ORIGINAL

13-059

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
SEP 10 2013
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: Freeport Memorial Hospital			
1045 W Stephenson St.			
City and Zip Code: Freeport, Illinois 61032			
County: Stephenson	Health Service Area	1	Health Planning Area: B02

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

Exact Legal Name: Freeport Memorial Hospital
Address: 1045 W Stephenson St
Name of Registered Agent: Michael Clark
Name of Chief Executive Officer: Michael Perry, MD
CEO Address: 1045 W Stephenson St Freeport, Il 61032
Telephone Number: 815-599-6000

Type of Ownership of Applicant/Co-Applicant

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

- [X] Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- 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.

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)

Name: Sharon Summers
Title: Executive Vice President/Chief Operating Officer
Company Name: Freeport Memorial Hospital
Address: 1045 W Stephenson St. Freeport, Illinois 61032
Telephone Number: 815-599-6151
E-mail Address: SSummers@FHN.org
Fax Number: 815-599-6868

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

Name: Nancy Cutler
Title: Chief Nursing Officer
Company Name: Freeport Memorial Hospital
Address: 1045 W Stephenson St Freeport, Il 60132
Telephone Number: 815-599-6335
E-mail Address: NCutler@FHN.org
Fax Number: 815-599-6868

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: Sharon Summers
Title: Executive Vice President/Chief Operating Officer
Company Name: Freeport Memorial Hospital
Address: 1045 W Stephenson St. Freeport, Ill 61032
Telephone Number: 815-599-6151
E-mail Address: SSummers@FHN.org
Fax Number: 815-599-6868

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Freeport Memorial Hospital
Address of Site Owner: 1045 W Stephenson , Freeport, Illinois 60132
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: Freeport Memorial Hospital

Address: 1045 W Stephenson St Freeport, IL 61032

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

- [X] Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

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

Flood Plain Requirements

[Refer to application instructions.]

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

[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:

☐ Substantive

☒ Non-substantive

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.

Freeport Memorial Hospital desires to discontinue the Pediatric category of service which consists of 15 certified Pediatric beds located on the 2nd floor of the Hospital. As per definition this is considered a non-substantive project.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			

None

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 0.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): 2-1-2014

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

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

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

☐ Cancer Registry
☐ APORS
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☐ All reports regarding outstanding permits

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

Cost Space Requirements

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

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

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT Applicable

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:FHN Memorial Hospital		**CITY:Freeport, Illinois 61032**			
REPORTING PERIOD DATES:		**From: 01/01/2012**	**to:01/01/2013**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	82	3535	15776		
Obstetrics	14	578	1278		
Pediatrics	15	95	134	15	0
Intensive Care	8	460	912		
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	119	4668	18,100		

CERTIFICATION

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

- X 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 Freeport 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.**

Michael Perry	Carol S Schuster
SIGNATURE	SIGNATURE
MICHAEL PERRY	Carol Schuster
PRINTED NAME	PRINTED NAME
PRES / CEO	Board Chair
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 5th day of September, 2013	Notarization: Subscribed and sworn to before me this 5th day of September, 2013
Tammy Edler	Tammy Edler
Signature of Notary	Signature of Notary
Seal "OFFICIAL SEAL" TAMMY EDLER Notary Public, State of Illinois My Commission Expires 3-11-15	Seal "OFFICIAL SEAL" TAMMY EDLER Notary Public, State of Illinois My Commission Expires 3-11-15

*Insert full name of the applicant

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.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. 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.

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.

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.
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.

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

File Number 2569-316-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

FREEPORT MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 10, 1938, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* AUGUST *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1322701256

Authenticate at: http://www.cyberdriveillinois.com

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ATTACHMENT I

Certificate of Good Standing

Attestation of Ownership

This letter will serve as documentation that Freeport Memorial Hospital, a Domestic Corporation, was incorporated under the laws of the State of Illinois June 1938. Freeport Memorial Hospital is the sole owner of the site.

Respectfully,

Michael Perry, M.D.
Chief Executive Officer

Attachment 2

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Attestation of Ownership

File Number 2569-316-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

FREEPORT MEMORIAL HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 10, 1938, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* AUGUST *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1322701256

Authenticate at: http://www.cyberdriveillinois.com

Pg 13 ATTACHMENT 3 operating Identity

Organizational Relationship

This section is not applicable as this is not a co-application nor anyone related or entity participating in the funding of the project.

Attachment 4

Organizational Relationship

Flood Plain Requirements

This section is not applicable as per phone conversation with Health Facilities Planning Staff.

Attachment 5

Flood Plain Requirement

Historic Resources Preservation Act Requirements

Not applicable to this project of discontinuation.

Attachment 6

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Historic Preservation

Project Costs and Sources of Funds

There are not project costs for the discontinuation of services for this project.

Attachment 7

Project costs

Safety Net Impact Statement

The discontinuation of the Pediatric category of service shall not negatively impact service delivery to the community. The relative few annual pediatric admission will be admitted to the hospital and cared for by appropriately trained nurses and support staff. Attached are three letters of support from the Rockford Hospitals which provide tertiary care for the local pediatric population.

FHN

July 11, 2013

Gary Kaatz
President and CEO
Rockford Health System
2400 North Rockton Avenue
Rockford, Illinois 61103-3681

Dear Mr. Kaatz,

FHN is in the process of completing the Health Facilities and Services Review Board CON application to discontinue fifteen (15) Pediatric beds and the Pediatric category of service. Hospital Pediatric admissions have continued to decline over the past several years and we have made the decision to convert the Pediatric rooms into private rooms for adult admissions. We will continue to provide Pediatric care for the occasional admission but we will no longer have a dedicated Pediatric Unit.

This application requires an Impact statement from health care facilities located within 45 minutes travel time from FHN. The purpose of this statement is to indicate the extent to which the discontinuation of service might affect service delivery for Rockford Memorial Hospital.

Thank you in advance for a letter of support for our request. Your letter may be sent to me directly here at FHN.

Sincerely,

Sharon Summers

Sharon Summers
Executive Vice President/Chief Operating Officer

MEMORIAL HOSPITAL

1045 West Stephenson Street, Freeport, IL 61032
Phone: 815-599-6000 Toll Free: 800-747-4131
Website: www.fhn.org

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FHN

July 11, 2013

David Schertz
President and CEO
OSF Saint Anthony Medical Center
5666 East State Street
Rockford, Illinois 61108-2472

Dear Mr. Schertz,

FHN is in the process of completing the Health Facilities and Services Review Board CON application to discontinue fifteen (15) Pediatric beds and the Pediatric category of service. Hospital Pediatric admissions have continued to decline over the past several years and we have made the decision to convert the Pediatric rooms into private rooms for adult admissions. We will continue to provide Pediatric care for the occasional admission but we will no longer have a dedicated Pediatric Unit.

This application requires an Impact statement from health care facilities located within 45 minutes travel time from FHN. The purpose of this statement is to indicate the extent to which the discontinuation of service might affect service delivery for OSF Saint Anthony Medical Center.

Thank you in advance for a letter of support for our request. Your letter may be sent to me directly here at FHN.

Sincerely,

Sharon Summers

Sharon Summers
Executive Vice President/Chief Operating Officer

MEMORIAL HOSPITAL

1045 West Stephenson Street, Freeport, IL 61032
Phone: 815-599-6000 Toll Free: 800-747-4131
Website: www.fhn.org

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FHN

July 11, 2013

William Gorski, MD
President and CEO
Swedish American Hospital
1401 East State Street
Rockford, Illinois 61104-2298

Dear Dr. Gorski,

FHN is in the process of completing the Health Facilities and Services Review Board CON application to discontinue fifteen (15) Pediatric beds and the Pediatric category of service. Hospital Pediatric admissions have continued to decline over the past several years and we have made the decision to convert the Pediatric rooms into private rooms for adult admissions. We will continue to provide Pediatric care for the occasional admission but we will no longer have a dedicated Pediatric Unit.

This application requires an Impact statement from health care facilities located within 45 minutes travel time from FHN. The purpose of this statement is to indicate the extent to which the discontinuation of service might affect service delivery for Swedish American.

Thank you in advance for a letter of support for our request. Your letter may be sent to me directly here at FHN.

Sincerely,

Sharon Summers

Sharon Summers
Executive Vice President/Chief Operating Officer

MEMORIAL HOSPITAL

1045 West Stephenson Street, Freeport, IL 61032
Phone: 815-599-6000 Toll Free: 800-747-4131
Website: www.fhn.org

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ATT 40

SWEDISHAMERICAN HEALTH SYSTEM

Winner Of The Lincoln Award For Excellence

WILLIAM R. GORSKI, M.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER

July 26, 2013

Sharon Summers
Executive Vice President/Chief Operating Officer
Memorial Hospital
1045 West Stephenson Street
Freeport, Illinois 61032

Dear Ms. Summers:

Your letter of July 11, 2013, has been received and reviewed in reference to Memorial Hospital in Freeport preparing to discontinue fifteen (15) Pediatric beds and the Pediatric category of service. I am writing this letter to inform you that in connection with the aforementioned discontinuation of services, we would not anticipate any material impact on the services provided by our Pediatrics and Women's services at SwedishAmerican Health System (SAHS).

Thank you for your letter soliciting our input, and please let us know if we could be of any further assistance.

Sincerely,

Bill Gorski, MD

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1313 East State Street, Rockford, Illinois 61104-2227 Phone (815) 489-4000 Fax (815) 967-5423 www.swedishamerican.org

OSF

SAINT ANTHONY MEDICAL CENTER

July 16, 2013

Sharon Summers
Executive Vice President/Chief Operating Officer
FHN
1045 W. Stephenson Street
Freeport, IL 61032

Re: Impact Statement – OSF Saint Anthony Medical Center

Dear Sharon:

Thank you for your letter notifying us of FHN's decision to discontinue the dedicated Pediatric category of service and fifteen (15) Pediatric beds in order to convert these rooms into private rooms for adult admissions. This will not have an adverse impact on OSF Saint Anthony Medical Center located at 5666 East State Street, Rockford, Illinois.

Sincerely,

David A. Schertz, FACHE
CEO – OSF Northern Region

pj

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ROCKFORD HEALTH system

Respectful Care

Office of the President and CEO
Gary E. Kaatz
Rockford Medical Building
2350 North Rockton Avenue, Suite 402
Rockford, Illinois 61103
Phone (815) 971-7250
Fax (815) 968-4908

July 25, 2013

Ms. Sharon Summers
Executive Vice President/Chief Operating Officer
Freeport Health Network
1045 West Stephenson Street
Freeport, IL 61032

Dear Ms. Summers:

This correspondence serves as documentation that Rockford Health System supports the decision of Freeport Health Network to discontinue fifteen pediatric beds and the pediatric category of service as reflected in its Certificate-of-Need application. The discontinuation of this service will not affect service delivery in pediatrics at Rockford Memorial Hospital.

As always, let us know if we can be of further assistance.

Sincerely yours,

GARY E. KAATZ
President and CEO

GEK/jap

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ATT 40

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 39, 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.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to 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.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2012**	**Year 2011**	**Year 2010**
Inpatient	63	69	102
Outpatient	1611	1,636	2,156
Total	1674	1705	2 258
Charity (cost in dollars)			
Inpatient	537,873	727.938	818.891
Outpatient	1,063,241	1,273,635	1,157,649
Total	1,601,114	2,001,573	1.976,540
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient	791	818	988
Outpatient	24,665	23,457	23,087
Total	25.456	24,275	24,075

	2012	2011	2010
Medicaid (revenue)			
Inpatient	3,230,602	2,867,639	1,873,164
Outpatient	3,519,591	3,902,589	3,503,915
Total	6,750,193	6,770,228	5,377,079

APPEND DOCUMENTATION AS ATTACHMENT 40, 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.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2012 Year	2011 Year	2010 Year
Net Patient Revenue	(3,963,621)	(4,337,598)	(3,599,047)
Amount of Charity Care (charges)	5,064,735	6,339,171	8,575,587
Cost of Charity Care	1,601,114	2,001,573	1,976,540

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.