

ILLINOIS HEALTH FACILITIES PLANNING BOARD

APPLICATION FOR PERMIT

February 2003 EDITION

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"The Illinois Department of Public Health does not discriminate on the basis of handicap in admission or access to, or treatment or employment in its programs and activities in compliance with Section 504 of the Rehabilitation Act of 1973, as amended. The Equal Employment Opportunity Officer is responsible for coordination of compliance efforts; voice (217) 785-2034; TTY (217) 785-2088."

ILLINOIS HEALTH FACILITIES PLANNING BOARD
525 WEST JEFFERSON STREET
SPRINGFIELD, ILLINOIS 62761-0001
(217) 782-3516

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR PERMIT

The Application for Permit form is to be used for all proposed construction or modification projects (including the acquisition of major medical equipment) subject to the permit requirements of the Illinois Health Facilities Planning Act. Persons making application should have and refer to the Planning Act and the rules promulgated thereunder (77 IAC 1100 et. seq.). This application form does not supersede any of those rules and requirements that are currently in effect.

The application form is divided into several sections, dealing with information requirements and review criteria for Parts 1110 and 1120. Complete and submit ONLY those sections along with the required attachments that are applicable to the type of project proposed. Questions concerning completion of this form may be directed to the Health Facilities Planning Board staff at (217) 782-3516. Copies of this application form are available on computer diskette and by electronic mail.

1. Please observe the following general requirements with respect to completion of the application:
 - A. Use this form as written and formatted.
 - B. Submit only those sections of the application form that are applicable to the proposed project. Attachments for each section should be appended after the last page of that section. Begin each attachment on a separate sheet and print or type the attachment identification in the lower right-hand corner of each attachment page.
 - C. Provide all information upon 8 ½"x11" paper and print or type the information only on one side of the page. All documents must be single sided and size 8 ½" by 11".
 - D. Information to be considered must be included with the applicable section attachments. References to appended material not included within the appropriate section will not be considered.
 - E. Upon completion of the application, number all pages consecutively at the bottom center of each page.
 - F. The application must be signed by the authorized representative(s) of each applicant entity.
 - G. If the application is bound, use only three-ring notebooks. It is recommended that only the copy containing the original signatures be placed in such a notebook.

Failure to follow these general requirements may result in the application being declared incomplete. In addition, failure to provide certain required information (e.g. not providing a site for the proposed project, or having an invalid entity listed as the applicant) may result in the application being declared null and void. Applicants are advised to read Part 1130 with respect to completeness (1130.620(c) and other requirements.

2. In addition to the requirements previously noted, applicants must comply with the following requirements:
 - A. FLOOD PLAIN REQUIREMENTS. Before an application for permit involving construction will be deemed complete, the applicant must provide documentation from the Division of Water Resources of the Illinois Department of Transportation (217/333-0447) that the project site is or is not in a flood plain, and that the location of the proposed project complies with the Flood Plain Rule under Executive Order #4, 1979.
 - B. HISTORICAL PRESERVATION REQUIREMENTS. In accordance with the requirements of the Illinois Historic Resources Preservation Act, the Health Facilities Planning Board is required to advise the Illinois Historic Preservation Agency of any projects that could affect historic resources. Specifically the Preservation Act provides for a review by the Historic Preservation Agency to determine if certain projects may impact upon historic resources. Such types of projects include:
 - i. Projects involving demolition of any structures; or
 - ii. Construction of new buildings; or

iii. Modernization of existing buildings.

Should any of these or other types of projects (including those for acquisition of major medical equipment) result in changes in the character or use of historic property or if there is any historic property located in an “area of potential effects,” review by the Historic Preservation Agency is required. “Area of potential effects” means the geographical area or areas within which an undertaking may cause changes in the character or use of historic properties.

In order to assure that any proposed construction or modernization project subject to certificate of need review is not delayed by the requirements of the Historic Resources Preservation Act, please submit the following information to the Illinois Historic Preservation Agency (Preservation Services Division, Old State Capitol, Springfield, Illinois 62701) so known or potential cultural resources within the project area can be identified, and the project’s effects on significant properties can be evaluated:

- i. General project description and address;
- ii. Topographic or metropolitan map showing the general location of the project;
- iii. Photographs of any standing buildings/structures within the project area;
- iv. Addresses for buildings/structures if present.

The Historic Preservation Agency will provide a determination letter concerning the applicability of the Preservation Act. Include the determination letter or comments from the Historic Preservation Agency with the submission of the application for permit. Information concerning the Historic Resources Preservation Act may be obtained by calling (217) 782-4836.

If a determination letter from the Historic Preservation Agency is not submitted, the following information **MUST** be submitted with the application for permit:

- i. Detailed map/site plans indicating the complete project area.
- ii. 35mm photographs of all buildings/structures within the project area, with addresses and construction date on the back of each photo.
- iii. Project narrative, with emphasis on the consequences of the plan on the building/structures within the project area.
- iv. Listing of federal and other state agencies which potentially would be involved in the project, either through funding, licensing, permitting or other forms of official support/approval.

Failure to provide a determination letter from the Historic Preservation Agency that the project is not subject to the Historic Resources Preservation Act or failure to provide the required information detailed above may result in delays in processing the application for permit.

3. An application processing fee (refer to 77 IAC 1130.620(f)(1)) for the determination of the application processing fee) is required to be submitted with most applications. If a fee is applicable, an initial fee of \$2,500 **MUST** accompany the application. The application is incomplete and review will not be initiated if the initial fee is not submitted. The State Agency will inform applicants of the amount of the fee balance, if any, that must be submitted. **Payment must be by check or money order and must be made payable to the Illinois Department of Public Health.**
4. Submit an original and one copy of all applicable sections of the application, including all attachments thereto. The original must contain original signatures in the certification portion of this form. **SUBMIT ALL COPIES TO:** Executive Secretary, Illinois Health Facilities Planning Board, 525 West Jefferson Street - Second Floor, Springfield, Illinois 62761-0001

**ILLINOIS HEALTH FACILITIES PLANNING BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION (IDEN)

This section must be completed for all projects.

A. Facility/Project Identification

Facility Name _____

B. Applicant Identification (provide for each co-applicant [refer to Part 1130.220] and insert after this page)

Exact Legal Name _____

Address _____

_____ Name of Registered Agent _____

Name of Chief Executive Officer _____ Title _____

CEO Address _____ Telephone No. (____) _____

Type of Ownership: Non-profit Corporation For-profit Corporation Limited Liability Company
 Partnership Governmental Sole Proprietorship Other (specify)

Corporations and limited liability companies must provide an Illinois certificate of good standing; partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-1 AFTER THE LAST PAGE OF THIS SECTION.

C. Primary Contact Person (person who is to receive correspondence or inquiries during the review period)

Name _____ Title _____

Company Name _____

Address _____

Telephone No. (____) _____ E-mail _____

Address _____ Fax Number (____) _____

D. Additional Contact Person (person such as consultant, attorney, financial representative, registered agent, etc. who also is authorized to discuss application and act on behalf of applicant)

Name _____ Title _____

Company Name _____

Address _____

_____ Telephone No. (____) _____

E-mail Address _____ Fax Number (____) _____

E. Post Permit Contact Person (person to whom all correspondence and inquiries pertaining to the project subsequent to permit issuance are to be directed)

Name _____ Title _____

Company Name _____

Address _____

_____ Telephone No. (____) _____

E-mail Address _____ Fax Number (____) _____

F. Site Ownership (complete this information for each applicable site and insert after this page)

Exact Legal Name of Person Who Owns Site _____
Address of Site Owner _____
Street Address or Legal Description of Site _____

G. Operating Entity/Licensee (complete this information for each applicable facility and insert after this page)

Exact Legal Name _____
Address _____

Type of Ownership: Non-profit Corporation For-profit Corporation Limited Liability Company
 Partnership Governmental Sole Proprietorship Other (specify)

Corporations and limited liability companies must provide an Illinois certificate of good standing; partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-2 AFTER THE LAST PAGE OF THIS SECTION.

H. Organizational Relationships

Provide (for each co-applicant) an organization chart containing the name and relationship of any person who is related (related person is defined in Part 1130.140). If the related person 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 IDEN-3 AFTER THE LAST PAGE OF THIS SECTION.

I. Status of Previous Certificate of Need Projects

Provide the project number for any of the applicant's projects that have received permits but are not yet complete (completion is defined in Part 1130.140) and provide the current status of the project. If all projects are complete, indicate NONE:

J. Flood Plain Requirements (refer to instructions for completion of this application)

Provide documentation regarding compliance with the Flood Plain requirements of Executive Order #4, 1979.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-4 AFTER THE LAST PAGE OF THIS SECTION.

K. Historic Resources Preservation Act Requirements (refer to instructions for completion of this application)

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-5 AFTER THE LAST PAGE OF THIS SECTION.

L. Project Classification (check those applicable, refer to Part 1110.40 and Part 1120.20.b)

- | | |
|--|---|
| 1. Part 1110 Classification | 2. Part 1120 Applicability or Classification: (check one only) |
| <input type="checkbox"/> Substantive | <input type="checkbox"/> Part 1120 Not Applicable <input type="checkbox"/> Category A Project |
| <input type="checkbox"/> Non-substantive | <input type="checkbox"/> DHS or DVA Project <input type="checkbox"/> Category B Project |

M. Narrative Description

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

N. 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 1190.40.b) of the component must be included in the estimated project cost. If the project contains components that are not related to the provision of health care, complete an additional table for the portions that are solely for health care and insert that table following this page (e.g. separate a nursing home's costs from the components of a retirement community; separate patient care area costs from a hospital project that includes a parking garage).

| PROJECT COST AND SOURCES OF FUNDS | |
|--|--|
| 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) | |
| ESTIMATED TOTAL PROJECT COST | |
| Cash and Securities | |
| Pledges | |
| Gifts and Bequests | |
| Bond Issues (project related) | |
| Mortgages | |
| Leases (fair market value) | |
| Governmental Appropriations | |
| Grants | |
| Other Funds and Sources | |
| TOTAL FUNDS | |

O. Related Project Costs

1. 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:

No land acquisition is related to project; Purchase Price \$ _____; Fair Market Value\$ _____

2. Does the project involve 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 \$ _____

P. Project Status and Completion Schedules

1. Indicate the stage of the project’s architectural drawings:

None or not applicable Schematics Preliminary Final Working

2. Provide the following dates (indicate N/A for any item that is not applicable):

25% of project costs expended _____ 50% of project costs expended _____
 75% of project costs expended _____ 95% of project costs expended _____
 100% of project costs expended _____ Midpoint of construction date _____
 Anticipated project completion date (refer to Part 1130.140) _____

3. 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 INFO-6 AFTER THE LAST PAGE OF THIS SECTION.

Q. Cost/Space Requirements

Provide in the format of the following example the gross square footage (GSF) and the attributable portion of total project cost for each department/area. Identify each piece of major medical equipment. 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 measurement plus the department or area’s portion of the surrounding circulation space. Indicate the proposed use of any vacated space.

| Department/Area | Cost | Gross Square Feet | | Amount of Proposed Total GSF That Is: | | |
|-------------------|-------------|-------------------|----------|---------------------------------------|-----------|------------------------|
| | | Existing | Proposed | New Const. | Remodeled | As is Vacated Space |
| Dietary | \$1,150,000 | 3,000 | 6,000 | 3,000 | 1,000 | 2,000 |
| Radiation Therapy | 3,250,000* | 4,000(1) | 5,500 | 5,500 | | |
| Medical Records | 300,000 | 2,500 | 6,500 | | 4,000(1) | 2,500 |
| TOTAL | 4,700,000 | 9,500 | 18,000 | 8,500 | 5,000 | 4,500 |

*Includes \$1,500,000 for an 18 MEV linear accelerator

(1) Existing radiation therapy space will be vacated and remodeled and converted to medical records.

APPEND DOCUMENTATION AS ATTACHMENT INFO-7 AFTER THE LAST PAGE OF THIS SECTION.

R. Facility Bed Capacity and Utilization

1. Complete the following chart as applicable. Complete a separate chart for each facility that is part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest 12 month period for which data is available. Any bed capacity discrepancy from the Inventory will result with the application being deemed incomplete.

FACILITY NAME _____ CITY _____

REPORTING PERIOD DATES: From _____ to _____

| Category of Service | Existing Beds | Number of Admissions | Patient Days | Bed Changes | Proposed Beds |
|----------------------|---------------|----------------------|--------------|-------------|---------------|
| Medical/Surgical | | | | | |
| Pediatrics | | | | | |
| Obstetrics | | | | | |
| Intensive Care | | | | | |
| Neonatal ICU | | | | | |
| Acute Mental Illness | | | | | |
| Rehabilitation | | | | | |
| Nursing Care | | | | | |
| Sheltered Care | | | | | |
| Other (identify) | | | | | |
| Other (identify) | | | | | |
| Other (identify) | | | | | |
| TOTALS | | | | | |

2. Is the facility certified for participation in the Medicare “swing bed” (i.e. acute care beds certified for extended care) program? _____ Yes _____ No
3. For the following categories of service, indicate the number of existing beds that are Medicare certified and the number of existing beds that are Medicaid certified (if none, so indicate):

| Service | # Medicare Beds | # Medicaid Beds |
|--------------|-----------------|-----------------|
| Nursing Care | _____ | _____ |
| ICF/DD Adult | _____ | _____ |
| Children DD | _____ | _____ |

S. Certification

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are in the case of a corporation, any two of its officers or members of its board of directors; in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist); in the case of a partnership, two of its general partners (or the sole general partner when two or more general partners do not exist); in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and in the case of a sole proprietor, the individual that is the proprietor. The signature(s) must be notarized. If the application has co-applicants, a separate certification page must be completed for each co-applicant and inserted following this page. One copy of the application must have the ORIGINAL signatures for all persons that sign for the applicant and for each of the co-applicants.

**This Application for Permit is filed on behalf of _____
* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

Signature

Printed Name

Printed Title

Signature

Printed Name

Printed Title

Notarization:
Subscribed and sworn to before me
this ____ day of _____

Notarization:
Subscribed and sworn to before me
this ____ day of _____

Signature of Notary

Seal

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION (DISC)

This section is applicable to any project that involves discontinuation of a health care facility or discontinuation of a category of service. Refer to Part 1130.140 for the definition of discontinuation. 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:

- A. The reasons for the discontinuation;
- B. The anticipated or actual date of discontinuation, or the date the last person was or will be discharged or treated, as applicable;
- C. The availability of other services or facilities in the planning area that are available and willing to assume the applicant's workload without conditions, limitations, or discrimination. Documentation must include letters from such facilities attesting to such ability and willingness to accommodate the applicant's workload;
- D. A closure plan indicating the process used to provide alternative services or facilities for the patients prior to or upon discontinuation;
- E. The anticipated use of the physical plant and equipment after discontinuation has occurred and the anticipated date of such use.

APPEND DOCUMENTATION AS ATTACHMENT DISC AFTER THE LAST PAGE OF THIS SECTION.

SECTION III. GENERAL REVIEW CRITERIA

This section is applicable to all projects EXCEPT those projects that are solely for discontinuation with no project costs and those projects that are non-substantive and subject only to a Part 1120 review. Refer to Part 1110.40 for the requirement for non-substantive projects.

A. Criterion 1110.230.a, Location

Check if the project will result in any of the following: establishment of a health care facility; establishment of a category of service; acquisition of major medical equipment (for treating inpatients) that is not or will not be located in a health care facility and is not being acquired by or on behalf of a health care facility. If NO boxes are checked, this criterion is not applicable. If any box is checked, read the criterion and submit the following:

1. A map (8 ½" x 11") of the area showing:
 - a. the location of the applicant's facility or project;
 - b. the name and location of all the other facilities providing the same service within the planning area and surrounding planning areas within 30 minutes travel time of the proposed facility;
 - c. the distance (in miles) and the travel time (under normal driving conditions) from the applicant's facility to each of the facilities identified in b. above;
 - d. an outline of the proposed target population area.
2. For existing facilities, provide patient origin data for all admissions for the last 12 months presented by zip code. Note this information must be based upon the patient's legal residence other than a health care facility for the last 6 months immediately prior to admission. For all other projects for which referrals are required patient origin data for the referrals must be provided.
3. The ratio of beds to population (population will be based upon the latest census data by zip code) within 30 minutes travel time of the proposed project.
4. The status of the project in the zoning process. Provide letter(s) from the appropriate local officials.
5. Evidence of legal site ownership, possession, or option to purchase or lease.

APPEND DOCUMENTATION AS ATTACHMENT GRC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.230.b, Background of Applicant

Read the criterion and submit the following information:

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable.
2. Proof of current licensing and, if applicable, certification and accreditation of all health care facilities owned or operated by the applicant.
3. A certification from the applicant listing any adverse action taken against any facility owned or operated by the applicant during the three (3) years prior to the filing of the application.

4. Authorization(s) permitting the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any action by the State Board.**

APPEND DOCUMENTATION AS ATTACHMENT GRC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.230.c, Alternatives to the Proposed Project

Read the criterion and provide the following information:

1. Provide a comparison of all of the alternatives considered including the alternative of doing nothing. The comparison must address cost benefit analyses, patient access, quality, and short and long-term financial benefits.
2. Discuss why the alternative of using other area facilities or resources to meet the needs identified in your project is not feasible.
3. Discuss why the alternative of utilizing underutilized bed or other space in the facility is not feasible.
4. If the alternative selected is based solely or in part on improved quality of care, provide empirical evidence (including quantified outcome data) that verifies improved quality of care.

APPEND DOCUMENTATION AS ATTACHMENT GRC-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.230.d, Need for the Project

Is the need for the project based upon need assessment per Part 1100 or a variance? Yes No.

If no is indicated, read the criterion and submit the following as applicable:

1. Copies of area market studies including explanations regarding how and when these studies were performed.
2. Calculation of the need for the beds or services including the models used to estimate the need (all assumptions used in the model and the mathematical calculations must be included).
3. Identification of the individuals likely to use the proposed beds or service by:

Provide letters from physicians or hospitals which document how many patients were referred for this service in the past 12 months, where the patients were referred and how many patients will be referred annually to the proposed project.

4. If the project is for the acquisition of major medical equipment that does NOT result in the establishment of a category of service, provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after acquisition.

APPEND DOCUMENTATION AS ATTACHMENT GRC-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.230.e, Size of Project

Read the criterion and provide the following:

1. For any department involved in this project that has a square footage which exceeds the State Norm found in Appendix B of Part 1110 or if no State Norm is shown in Appendix B, provide:
 - a. a rationale explaining how the proposed square footage was determined;
 - b. copies of any standards used to determine appropriate square footage;
 - c. architectural drawings showing any design impediments in the existing facility; and
 - d. if the project is for the conversion of beds from one category of service to another an explanation as to why the excess space within the facility cannot be more appropriately used for other purposes.

APPEND DOCUMENTATION AS ATTACHMENT GRC-5 AFTER THE LAST PAGE OF THIS SECTION.

2. If the project involves a category of service for which the State Board has established utilization targets, provide the following:
 - a. projected utilization for the first two years of operation after project completion;
 - b. an explanation regarding how these projections were developed;
 - c. copies of any contracts with new physicians or professional staff;
 - d. a list of any new procedures which will affect the workload of the facility.

APPEND DOCUMENTATION AS ATTACHMENT GRC-6 AFTER THE LAST PAGE OF THIS SECTION.

**SECTION IV. REVIEW CRITERIA RELATING ONLY TO MASTER DESIGN
AND RELATED PROJECTS (MDP)**

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

A. Criterion 1110.235.a, System Impact of Master Plan

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; and
2. How the services proposed in future projects will improve access to planning area residents; and
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, and any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

APPEND DOCUMENTATION AS ATTACHMENT MDP-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.235.b, Master Plan or Related Future Projects

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

1. The anticipated completion date(s) for the future construction or modification 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 as, 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 or modification project(s) based upon
 - a. historical service/bed utilization levels;
 - b. projected trends in utilization (include the rationale and projection assumptions used in such projections);
 - c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and

- d. anticipated changes in the delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

APPEND DOCUMENTATION AS ATTACHMENT MDP-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.235.c, Relationship to Previously Approved Master Design Projects

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 MDP-3 AFTER THE LAST PAGE OF THIS SECTION.

**SECTION V. REVIEW CRITERIA RELATING TO MERGERS, CONSOLIDATIONS
AND ACQUISITIONS/CHANGES OF OWNERSHIP (MCA)**

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

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.

APPEND DOCUMENTATION AS ATTACHMENT MCA-1 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT MCA-2 AFTER THE LAST PAGE OF THIS SECTION.

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 ATTACHMENT MCA-3 AFTER THE LAST PAGE OF THIS SECTION.

**SECTION VI. REVIEW CRITERIA RELATING TO ESTABLISHMENT OF ADDITIONAL BEDS OR
SUBSTANTIAL CHANGE IN BED CAPACITY (BEDS)**

This section is applicable to all projects proposing the establishment of additional beds or the conversion of beds from one category of service to another.

A. Criterion 1110.320.b, Allocation of Additional Beds

Read this criterion and explain how establishment of the new category of service will improve the distribution or accessibility of the service. Include any supporting documentation.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.320.c, Addition of Beds to Existing Facilities

Read this criterion and address the following:

1. If applicable, explain why it is not architecturally or programmatically feasible to rearrange and use presently underutilized bed capacity for this project.
2. Provide documentation that there will not be sufficient space in the proposed room to accommodate any additional beds.
3. Provide a comparison of the applicant facility's average length of stay with the length of stay of any similar facilities in the planning area. If there is a discrepancy, provide a rationale.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-2 AFTER THE LAST PAGE OF THIS SECTION.

SECTION VII. REVIEW CRITERIA RELATING TO ALL MODERNIZATION PROJECTS (MOD)

This section is applicable to all projects proposing modernization. Modernization includes, but is not limited to: expanding a department, acquiring major medical equipment, remodeling, or constructing additions or new buildings.

A. Specific Information Requirements

Indicate if the following areas or departments are to be modernized and provide the information as applicable.

1. AMBULATORY CARE (Include all outpatient clinics) -- Is this area being modernized? Yes No

If yes, provide:

- a. The number of visits for each of the last three years:

| | | | |
|--------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number | _____ | _____ | _____ |

- b. The number of treatment/examination rooms: Existing _____ Proposed _____

2. AMBULATORY SURGERY TREATMENT CENTERS-- Is this area being modernized? Yes No

If yes, provide:

- a. The number of procedures for each of the last three years:

| | | | |
|--------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number | _____ | _____ | _____ |

- b. The number of visits for each of the last three years:

| | | | |
|--------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number | _____ | _____ | _____ |

- c. The number of operating rooms for each of the last three years:

| | | | |
|--------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number | _____ | _____ | _____ |

3. CARDIAC CATHETERIZATION -- Is this area being modernized? Yes No

If yes, provide the number of inpatient, outpatient, and total procedures (patient visits) performed on adults and on pediatric patients for each of the past three years:

| | ADULT | | | PEDIATRIC | | | |
|------------|-------|-------|-------|------------|-------|-------|-------|
| Year | _____ | _____ | _____ | Year | _____ | _____ | _____ |
| Inpatient | _____ | _____ | _____ | Inpatient | _____ | _____ | _____ |
| Outpatient | _____ | _____ | _____ | Outpatient | _____ | _____ | _____ |
| Total | _____ | _____ | _____ | Total | _____ | _____ | _____ |

4. EEG DEPARTMENT OR AREA -- Is this area being modernized? Yes No

If yes, provide the number of inpatient, outpatient, and total procedures for each of the past three years:

| | | | |
|------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient | _____ | _____ | _____ |
| Outpatient | _____ | _____ | _____ |
| Total | _____ | _____ | _____ |

5. EKG DEPARTMENT OR AREA -- Is this area being modernized? Yes No

If yes, provide the number of inpatient, outpatient, and total procedures for each of the past three years:

| | | | |
|------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient | _____ | _____ | _____ |
| Outpatient | _____ | _____ | _____ |
| Total | _____ | _____ | _____ |

6. HEMODIALYSIS SERVICES -- Is this area being modernized? Yes No

If yes, provide the following information:

- a. The number of treatment stations: existing _____ proposed _____
- b. The number of treatments performed for each of the last three years:

| | | | |
|------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Treatments | _____ | _____ | _____ |

7. LABOR-DELIVERY-RECOVERY -- Is this area being modernized? Yes No

If yes, provide the following information:

- a. The number of
- b. The number of procedures and deliveries for each of the last three years:

| | | | | | |
|-------------------------|-------|------------|-------|-------|-------|
| Labor rooms | _____ | Year | _____ | _____ | _____ |
| Delivery/birthing rooms | _____ | Procedures | _____ | _____ | _____ |
| Recovery stations | _____ | Deliveries | _____ | _____ | _____ |
| LDR's | _____ | | | | |
| LDRP rooms | _____ | | | | |

8. LABORATORY SERVICES -- Is this area being modernized? Yes No

If yes, provide the number of equivalent full-time employees (FTE's) employed in the laboratory _____

9. MAGNETIC RESONANCE IMAGING -- Is this area being modernized? Yes No

If yes, provide the following information for each of the last three years:

| | | | |
|------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number of visits | _____ | _____ | _____ |
| Number of scans | _____ | _____ | _____ |

10. NURSERY (other than neonatal intensive care units) -- Is this area being modernized? Yes No
 If yes, provide the following for each of the last three years:

| | | | |
|------------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Number of newborns | _____ | _____ | _____ |
| Number of patient days | _____ | _____ | _____ |

11. OCCUPATIONAL THERAPY -- Is this area being modernized? Yes No
 If yes, provide the following information for each of the last three years:

| | | | |
|-----------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient treatments | _____ | _____ | _____ |
| Outpatient treatments | _____ | _____ | _____ |
| Number of visits | _____ | _____ | _____ |

12. PHYSICAL THERAPY -- Is this area being modernized? Yes No
 If yes, provide the following information for each of the last three years.

| | | | |
|-----------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient treatments | _____ | _____ | _____ |
| Outpatient treatments | _____ | _____ | _____ |
| Total treatments | _____ | _____ | _____ |
| Number of visits | _____ | _____ | _____ |

13. PULMONARY FUNCTION -- Is this area being modernized? Yes No
 If yes, provide the following information for each of the last three years.

| | | | |
|-----------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient procedures | _____ | _____ | _____ |
| Outpatient procedures | _____ | _____ | _____ |
| Total procedures | _____ | _____ | _____ |
| Number of visits | _____ | _____ | _____ |

14. RECOVERY (SURGICAL) -- Is this area being modernized? Yes No
 If yes, provide the existing and proposed number of stations by type:

| | | |
|---------------------|----------|----------|
| | Existing | Proposed |
| Inpatient | _____ | _____ |
| Outpatient Stage I | _____ | _____ |
| Outpatient Stage II | _____ | _____ |

15. RESPIRATORY THERAPY -- Is this area being modernized? Yes No
 If yes, provide the following information for each of the last three years.

| | | | |
|-----------------------|-------|-------|-------|
| Year | _____ | _____ | _____ |
| Inpatient treatments | _____ | _____ | _____ |
| Outpatient treatments | _____ | _____ | _____ |
| Total treatments | _____ | _____ | _____ |
| Number of visits | _____ | _____ | _____ |

16. DIAGNOSTIC RADIOLOGY -- Is this area being modernized? Yes No
If yes, provide the following information classifying procedure rooms as general or special according to the type of machines employed.

General machines are:

- Radiographic
- Fluoroscopic
- Radiographic/Fluoroscopic
- Tomographic (linear)
- Tomographic (multi-directional)

Special machines are:

- Angiographic
- CT Scanner
- Mammography
- Sonographic (ultrasound)

- a. Provide the number of existing and proposed general procedure rooms by machine type.
- b. Provide the number of existing and proposed special procedure rooms by machine type.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1A AFTER THE LAST PAGE OF THIS SECTION.

17. EMERGENCY SERVICES -- Is this area being modernized? Yes No
If yes, provide the following information:

- a. The number of existing and proposed treatment/examination rooms;
- b. A list of any of the above rooms that are or will be used for purposes other than general treatment;
- c. The number of visits for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1B AFTER THE LAST PAGE OF THIS SECTION.

18. INPATIENT BED AREA -- Is this area being modernized? Yes No
If yes, provide the following information:

- a. The number of existing and proposed private rooms, semi-private rooms, and three or more occupancy rooms (by category of service for each type of room) for the entire facility and for the project;
- b. Line drawings showing the configuration of the unit(s) being modernized.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1C AFTER THE LAST PAGE OF THIS SECTION.

19. NUCLEAR MEDICINE -- Is this area being modernized? Yes No
If yes, provide the following information:

- a. A list of the existing and proposed major pieces of equipment;
- b. The existing and proposed number of procedure rooms;
- c. The number of inpatient, outpatient, and total procedures done for each of the last three years;
- d. A breakdown of the procedures into types of procedures and machine time/procedure for the last year.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1D AFTER THE LAST PAGE OF THIS SECTION.

20. RADIATION THERAPY -- Is this area being modernized? Yes No

If yes, provide the following information:

- a. The number of treatments and the number of "courses of treatment" for each of the last three years;
- b. A list of the existing and proposed pieces of megavoltage equipment.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1E AFTER THE LAST PAGE OF THIS SECTION.

21. SURGERY -- Is this area being modernized? Yes No

If yes, provide the following information:

- a. The existing and proposed number of procedure rooms. Indicate the use of these rooms such as general, open heart, eye, endoscopy, and cystology. Indicate how many rooms are dedicated solely to outpatient surgery, solely to inpatient surgery, and how many are used for both.
- b. The inpatient, outpatient, and total hours of utilization (including clean-up and set-up time) for each of the last three years;
- c. The total hours of utilization (including clean-up and set-up time) for each type of procedure room for each of the last three years;
- d. The number of inpatient, outpatient, and total surgical visits for each type of surgical specialty for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1F AFTER THE LAST PAGE OF THIS SECTION.

22. OTHER DEPARTMENTS OR AREAS – Are any other areas being modernized? Yes No

If yes, identify the area(s) and provide workload data for each area for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENTS MOD-1G, MOD-1H, MOD-1I, MOD 1J, etc. AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.420.b, Modern Facilities

A criterion must be claimed for EACH department or area to be modernized. The justification for each department or area must be on a separate page. Choose the criterion or criteria which most clearly approximates the reason for proposing the modernization.

At least ONE of the following two criteria must be claimed for EACH department or area proposed for modernization.

1. Read criterion 1110.420.b.1. **This criterion cannot be used to justify any increase in square footage. If expansion of a department is proposed, criterion 1110.420.b.2 must be claimed.**

Indicate if this criterion is claimed and submit the following:

- a. the age of the building or piece of equipment;
- b. the downtime experienced on the piece of equipment for each of the last three years;
- c. the cost of repair experienced on the piece of equipment for each of the last three years;

- d. a detailed explanation of why and how it was determined that the building or piece of equipment was deteriorated and needs to be replaced;
- e. provide copies of any licensing, certification, or fire protection citations.

APPEND DOCUMENTATION AS ATTACHMENT MOD-2 AFTER THE LAST PAGE OF THIS SECTION.

- 2. Read Criterion 1110.420.b.2. Identify if this criterion is claimed and submit the following information:
 - a. a detailed explanation of why and how it was determined that expansion of the department or area was necessary;
 - b. a discussion of the alternatives considered to expanding the department (e.g. increasing the hours or days of operation) and why the alternatives were rejected.

APPEND DOCUMENTATION AS ATTACHMENT MOD-3 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.420.c, Major Medical Equipment

Read Criterion 1110.420.c and provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after becoming operational.

APPEND DOCUMENTATION AS ATTACHMENT MOD-4 AFTER THE LAST PAGE OF THIS SECTION.

SECTION VIII. REVIEW CRITERIA RELATING TO MEDICAL-SURGICAL, PEDIATRIC, OBSTETRICS, AND INTENSIVE CARE SERVICES (ACUTE)

The section is applicable to all projects proposing the addition of Medical/Surgical, Obstetric, Pediatric, or ICU beds.

A. Criterion 1110.530.a, Unit Size

Read the criterion and indicate if the existing or proposed facility is located within a MSA. Yes No

B. Criterion 1110.530.b, Variances to Computed Bed Need

Read the criterion and, if applicable, address one of the following variances.

1. Criterion 1110.530.b.1, High Occupancy. Indicate if chosen and submit the following information:
 - a. patient days and admissions for each of the last two years for the service involved;
 - b. explain why it is not feasible to convert underutilized services to meet the identified demand;
 - c. document that the number of beds proposed will not exceed the number needed to meet the target occupancy.
 - d. if projections are utilized to support the need for beds, document the following:
 - 1) the projections are based upon population projections from the U.S. Bureau of the Census;
 - 2) the projections are for a period of not more than 5 years from the date the application is submitted;
 - 3) the projections are zip code based and age specific; and
 - 4) the projections are based upon the applicant's service area as defined by historical patient origin, and do not include any projected change in market share.

APPEND DOCUMENTATION AS ATTACHMENT ACUTE-1 AFTER THE LAST PAGE OF THIS SECTION.

2. Criterion 1110.530.b.2, Medically Underserved Population. Indicate if chosen and submit the following information:
 - a. a map showing the location of all other area providers;
 - b. a list of the travel times to other area providers;
 - c. a detailed description of the admission restrictions of the other area facilities;
 - d. documentation that access is restricted in the planning area;
 - e. documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified;
 - f. an explanation of how the proposed project will improve the access to care;

APPEND DOCUMENTATION AS ATTACHMENT ACUTE-2 AFTER THE LAST PAGE OF THIS SECTION.

SECTION IX. REVIEW CRITERIA RELATING TO COMPREHENSIVE REHABILITATION SERVICES (REHAB)

This section is applicable to all projects proposing to establish or to add rehabilitation beds.

A. Criterion 1110.630.b, Access Variance to Computed Bed Need

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

1. A map showing the location of all of the other facilities in the planning area which offer inpatient rehabilitation services.
2. A list of the other rehabilitation programs in the planning area showing the distance and travel time to each.
3. A detailed description of the access restrictions, if any, for each of the area facilities.
4. Documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified as having restricted access.

APPEND DOCUMENTATION AS ATTACHMENT REHAB-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.630.c, Staffing Requirements

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

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

APPEND DOCUMENTATION AS ATTACHMENT REHAB-2 AFTER THE LAST PAGE OF THIS SECTION.

SECTION X. REVIEW CRITERIA RELATING TO ACUTE MENTAL ILLNESS (AMI)

This section is applicable to all projects proposing the addition of acute mental illness beds.

A. Criterion 1110.730.a, Unit Size

Read the criterion and indicate if the proposed facility is located within an MSA? Yes No

B. Criterion 1110.730.b, Supportive Mental Health Services

Read the criterion and provide copies of the executed formal agreements required.

APPEND DOCUMENTATION AS ATTACHMENT AMI-1 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.730.c, Variance to Bed Need

Read the criterion and if a variance is being claimed address the following:

1. High Occupancy—provide documentation that the proposed number of beds are needed to reduce the facility's high occupancy and that the proposed number of beds will not exceed the number needed to meet the target occupancy specified in Part 1100; or
2. Access—provide documentation that addresses the following:
 - a. restrictive admission policies by facilities currently providing the service in the area; and/or
 - b. the location of existing services requires an excessive amount of travel time (more than 45 minutes under normal driving conditions) for planning area residents to receive services; and
 - c. there is a sufficient available number of patients in need of the proposed service to assure that the project will achieve, within the first year of operation, the target occupancy specified in Part 1100.

APPEND DOCUMENTATION AS ATTACHMENT AMI-2 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.730.d, Type of Admissions

Read the criterion and provide letters from the physician(s) who propose to refer patients to the applicant's facility. Each of these letters must identify the number of patients proposed to be referred to the facility, and the number of patients referred to a similar facility in the last 12 months. The physician must identify these past referrals by patient number, and diagnosis and indicate where these patients were referred for treatment.

APPEND DOCUMENTATION AS ATTACHMENT AMI-3 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XI. REVIEW CRITERIA RELATING TO NEONATAL INTENSIVE CARE (NICU)

This section is applicable to all projects proposing to add neonatal intensive care beds for which an exemption was not obtained.

A. 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.

APPEND DOCUMENTATION AS ATTACHMENT NICU-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.930.b, Letter of Agreement

Read the criterion and provide the required letter of agreement.

APPEND DOCUMENTATION AS ATTACHMENT NICU-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.930.c, Need for Additional Beds

Read the criterion and provide the following information:

1. The patient days and admissions for the affiliated center for each of the last two years; or
2. An explanation as to why the existing providers of this service in the planning area cannot provide care to your projected caseload.

APPEND DOCUMENTATION AS ATTACHMENT NICU-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.930.d, Obstetric Service

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

APPEND DOCUMENTATION AS ATTACHMENT NICU-4 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XII. REVIEW CRITERIA RELATING TO OPEN HEART SURGERY (OHS)

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

A. Criterion 1110.1230.a, Peer Review

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

APPEND DOCUMENTATION AS ATTACHMENT OHS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.1230.b, Establishment of Open Heart Surgery

Read the criterion and provide the following information:

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

APPEND DOCUMENTATION AS ATTACHMENT OHS-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.1230.c, Unnecessary Duplication of Services

Read the criterion and address the following:

1. 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.
2. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities sent letters.
3. Provide a copy of all of the responses received.

APPEND DOCUMENTATION AS ATTACHMENT OHS-3 AFTER THE LAST PAGE OF THIS SECTION.

D. 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.

APPEND DOCUMENTATION AS ATTACHMENT OHS-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1230.e, 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. Application filed for a position.
4. Signed contracts with the required staff.
5. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT OHS-5 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XIII. REVIEW CRITERIA RELATING TO CARDIAC CATHETERIZATION (CATH)

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.

A. Criterion 1110.1330.a, Peer Review

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.1330.b, Establishment or Expansion of Cardiac Catheterization Service

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

1. A map (8 1/2" x 11") showing the location of the other hospitals within the planning area.
2. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.
3. 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.

APPEND DOCUMENTATION AS ATTACHMENT CATH-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.1330.c, Unnecessary Duplication of Services

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

1. 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.
2. Copies of the responses received from the facilities to which the letter was sent.

APPEND DOCUMENTATION AS ATTACHMENT CATH-3 AFTER THE LAST PAGE OF THIS SECTION.

D. 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.

APPEND DOCUMENTATION AS ATTACHMENT CATH-4 AFTER THE LAST PAGE OF THIS SECTION.

E. 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.

APPEND DOCUMENTATION AS ATTACHMENT CATH-5 AFTER THE LAST PAGE OF THIS SECTION.

F. 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.

APPEND DOCUMENTATION AS ATTACHMENT CATH-6 AFTER THE LAST PAGE OF THIS SECTION.

G. 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.

APPEND DOCUMENTATION AS ATTACHMENT CATH-7 AFTER THE LAST PAGE OF THIS SECTION.

H. Criterion 1110.1330.h, Continuity of Care

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-8 AFTER THE LAST PAGE OF THIS SECTION.

I. Criterion 1110.1330.i, Multi-institutional Variance

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

1. A copy of a fully executed affiliation agreement between the two facilities involved.
2. Names and positions of the shared staff at the two facilities.
3. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.
4. A cost comparison between the proposed project and expansion at the existing operating program.
5. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.
6. The number of catheterization laboratories at the operating program.
7. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.
8. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT CATH-9 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XIV. REVIEW CRITERIA RELATING TO END STAGE RENAL DISEASE (ESRD)

This section is applicable to projects proposing to establish a new ESRD facility or service, to relocate an existing ESRD facility or to add stations to an existing ESRD facility or service.

A. Criterion 1110.1430.a, Data System

Is the project for the relocation of or the addition of stations to an existing facility? Yes No . If yes is indicated, this criterion is not applicable, if no is indicated, read the criterion and complete the following:

Does an ESRD data system presently exist and function? Yes No

If no, will a data system be established? Yes No

B. Criterion 1110.1430.b, Minimum Size of Renal Dialysis Center or Renal Dialysis Facilities

Read the criterion and address the following:

Is the facility located within an MSA? Yes No . If yes, provide the MSA population

C. Criterion 1110.1430.c, Variance to Station Need

Read the criterion and if the inventory indicates excess stations in the HSA, provide the following information:

1. For new facilities
 - a. a map showing the location of and distance and travel time to all ESRD facilities within 30 minutes travel time of the proposed facility and an explanation as to how the 30 minutes travel time distance was determined;
 - b. an explanation of the access problems experienced by patients attempting to utilize these facilities;
 - c. evidence that the patients experiencing access problems will utilize the proposed facility in sufficient numbers to meet the target utilization levels;
 - d. evidence that the existing facilities within 30 minutes travel time of the proposed facility will not be adversely affected.
2. For existing facilities proposing to add stations, the existing facility's experienced utilization for the latest 12-month period for which data is available.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-1 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.1430.d, Support Services

Read the criterion (which is applicable ONLY to applicants proposing to establish a new facility and not to existing facilities that are relocating or adding stations) and if applicable, provide a list of the support services available on site and indicate the hours these services are available. For those services not being provided at the facility, provide a written agreement with another area facility agreeing to provide those services.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-2 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1430.e, Affiliation Agreements

Is the project for the relocation of or the addition of stations to an existing facility? Yes No . If yes is indicated, this criterion is not applicable; if no is indicated, read the criterion and provide copies of all agreements to insure provision of inpatient care and other hospital services.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-3 AFTER THE LAST PAGE OF THIS SECTION.

F. Criterion 1110.1430.f, Self-care and Home Dialysis

Is the project for the relocation of or the addition of stations to an existing facility? Yes No . If yes is indicated, this criterion is not applicable, if no is indicated, read the criterion and provide certification that these services will be provided at the proposed facility or provide copies of all agreements for the provision of these services by other providers.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-4 AFTER THE LAST PAGE OF THIS SECTION.

G. Criterion 1110.1430.g, Relocation of Facilities

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

1. The number of treatments performed at the facility in the last 12 months.
2. An explanation of how the proposed new location will improve access to care for the facility's patients.
3. Documentation that the existing facility needs to be replaced.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-5 AFTER THE LAST PAGE OF THIS SECTION.

H. Criterion 1110.1430.h, Addition of Stations

Read the criterion and provide the following information:

1. The number of treatments performed at the applicant facility in the last 12 months.
2. The number of additional patients to be referred to the proposed facility.
3. The source of the projected patient volume.
4. Notarized letters from projected referral sources indicating how many patients they will refer, where these patients are currently receiving care, and the initials of the prospective patients.
5. Documentation that the proposed project will not adversely impact the workload at any other existing facility within 30 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-6 AFTER THE LAST PAGE OF THIS SECTION.

I. Criterion 1110.1430.i, Quality of Care

Read the criterion and provide the following information:

1. The percentage of patients treated for the latest 12-month period for which data is available that achieved a urea reduction ratio of 0.65 or better;

2. The percentage of patients treated for the latest 12-month period for which data is available that achieved a hematocrit level of 31% or better.

APPEND DOCUMENTATION AS ATTACHMENT ESRD-7 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XV. REVIEW CRITERIA RELATING TO NON-HOSPITAL AMBULATORY SURGERY (ASTC)

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.

A. Criterion 1110.1540.a, Scope of Services Provided

Read the criterion and complete the following:

1. Indicate which of the following types of surgery are proposed:

- | | | |
|--|---|--------------------------------------|
| a. <input type="checkbox"/> Cardiovascular | f. <input type="checkbox"/> Obstetrics/Gynecology | k. <input type="checkbox"/> Plastic |
| b. <input type="checkbox"/> Dermatology | g. <input type="checkbox"/> Ophthalmology | l. <input type="checkbox"/> Podiatry |
| c. <input type="checkbox"/> Gastroenterology | h. <input type="checkbox"/> Oral/Maxillofacial | m. <input type="checkbox"/> Thoracic |
| d. <input type="checkbox"/> General/Other | i. <input type="checkbox"/> Orthopaedic | n. <input type="checkbox"/> Urology |
| e. <input type="checkbox"/> Neurology | j. <input type="checkbox"/> Otolaryngology | |

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

B. Criterion 1110.1540.b, Target Population

Read the criterion and provide the following:

1. On a map (8 1/2" x 11"), outline the intended geographic services area (GSA).
2. Indicate the population within the GSA and how this number was obtained.
3. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-1 AFTER THE LAST PAGE OF THIS SECTION.**C. Criterion 1110.1540.c, Projected Patient Volume**

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

1. The number of referrals anticipated annually for each specialty.
2. 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.
3. A statement that the projected patient volume will come from within the proposed GSA.
4. A statement that the information in the referral letter is true and correct to the best of his or her belief.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-2 AFTER THE LAST PAGE OF THIS SECTION.**D. Criterion 1110.1540.d, Treatment Room Need Assessment**

Read the criterion and provide:

1. The number of procedure rooms proposed.
2. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-3 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1540.e, Impact on Other Facilities

Read the criterion and provide:

1. 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.
2. A list of the facilities contacted. NOTE: Facilities must be contacted by registered mail.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-4 AFTER THE LAST PAGE OF THIS SECTION.

F. Criterion 1110.1540.f, Establishment of New Facilities

Read the criterion and provide:

1. A list of services that the proposed facility will provide that are not currently available in the GSA; or
2. Documentation that the existing facilities in the GSA have restrictive admission policies; or
3. For co-operative ventures,
4. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and
5. The hospital's surgical utilization data for the latest 12 months, and
6. 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
7. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-5 AFTER THE LAST PAGE OF THIS SECTION.

G. Criterion 1110.1540.g, Charge Commitment

Read the criterion and provide:

1. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.
2. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

APPEND DOCUMENTATION AS ATTACHMENT ASTC-6 AFTER THE LAST PAGE OF THIS SECTION.

H. 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 ATTACHMENT ASTC-7 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XVI. REVIEW CRITERIA RELATING TO GENERAL LONG-TERM CARE (GLTC)

This section is applicable to all projects proposing the establishment or addition of general long-term care beds.

A. Criterion 1110.1730.a, Facility Size

Read the criterion and if the proposed project or facility involved has or will have in excess of 250 beds, submit the following:

1. An explanation of how the facility design and program will provide personalized patient care.
2. Copies of the latest two years' licensing surveys.
3. The Department of Public Aid rating for each of the last two years.

APPEND DOCUMENTATION AS ATTACHMENT GLTC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.1730.b, Community Related Functions

Read the criterion and submit copies of letters of endorsement from community groups that are within the town or community in which the proposed project will be located for this project.

APPEND DOCUMENTATION AS ATTACHMENT GLTC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.1730.c, Zoning

Read the criterion and provide a letter from the appropriate zoning official which indicates that the proposed location is appropriately zoned or that a zoning variance is being sought.

APPEND DOCUMENTATION AS ATTACHMENT GLTC-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.1730.d, Variance to Computed Bed Need

Read the criterion and, if applicable, choose one of the following variances.

1. Criterion 1110.1730.d.1, Defined Population--if chosen, submit the following information:
 - a. Document that the proposed project is directly owned, sponsored or affiliated with the defined population claimed. Submit documentation such as legal documents establishing the ownership, sponsorship or affiliation of the applicant facility within the claimed defined population.
 - b. Specify the defined population to be served identifying both the religious, fraternal or ethnic group to be served and the geographic area where the group is located.
 - c. Provide a map showing the geographic area (GA) and provide population data indicating that the population proposed to be served is currently living within the GA.
 - d. Provide copies of the proposed occupancy agreements and admission policies for the facility.
 - e. Explain how at least 85% of the patients/residents needing the facility's services will be members of the defined population.
 - f. Explain which services to be provided by the proposed project do not exist in the service area where the facility is or will be located.
 - g. Explain why the services to be provided cannot be instituted at existing facilities in the service area in sufficient numbers to meet the group's needs.
 - h. Justification for the number of beds proposed and how 90% occupancy will be maintained.

- i. Provide population data indicating the number of patients/residents from the claimed defined population group needing the facility's services including patient origin data by zip code.
- j. Indicate how you will be able to attract these patients.

APPEND DOCUMENTATION AS ATTACHMENT GLTC-4 AFTER THE LAST PAGE OF THIS SECTION.

2. Criterion 1110.1730.d.2, Continuum of Care--if chosen, submit the following information:
 - a. Indicate how the proposed project will provide a continuum of care for a geriatric population that includes independent living and related health and social service. (Include a description of the health and social services to be provided).
 - b. Provide a copy of the admission policies for the nursing facility.
 - c. Provide a letter indicating that the long-term care facility will be developed after the housing complex has been established; or if the long-term care facility is being developed as part of the total housing construction program that:
 - i. the entire complex is one inseparable project;
 - ii. there is a documented demand for housing;
 - iii. long-term care beds will be built concurrently with the residential units.
 - d. Provide an independent market study showing the number of patients needing the facilities.
 - e. Provide a copy of the written policies of operation.

APPEND DOCUMENTATION AS ATTACHMENT GLTC-5 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XVII. REVIEW CRITERIA RELATING TO SPECIALIZED LONG-TERM CARE (SLTC)

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

A. Criterion 1110.1830.b, Community Related Functions

Read the criterion and submit the following information:

1. 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;
2. letters of support from social, social service and economic groups in the community;
3. letters of support from municipal/elected officials who represent the area where the project is located.

APPEND DOCUMENTATION AS ATTACHMENT SLTC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. 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:

1. 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;
2. a description of the public transportation services available to the proposed residents;
3. a description of the specialized services (other than day programming) available to the residents;
4. a description of the availability of community activities available to the facility's residents.
5. documentation of the availability of community workshops.

APPEND DOCUMENTATION AS ATTACHMENT SLTC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. 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.

APPEND DOCUMENTATION AS ATTACHMENT SLTC-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.1830.e, Long-term Medical Care for Children Category of Service

Read the criterion and submit the following information:

1. a map outlining the target area proposed to be served;
2. 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;
3. any reports/studies that show the points of origin of past patients/residents admissions to the facility;
4. describe the special programs or services proposed and explain the relationship of these programs to the needs of the specialized population proposed to be served.
5. indicate why the services in the area are insufficient to meet the needs of the area population;

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

APPEND DOCUMENTATION AS ATTACHMENT SLTC-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1830.f, Zoning

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

APPEND DOCUMENTATION AS ATTACHMENT SLTC-5 AFTER THE LAST PAGE OF THIS SECTION.

F. Criterion 1110.1830.g, Establishment of Chronic Mental Illness

Read the criterion and provide the following:

1. documentation of how the resident population has changed making the proposed project necessary.
2. indicate which beds will be closed to accommodate these additional beds.
3. the number of admissions for this type of care for each of the last two years.

APPEND DOCUMENTATION AS ATTACHMENT SLTC-6 AFTER THE LAST PAGE OF THIS SECTION.

G. Criterion 1110.1830.i, Variance to Computed Bed Need for Establishment of Beds for Developmentally Disabled Adults for Placement of Residents from DHS State Operated Beds

Read this criterion and submit the following information:

1. documentation that all of the residents proposed to be served are now residents of a DHS facility;
2. 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;
3. 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;
4. 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;
5. 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;
6. documentation that each of the proposed relocations will save the State money;
7. a statement that the facility will only accept future referrals from an area DHS facility if a bed is available;
8. 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 SLTC-7 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XVIII. REVIEW CRITERIA RELATING TO EXTRA-RENAL ORGAN TRANSPLANTATION (TRANS)

This section is applicable to projects involving the establishment of the extra-renal organ transplantation service.

A. Criterion 1110.2330.a, Establishment of a Program

Read the criterion and provide the following:

1. documentation that the applicant is a teaching institution;
2. documentation that the proposed program will be performed in conjunction with graduate medical education; and
3. a written agreement detailing relationship of the proposed program to the school's graduate medical education.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.2330.b, Physical Facilities

Read the criterion and provide:

1. documentation of the availability of sufficient space in the operating and recovery rooms, and the intensive care area. Provide Gross Square Feet (GSF) for each of these areas and the proportionate GSF allocated to this project.
2. a staffing plan and explain how it complies with regulatory requirements. Indicate budgeted positions, qualifications, and specialties of the people who will be used to staff the program.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.2330.c, Access to Donor Organs

Read the criterion and provide:

1. documentation of membership in the National Organ Procurement and Transplantation Network.
2. documentation of membership in a Regional Organ Procurement Agency.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.2330.d, Recipient Selection

Read the criterion and provide a copy of your procedures for selecting candidates and distribution of organs.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.2330.e, Surgical Staff

Read the criterion and provide the detailed documentation required in this criterion.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-5 AFTER THE LAST PAGE OF THIS SECTION.

F. Criterion 1110.2330.f, Collaborative Support

Read the criterion and document collaboration in all specialty areas listed and how this will be accomplished.

APPEND DOCUMENTATION AS ATTACHMENT TRANS-6 AFTER THE LAST PAGE OF THIS SECTION.

G. Criterion 1110.2330.g, Ancillary Services

Read the criterion and document access to all services cited in this criterion. Indicate how these services will be provided (i.e., on site, by contract, etc.).

APPEND DOCUMENTATION AS ATTACHMENT TRANS-7 AFTER THE LAST PAGE OF THIS SECTION.

H. Criterion 1110.2330.h, Data

Read the criterion and provide a letter agreeing to provide all data requested by the State Agency (as outlined in this criterion).

APPEND DOCUMENTATION AS ATTACHMENT TRANS-8 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XIX. REVIEW CRITERIA RELATING TO KIDNEY TRANSPLANTATION (KDNY)

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

A. Criterion 1110.2430.a, Establishment of Facilities

Read the criterion and provide:

1. a map showing the population base proposed to be served.
2. the total population within the target area and the source of the population figures.

APPEND DOCUMENTATION AS ATTACHMENT KDNY-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.2430.b, Kidney Transplantation Center

Read the criterion and provide:

1. certification that laboratory services, social services, dietetic services, self-care dialysis support services, inpatient dialysis services, pharmacy, and specialized blood facilities (including tissue typing) are available on the premises.
2. participation in a recipient registry.

APPEND DOCUMENTATION AS ATTACHMENT KDNY-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.2430.c, Affiliation Agreements

Read the criterion and provide documentation that the facility is a teaching institution.

APPEND DOCUMENTATION AS ATTACHMENT KDNY-3 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XX. REVIEW CRITERIA AND INFORMATION REQUIREMENTS RELATING TO THE SUBACUTE CARE HOSPITAL MODEL (SAC)

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

A. Criterion 1110.2530.a, Distinct Unit

1. 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.
2. 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.
3. Provide a staffing plan with staff qualifications and explain how non-dedicated staffing services will be provided.

APPEND DOCUMENTATION AS ATTACHMENT SAC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.2530.b, Contractual Relationship

1. 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.
2. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. 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.

1. 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:

- a. 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;
- b. the assumptions used in developing both sets of financial statements;
- c. 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;
- d. a narrative explanation as to how the proposed project will allow you to meet the financial ratios;
- e. 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
- f. historical financial statements for each of the last three calendar years.

APPEND DOCUMENTATION AS ATTACHMENT SAC-3 AFTER THE LAST PAGE OF THIS SECTION.

2. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-4 AFTER THE LAST PAGE OF THIS SECTION.

3. 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.**

APPEND DOCUMENTATION AS ATTACHMENT SAC-5 AFTER THE LAST PAGE OF THIS SECTION.

4. 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).

APPEND DOCUMENTATION AS ATTACHMENT SAC-6 AFTER THE LAST PAGE OF THIS SECTION.

5. Case-mix and Utilization

Provide the following information:

- a. the number of admissions and patient days for each of the last five years for each of the following:
 - i. Ventilator cases
 - ii. Head trauma cases
 - iii. Rehabilitation cases including spinal cord injuries
 - iv. Amputees
 - v. Other orthopedic cases requiring subacute care (Specify diagnosis)
 - vi. Other complex diagnosis which included physiological monitoring on a continuous basis
- b. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-7 AFTER THE LAST PAGE OF THIS SECTION.

6. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-8 AFTER THE LAST PAGE OF THIS SECTION.

7. 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

APPEND DOCUMENTATION AS ATTACHMENT SAC-9 AFTER THE LAST PAGE OF THIS SECTION.

D. Rule 1110.2540.c, State Board Prioritization-Long-Term Care Facilities

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

1. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-10 AFTER THE LAST PAGE OF THIS SECTION.

2. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-11 AFTER THE LAST PAGE OF THIS SECTION.

3. 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).

APPEND DOCUMENTATION AS ATTACHMENT SAC-12 AFTER THE LAST PAGE OF THIS SECTION.

4. Case-mix and Utilization

Provide the following information:

a. the number of admissions and patient days for each of the last five years for each of the following:

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

b. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-13 AFTER THE LAST PAGE OF THIS SECTION.

5. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-14 AFTER THE LAST PAGE OF THIS SECTION.

6. 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
- One or more speech therapists

APPEND DOCUMENTATION AS ATTACHMENT SAC-15 AFTER THE LAST PAGE OF THIS SECTION.

7. 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.

APPEND DOCUMENTATION AS ATTACHMENT SAC-16 AFTER THE LAST PAGE OF THIS SECTION.

8. 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.**

APPEND DOCUMENTATION AS ATTACHMENT SAC-17 AFTER THE LAST PAGE OF THIS SECTION.

E. 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:

1. letters from health facilities establishing referral agreement for subacute hospital patients;
2. letters from physicians indicating that they will refer subacute patients to your proposed facility;
3. 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):
 - a. Ventilator cases
 - b. Head trauma cases
 - c. Rehabilitation cases including spinal cord injuries
 - d. Amputees
 - e. Other orthopedic cases requiring subacute care (Specify diagnosis)
 - f. Other complex diagnoses which included physiological monitoring on a continuous basis.

APPEND DOCUMENTATION AS ATTACHMENT SAC-18 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XXI. REVIEW CRITERIA AND INFORMATION REQUIREMENTS RELATING TO THE POSTSURGICAL RECOVERY CARE CENTERS ALTERNATIVE HEALTH CARE MODEL (PRC)

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

A. Criterion 1110.2630.a, Need/Unit Size

Read the criterion and provide the following information:

1. the number of postsurgical recovery center beds proposed;
2. the anticipated number of patients who will utilize the facility; and
3. for each surgical referral site, for the latest 12 months:
 - a. the name of the surgical referral site;
 - b. the number of inpatient surgical cases that could have received postsurgical recovery services within the model if it had been available;
 - c. the number of the cases identified above expected to be referred to this model and the rationale therefore;
 - d. patient identification numbers for each patient;
 - e. ICD 9 Code or procedure type for each patient; and
 - f. the experienced length of stay for each patient.

APPEND DOCUMENTATION AS ATTACHMENT PRC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.2630.b, Staffing

Read the criterion and submit the following information:

1. 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.
2. A detailed staffing plan identifying the number and type of staff positions dedicated to the model.
3. 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.
4. 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.

APPEND DOCUMENTATION AS ATTACHMENT PRC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.2630.c, Patient Mix

Read the criterion and provide the following information:

1. A listing of the types of surgical procedures that will require care in the postsurgical recovery model.
2. 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) | _____ |
3. The patient recovery care protocols including an explanation of how patient safety will be assured.

APPEND DOCUMENTATION AS ATTACHMENT PRC-3 AFTER THE LAST PAGE OF THIS SECTION.**D. Criterion 1110.2630.d, Travel Time/Patient Transfer**

Read the criterion and provide the following information:

1. 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.
2. 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.

APPEND DOCUMENTATION AS ATTACHMENT PRC-4 AFTER THE LAST PAGE OF THIS SECTION.**E. Criterion 1110.2630.e, On-Site Emergency Care**

Read the criterion and provide the following information:

1. All protocols established for the treatment of emergency patients and the applicant facility's requirements concerning staff training for emergency patient care.
2. Provide documentation that a crash cart will be available on-site and that staff trained in cardiac defibrillation will be available at all times.

APPEND DOCUMENTATION AS ATTACHMENT PRC-5 AFTER THE LAST PAGE OF THIS SECTION.**F. 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:

1. The name and population of the county in which the proposed facility will be located.
2. Name the source of the population figures.
3. Will the proposed facility be owned or operated by an existing hospital? Yes No
4. Will the proposed 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.
5. 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.
6. Provide total revenue, Medicare revenue, and Medicaid revenue for each surgical referral site.
7. Provide a copy of the applicant facility's current accreditation letter if applicable.

APPEND DOCUMENTATION AS ATTACHMENT PRC-6 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XXII. REVIEW CRITERIA AND INFORMATION REQUIREMENTS RELATING TO THE CHILDREN'S RESPITE CARE ALTERNATIVE HEALTH CARE MODEL (CRC)

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-1 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-2 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-3 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-4 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-5 AFTER THE LAST PAGE OF THIS SECTION.

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

APPEND DOCUMENTATION AS ATTACHMENT CRC-6 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRC-7 AFTER THE LAST PAGE OF THIS SECTION.

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

**SECTION XXIII. REVIEW CRITERIA AND INFORMATION REQUIREMENTS RELATING TO THE
COMMUNITY-BASED RESIDENTIAL REHABILITATION CENTER
ALTERNATIVE HEALTH CARE MODEL (CRRC)**

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.

APPEND DOCUMENTATION AS ATTACHMENT CRRC-1 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRRC-2 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRRC-3 AFTER THE LAST PAGE OF THIS SECTION.

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.

APPEND DOCUMENTATION AS ATTACHMENT CRRC-4 AFTER THE LAST PAGE OF THIS SECTION.

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 ATTACHMENT CRRC-5 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XXIV. REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

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

Does the applicant (or the entity that is responsible for financing the project or is responsible for assuming the applicant’s debt obligations in case of default) have a bond rating of “A” or better? Yes No .

If yes is indicated, submit proof of the bond rating of “A” or better (that is less than two years old) from Fitch’s, Moody’s or Standard and Poor’s rating agencies and go to Section XXX. If no is indicated, submit the most recent three years’ audited financial statements including the following:

- 1. Balance sheet
- 2. Income statement
- 3. Change in fund balance
- 4. Change in financial position

APPEND THE REQUIRED DOCUMENTS AS ATTACHMENT FINANCIALS AND PLACE AFTER ALL OTHER APPLICATION ATTACHMENTS INCLUDING THE REMAINING ATTACHMENTS FOR THIS SECTION AND FOR SECTION XXX.

A. Criterion 1120.210.a, Financial Viability

1. Viability Ratios

If proof of an “A” or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

| Provide Data for Projects Classified as: | Category A or Category B (last three years) | | | Category B |
|--|---|--|--|------------|
| 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. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of “A” or better has not been provided.

APPEND DOCUMENTATION AS ATTACHMENT FIN-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.210.b, Availability of Funds

If proof of an “A” or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

- _____ Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.
- _____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.
- _____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.
- _____ Debt Financing (indicate type(s) _____)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.
- _____ Governmental Appropriations
Provide 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, provide a resolution or other action of the governmental unit attesting to such future funding.
- _____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.
- _____ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.
- _____ TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT FIN-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.210.c, Operating Start-up Costs

If proof of an “A” or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes No . If yes is indicated read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

SECTION XXV. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

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

A. Criterion 1120.310.a, Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes No . If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of “A” or better been provided? Yes No . If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? Yes No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

APPEND DOCUMENTATION AS ATTACHMENT ECON-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.310.b, Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

APPEND DOCUMENTATION AS ATTACHMENT ECON-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.310.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 | | | | | | | | | |
|--|------------------------------|---|-----------------------------|---|------------------------------|---|----------------------|--------------------|-----------------------|
| Department (list below) | A | B | C | D | E | F | G | H | Total Cost (G + H) |
| | Cost/Square Foot New Mod. | | Gross Sq. Ft. New Circ.* | | Gross Sq. Ft. Mod. Circ.* | | Const. \$ (A x C) | Mod. \$ (B x E) | |
| | | | | | | | | | |
| Contingency | | | | | | | | | |
| TOTALS | | | | | | | | | |

*Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:
 - a. that the lowest net cost available has been selected; or
 - b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

APPEND DOCUMENTATION AS ATTACHMENT ECON-3 AFTER THE LAST PAGE OF THIS SECTION.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

APPEND DOCUMENTATION AS ATTACHMENT ECON-4 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1120.310.d, Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310.e, Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes No . If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130.f (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310.f, Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes No . If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT ECON-5 AFTER THE LAST PAGE OF THIS SECTION.