technology, care delivery techniques or p hysician availability that would support the p r ojected utilization levels.

Criterion 77 Ill. Adm. Code 1110.130(c) - Relationship to Previously Approved Master Design Projects

Rear the criterion which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit.

2. The estimated project cost for the proposed projects and also for the totalconstruction/modification projects approved in the master design permit.

3. An item-by-item comparison of the construction elements (i.e., site, number of buildings, numberof floors, etc.) in the proposed project to the approved master design project.

4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT 18 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

A. Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

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

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need	X		
1110.200(b)(2) - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Establishment of Category of Service	X		
1110.200(b)(4) - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110.200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 19 AFTER THE LAST PAGE OF THE APPLICATION.			

B. Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize the Comprehensive Physical Rehabilitation category of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ **Comprehensive Physical Rehabilitation**		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.205(b)(1) - Planning Area Need	X		
1110.205(b)(2) - Service to Planning Area Residents	X	X	
1110.205(b)(3) - Establishment of Category of Service	X		
1110.205(b)(4) - Expansion of Existing Category of Service		X	
1110.205(b)(5) - Service Accessibility	X		
1110.205(c)(1) - Unnecessary Duplication of Services	X		
1110.205(c)(2) - Maldistribution	X		
1110.205(c)(3) - Impact of Project on Other Area Providers	X		
1110.205(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.205(d)(4) – Occupancy			X
1110.205(e)(1) - Staffing Availability	X	X	
1110.205(f) - Performance Requirements	X	X	X
1110.205(g) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 20 AFTER THE LAST PAGE OF THE APPLICATION.			

C. Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize the Acute Mental Illness and Chronic Mental Illness categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Acute Mental Illness		
☐ Chronic Mental Illness		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.210(b)(1) - Planning Area Need	X		
1110.210(b)(2) - Service to Planning Area Residents	X	X	
1110.210(b)(3) - Establishment of Category of Service	X		
1110.210(b)(4) - Expansion of Existing Category of Service		X	
1110.210(b)(5) - Service Accessibility	X		
1110.210(c)(1) - Unnecessary Duplication of Services	X		
1110.210(c)(2) - Maldistribution	X		
1110.210(c)(3) - Impact of Project on Other Area Providers	X		
1110.210(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.210(d)(4) - Occupancy			X
1110.210(e)(1) - Staffing Availability	X	X	
1110.210(f) - Performance Requirements	X	X	X
1110.210(g) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 21 AFTER THE LAST PAGE OF THE APPLICATION.			

D. Open Heart Surgery

1. Applicants proposing to establish, expand and/or modernize the Open-Heart Surgery category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Open Heart Surgery		

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

1. Criterion 77 Ill. Adm. Code 1110.220(b)(1), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 77 Ill. Adm. Code 1110.220(b)(2), Establishment

Read the criterion and provide the following information:

a. The number of cardiac catheterizations (patients) performed in the latest 12-month period for which data is available.
b. The number of patients referred to for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

3. Criterion 77 Ill. Adm. Code 1110.220(b)(3), Unnecessary Duplication of Services

Read the criterion and address the following:

a. Contact all existing facilities within 90 minutes' travel time of your facility which currently provide or are approved to provide open heart surgery to determine what the impact of the proposed project will be on their facility.
b. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities that were sent letters.
c. Provide a copy of all the responses received.

4. Criterion 77 Ill. Adm. Code 1110.220(b)(4), Support Services

Read the criterion and indicate on a service-by-service basis which of the services listed in this criterion are available on a 24-hour inpatient basis and explain how any services not available on a 24-hour inpatient basis can be immediately always mobilized for emergencies.

5. Criterion 77 Ill. Adm. Code 1110.220(b)(5), Staffing

Read the criterion and for those positions described under this criterion provide the following information:

a. The name and qualifications of the person currently filling the job.
b. Application filed for a position.
c. Signed contracts with the required staff.
d. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT 22 AFTER THE LAST PAGE OF THE APPLICATION.

E. Cardiac Catheterization

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Cardiac Catheterization		

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

1. Criterion 77 Ill. Adm. Code 1110.225(a), Peer Review and Registry

Read the criterion and submit a detailed explanation of your peer review program and your participation in a national registry.

2. Criterion 77 Ill. Adm. Code 1110. 225(b), Establishment or Expansion

Read the criterion and, if applicable, submit the following information:

a. The utilization of existing providers of cardiac catheterization in the planning area.

b. If existing providers of this service in the planning area have not met target utilization, the applicant can document historical physician referral volume for the prior 3 years for the service that exceeds the target utilization. The physician referral letter(s) must contain the following:

1. Physician's office address;
2. Physician's medical specialty;
3. Name and location of the hospital where the patient was referred to;
4. Patient's date of birth;
5. Patient origin by zip code of residence;
6. Notarized signature and type or printed name of the referring physician; and
7. The referral letter must also attest that patient referrals have not been used to support another pending or approved CON application for the subject service.

c. NOTE: If an ASTC proposes providing this service, it shall only perform cardiac catheterization procedures approved by IDPH (see 77 Ill. Adm. Code 205.135(b) and (c)).

3. Criterion 77 Ill. Adm. Code 1110.225(c), Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letters sent to all facilities within the planning area that provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 77 Ill. Adm. Code 1110.225(d), Modernization

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 77 Ill. Adm. Code 1110.225(e), Support Services

Read the criterion and indicate on a service-by-service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 77 Ill. Adm. Code 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in proximity, explain why.

7. Criterion 77 Ill. Adm. Code 1110.225(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. Criterion 77 Ill. Adm. Code 1110.225(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s) and associated protocols.

9. Criterion 77 Ill. Adm. Code 1110.225(i), Accreditation

Read the criterion and submit one of the following:

a. A copy of the catheterization laboratory's accreditation;

b. A copy of the facility's application for accreditation for its catheterization laboratory; or

c. A letter from an accreditation agency indicating the process and requirements needed to receive accreditation.

APPEND DOCUMENTATION AS ATTACHMENT 23 AFTER THE LAST PAGE OF THE APPLICATION.

F. In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☐ In-Center Hemodialysis		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.230(b)(1) - Planning Area Need	X		
1110.230(b)(2) - Service to Planning Area Residents	X	X	
1110.230(b)(3) - Establishment of Category of Service	X		
1110.230(b)(4) - Expansion of Existing Category of Service		X	
1110.2300(b)(5) - Service Accessibility	X		
1110.230(c)(1) - Unnecessary Duplication of Services	X		
1110.230(c)(2) - Maldistribution	X		
1110.230(c)(3) - Impact of Project on Other Area Providers	X		
1110.230(d)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.230(e) - Staffing	X	X	
1110.230(f) - Support Services	X	X	X
1110.230(g) - Minimum Number of Stations	X		
1110.230(h) - Continuity of Care	X		
1110.230(I) - Relocation (if applicable)	X		
1110.230(j) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 24 AFTER THE LAST PAGE OF THE APPLICATION FORM.			

4. **Projects for relocation** of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 77 Ill. Adm. Code 1110.230(i) - Relocation of an in-center hemodialysis facility.

APPEND DOCUMENTATION AS ATTACHMENT 24 AFTER THE LAST PAGE OF THE APPLICATION.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.(see 77 Ill. Adm. Code Appendix A)

ASTC Service
☐ **Cardiovascular**
☐ **Colon and Rectal Surgery**
☐ **Dermatology**
☐ **General Dentistry**
☐ **General Surgery**
☐ **Gastroenterology**
☐ **Neurological Surgery**
☐ **Nuclear Medicine**
☐ **Obstetrics/Gynecology**
☐ **Ophthalmology**
☐ **Oral/Maxillofacial Surgery**
☐ **Orthopedic Surgery**
☐ **Otolaryngology**
☐ **Pain Management**
☐ **Physical Medicine and Rehabilitation**
☐ **Plastic Surgery**
☐ **Podiatric Surgery**
☐ **Radiology**
☐ **Thoracic Surgery**
☐ **Urology**
☐ **Other**_____

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment	X	
1110.235(c)(4) – Expansion		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X
APPEND DOCUMENTATION AS ATTACHMENT 25 AFTER THE LAST PAGE OF THE APPLICATION.		

H. Postsurgical Recovery Care Center

A. Criterion 77 Ill. Adm. Code 1110.255(b), Review Criteria

Read the criterion and provide the following information:

1. The number of beds proposed (per Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3] and 77 Ill. Adm. Code 1100.750(d), a facility cannot exceed 20 beds).
.
2. The number of beds is justified (using the 80% target occupancy rate, see 77 Ill. Adm. Code 1100.750(e)) based upon the anticipated number of patients who will utilize the service. Documentation shall consist of:

   a. Patient identification numbers;
   b. ICD 10 Code or procedure type;
   c. Length of stay; and
   d. Surgical referral site for each inpatient surgical case that occurred in surgical referral sites over the last 12-month period that could have received surgical recovery services within the model if it had been available.

3. Document that the facility will:

   a. Be a separate and distinct facility;
   b. Have a dedicated nursing staff that is assigned only to cover the model;
   c. Have a medical director, including a signed commitment to the facility by this person stating a willingness to hold that position;
   d. Have on-call physician coverage that is available 24 hours a day / 7 days per week; and
   e. Provide design drawings of the facility.

4. Document that the facility can provide recovery care to patients receiving a variety of surgical procedures. (see 77 Ill. Adm. Code 1110.255(b)(2)).

5. Document that anticipated referrals result in admissions coming from at least three of the surgical specialties and that each of the three specialty groups represents a minimum of 10% of facility admissions totaling at least 30%. Documentation shall consist of a detailed listing of the types of surgical procedures to be performed for which recovery care will be provided and how recovery care will be given to each type of patient.

6. Document that the facility will provide on-site emergency services to stabilize a patient for transfer to an acute care facility. Documentation shall consist of all protocols for the treatment of emergency patients and the requirement by the model for the education of staff in emergency procedures.

B. Criterion 77 Ill. Adm. Code 1110.255(c), HFSRB Evaluation

1. An applicant must meet the development restrictions stipulated in Sections 30(a) of the Alternative Health Care Delivery Act [210 ILCS 3] and 77 Ill. Adm. Code 1100.750(c).

2. All applications for each planning area (see 77 Ill. Adm. Code 1100.750(a)) shall be ranked based on the points awarded in 77 Ill. Adm. Code 1110.255(c)(2)(B).

3. An application must receive a minimum of 30 points to be considered for approval (see 77 Ill. Adm. Code 1110.255(c)(2)(C)).

APPEND DOCUMENTATION AS ATTACHMENT 26 AFTER THE LAST PAGE OF THE APPLICATION.

I. Community-Based Residential Rehabilitation Center

A. Criterion 77 Ill. Adm. Code 1110.260(b)(1), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan that identifies the number and type of staff positions dedicated to the model and the qualifications for each position.

2. How special staffing circumstances will be handled.

7. The staffing patterns for the proposed center; and

8. The way non-dedicated staff services will be provided.

B. Criterion 77 Ill. Adm. Code 1110.260(b)(2), Mandated Services

Read the criterion and provide a narrative description documenting how the applicant will provide the minimum range of services required by the Alternative Health Care Delivery Act and specified in 1110.2820(b).

C. Criterion 77 Ill. Adm. Code 1110.260(b)(3), Unit Size

Read the criterion and provide a narrative description that identifies the number and location of all beds in the model. Include the total number of beds for each residence and the total number of beds for the model.

D. Criterion 77 Ill. Adm. Code 1110.260(b)(4), Utilization

Read the criterion and provide documentation that the target utilization for the model will be achieved by the second year of the model's operation. Include supporting information such as historical utilization trends, population growth, expansion of professional staff or programs, and the provision of new procedures that may increase utilization.

E. Criterion 77 Ill. Adm. Code 1110.260(b)(5), Background of Applicant

Read the criterion and provide documentation that demonstrates the applicant's experience in providing the services required by the model. Provide evidence that the programs offered in the model have been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Brain Injury Community-Integrative Program for at least three of the last five years.

APPEND DOCUMENTATION AS ATTACHMENT 27 AFTER THE LAST PAGE OF THE APPLICATION.

J. Long Term Acute Care Hospital

1. Applicants proposing to establish, expand and/or modernize Long Term Acute Care Hospital Bed projects must submit the following information:

2. Indicate the bed service(s) and capacity changes by Service:
Indicate the # of beds by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ **LTACH**		
☐ **Intensive Care**		
☐ _____		

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

:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.265(b)(1) - Planning Area Need	X		
1110.265(b)(2) - Service to Planning Area Residents	X	X	
1110.265(b)(3) - Establishment	X		
1110.265(b)(4) - Expansion		X	
1110.265(b)(5) - Service Accessibility	X		
1110.265(c)(1) - Unnecessary Duplication of Services	X		
1110.265(c)(2) - Maldistribution	X		
1110.265(c)(3) - Impact of Project on Other Area Providers	X		
1110.265(d)(1), (2), and (3) Deteriorated Facilities			X
1110.265(d)(4) - Occupancy			X
110.265(e) - Staffing Availability	X	X	
1110.265(f) - Performance Requirements	X	X	X
1110.265(g) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 28 AFTER THE LAST PAGE OF THE APPLICATION.			

K. Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than
categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐		
☐		
☐		

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) − Need Determination − Establishment
Service Modernization	(c)(1) – Deteriorated Equipment or Facilities
	and/or
	(c)(2) − Necessary Expansion
	plus
	(c)(3)(A) − Utilization − Major Medical Equipment
	or
	(c)(3)(B) − Utilization − Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 29 AFTER THE LAST PAGE OF THE APPLICATION.	

L. Freestanding Emergency Center Medical Services

These criteria are applicable only to those projects or components of projects involving the freestanding emergency center medical services (FECMS) category of service.

A. Criterion 77 Ill. Adm. Code 1110.280 – Establishment

Read the criterion and provide the following information:

1. Projected Utilization – Provide the projected number of patient visits per day for each treatment station in the FEC based upon 24-hour availability, including an explanation of how the projection was determined see (77 Ill. Adm. Code 1110.280(c)(3)(B)).

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data (see 77 Ill. Adm. Code 1110.280(b)(5)(A)).

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated (see 77 Ill. Adm. Code 1110.280(b)(5)(B)).

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the FEC from the Resource Hospital, (including an explanation of how that distance was calculated), and identification of the Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status (see 77 Ill. Adm. Code 1110.280(b)(5)(C)).

5. Certification signed by two authorized representative(s) of the applicant entity(s) that they have reviewed, understand and plan to comply with both of the following requirements (see 77 Ill. Adm. Code 1110.280(b)(6)):

   A) The requirements of becoming a Medicare provider of freestanding emergency services; and

   B) The requirements of becoming licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the proposed FEC (see 77 Ill. Adm. Code 1110.280(c)):

   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes' travel time from the proposed site, indicating how the travel time was calculated.

   B) Provide a list of the projected patient volume for the proposed FEC, categorized by zip code. Indicate what percentage of this volume represents residents from the proposed FEC's service area.

   C) Provide either of the following:

      a) Letters from authorized representatives of hospitals, or other FECs, that are part of the Emergency Medical Services System (EMSS) for the defined service area, that contain patient origin information by zip code, (each letter shall contain a certification by the authorized representative that the representations contained in the letter are true and correct). A complete set of the letters with original notarized signatures shall accompany the application for permit, or

b) Patient origin information by zip code from independent data sources (e.g., Illinois Health and Hospital Association COMP data or IDPH hospital discharge data), based upon the patient's legal residence, for patients receiving services in the existing service area's facilities' emergency departments (EDs), verifying that at least 50% of the ED patients served during the last 12-month period were residents of the service area.

7. Area Need; Service Demand – Historical Utilization (see 77 Ill. Adm. Code 1110.280(c)(3)(A))

A) Provide the annual number of ED patients that have received care at facilities that are in the FEC's service area for the latest two-year period prior to submission of the application

B) Provide the estimated number of patients anticipated to receive services at the proposed FEC, including an explanation of how the projection was determined.

8. Area Need; Service Accessibility - Document one of the following (using supporting documentation as specified in accordance with the requirements of 77 Ill. Adm. Code 1110.280(c)(4)(B)):

A) The absence of the proposed ED service within the service area.

B) The area population and existing care system exhibit indicators of medical care problems,

C) All existing emergency services within the 30-minute travel time meet or exceed the utilization standard specified in 77 Ill Adm. Code 1100.

9. Unnecessary Duplication - Document the project will not result in an unnecessary duplication by providing the following information (see 77 Ill. Adm. Code 1110.280(d)(1)):

A) A list of all zip code areas (in total or in part) that are located within 30 minutes normal travel time of the project's site.

B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provides emergency medical services.

10. Unnecessary Maldistribution - Document the project will not result in maldistribution of services by documenting the following (see 77 Ill. Adm. Code 1110.280(d)(2)):

A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing ED departments within 30 minutes travel time of the applicant's site; or

B) That there is not an insufficient population to provide the volume or caseload necessary to utilize the ED services proposed by the project at or above utilization standards.

11. Impact on Area Providers (see 77 Ill. Adm. Code 1110.280(d)(3)) – Document that, within 24 months after project completion, the project will not lower the utilization of other service area providers below, or further below, the utilization standards specified in 77 Ill. Adm. Code 1100.

12. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (see 77 Ill. Adm. Code 1110.280(f)).

B. Criterion 77 Ill. Adm. Code 1110.280 – Expansion

Read the criterion and provide the following information:

1. Identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data (see 77 Ill. Adm. Code 1110.280(b)(5)(A)).

2. Identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated (see 77 Ill. Adm. Code 1110.280(b)(5)(B)).

3. Identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status (see 77 Ill. Adm. Code 1110.280(b)(5)(C)).

4. Copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements (see 77 Ill. Adm. Code 1110.280(a)(b)(A) and (B)).

   A) The requirements of being a Medicare provider of freestanding emergency services; and

   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

5. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the expanded FEC (see 77 Ill. Adm. Code 1110.280(c)(2)):

   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes' travel time from the expanded FEC, indicating how the travel time was calculated.

   B) Provide a list of the historical (latest 12-month period) patient volume for the existing FEC, categorized by zip code, based on the patient's legal residence. Indicate what percentage of this volume represents residents from the existing FEC's service area, based on patient's legal residence.

6. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (see 77 Ill. Adm. Code 1110.280(f)).

C. Criterion 77 Ill. Adm. Code 1110.280 – Modernization

Read the criterion and provide the following information:

1. Historic number of visits (based on the latest 12-month period) for the existing FEC.

2. Identification of the municipality of the FEC and FECMS and the municipality's population based on the most recently available U.S. Census Bureau data (see 77 Ill. Adm. Code 1110.280(b)(5)(A)).

3. Identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated (see 77 Ill. Adm. Code 1110.280(b)(5)(B)).

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status (see 77 Ill. Adm. Code 1110.280.(b)(5)(C)).

5. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements (see 77 Ill. Adm. Code 1110.280(b)(6)(A) and (B)):

   A) The requirements of being a Medicare provider of freestanding emergency services; and

   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Category of Service Modernization - Document that the existing treatment 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 high cost of maintenance, non-compliance with licensing or life safety codes, changes in standards of care, or additional space for diagnostic or therapeutic purposes. Documentation shall include the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) Inspection reports, and Joint Commission on Accreditation of Healthcare Organizations reports. Other documentation shall include the following, as applicable to the factors cited in the application, copies of maintenance reports, copies of citations for life safety code violations, and other pertinent reports and data.

APPEND DOCUMENTATION AS ATTACHMENT 30 AFTER THE LAST PAGE OF THE APPLICATION.

M. Birth Center

Applicants proposing to establish, expand, or modernize a Birth Center must submit the following information (as applicable):

Indicate the bed service(s) and capacity changes by Service:
Indicate the # of beds by action(s):

Category of Service	# Existing Beds *	# Proposed Beds *
☐ **Birth Center**		

* Per Section 5(3) of the Birth Center Licensing Act [210 ILCS 170], a Birth Center can have a maximum of 10 beds.

Review the applicable criteria and submit the required documentation:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.285(c)(2) - Service to Area Residents	X	X	
1110.285(c)(3) - Service Accessibility	X	X	
1110.285(d)(1) - Unnecessary Duplication	X		
1110.285(d)(2) - Maldistribution	X		
1110.285(d)(3-4) - Impact of Project on Other Providers	X		
1110.285(e) - Modernization			X
1110.285(f) - Staffing Availability	X		
1110.285(g) - Charity Care	X		
1110.285(h) - Admission Policies	X		
1110.285(i) - Transfer Agreement and Hospital Proximity	X		
1110.285(j) - Prenatal Care and Community Education	X		
1110.285(k) - Quality Assurance	X		

APPEND DOCUMENTATION AS ATTACHMENT 31 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION VII. AVAILABILITY OF FUNDS

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, or A3 or better from Moody's. The rating shall be affirmed within the latest 18-month period before submitting 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)

VII. Criterion – 77 Ill. Adm. Code 1120.120 - AVAILABILITY OF FUNDS

Document financial resources are available and equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable (indicate the dollar amount to be provided from the following sources):

_____	a)	Cash and Securities − (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) 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 − summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable 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 timetable of receipts.
_____	d)	Debt − a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing 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 discount 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 − 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 − 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 32 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION VIII. FINANCIAL VIABILITY

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

Financial Viability Waiver

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

1. "A" Bond rating or better (see 77 Ill. Adm. Code 1120.20(b)(3)).
2. All the project's capital expenditures are completely funded through internal sources (see 77 Ill. Adm. Code 1120.130(a)(1)).
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent (see 77 Ill. Adm. Code 1120.130(a)(2)).
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (see 77 Ill. Adm. Code 1120.130(a)(3)).

APPEND DOCUMENTATION AS ATTACHMENT 33 AFTER THE LAST PAGE OF THE APPLICATION.

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 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 (see 77 Ill. Adm. Code 1120.130(b))

.

	Historical 3 Years			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				

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.

Variance (see 77 Ill. Adm. Code 1120.130(c))

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 34 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION IX. ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements (see 77 Ill. Adm. Code 1120.140(a))

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

1) 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) Total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts 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 liquidating existing investments, and existing investments are retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing (see 77 Ill. Adm. Code 1120.140(b))

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) Selected form of debt financing for the project will be at the lowest net cost available.

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

C. Reasonableness of Project and Related Costs (see 77 Ill. Adm. Code 1120.140(c))
Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs (see 77 Ill. Adm. Code 1120.140(d))
Applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs (see 77 Ill. Adm. Code 1120.140(e))
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 35 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. Project's impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community,** if reasonably known by the applicant (see 77 Ill. Adm. Code 1110.110(c)(1)(A)).

2. Project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known by the applicant (see 77 Ill. Adm. Code 1110.110(c)(1)(B)).

3. How the discontinuation of a facility or service might impact remaining safety net providers in each community, if reasonably known by the applicant (see 77 Ill. Adm. Code 1110.110(c)(1)(C)).

4. For the 3 fiscal years before submitting the application, a certification describing the amount of charity care provided by the applicant. Hospital applicants must be in accordance with reporting requirements for charity care in the Community Benefits Act [210 ILCS 76]. Non-hospital applicants shall report charity care at cost, in accordance with a methodology specified by HFSRB (see 77 Ill. Adm. Code 1110.110(c)(2)(A)).

5. For the 3 fiscal years before submitting the application, a certification of the amount of care provided to Medicaid patients. Applicants shall provide Medicaid information consistent with the information reported to HFSRB regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required in Section 13 of the Act and published in the Annual Hospital Profile (see 77 Ill. Adm. Code 1110.110(c)(2)(B)).

6. If reasonably known by the applicant, certification of the number of referrals made to the applicant's facility from Federally Qualified Health Centers, Federally Qualified Health Center Look-Alikes, or Rural Health Clinics for patients seeking care (see 77 Ill. Adm. Code 1110.110(c)(2)(C)).

7. Information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service (see 77 Ill. Adm. Code 1110.110(c)(2)(D)).

9. A list of health care facilities in the planning area or geographic service area (as applicable) that are similar to the applicant's facility (see 77 Ill. Adm. Code 1110.110(c)(2)(E)(i-iii).

10. The impact the applicant's project will have on the utilization of the facilities identified in 77 Ill. Adm. Code 1110.110(c)(2)(E)(i-iii) (see 77 Ill. Adm. Code 1110.110(c)(2)(E)(iv).

A table in the following format must be provided as part of Attachment 36.

Safety Net Information per Public Act 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			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects (see 77 Ill. Adm. Code 1120.20(c)).

1. All applicants and co-applicants must indicate the amount of charity care provided 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 health care facilities, the report shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant must 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 health care facility, it must 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 [see 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 37.

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

APPEND DOCUMENTATION AS ATTACHMENT 37 AFTER THE LAST PAGE OF THE APPLICATION.

SECTION XI - SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: _____
(Name) (Address)

_____
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: _____
(Address) (City) (State)

_____
(County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No ___?

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance. If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

_____
(City) (State) (ZIP Code) (Telephone Number)

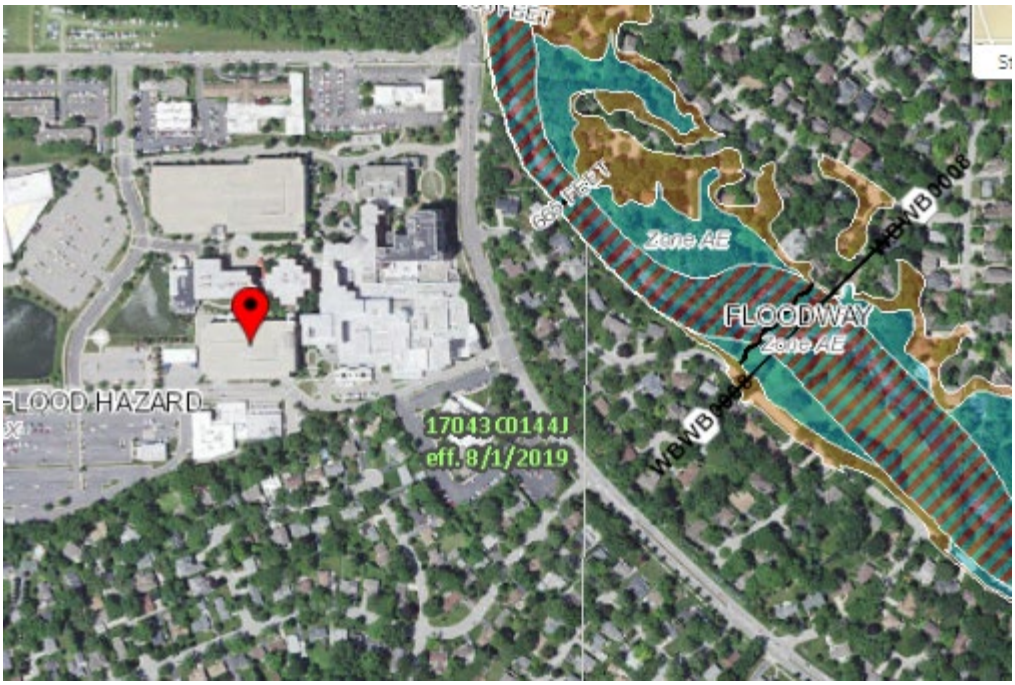
Signature:_____ Date: _____

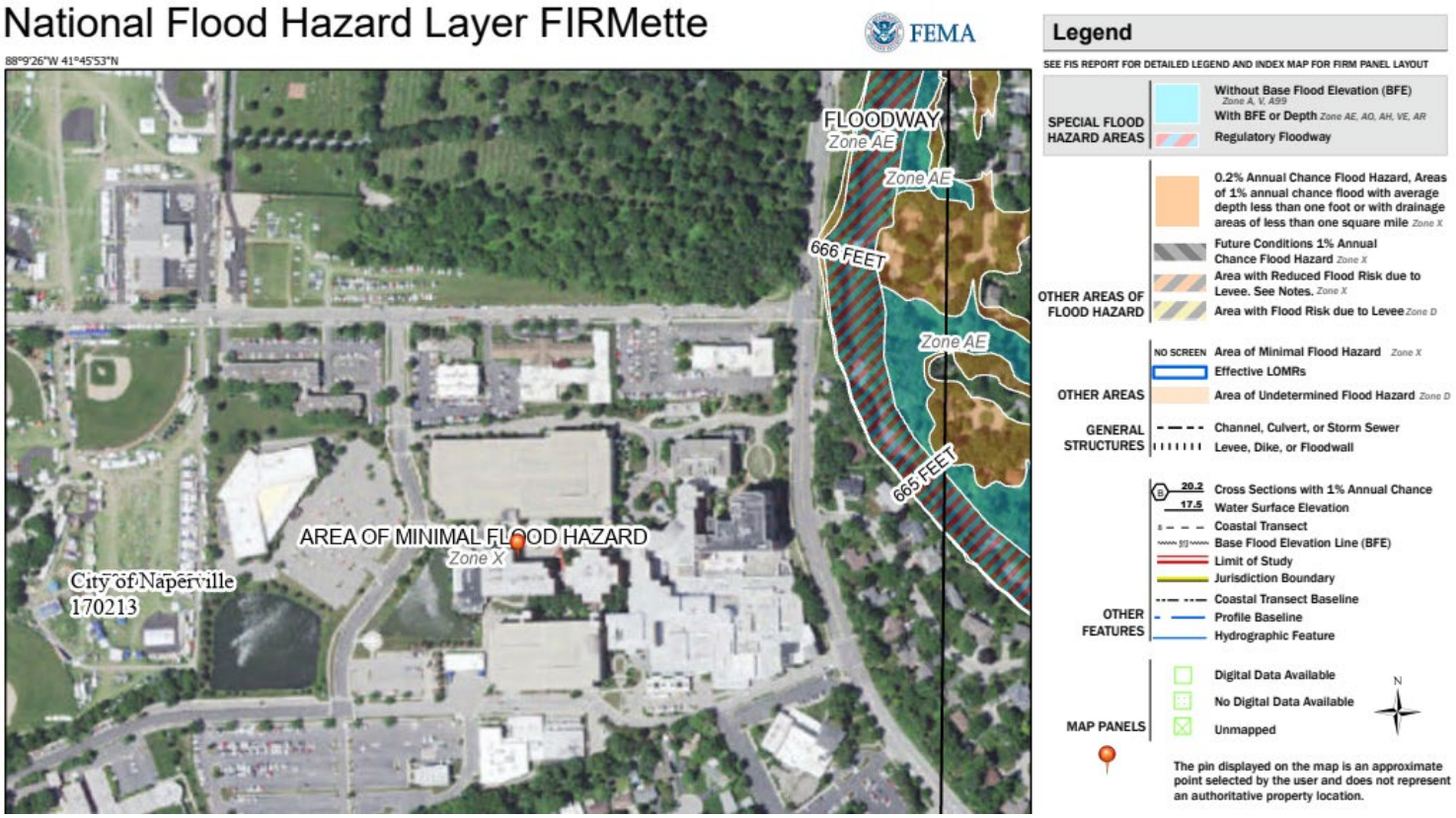
NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need assistance, contact the Illinois Statewide Floodplain Program at 217-782-4428

Floodplain Map Example

The image below is an example of the floodplain mapping required as part of the IDPH swimming facility construction permit showing that the swimming pool, to undergo a major alteration, is outside the mapped floodplain.





After paginating the application, indicate, in the chart below, the page numbers for the attachments:

INDEX OF ATTACHMENTS		
Number	**Description**	**Pages**
1	Applicant Identification	
2	Site Ownership	
3	Persons with 5% or greater interest in the licensee must be identified with the percentage of ownership	
4	Organizational Relationships	
5	Flood Plain Requirements	
6	Illinois State Agency Historic Resources Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document (if required)	
9	Cost Space Requirements	
10	Discontinuation	
11	Background, Purpose, and Alternatives	
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	Master Design and Related Projects	
	Service Specific	
19	Medical Surgical, Pediatrics, Obstetrics, ICU	
20	Comprehensive Physical Rehabilitation	
21	Acute Mental Illness	
22	Open Heart Surgery	
23	Cardiac Catheterization	
24	In-Center Hemodialysis	
25	Non-Hospital Based Ambulatory Surgery	
26	Post Surgical Recovery Care Center	
27	Community-Based Residential Rehabilitation Center	
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29	Clinical Service Areas Other Than Categories of Service	
30	Freestanding Emergency Center Medical Services	
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	Financial and Economic Feasibility	
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33	Financial Waiver	
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	Flood Plain	
38	Flood Plain Information	