10-040

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT
ORIGINAL

RECEIVED
JUN 18 2010
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Lawrence County Memorial Hospital		
Street Address: 2200 State Street		
City and Zip Code: Lawrenceville 62439		
County: Lawrence	Health Service Area: 5	Health Planning Area: F-03

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Lawrence County Memorial Hospital
Address: 2200 State street
Name of Registered Agent: Doug Florkowski
Name of Chief Executive Officer: Doug Florkowski
CEO Address: 2200 State Street
Telephone Number: 618-943-7200

Type of Ownership of Applicant/Co-Applicant

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- X Governmental
- ☐ Sole Proprietorship
- ☐ Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing. N/A, we are a government entity and have never been issued this certificate**
- o 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. **N/A, there are no partnerships**

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: Doug Florkowski
Title: Chief Executive Officer
Company Name: Lawrence County Memorial Hospital
Address: 2200 State Street
Telephone Number: 618-943-7200
E-mail Address: dflorkowski@lcmhosp.org
Fax Number: 618-943-7233

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

Name: Jerry Klein
Title: Chief Financial Officer
Company Name: Lawrence County Memorial Hospital
Address: 2200 State Street
Telephone Number: 618-943-7202
E-mail Address: jklein@lcmhosp.org
Fax Number: 618-943-7233

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: Rita Garvey
Title: Chief Nursing Officer
Company Name: Lawrence County Memorial Hospital
Address: 2200 State Street
Telephone Number: 618-943-7208
E-mail Address: rgarvey@lcmhosp.org
Fax Number: 618-943-7233

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Lawrence County Memorial Hospital
Address of Site Owner: 2200 State Street
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: Lawrence County Memorial Hospital

Address: 2200 State Street

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- X Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. **N/A, we are a government entity and have never been issued this certificate**
- 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. **N/A, there are no partnerships**
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. N/A, there are no other owners**

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. **N/A, there are no related entities**

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

N/A, the application is for discontinuation of a service

[Refer to application instructions.]

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** or **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)**.

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

N/A, the application is for discontinuation of a service

[Refer to application instructions.]

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

2. 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.

Lawrence County Memorial Hospital (LCMH) is a licensed critical access hospital. LCMH is licensed for twenty-five (25) Medical Surgical beds and ten (10) Acute/ Chronic Mental Illness beds.

Lawrence County Memorial Hospital is applying to discontinue ten (10) Acute/ Chronic Mental Illness service beds.

Rationale per 20 IL CS 3960.

Project Costs and Sources of Funds
N/A, the application is for discontinuation of a service

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	**$0**	**$0**	**$0**
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	**$0**	**$0**	**$0**
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 N/A; there are no related 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 X No Purchase Price: $__________ Fair Market Value: $__________
The project involves the establishment of a new facility or a new category of service ☐ Yes X 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 $ 0 __________.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings: X None or not applicable ☐ Preliminary ☐ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): **Upon State Board Approval**
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **N/A, there are no expenditures** ☐ 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

Are the following submittals up to date as applicable: **X** Cancer Registry **X** APORS **X** All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted **X** 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.**
There are no associated costs of square footage as there is no new construction. Vacated space will be utilized for a provider based surgical/ specialist clinic.

		Department Gross Square Feet		Amount of Proposed Total *Department* Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE	$0						
Medical Surgical	$0	1022					1022
Intensive Care	$0						
Diagnostic Radiology	$0						
MRI	$0						
Total Clinical	$0	1022					1022
Acute/ Chronic Mental Illness	$0						
NON REVIEWABLE	$0						
Administrative	$0	1835					1835
Parking	$0						
Gift Shop	$0						
	$0						
Total Non-clinical	$0	1835					1835
TOTAL	$0	**2857**					2857

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: Lawrence County Memorial Hospital			**CITY: Lawrenceville**		
REPORTING PERIOD DATES:		**From: July 1, 2008**		**to: June 30, 209**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	25	862	2,861	0	25
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	10	0	0	Minus 10	0
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	35	862	2,861	Minus 10	25

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Lawrence County Memorial Hospital* 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.

Douglas Florkowski, CEO
SIGNATURE

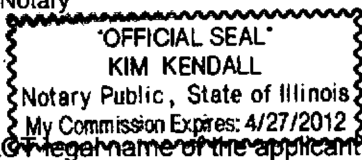
Douglas Florkowski
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 17th day of June, 2010

Kim Kendall
Signature of Notary

Seal



*Insert EXACT legal name of the applicant

FHPMA, CFO
SIGNATURE

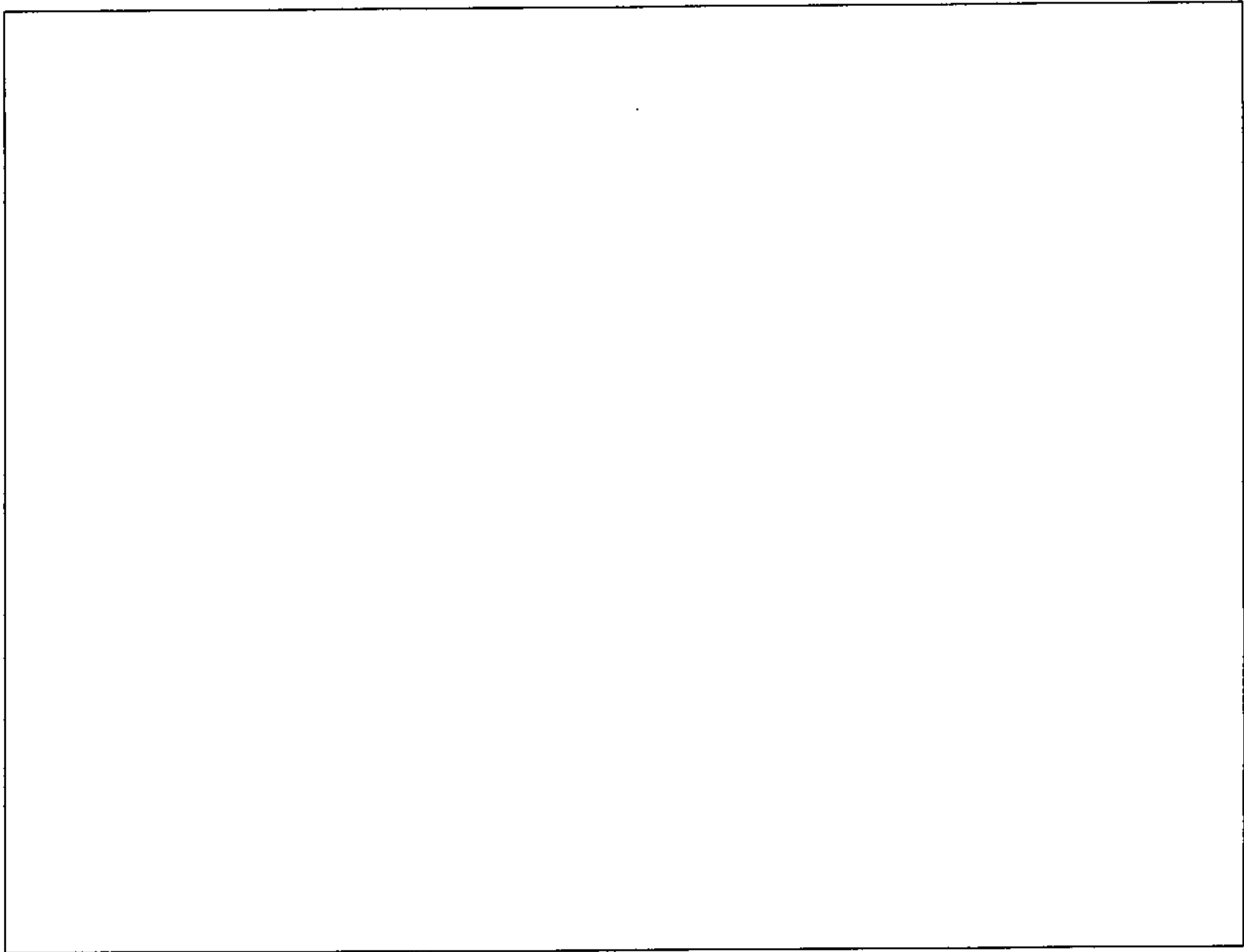
Gerald Klein
PRINTED NAME

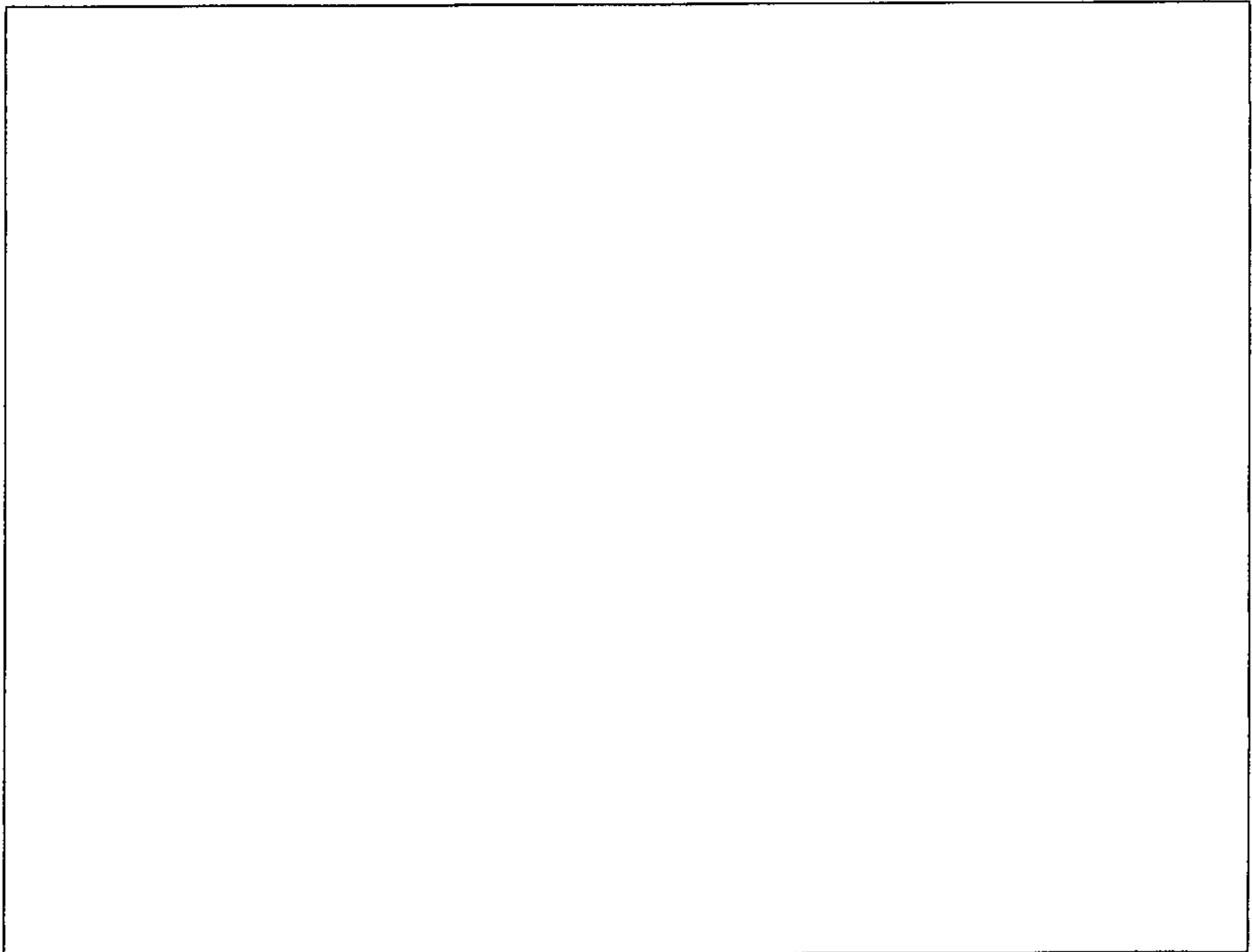
Chief Financial Officer
PRINTED TITLE

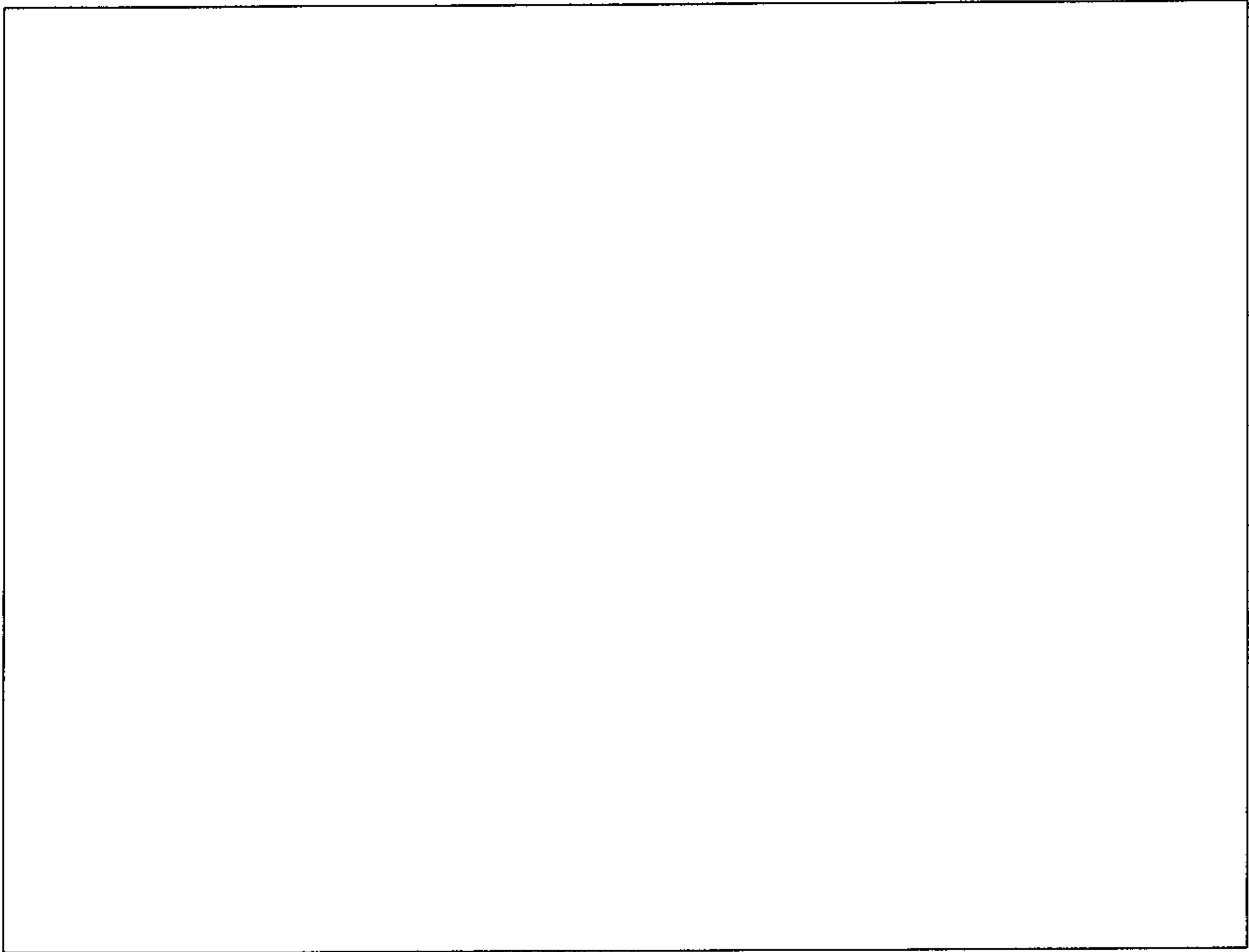
Notarization:
Subscribed and sworn to before me
this 17th day of June, 2010

Kim Kendall
Signature of Notary

Seal







SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.

Ten (10) Acute/ Chronic Mental Illness beds

2. Identify all of the other clinical services that are to be discontinued.

N/A

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

Upon State Board Approval

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.

The vacated space will be utilized for a hospital based surgical/ specialty clinic that will service the specialists' needs for the people of Lawrence County.

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.

All medical records will be stored on hospital property and maintained in accordance with the State of Illinois guidelines for ten (10) years after the last date of service. All medical records pertaining to minors will be maintained for ten (10) after reaching the age of majority.

6. 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 60 days following the date of discontinuation.

N/A, this not a discontinuation of an entire facility.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

The reason for discontinuation of the 10 Acute/ Chronic Mental illness beds is that service is not financially viable. During Fiscal year 2007, the average daily census of the Acute/ Chronic Mental Illness service was 4.8 patients (48% capacity), resulting in an operating loss of $168,204 per year. The operational break-even point would have required that the service maintained an 80% occupancy rate. This service has never met this threshold in any given month of operation for the life of the service.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.

The discontinuation of the acute/ chronic mental services would not have an adverse effect upon the immediate market area as evidenced by the fact that 80% of the service referrals came from outside our facilities market area. Patients that require acute/ chronic mental services are currently receiving services at Richland Memorial Hospital, IL (20 miles away), Good Samaritan Hospital, IN (10 miles away) and Davies Community Hospital, IN (35 miles away). All these hospitals have psychiatric services.

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 45 minutes travel time of the applicant facility.

See attachment 10a

3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

See attachment 10b

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III – 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.

Lawrence County Memorial Hospital, see attachment 11

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

N/A, there have been no adverse actions taken against our institution.

3. 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.**

We have no objections to the HFSRB and DPH having access to any and all documentation necessary to verify the information submitted without limitation.

4. 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.

N/A, this is the first application submitted this year.

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.

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.

N/A, the application is for discontinuation of a service

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

N/A, the application is for discontinuation of a service

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.]

N/A, the application is for discontinuation of a service

4. Cite the sources of the information provided as documentation.

N/A, the application is for discontinuation of a service

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

N/A, the application is for discontinuation of a service

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

N/A, the application is for discontinuation of a service

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.

ALTERNATIVES

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

Alternative options must include:

A) Proposing a project of greater or lesser scope and cost; **N/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;

Lawrence County Memorial Hospital was already partnered with Horizon Behavioral Health. Horizon specializes in developing and operating behavioral health programs across the country. Despite their best efforts, the program was unable to cut the financial losses it was incurring. Due to the nature of the services being provided, they could not be provided in alternate settings.

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; and

As stated in subsection (B), other healthcare resources were utilized for the service.

D) Provide the reasons why the chosen alternative was selected.

The only alternative to closing the geriatric psych unit was for Lawrence County Memorial Hospital to continue to incur the operating loss. The alternate was not selected, as it was not in the best interest of the hospital.

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.**

The alternative of continuing to operate the service was rejected for the following reasons: Despite have a full time marketing staff member and three long term care nursing facilities in Lawrence County, the service was not able to provide a budget neutral operational position for our hospital. Lawrence County Memorial Hospital was unable to subsidize the acute/ chronic mental illness service due to operating losses of $349,949 in Fiscal Year 2007 with the service. As previously stated, During Fiscal year 2007, the average daily census of the acute/ chronic mental health unit was 4.8 patients (48% capacity); resulting in an operating loss of $168,000 per year. The operational break-even point would have required that the unit maintained an 80% occupancy rate. This service has never exceeded this threshold in any given month of operation for the life of the service.

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

N/A, due to the discontinuation of the service there is no empirical evidence available to provide that would verify quality outcomes.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

N/A, the application is for discontinuation of a service

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT: **N/A, the application is for discontinuation of a service**

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::

   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;

   b. 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;

   c. 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.

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

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION: **N/A, the application is for discontinuation of a service**

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.

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

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

UNFINISHED OR SHELL SPACE: N/A, the application is for discontinuation of a service

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
   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 are 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, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES: N/A, the application is for discontinuation of a service

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 V. - MASTER DESIGN AND RELATED PROJECTS

N/A, the application is for discontinuation of a service

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

Criterion 1110.235(a) - System Impact of Master Design

N/A, the application is for discontinuation of a service

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; and
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 will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b) - Master Plan or Related Future Projects

N/A, the application is for discontinuation of a service

Read the criterion and provide documentation regarding the need for all beds and services to be developed, and also, 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 that 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
   c. projections);
   d. 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 physician availability that would support the projected utilization levels.

Criterion 1110.235(c) - Relationship to Previously Approved Master Design Projects

N/A, the application is for discontinuation of a service

READ 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 total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT-18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

N/A, the application is for discontinuation of a service

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.

A. 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.

B. 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.

C. 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.
   a. the location (town and street address);
   b. the number of beds;
   c. a list of services; and
   d. 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 <u>ATTACHMENT-19,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

N/A, the application is for discontinuation of a service

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning 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).

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

N/A, the application is for discontinuation of a service

1. Applicants proposing to establish, expand and/or modernize 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):

☐ **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
1110.530(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.530(c)(1) -	Unnecessary Duplication of Services	X		
1110.530(c)(2) -	Maldistribution	X	X	
1110.530(c)(3) -	Impact of Project on Other Area Providers	X		
1110.530(d)(1) -	Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS <u>ATTACHMENT-20,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

B. Criterion 1110.630 - Comprehensive Physical Rehabilitation

N/A, the application is for discontinuation of a service

1. Applicants proposing to establish, expand and/or modernize 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):

☐ **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
1110.630(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.630(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.630(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.630(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.630(b)(5) - Planning Area Need - Service Accessibility	X		
1110.630(c)(1) - Unnecessary Duplication of Services	X		
1110.630(c)(2) - Maldistribution	X		
1110.630(c)(3) - Impact of Project on Other Area Providers	X		
1110.630(d)(1) - Deteriorated Facilities			X
1110.630(d)(2) - Documentation			X
1110.630(d)(3) - Documentation Related to Cited Problems			X
1110.630(d)(4) - Occupancy			X
1110.630(e(1) and (2) - Staffing	X	X	
1110.630(e)(2) - Personnel Qualifications	X		
1110.630(f) - Performance Requirements	X	X	X
1110.630(g) - Assurances	X	X	X

APPEND DOCUMENTATION AS <u>ATTACHMENT-21,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

N/A, the application is for discontinuation of a service

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

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

☐ 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
1110.730(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.730(c)(1) -	Unnecessary Duplication of Services	X		
1110.730(c)(2) -	Maldistribution	X		
1110.730(c)(3) -	Impact of Project on Other Area Providers	X		
1110.730(d)(1) -	Deteriorated Facilities			X
1110.730(d)(2) -	Documentation			X
1110.730(d)(3) -	Documentation Related to Cited Problems			X
1110.730(d)(4) -	Occupancy			X
1110.730(e(1)) -	Staffing Availability	X	X	
1110.730(f) -	Performance Requirements	X	X	X
1110.730(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Criterion 1110.930 - Neonatal Intensive Care

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to add neonatal intensive care beds.

1. **Criterion 1110.930(a), Staffing**

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

   1. The name and qualifications of the person currently filling the job.
   2. Letters of interest from potential employees.
   3. Applications filed for each position.
   4. Signed contracts with the required staff.
   5. A detailed explanation of how you will fill the positions.

2. **Criterion 1110.930(b), Letter of Agreement**

   Read the criterion and provide the required letter of agreement.

3. **Criterion 1110.930(c), Need for Additional Beds**

   Read the criterion and provide the following information:

   a. The patient days and admissions for the affiliated center for each of the last two years; or

   b. An explanation as to why the existing providers of this service in the planning area cannot provide care to your projected caseload.

4. **Criterion 1110.930(d), Obstetric Service**

   Read the criterion and provide a detailed assessment of the obstetric service capability.

APPEND DOCUMENTATION AS ATTACHMENT-23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Criterion 1110.1230 - Open Heart Surgery

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish the open heart surgery category of service.

1. **Criterion 1110.1230(a), Peer Review**

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

2. **Criterion 1110.1230(b), Establishment of Open Heart Surgery**

   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 for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

3. **Criterion 1110.1230(c), 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 sent letters.
   c. Provide a copy of all of the responses received.

4. **Criterion 1110.1230(d), 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 mobilized for emergencies at all times.

5. **Criterion 1110.1230(e), 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. Letters of interest from potential employees.
   c. Application filed for a position.
   d. Signed contracts with the required staff.
   e. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT-24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Criterion 1110.1330 - Cardiac Catheterization

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish or modernize a cardiac catheterization category of service or to replace existing cardiac catheterization equipment.

1. **Criterion 1110.1330(a), Peer Review**

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

2. **Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service**

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

   a. A map (8 1/2" x 11") showing the location of the other hospitals providing cardiac catheterization service within the planning area.

   b. The number of cardiac catheterizations performed for the last l2 months at each of the hospitals shown on the map.

   c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. **Criterion 1110.1330(c), Unnecessary Duplication of Services**

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

   a. Copies of the letter sent to all facilities within 90 minutes travel time which currently 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 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories**

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

5. **Criterion 1110.1330(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 1110.1330(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 close proximity explain why.

7. **Criterion 1110.1330(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 1110.1330(h), Continuity of Care**

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

9. Criterion 1110.1330(i), Multi-institutional Variance

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

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT-25 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Criterion 1110.1430 - In-Center Hemodialysis

N/A, the application is for discontinuation of a service

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

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

☐ **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
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - Support Services	X	X	X
1110.1430(g) - Minimum Number of Stations	X		
1110.1430(h) - Continuity of Care	X		
1110.1430(j) - Assurances	X	X	X

APPEND DOCUMENTATION AS <u>ATTACHMENT-26,</u> IN NUMERIC SEQUENTIAL ORDER 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 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

H. Non-Hospital Based Ambulatory Surgery

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. **Criterion 1110.1540(a), Scope of Services Provided**

   Read the criterion and complete the following:

   a. Indicate which of the following types of surgery are being proposed:

_____Cardiovascular	_____Obstetrics/Gynecology	_____Pain Management
_____Dermatology	_____Ophthalmology	_____Podiatry
_____Gastroenterology	_____Oral/Maxillofacial	_____Thoracic
_____General/Other	_____Orthopedic	_____Otolaryngology
_____Neurology	_____Plastic	_____Urology

   b. Indicate if the project will result in a _____ limited or _____ a multi-specialty ASTC.

2. **Criterion 1110.1540(b), Target Population**

   Read the criterion and provide the following:

   a. On a map (8 ½" x 11"), outline the intended geographic services area (GSA).

   b. Indicate the population within the GSA and how this number was obtained.

   c. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

3. **Criterion 1110.1540(c), Projected Patient Volume**

   Read the criterion and provide signed letters from physicians that contain the following:

   a. The number of referrals anticipated annually for each specialty.

   b. For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.

   c. A statement that the projected patient volume will come from within the proposed GSA.

   d. A statement that the information in the referral letter is true and correct to the best of his or her belief.

4. **Criterion 1110.1540(d), Treatment Room Need Assessment**

   Read the criterion and provide:

   a. The number of procedure rooms proposed.

   b. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

5. **Criterion 1110.1540(e), Impact on Other Facilities**

   Read the criterion and provide:

   a. A copy of the letter sent to area surgical facilities regarding the proposed project's impact on their workload. NOTE: This letter must contain: a description of the project including its size, cost, and projected workload; the location of the proposed project; and a request that the facility

administrator indicate what the impact of the proposed project will be on the existing facility.

b. A list of the facilities contacted. **NOTE**: Facilities must be contacted by a service that provides documentation of receipt such as the US. Postal Service, FedEx or UPS. The documentation must be included in the application for permit.

6. Criterion 1110.1540(f), Establishment of New Facilities

Read the criterion and provide:

a. A list of services that the proposed facility will provide that are not currently available in the GSA; or

b. Documentation that the existing facilities in the GSA have restrictive admission policies; or

c. For co-operative ventures,

a. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and

b. The hospital's surgical utilization data for the latest 12 months, and

c. Certification that the existing hospital will not increase its operating room capacity until such a time as the proposed project's operating rooms are operating at or above the target utilization rate for a period of twelve full months; and

d. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

7. Criterion 1110.1540(g), Charge Commitment

Read the criterion and provide:

a. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.

b. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

8. Criterion 1110.1540(h), Change in Scope of Service

Read the criterion and, if applicable, document that existing programs do not currently provide the service proposed or are not accessible to the general population of the geographic area in which the facility is located.

APPEND DOCUMENTATION AS <u>ATTACHMENT-27,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

I. Criterion 1110.1730 - General Long Term Care

N/A, the application is for discontinuation of a service

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

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

☐ **General Long Term Care**		

2. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X				
1110.1730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X			
1110.1730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X				
1110.1730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X			
1110.1730(b)(5) - Planning Area Need - Service Accessibility	X				
1110.1730(c)(1) - Description of Continuum of Care				X	
1110.1730(c)(2) - Components				X	
1110.1730(c)(3) - Documentation				X	
1110.1730(d)(1) - Description of Defined Population to be Served					X
1110.1730(d)(2) - Documentation of Need					X
1110.1730(d)(3) - Documentation Related to Cited Problems			X		
1110.1730(e)(1) - Unnecessary Duplication of Services	X				
1110.1730(e)(2) - Maldistribution	X				
1110.1730(e)(3) - Impact of Project on Other Area Providers	X				
1110.1730(f)(1) - Deteriorated Facilities			X		
1110.1730(f)(2) & (3) - Documentation			X		

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(f)(4) -	Utilization			X		
1110.1730(g) -	Staffing Availability	X	X		X	X
1110,1730(h) -	Facility Size	X	X	X	X	X
1110.1730(i) -	Community Related Functions	X		X	X	X
1110.1730(j) -	Zoning	X		X	X	X
1110.1730(k) -	Assurances	X	X	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-28, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

J. Criterion 1110.1830 - Specialized Long Term Care

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing specialized long-term care services or beds.

1. **Criterion 1110.1830(b), Community Related Functions**

   Read the criterion and submit the following information:

   a. a description of the process used to inform and receive input from the public including those residents living in close proximity to the proposed facility's location;

   b. letters of support from social, social service and economic groups in the community;

   c. letters of support from municipal/elected officials who represent the area where the project is located.

2. **Criterion 1110.1830(c), Availability of Ancillary and Support Services**

   Read the criterion, which applies only to ICF/DD 16 beds and fewer facilities, and submit the following:

   a. a copy of the letter, sent by certified mail return receipt requested, to each of the day programs in the area requesting their comments regarding the impact of the project upon their programs and any response letters;

   b. a description of the public transportation services available to the proposed residents;

   c. a description of the specialized services (other than day programming) available to the residents;

   d. a description of the availability of community activities available to the facility's residents.

   e. documentation of the availability of community workshops.

3. **Criterion 1110.1830(d), Recommendation from State Departments**

   Read the criterion and submit a copy of the letters sent, including the date when the letters were sent, to the Departments of Human Services and Public Aid requesting these departments to indicate if the proposed project meets the department's planning objectives regarding the size, type, and number of beds proposed, whether the project conforms or does not conform to the department's plan, and how the project assists or hinders the department in achieving its planning objectives.

4. **Criterion 1110.1830(e), Long-term Medical Care for Children Category of Service**

Read the criterion and submit the following information:

   a. a map outlining the target area proposed to be served;

   b. the number of individuals age 0-18 in the target area and the number of individuals in the target area that require the type of care proposed, include the source documents for this estimate;

   c. any reports/studies that show the points of origin of past patients/residents admissions to the facility;

   d. describe the special programs or services proposed and explain the relationship of theses programs to the needs of the specialized population proposed to be served.

   e. indicate why the services in the area are insufficient to meet the needs of the area population;

f. documentation that the 90% occupancy target will be achieved within the first full year of

5. **Criterion 1110.1830(f), Zoning**

Read the criterion and provide a letter from an authorized zoning official that verifies appropriate zoning.

6. **Criterion 1110.1830(g), Establishment of Chronic Mental Illness**

Read the criterion and provide the following:

a. documentation of how the resident population has changed making the proposed project necessary.

b. indicate which beds will be closed to accommodate these additional beds.

c. the number of admissions for this type of care for each of the last two years.

7. **Criterion 1110.1830(i), Variance to Computed Bed Need for Establishment of Beds Developmentally Disabled Adults for Placement of Residents from DHS State Operated Be**

Read this criterion and submit the following information:

a. documentation that all of the residents proposed to be served are now residents of a DHS facility;

b. documentation that each of the proposed residents has at least one interested family member who resides in the planning area or at least one interested family member that lives out of state but within 15 miles of the planning area boundary where the facility is or will be located;

c. if the above is not the case then you must document that the proposed resident has lived in a DHS operated facility within the planning area in which the proposed facility is to be located for more than 2 years and that the consent of the legal guardian has been obtained;

d. a letter from DHS indicating which facilities in the planning area have refused to accept referrals from the department and the dates of any refusals and the reasons cited for each refusal;

e. a copy of the letter (sent certified–return receipt requested) to each of the underutilized facilities in the planning area asking if they accept referrals from DHS-operated facilities, listing the dates of each past refusal of a referral, and requesting an explanation of the basis for each refusal;

f. documentation that each of the proposed relocations will save the State money;

g. a statement that the facility will only accept future referrals from an area DHS facility if a bed is available;

h. an explanation of how the proposed facility conforms with or deviates from the DHS comprehensive long range development plan for developmental disabilities services.

APPEND DOCUMENTATION AS ATTACHMENT-29, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

K. Criterion 1110.2330 - Selected Organ Transplantation

N/A, the application is for discontinuation of a service

This section is applicable to projects involving the establishment or modernization of the Selected Organ Transplantation service.

1. Applicants proposing to establish or modernize Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes by Service: Indicate # of rooms changed by action(s):

☐		

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

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2330(b)(1) - Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2330(b)(2) - Planning Area Need - Service to Planning Area Residents	X	
1110.2330(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2330(b)(4) - Planning Area Need - Service Accessibility	X	
1110.2330(c)(1) - Unnecessary Duplication of Services	X	
1110.2330(c)(2) - Maldistribution	X	
1110.2330(c)(3) - Impact of Project on Other Area Providers	X	
1110.2330(d)(1) - Deteriorated Facilities		X
1110.2330(d)(2) - Documentation		X
1110.2330(d)(3) - Documentation Related to Cited Problems		X
1110.2330(d)(4) - Utilization		X
1110.2330(e) - Staffing Availability	X	
1110.2330(f) - Surgical Staff	X	
1110.2330(g) - Collaborative Support	X	
1110.2330(h) - Support Services	X	
1110.2330(i) - Performance Requirements	X	X
1110.2330(j) - Assurances	X	X

APPEND DOCUMENTATION AS <u>ATTACHMENT-30</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

L. Criterion 1110.2430 - Kidney Transplantation

N/A, the application is for discontinuation of a service

This section is applicable to all projects involving the establishment of the kidney transplantation service.

1. Applicants proposing to establish or modernize Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes: Indicate # of key rooms by action:

☐		

3. **READ the applicable review criteria outlined below and submit required documentation for the criteria printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2430(b)(1) - Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	
1110.2430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2430(b)(4) - Planning Area Need - Service Accessibility	X	
1110.2430(c)(1) - Unnecessary Duplication of Services	X	
1110.2430(c)(2) - Maldistribution	X	
1110.2430(c)(3) - Impact of Project on Other Area Providers	X	
1110.2430(d)(1) - Deteriorated Facilities		X
1110.2430(d)(2) - Documentation		X
1110.2430(d)(3) - Documentation Related to Cited Problems		X
1110.2430(d)(4) - Utilization		X
1110.2430(e) - Staffing Availability	X	
1110.2430(f) - Surgical Staff	X	
1110.2430(g) - Support Services	X	
1110.2430(h) - Performance Requirements	X	X
1110.2430(i) - Assurances	X	X

APPEND DOCUMENTATION for "Surgical Staff" and "Support Services", AS ATTACHMENT-31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

APPLICABLE REVIEW CRITERIA	Establish	Modernize

M. Criterion 1110.2530 - Subacute Care Hospital Model

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish a subacute care hospital model.

1. **Criterion 1110.2530(a), Distinct Unit**

   a. Provide a copy of the physical layout (an architectural schematic) of the subacute unit (include the room numbers) and describe the travel patterns to support services and patient and visitor access.

   b. Provide a summary of shared services and staff and how costs for such will be allocated between the unit and the hospital or long-term care facility.

   c. Provide a staffing plan with staff qualifications and explain how non-dedicated staffing services will be provided.

2. **Criterion 1110.2530(b), Contractual Relationship**

   a. If the applicant is a licensed long-term care facility or a previously licensed general hospital the applicant must provide a copy of a contractual agreement (transfer agreement) with a general acute care hospital. Provide the travel time to the facility which signed the contract. Explain how the procedures for providing emergency care under this contract will work.

   b. If the applicant is a licensed general hospital the applicant must document that its emergency capabilities continue to exist in accordance with the requirements of hospital licensure.

3. **Rule 1110.2540(b), State Board Prioritization of Hospital Applications**

   Read this rule which applies only to hospital applications and provide the requested information as applicable.

   a. Financial Support

   Will the subacute care model provide the necessary financial support for the facility to provide continued acute care services? Yes___ No _____

   If yes, submit the following information:

   (1) projected two years of financial statements that exclude the financial impact of the subacute care hospital model as well as two years of projected financial statements which include the financial impact of the subacute care hospital model;

   (2) the assumptions used in developing both sets of financial statements;

   (3) a narrative description of the factors within the facility or the area which will prevent the facility from complying with the financial ratios within the next two years without the proposed project;

   (4) a narrative explanation as to how the proposed project will allow you to meet the financial ratios;

   (5) if the projected financial statements (which include the subacute impact) at the applicant facility fail to meet the Part 1120 financial ratios, provide a copy of a binding agreement with another institution which guarantees the financial viability of the subacute hospital model for a period of five years; and

   (6) historical financial statements for each of the last three calendar years.

Subacute Care Hospital Model (continued)

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Multi-Institutional System

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the acute care facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

d. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

e. Casemix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnosis which included physiological monitoring on a continuous basis

(2) for multi-institutional systems provide the above information from each of the signatory facilities. If more than one signatory is involved, provide separate sheets for each one.

f. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMOs.

g. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation must consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill these positions are presently employed at the applicant facility.

-Full-time medical director exclusively for the model
-Two or more full-time (FTEs) physical therapist
-One or more occupational therapists
-One or more speech therapists

Subacute Care Hospital Model (continued)

4. Rule 1110.2540(c), State Board Prioritization-Long-Term Care Facilities

This rule applies to only to LTC facility applications. READ the criterion and submit the required information, as applicable.

a. Exceptional Care

Has the applicant facility had an Exceptional Care Contract with the Illinois Department of Public Aid for at least two years in the past four years? Yes ____ No

If yes, provide copies of the Exceptional Care contract with the Illinois Department of Public Aid for each of the last four years.

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

d. Case Mix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses which included physiological monitoring on a continuous basis

(2). for multi-institutional systems, provide the same information from each of the signatory facilities. If more than one signatory is involved, provide a separate sheet for each one.

e. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMO's.

f. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation shall consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill the positions are currently employed by the applicant facility.

-Full-time medical director exclusively for the model
-Two or more full time (FTEs) physical therapists
-One or more occupational therapists

Subacute Care Hospital Model (continued)

-One or more speech therapists

g. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐ If yes, provide a copy of the latest Joint Commission letter of accreditation.

h. Multi-Institutional Arrangements

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

5. Section 1110.2540(d), State Board Prioritization of Previously Licensed Hospitals - Chicago

This section must be completed only by applicants whose site was previously licensed as a hospital in Chicago. Provide the following information:

a. letters from health facilities establishing referral agreement for subacute hospital patients;

b. letters from physicians indicating that they will refer subacute patients to your proposed facility;

c. the number of admissions and patient days for each of the last five years for each of the following types of patients (this information must be provided from each referring facility):

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses which included physiological monitoring on a continuous basis.

APPEND DOCUMENTATION AS ATTACHMENT-32, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

N. Criterion 1110.2630 - Post Surgical Recovery Care Center

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish a Postsurgical Recovery Care Center Alternative Health Care Model.

Post Surgical Recovery Care Center

1. Criterion 1110.2630(a), Need/Unit Size

Read the criterion and provide the following information:

a. the number of postsurgical recovery center beds proposed;

b. the anticipated number of patients who will utilize the facility; and

c. for each surgical referral site, for the latest 12 months:

1. the name of the surgical referral site;
2. the number of inpatient surgical cases that could have received postsurgical recovery services within the model if it had been available;
3. the number of the cases identified above expected to be referred to this model and the rationale therefore;
4. patient identification numbers for each patient;
5. ICD 9 Code or procedure type for each patient; and
6. the experienced length of stay for each patient.

2. Criterion 1110.2630(b), Staffing

Read the criterion and submit the following information:

a. A copy of the plans of the physical layout (design drawings) of the proposed facility. Indicate on these plans the manner by which the proposed area will be physically separate and identifiable from the remaining areas of the health care facility.

b. A detailed staffing plan identifying the number and type of staff positions dedicated to the model.

c. The name and qualifications of the proposed Medical Director including a signed commitment to the facility by that person stating a willingness to hold such a position.

d. Evidence that an on-call physician, licensed to practice medicine in all of its branches, can be physically present at the model within 15 minutes on a 24 hour per day seven day per week basis.

3. Criterion 1110.2630(c), Patient Mix

Read the criterion and provide the following information:

a. A listing of the types of surgical procedures that will require care in the postsurgical recovery model.

b. The anticipated number of admissions (for the first year of operation) for the following specialties:

General Surgery_____ Eyes-Ears-Nose-Throat _____ Obstetric/Gynecology ____
Orthopedic _____ Plastic Surgery _____ Ophthalmology ____
Urology_____ Gastroenterology _____ Other (specify) ____

c. The patient recovery care protocols including an explanation of how patient safety will be assured.

POSTSURGICAL RECOVERY CARE CENTER (continued)

4. Criterion 1110.2630(d) Travel Time/Patient Transfer

Read the criterion and provide the following information:

a. A map identifying all surgical referral sites for the proposed facility. Indicate distances in miles and travel times by medical transport between each of the surgical referral sites and the applicant facility. Indicate how the travel time was determined.

b. Name of the person (and the position/title) who will have the responsibility for the transfer of patients from the surgical site to the postsurgical recovery center and copies of the protocols to be used in patient transfers to the Postsurgical Recovery Care Center from each surgical referral site.

5. Criterion 1110.2630(e), On-Site Emergency Care

Read the criterion and provide the following information:

a. All protocols established for the treatment of emergency patients and the applicant facility's requirements concerning staff training for emergency patient care.

b. Provide documentation that a crash cart will be available on-site and that staff trained in cardiac defibrillation will be available at all times.

6. Rule 1110.2640(b), State Board Review-Prioritization of Applications for Postsurgical Recovery Care Center Alternative Health Care Model

This rule applies to all applicants proposing to establish a Postsurgical Recovery Centers Alternative Health Care Model. Read the criterion and provide the following information:

a. The name and population of the county in which the proposed facility will be located.

b. Name the source of the population figures.

c. Will the proposed facility be owned or operated by an existing hospital? Yes ☐ No

d. Will the project be located within or attached to an existing facility? Yes ☐ No ☐
If yes, give the name of the hospital or ASTC and date of initial license

e. Will the proposed project be located in a Medically Underserved Area as designated by the Department of Health and Human Services? Yes ☐ No ☐ If yes, provide documentation that the facility is located in such an area.

f. Provide total revenue, Medicare revenue, and Medicaid revenue for each surgical referral site.

g. Provide a copy of the applicant facility's current accreditation letter if applicable.

APPEND DOCUMENTATION AS ATTACHMENT-33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

O. Criterion 1110.2730 - Children's Community-Based Health Care Center

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish a Children's Respite Care Alternative Health Care Model.

A. Criterion 1110.2730(a), Admission Policy

Read the criterion and provide the following information:

1. Copies of all admission policies to be in effect at the proposed facility; and

2. Certification that no admission restrictions due to age, race, diagnosis, or source of payment will occur.

B. Criterion 1110.2730(b), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan for the proposed facility (unit) identifying the number and type of staff positions dedicated to the model;

2. The name and qualifications of the proposed Medical Director including a signed commitment to the facility by that person stating a willingness to hold such a position;

3. A job description for the medical director detailing the position responsibilities; and

4. Documentation as to how special staffing circumstances will be handled.

C. Criterion 1110.2730(c), Mandated Services

Read the criterion and provide a narrative explaining how the services required under the Alternative Health Care Delivery Act and referenced in Section 1110.2720(b) will be provided.

D. Criterion 1110.2730(d), Acute Care Backup

Read the criterion and provide the following information:

1. A signed referral agreement with an acute care facility for the referral of emergency patients;

2. A map identifying the location of the acute care facility; and

3. The travel time to the acute care facility from the applicant facility. Explain how the travel time was calculated.

E. Criterion 1110.2730(e), Patient Screening/Emergency Care

Read the criterion and provide the following information:

1. All protocols established for the screening of potential residents for the severity of medical conditions associated with the required care for the child;

2. Documentation that a care plan will be developed for each child admitted. Explain how this care plan will be developed; and

3. A narrative which explains how emergency situations will be handled.

F. Criterion 1110.2730(f), Education

Read the criterion and provide the following information:

1. Documentation that children who participate in educational programs will continue to receive such services during their stay at the facility; and

CHILDREN'S RESPITE CARE ALTERNATIVE HEALTH CARE MODEL (continued)

2. Identify the person or position who has the responsibility for maintaining these services and explain how the services will be provided.

G. Criterion 1110.2730(g), Age Specific Needs

Read the criterion and provide a narrative description of staff expertise as it pertains to the specific care needs required of the various age groups that will be admitted.

H. Rule 1110.2740(b)(2)(D),

Read the criterion and indicate if the proposed facility is located in a Health Professional Shortage Area as designated by the Department of Health and Human Services.
Yes ☐ No ☐

APPEND DOCUMENTATION AS ATTACHMENT-34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

P. Community-Based Residential Rehabilitation Center

N/A, the application is for discontinuation of a service

This section is applicable to all projects proposing to establish a Community-based Residential Rehabilitation Center Alternative Health Care Model.

A. Criterion 1110.2830(a), 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; and
2. How special staffing circumstances will be handled; and
3. The staffing patterns for the proposed center; and
4. The manner in which non-dedicated staff services will be provided.

B. Criterion 1110.2830(b), Mandated Service

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 1110.2830(c), 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 1110.2830(d), 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 1110.2830(e), 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 <u>ATTACHMENT-35,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Q. 1110.2930 - Long Term Acute Care Hospital

N/A, the application is for discontinuation of a service

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):

☐ 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
1110.2930(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.2930(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.2930(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.2930(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2930(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.2930(c)(1) -	Unnecessary Duplication of Services	X		
1110.2930(c)(2) -	Maldistribution	X		
1110.2930(c)(3) -	Impact of Project on Other Area Providers	X		
1110.2930(d)(1) -	Deteriorated Facilities			X
1110.2930(d)(2) -	Documentation			X
1110.2930(d)(3) -	Documentation Related to Cited Problems			X
1110.2930(d)(4) -	Occupancy			X
110.2930(e) -	Staffing Availability	X	X	
1110.2930(f) -	Performance Requirements	X	X	X
1110.2930(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

N/A, the application is for discontinuation of a 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):

☐		
☐		
☐		

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 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-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

S. Freestanding Emergency Center Medical Services

N/A, the application is for discontinuation of a service

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 1110.3230 – ESTABLISHMENT OF FREESTANDING EMERGENCY CENTER (MEDICAL SERVICES

Read the criterion and provide the following information:

1. 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.

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.

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.

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.

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:
   - 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:
   - 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) Provide letters from authorized representatives of hospitals, or other FEC facilities, 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 Hospital Association CompData 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

Freestanding Emergency Center Medical Services (continued)

served during the last 12-month period were residents of the service area.

7. Area Need; Service Demand – Historical Utilization
   A) Provide the annual number of ED patients that have received care at facilities that are located 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 the following (using supporting documentation as specified in accordance with the requirements of 77 IAC 1110.3230(b)(4)(B) Supporting Documentation):
   i) The absence of the proposed ED service within the service area;
   ii) The area population and existing care system exhibit indicators of medical care problems,
   iii) All existing emergency services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 IAC 1100.

9. Unnecessary Duplication - Document that the project will not result in an unnecessary duplication by providing the following information:
   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 provide emergency medical services.

10. Unnecessary Maldistribution - Document that the project will not result in maldistribution of services by documenting the following:
    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 that is below the utilization standard established pursuant to 77 I AC 1100.800; or
    B) Insufficient population to provide the volume or caseload necessary to utilize the ED services proposed by the project at or above utilization standards.

11. Unnecessary Duplication/Maldistribution – Document that, within 24 months after project completion, the proposed 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 (using supporting documentation in accordance with the requirements of 77 IAC 1110.3230(c)(4)).

12. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.3230(e)).

B. Criterion 1110.3230 – EXPANSION OF EXISTING FREESTANDING EMERGENCY CENTER MEDICAL SERVICES

Read the criterion and provide the following information:

1. 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.

Freestanding Emergency Center Medical Services (continued)

2. 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.

3. 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.

4. 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:
   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:
   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 (in accordance with the requirements of 1110.3230(e)).

C. Criterion 1110.3230 – MODERNIZATION OF EXISTING FREESTANDING EMERGENCY CENTER MEDICAL SERVICES) CATEGORY OF SERVICE

Read the criterion and provide the following information:

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

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.

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.

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.

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:
   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].

Freestanding Emergency Center Medical Services
(continued)

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-38, 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)**

VIII. - 1120.120 - Availability of Funds

N/A, the application is for discontinuation of a service

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:**

Amount	Source
_____	a) 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;
_____	d) Debt – a statement of the estimated terms end 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-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

N/A, the application is for discontinuation of a service

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. **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-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 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				

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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

N/A, the application is for discontinuation of a service

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

A. 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:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. 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.

C. 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).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
	A	B	C	D	E	F	G	H	
Department (list below)	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	Total Cost (G + H)
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. 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.

E. 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 -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. 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.
LCMH is not aware that the discontinuation of geriatric psych services would have any impact on essential safety net services in the community. Safety net Services would still be readily available to the community. Currently, if a patient that requires mental health services presents to our Emergency Department, the ED physician assesses that patient and contacts the on call behavioral health specialist at our local health department. The behavioral health specialist would assess the patient and determine if the patient would need to be transferred to a behavioral health center for treatment or is cleared for discharge.

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.
N/A, this discontinued service is not considered a safety net service.

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.
There would be no impact on the safety net providers within surrounding communities, please refer to #1 above.

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 Medicaid Patients. 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.
N/A, there is no other relevant information

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)	**2009**	**2008**	**2007**
Inpatient	3	6	5
Outpatient	266	179	86
Total	**269**	**185**	**91**
Charity (cost In dollars)			
Inpatient	$7,075	$29,620	$22,300
Outpatient	$130,977	$96,554	$39,795
Total	$138,052	$126,174	$62,095
MEDICAID			
Medicaid (# of patients)	**2009**	**2008**	**2007**
Inpatient	95	156	116
Outpatient	8,823	7,994	4,923
Total			
Medicaid (revenue)			

Inpatient	$432,244	$749,856	$508,154
Outpatient	$4,508,127	$3,928,216	$3,030,672
Total	$4,940,371	$4,678,072	$3,538,826

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

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.

N/A, this is the only facility

2. 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.

N/A, we are an existing facility

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.

CHARITY CARE			
	2009	**2008**	**2007**
Net Patient Revenue	**$10,578,529**	**$10,347,347**	**$9,923,046**
Amount of Charity Care (charges)	**$285,231**	**$254,742**	**$121,494**
Cost of Charity Care	**$138,052**	**$126,174**	**$62,095**
Ratio of charity care cost to net patient revenue:	.013	.012	.006

APPEND DOCUMENTATION AS ATTACHMENT-44, 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
1	Applicant/Coapplicant Identification including Certificate of Good Standing	N/A
2	Site Ownership	60
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	N/A
5	Flood Plain Requirements	N/A
6	Historic Preservation Act Requirements	N/A
7	Project and Sources of Funds Itemization	N/A
8	Obligation Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	61, 62
11	Background of the Applicant	63
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
14	Size of the Project	N/A
15	Project Service Utilization	N/A
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
		N/A
	Service Specific:	N/A
20	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	N/A
27	Non-Hospital Based Ambulatory Surgery	N/A
28	General Long Term Care	N/A
29	Specialized Long Term Care	N/A
30	Selected Organ Transplantation	N/A
31	Kidney Transplantation	N/A
32	Subacute Care Hospital Model	N/A
33	Post Surgical Recovery Care Center	N/A
34	Children's Community-Based Health Care Center	N/A
35	Community-Based Residential Rehabilitation Center	N/A
36	Long Term Acute Care Hospital	N/A
37	Clinical Service Areas Other than Categories of Service	N/A
38	Freestanding Emergency Center Medical Services	N/A
		N/A
	Financial and Economic Feasibility:	N/A
39	Availability of Funds	N/A
40	Financial Waiver	N/A
41	Financial Viability	N/A
42	Economic Feasibility	N/A
43	Safety Net Impact Statement	64
44	Charity Care Information	65

CERTIFICATE OF STATUS OF EXEMPT PROPERTY

File

LAWRENCE COUNTY , ILLINOIS
CHIEF CO ASSESMENT OFFICE
CTHS ANNEX-1106 JEFFERSON
LAWRENCEVILLE, IL 62439

PHONE: 618-943-2719

RECEIVED
APR - 1 2002
SUPERVISOR ASSESSMENTS
LAWRENCE COUNTY, IL

LAWRENCE COUNTY MEMORIAL
HOSPITAL
2200 STATE STREET
LAWRENCEVILLE IL 62439-0000

IN ACCORDANCE WITH SECTION 15-10 OF THE PROPERTY TAX CODE (35 ILCS 200/15-10), THIS CERTIFICATION IS HEREBY SUBMITTED. AS TITLEHOLDER OR AS BENEFICIAL OWNER OF THE RIGHTS TO THE PROPERTY(S) LISTED BELOW, IT IS HEREBY DECLARED THAT AS OF JANUARY 1, 2002, THERE HAS NOT BEEN A CHANGE IN OWNERSHIP OR USE OF THE PROPERTY(S) SINCE THE INITIAL ISSUANCE OF THE CERTIFICATE OF EXEMPTION(S) BY THE ILLINOIS DEPARTMENT OF REVENUE, EXCEPT AS NOTED.

LAWRENCE TOWNSHIP
06-001-660-20
LAWRENCE COUNTY MEMORIAL
HOSPITAL
2200 STATE STREET
LAWRENCEVILLE IL 62439-0000

PT LOT 22 C E BUCHANAN SURVEY, LAND BETWEEN PORTER AVENUE AND STATE STREET AS DESCRIBED IN DEEDS BK 92 PG 307, BK 92 PG 315, BK 5 PG 590, 120' OFF N END LOT 9 C.E. BUCHANAN BK 97 PG 507--D.O.R. DOCKET #99-51-27

(ON THE FOLLOWING DESCRIPTIONS: IF NONE, STATE NONE)

DESCRIBE CHANGE IN OWNERSHIP: NONE

DATE OWNERSHIP CHANGED: ____________

DESCRIBE CHANGE IN USE: (BE SPECIFIC) ____________

DATE USE CHANGED: ____________

IS ANY OF THIS PROPERTY LEASED? YES NO

IF YES, ATTACH COPIES OF ANY LEASE AGREEMENTS NOT PREVIOUSLY SUBMITTED.

[ ] IF MARKED, THIS OFFICE IS REQUESTING YOU TO PROVIDE A COPY OF YOUR ORIGINAL CERTIFICATE OF EXEMPTION ISSUED BY THE DEPARTMENT OF REVENUE. ATTACH AND RETURN A COPY WITH THIS DOCUMENT.

I HEREBY CERTIFY THIS TO BE A TRUE AND CORRECT REPORTING OF THE FACTS CONCERNING THIS PROPERTY.

SIGNATURE: [signature] DATE: 4-1-02

TITLE: [illegible] PHONE: 618-943-1000

***** IMPORTANT *****

THIS SHOULD BE COMPLETED AND RETURNED TO THE LAWRENCE COUNTY COUNTY ASSESSOR/CHIEF COUNTY ASSESSING OFFICER PRIOR TO APRIL 1, 2002. FAILURE TO FILE SHALL CONSTITUTE CAUSE TO TERMINATE THE EXEMPTION.

ATTACHMENT 2

Doug Florkowski

From: Doug Florkowski
Sent: Monday, June 14, 2010 2:19 PM
To: 'dallen@richlandmemorial.com'
Subject: FW: CON permit application impact statement request

Dave,

First and foremost, thanks for your time and assistance on this issue. I have included the section from the application. The highlighted section is the issue your letter will address.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.

The discontinuation of the acute/ chronic mental service would not have an adverse effect upon the immediate market area as evidenced by the fact that 80% of the service referrals came from outside our facilities market area. Patients that require acute/ chronic mental illness services are currently going to Richland Memorial Hospital, IL (20 miles away), Good Samaritan Hospital, IN (10 miles away) and Davies Community Hospital, IN (35 miles away). All these hospitals have psychiatric services.

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 45 minutes travel time of the applicant facility.

3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

If you would, go ahead and mail the letter to me and I will include it in our application.

Again, I appreciate your help and congrats on your new Surgeon!

Doug Florkowski, CEO
Lawrence County Memorial Hospital
2200 State Street
Lawrenceville, Illinois 62439

618-943-7200 Office
618-943-7233 Fax

Richland Memorial Hospital

800 East Locust Street • Olney, IL 62450-2598
618.395.2131 • fax 618.392.3228

June 15, 2010

Mr. Doug Florkowski, CEO
Lawrence County Memorial Hospital
2200 State Street
Lawrenceville, IL 62439

Dear Doug;

The discontinuation of psychiatric services at Lawrence County Memorial Hospital has not had an adverse impact on psychiatric services provided at Richland Memorial Hospital. We continue to have the physical capacity and are fortunate to have the professional capacity to treat referred psychiatric patients from Lawrence County.

If you have any questions or need further information, please contact me.

Sincerely,

David B. Allen
Chief Executive Officer

ATTACHMENT 10 b

State of Illinois 1927310

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/10	BGBD	0001255

FULL LICENSE

CRITICAL ACCESS HOSP

EFFECTIVE: 07/01/09

BUSINESS ADDRESS

LAWRENCE COUNTY MEMORIAL HOSPITAL

2200 WEST STATE STREET

LAWRENCEVILLE IL 62439

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4/97 •

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2009**	**2008**	**2007**
Inpatient	3	6	5
Outpatient	266	179	86
Total	**269**	**185**	**91**
Charity (cost in dollars)			
Inpatient	$7,075	$29,620	$22,300
Outpatient	$130,977	$96,554	$39,795
Total	$138,052	$126,174	$62,095
MEDICAID			
Medicaid (# of patients)	**2009**	**2008**	**2007**
Inpatient	95	156	116
Outpatient	8,823	7,994	4,923
Total			
Medicaid (revenue)			
Inpatient	$432,244	$749,856	$508,154
Outpatient	$4,508,127	$3,928,216	$3,030,672
Total	$4,940,371	$4,678,072	$3,538,826

ATTACHMENT 43

CHARITY CARE			
	2009	2008	2007
Net Patient Revenue	$10,578,529	$10,347,347	$9,923,046
Amount of Charity Care (charges)	$285,231	$254,742	$121,494
Cost of Charity Care	$138,052	$126,174	$62,095
Ratio of charity care cost to net patient revenue:	.013	.012	.006

ATTACHMENT 44