HEALTH FACILITIES PLANNING BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Processing, Classification Policies and Review Criteria

2) Code Citation: 77 Ill. Adm. Code 1110

3)

Section Numbers:	Proposed Action:
1110.10	Amend
1110.30	Repeal
1110.40	Amend
1110.50	Repeal
1110.55	Repeal
1110.60	Repeal
1110.65	Repeal
1110.110	Repeal
1110.120	Repeal
1110.130	Amend
1110.210	Amend
1110.220	Repeal
1110.230	Amend
1110.234	New
1110.310	Repeal
1110.320	Repeal
1110.410	Repeal
1110.420	Repeal
1110.510	Repeal
1110.520	Repeal
1110.530	Amend
1110.610	Repeal
1110.620	Repeal
1110.630	Amend
1110.710	Repeal
1110.720	Repeal
1110.730	Amend
1110.1410	Repeal
1110.1420	Repeal
1110.1430	Amend
1110.1710	Repeal
1110.1720	Repeal
1110.1730	Amend
1110.2310	Repeal

1110.2320	Repeal
1110.2330	Amend
1110.2410	Repeal
1110.2420	Repeal
1110.2430	Amend
1110.2510	Amend
1110.2520	Repeal
1110.2540	Amend
1110.2610	Amend
1110.2620	Repeal
1110.2640	Amend
1110.2710	Amend
1110.2720	Repeal
1110.2730	Amend
1110.2740	Amend
1110.2750	Amend
1110.2810	Amend
1110.2820	Repeal
1110.2830	Amend
1110.2930	New
1110.3030	New

4) Statutory Authority: Illinois Health Facilities Planning Act [20 ILCS 3960]

5) A Complete Description of the Subjects and Issues Involved: General Applicability and Project Classification: Section 1110.10 was updated and outlines the responsibilities of the applicant to address all pertinent review criteria when a submitting a CON application. In Section 1110.40, there are language changes for clarification and an updated table showing project type and the corresponding applicable review criteria that must be addressed. Sections 1110.30, 1110.50 and 1110.55 will be repealed since they are obsolete. Section 1110.60 will be repealed, since the definition and review requirements have been incorporated into other sections of HFPB rules; and Section 1110.65 will be repealed, since no applications were ever received under this Section, and revisions to the statute concerning non-clinical care areas and a higher capital expenditure threshold have reduced the need for this option.

Discontinuation: In Section 1110.130, amendments add and clarify information requirements, including the disposition and relocation of medical records; certification that all required data will be submitted to HFPB/IDPH no later than 60 days following

the date of discontinuation; and documentation that the proposed discontinuation will not have an adverse impact on access to care for residents of the facility's market area.

Definitions: Proposed amendments would consolidate all definitions in Part 1100 and Part 1110 to Section 1100.220 – General Definitions. The proposed relocation and consolidation of definitions provides a central source for all review-based definitions. This will simplify the process of searching for definitions related to project review subjects and criteria.

Sections 1110.220; 1110.520; 1110.620; 1110.720; 1110.920; 1110.1420; 1110.1720; 1110.2320; 1110.2420; 1110.2520; 1110.2620; 1110.2720; and 1110.2820 will be repealed.

General Requirements: Proposed Sections 1110.210 and 1110.230 change Review Criteria to Information Requirements. The proposed Information Requirements will present an overview of the applicant, the proposed project, and all options considered and rejected, in favor of the proposed project. The three Information Requirements to be addressed are: Background of Applicant; Purpose of Project; and Alternatives to the Proposed Project.

Two of the redundant existing review criteria are incorporated into Category of Service review criteria in Sections F through AE of Part 1110. Existing criterion Project Scope and Size has been relocated to proposed Section 1110.232.

Project Scope and Size, Utilization and Unfinished/Shell Space: In the proposed new Section 1110.232, review criteria for both Size of Project and Project Services Utilization are relocated to a new Section (1110.234), which incorporates criteria concerning the physical aspects of a project, as well as utilization for projects that involve services, functions or equipment for which HFPB has not established utilization or occupancy standards in Part 1100.

In addition, this rule includes a new criterion for the review of Unfinished/Shell Space. HFPB is required to consider shell space or unfinished space proposed in a project, per a mandate of the Health Facilities Planning Act.

Category of Service Rules: A new format has been developed for all Category of Service review criteria. The new format reflects the intent and purposes of the Health Facilities Planning Act, and since the format will be applied to all Category of Service review

criteria, it provides a uniform approach to the review and assessment of proposed projects.

The proposed new format retains most of the existing requirements, and also incorporates Need and Location requirements from the existing General Review Criteria in Section 1110.230. Subparts D and E will be repealed, since the requirements have been incorporated into the Category of Service review criteria.

A new Section was added for one (1) new Category of Service: Long Term Acute Care Hospital – Review Criteria.

In addition, another new Section was added containing review criteria for Clinical Service Areas Other than Categories of Service.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes.

Section Numbers:	Proposed Action:	Illinois Register Citation:
1110.210	Amend	31 Ill. Reg. 5935; 4/20/07
1110.220	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.230	Amend	31 Ill. Reg. 5935; 4/20/07
1110.234	New	31 Ill. Reg. 5935; 4/20/07
1110.310	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.320	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.410	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.420	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.510	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.520	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.530	Amend	31 Ill. Reg. 5935; 4/20/07
1110.610	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.620	Repeal	31 Ill. Reg. 5935; 4/20/07

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1110.630	Amend	31 Ill. Reg. 5935; 4/20/07
1110.1410	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.1420	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.1430	Amend	31 Ill. Reg. 5935; 4/20/07
1110.2310	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.2320	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.2330	Amend	31 Ill. Reg. 5935; 4/20/07
1110.2410	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.2420	Repeal	31 Ill. Reg. 5935; 4/20/07
1110.2430	Amend	31 Ill. Reg. 5935; 4/20/07
1110.3030	New	31 Ill. Reg. 5935; 4/20/07
1110.3210	Amend	32 Ill. Reg. 1050; 1/25/08
1110.3230	Amend	32 Ill. Reg. 1050; 1/25/08

11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Public Hearing
Friday, February 15, 2008

at 1:00-4:00 p.m.
James R. Thompson Center
100 W. Randolph Street
Conference Room #9-031
Chicago, Illinois

In addition, public comment may be submitted within 45 calendar days from the date of publication of the proposed rulemaking to:

Claire Burman
Coordinator, Rules Development
Illinois Health Facilities Planning Board
100 W. Randolph Street, 6th Floor
Chicago, Illinois 60601

312/814-2565

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e-mail: CLAIRE.BURMAN@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hospitals, long term care facilities, ESRD facilities, Ambulatory Surgical Treatment Centers, Comprehensive Physical Rehabilitation Centers

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2006

The full text of the Proposed Amendments begins on the next page:

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TITLE 77: PUBLIC HEALTH
CHAPTER II: HEALTH FACILITIES PLANNING BOARD
SUBCHAPTER a: ILLINOIS HEALTH CARE FACILITIES PLAN

PART 1110
PROCESSING, CLASSIFICATION POLICIES AND REVIEW CRITERIA

SUBPART A: GENERAL APPLICABILITY AND PROJECT CLASSIFICATION

Section
1110.10 Introduction and Applicability~~to Part 1110~~
1110.20 Projects Required to Obtain a Permit (Repealed)
1110.30 Processing and Reviewing Applications (Repealed)
1110.40 Classification of Projects and Applicable Review Criteria
1110.50 Recognition of Services which~~Which~~ Existed Prior to Permit Requirements (Repealed)
1110.55 Recognition of Non-hospital Based Ambulatory Surgery Category of Service (Repealed)
1110.60 Master Design Projects (Repealed)
1110.65 Master Plan or Capital Budget Projects (Repealed)

SUBPART B: REVIEW CRITERIA – DISCONTINUATION

Section
1110.110 Introduction (Repealed)
1110.120 Discontinuation – Definition (Repealed)
1110.130 Discontinuation – Review Criteria

SUBPART C: GENERAL PURPOSE, MASTER DESIGN, AND FACILITY CONVERSION - INFORMATION REQUIREMENTS AND~~CHANGES OF OWNERSHIP~~ REVIEW CRITERIA

Section
1110.210 Introduction
1110.220 Definitions – General Review Criteria (Repealed)
1110.230 Project Purpose, Background and Alternatives – Information Requirements~~General Review Criteria~~
1110.234 Project Scope and Size, Utilization and Unfinished/Shell Space – Review Criteria
1110.235 Additional General Review Criteria for Master Design and Related Projects Only

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SUBPART I: CATEGORY OF SERVICE REVIEW CRITERIA – SUBSTANCE ABUSE/ADDICTION TREATMENT

Section
1110.810 Introduction (Repealed)
1110.820 Substance Abuse/Addiction Treatment – Definitions (Repealed)
1110.830 Substance Abuse/Addiction Treatment – Review Criteria (Repealed)

SUBPART J: CATEGORY OF SERVICE REVIEW CRITERIA – NEONATAL INTENSIVE CARE

Section
1110.910 Introduction
1110.920 Neonatal Intensive Care – Definitions
1110.930 Neonatal Intensive Care – Review Criterion

SUBPART K: CATEGORY OF SERVICE REVIEW CRITERIA – BURN TREATMENT

Section
1110.1010 Introduction (Repealed)
1110.1020 Burn Treatment – Definitions (Repealed)
1110.1030 Burn Treatment – Review Criteria (Repealed)

SUBPART L: CATEGORY OF SERVICE REVIEW CRITERIA – THERAPEUTIC RADIOLOGY

Section
1110.1110 Introduction (Repealed)
1110.1120 Therapeutic Radiology – Definitions (Repealed)
1110.1130 Therapeutic Radiology – Review Criteria (Repealed)

SUBPART M: CATEGORY OF SERVICE REVIEW CRITERIA – OPEN HEART SURGERY

Section
1110.1210 Introduction
1110.1220 Open Heart Surgery – Definitions

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Section
1110.2210 Introduction (Repealed)
1110.2220 Extracorporeal Shock Wave Lithotripsy – Definitions (Repealed)
1110.2230 Extracorporeal Shock Wave Lithotripsy – Review Criteria (Repealed)

SUBPART X: CATEGORY OF SERVICE REVIEW CRITERIA – SELECTED ORGAN TRANSPLANTATION

Section
1110.2310 Introduction (Repealed)
1110.2320 Selected Organ Transplantation – Definitions (Repealed)
1110.2330 Selected Organ Transplantation – Review Criteria

SUBPART Y: CATEGORY OF SERVICE REVIEW CRITERIA – KIDNEY TRANSPLANTATION

Section
1110.2410 Introduction (Repealed)
1110.2420 Kidney Transplantation – Definitions (Repealed)
1110.2430 Kidney Transplantation – Review Criteria

SUBPART Z: CATEGORY OF SERVICE REVIEW CRITERIA – SUBACUTE CARE HOSPITAL MODEL

Section
1110.2510 Introduction
1110.2520 Subacute Care Hospital Model – Definitions (Repealed)
1110.2530 Subacute Care Hospital Model – Review Criteria
1110.2540 Subacute Care Hospital Model – HFPB~~State Board~~ Review
1110.2550 Subacute Care Hospital Model – Project Completion

SUBPART AA: CATEGORY OF SERVICE REVIEW CRITERIA – POSTSURGICAL RECOVERY CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section
1110.2610 Introduction
1110.2620 Postsurgical Recovery Care Center Alternative Health Care Model – Definitions (Repealed)
1110.2630 Postsurgical Recovery Care Center Alternative Health Care Model – Review

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AUTHORITY: Implementing and authorized by the Illinois Health Facilities Planning Act [20 ILCS 3960].

SOURCE: Fourth Edition adopted at 3 Ill. Reg. 30, p. 194, effective July 28, 1979; amended at 4 Ill. Reg. 4, p. 129, effective January 11, 1980; amended at 5 Ill. Reg. 4895, effective April 22, 1981; amended at 5 Ill. Reg. 10297, effective September 30, 1981; amended at 6 Ill. Reg. 3079, effective March 8, 1982; emergency amendments at 6 Ill. Reg. 6895, effective May 20, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 11574, effective September 9, 1982; Fifth Edition adopted at 7 Ill. Reg. 5441, effective April 15, 1983; amended at 8 Ill. Reg. 1633, effective January 31, 1984; codified at 8 Ill. Reg. 18498; amended at 9 Ill. Reg. 3734, effective March 6, 1985; amended at 11 Ill. Reg. 7333, effective April 1, 1987; amended at 12 Ill. Reg. 16099, effective September 21, 1988; amended at 13 Ill. Reg. 16078, effective September 29, 1989; emergency amendments at 16 Ill. Reg. 13159, effective August 4, 1992, for a maximum of 150 days; emergency expired January 1, 1993; amended at 16 Ill. Reg. 16108, effective October 2, 1992; amended at 17 Ill. Reg. 4453, effective March 24, 1993; amended at 18 Ill. Reg. 2993, effective February 10, 1994; amended at 18 Ill. Reg. 8455, effective July 1, 1994; amended at 19 Ill. Reg. 2991, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 7981, effective May 31, 1995, for a maximum of 150 days; emergency expired October 27, 1995; emergency amendment at 19 Ill. Reg. 15273, effective October 20, 1995, for a maximum of 150 days; recodified from the Department of Public Health to the Health Facilities Planning Board at 20 Ill. Reg. 2600; amended at 20 Ill. Reg. 4734, effective March 22, 1996; amended at 20 Ill. Reg. 14785, effective November 15, 1996; amended at 23 Ill. Reg. 2987, effective March 15, 1999; amended at 24 Ill. Reg. 6075, effective April 7, 2000; amended at 25 Ill. Reg. 10806, effective August 24, 2001; amended at 27 Ill. Reg. 2916, effective February 21, 2003; amended at 32 Ill. Reg. _____, effective _____.

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SUBPART A: GENERAL APPLICABILITY AND PROJECT CLASSIFICATION

Section 1110.10 Introduction and Applicability~~to Part 1110~~

An application for permit *shall be made to HFPB* and shall *contain such information as HFPB deems necessary* [20 ILCS 3960/6]. The applicant is responsible for addressing all pertinent review criteria that relate to the scope of a construction or modification project or to a project for the acquisition of major medical equipment. Applicable review criteria may include, but are not limited to, general review criteria, discontinuation, modernization, category of service criteria, and financial and economic feasibility criteria. Applications for permit shall be processed, classified and reviewed in accordance with all applicable HFPB rules. HFPB shall consider a project's conformance with all applicable review criteria in evaluating applications and in determining whether a permit should be issued. Definitions pertaining to this Part are contained in the Act and in 77 Ill. Adm. Code 1100 and 1130. HFPB's procedural rules relating to the processing and review of applications for permit are contained in 77 Ill. Adm. Code 1130.~~This Part of the Plan addresses activities and requirements utilized in the submission of an application for permit, its subsequent processing and the criteria applied in the review of a proposed project.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.30 Processing and Reviewing Applications (Repealed)

~~The procedures for processing and reviewing all applications for permit are specified in 77 Ill. Adm. Code 1130 (Health Facilities Planning Procedural Rules).~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.40 Classification of Projects and Applicable Review Criteria

When an application for permit has been received by HFPB~~the State Board~~, the Executive Secretary shall classify the project into one of the following classifications:

a) Emergency Review Classification

1) An emergency review classification applies only to~~Emergency projects are subject to the review process and are~~ those construction or modification projects that affect the inpatient operation of a health care facility and are

necessary because ~~there exists~~ one or more of the following conditions exist:

A) An imminent threat to the structural integrity of the building; or

B) An imminent threat to the safe operation and functioning of the mechanical, electrical~~,~~ or comparable systems of the building.

2) Applications classified as emergency will be reviewed for conformance~~Since the State Board recognizes that applications for emergency projects must be processed as expeditiously as possible, all applications will be reviewed in accordance~~ with the following review criteria:

A) Documentation has been provided that verifies the existence of one or both of the conditions specified~~the project is indeed an emergency project as defined~~ in subsection (a)(1)(A) or (B); and

B) Failure~~failure~~ to proceed immediately with the project would result in closure or impairment of the inpatient operation of the facility; and

C) The~~the~~ emergency conditions did not exist longer than 30 days prior to the receipt of the application for permit~~requesting the emergency classification~~.

b) Non-Substantive Review Classification~~.~~
Non-substantive projects are those construction or modification projects that are solely and entirely limited in scope to the type of project detailed in the following table. Applications classified as non-substantive will be reviewed for conformance with the applicable review criteria detailed in the following table for the type of project specified.~~establishment, construction, modification or equipment projects which consist solely of the characteristics detailed in this subsection. Applications shall be evaluated only against the following applicable review criteria of the Sections or Parts specified.~~

Type of Project~~Applicable Project Type~~	Applicable Review Criteria
~~Establishment of long-term care~~	~~Section 1110.230 and Part 1120~~

~~facilities licensed by the Department of Children and Family Services~~	
Discontinuation of ~~beds or~~ category of service	Section 1110.130 and Subpart AF, as applicable~~Part 1120~~
Facility conversion (e.g., change of ownership)~~Changes of ownership~~	Sections 1110.230~~(b)~~, 1110.234, 1110.240, and Subpart AF~~Part 1120~~
Long-term care for the Developmentally Disabled (Adult and Children) Categories of Service	Sections~~Section~~ 1110.230,~~; Section~~ 1110.234,~~1110.320(b); Section~~ 1110.1830,~~;~~ and Subpart AF~~Part 1120~~
Acute Care Beds Certified for Extended Care Category of Service as defined by the Centers for Medicare and Medicaid Services~~Health Care Financing Administration~~ (42 CFR 405.471 (1987))	Sections~~Section~~ 1110.230, 1110.234,~~(a), (c), (e);~~ and Subpart AF~~Part 1120~~
In-Center Hemodialysis~~Chronic Renal Dialysis~~ Category of Service	Sections~~Section~~ 1110.230,~~;~~ 1110.234,~~Part~~ 1110.1430,~~;~~ and Subpart AF~~Part 1120~~
Projects intended solely to provide care to patients suffering from Acquired Immunodeficiency Syndrome (AIDS) or related disorders	Sections~~Section~~ 1110.230,~~;~~ 234,~~Section 1110.320; Section 1110.420;~~ and Subpart AF~~Part 1120~~
~~Replacement of diagnostic or therapeutic equipment with comparable equipment to be utilized for a similar purpose~~	~~Section 1110.420(b); and Part 1120~~
Master design projects	Sections 1110.230, 1110.234, 1110.235, Subpart AF and Sections pertaining to any category of service proposed in the Master Plan Projects

Outpatient diagnostic and treatment facilities and space (including doctors offices), provided that the cost of all diagnostic and treatment components of the project does not exceed the capital expenditure review threshold~~Medical office buildings, fitness centers, and other non-inpatient space~~	Sections~~Section~~ 1110.230, 1110.234,~~(c), (d) and e);~~ and Subpart AF~~Part 1120~~
Fitness centers	Sections 1110.230, 1110.234, and Subpart AF
Community-Based Residential Rehabilitation Center Alternative Health Care Model	Section 1110.2830

c) Substantive Review Classification~~.~~
Substantive projects are those projects that are not classified as either emergency or non-substantive. Applications classified as substantive will be reviewed for conformance with all applicable review criteria contained in this Part.~~All projects that do not include components specified in subsection (b) shall be subject to review and shall be classified substantive unless they are found to be emergency projects as delineated in subsection (a).~~

~~d)~~ ~~Classification of projects with both non-substantive and substantive components. Projects which include both substantive and non-substantive components shall be classified as substantive.~~

d~~e~~) Classification Appeal~~.~~
Appeal of any classification may be made to HFPB~~the State Board~~ at the next scheduled ~~State Board~~ meeting following the date of the Executive Secretary's determination.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.50 Recognition of Services which Existed Prior to Permit Requirements (Repealed)

~~Upon the expiration of thirty days following the effective date of this regulation, the State Board~~

~~will no longer accept petitions from any person seeking to prove that a particular category of service was in existence at a health care facility prior to the effective date of Board regulations requiring a permit for establishment of that service. As of that date, persons seeking recognition of a category of service must file an application for permit and receive approval for establishment of that service unless a specific provision exists within this Part regarding recognition of the category of service by the State Board.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.55 Recognition of Non-hospital Based Ambulatory Surgery Category of Service (Repealed)

~~a)~~ ~~Due to revisions in 77 Ill. Adm. Code 205.110 of the Agency's licensure standards for ambulatory surgical treatment centers (effective November 1, 1989), the State Board shall recognize the existence of the non-hospital based ambulatory surgery category of service for unlicensed facilities which become subject to such licensure requirements if the following documentation is submitted to the State Board:~~

~~1)~~ ~~verification that outpatient surgery had been performed at the facility prior to January 1, 1989; and~~

~~2)~~ ~~verification that due to revisions in 77 Ill. Adm. Code 205.110, effective November 1, 1989, the facility must obtain a license as an ambulatory surgical treatment center; or~~

~~3)~~ ~~verification that the facility was certified for reimbursement under Title XVIII of the Social Security Act (42 U.S.C.A. 1395x) for ambulatory surgery on or before January 1, 1989.~~

~~b)~~ ~~Documentation must be in the form of copies of medical records indicating the date of performance of surgical procedures at the facility, letter(s) from the Agency's licensure program stating that a license must be obtained, or a copy of the approval letter for participation in Title XVIII.~~

~~c)~~ ~~Recognition by the State Board of the non-hospital based ambulatory surgery category of service exempts the facility from the requirement of obtaining a permit for establishment of a health care facility and establishment of the service.~~

~~Such exemption shall be valid and remain in effect provided that the following requirements are met:~~

~~1)~~ ~~the procedures and scope of services provided at the facility remain restricted to the medical specialty(ies) (e.g. podiatry, ophthalmology, plastic surgery) in operation on or before January 1, 1989; and~~

~~2)~~ ~~the facility has obtained a license from the Agency no later than January 1, 1991; and~~

~~3)~~ ~~the facility has petitioned the State Board for recognition of the service no later than 90 days after the effective date of the revisions to Part 205.110.~~

~~d)~~ ~~Upon issuance of a license by the Agency, the ambulatory surgical treatment center shall be subject to the provisions of the Act regarding subsequent transactions which require permit. Failure to comply with any of the requirements of Section 1110.55(b) or subsequent discontinuation of the facility will void the recognition and exemption, and a permit will be required to establish the category of service.~~

~~e)~~ ~~The provisions of this Section became effective November 1, 1989.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.60 Master Design Projects (Repealed)

~~a)~~ ~~Definition~~
~~Master Design Project means a proposed project solely for the planning and/or design costs associated with an institutional master plan or with one or more future construction or modification projects. Project costs include: preplanning costs, site survey and soil investigation costs, architects fees, consultant fees and other fees related to planning or design. The master design project is for planning and design only and shall not contain any construction elements.~~

~~b)~~ ~~Review Coverage~~
~~Master design projects shall be classified as substantive. Such projects shall be reviewed to determine the financial and economic feasibility of the master design project itself, the need for the proposed master plan or for the future construction or modification projects, and the financial and economic feasibility of the~~

~~proposed master plan or of the future construction or modification projects. Findings concerning the need for beds and services and financial feasibility made during the review of the master design project are applicable only for the master design project. Approval by the State Board of a master design project does not obligate approval or positive findings on future construction or modification projects implementing the design. Future applications including those involving the replacement or addition of beds are subject to the review criteria and bed need in effect at the time of State Board review.~~

~~c)~~ ~~Applicable Review Standards~~

~~1)~~ ~~The estimated project costs of a master design project shall be subject to review only under the applicable review criteria of 77 Ill. Adm. Code 1120.~~

~~2)~~ ~~The master plan or the future construction or modification projects proposed pursuant to the master design project shall be subject to the applicable review criteria of 77 Ill. Adm. Code 1120 and the following review criteria found in this Part:~~

~~Section 1110.230(a)~~	~~Location~~
~~Section 1110.230(b)~~	~~Background of Applicant~~
~~Section 1110.230(c)~~	~~Alternatives to the Proposed Project~~
~~Section 1110.235~~	~~Additional General Review Criteria for Master Design and Related Projects Only~~
~~Section 1110.320(a)~~	~~Establishment of Additional Hospitals~~
~~Section 1110.320(b)~~	~~Allocation of Additional Beds~~
~~Section 1110.420(b)~~	~~Modern Facilities~~
~~Section 1110.530(a)~~	~~Unit Size~~
~~Section 1110.630(a)~~	~~Facility Size~~

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~~Section 1110.730(a)~~	~~Unit Size~~
~~Section 1110.1230(b)~~	~~Establishment of Open Heart Surgery~~
~~Section 1110.1330(b)~~	~~Establishment or Expansion of Cardiac Catheterization Service~~
~~Section 1110.1330(d)~~	~~Modernization of Existing Cardiac Catheterization Equipment~~
~~Section 1110.1430(b)~~	~~Minimum Size of Renal Dialysis Center or Renal Dialysis Facilities~~
~~Section 1110.1730(a)~~	~~Facility Size~~
~~Section 1110.1730(c)~~	~~Zoning~~
~~Section 1110.1830(a)~~	~~Facility Size~~
~~Section 1110.1830(d)~~	~~Recommendation from State Department~~
~~Section 1110.1830(f)~~	~~Zoning~~
~~Section 1110.2330(a)~~	~~Establishment of a Program~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.65 Master Plan or Capital Budget Projects (Repealed)

~~a)~~ ~~Definition~~
~~Master Plan or Capital Budget Project means a series of proposed capital expenditures and other transactions that are to be initiated by or on behalf of a health care facility over a given period of time that does not exceed 24 consecutive calendar months. The expenditures or transactions may or may not be related or interdependent and may be undertaken by one or more construction contracts, leases, or other forms of obligation.~~

~~b)~~ ~~Review Coverage~~

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~~Master Plan or Capital Budget projects shall be classified as substantive and be reviewed for conformance with the applicable review criteria of this Part and 77 Ill. Adm. Code 1120.~~

~~c)~~ ~~Submission of Application for Permit~~
~~The submission of an application for permit for a Master Plan or Capital Budget project is optional. An applicant may submit separate applications for permit for any individual project or transaction that in and of itself requires a permit.~~

~~d)~~ ~~Obligation, Completion, Alteration~~
~~All expenditures or transactions that are components of a Master Plan or Capital Budget shall be considered obligated upon receipt of the notarized certification of obligation described at 77 Ill. Adm. Code 1130.140. All components of the Master Plan or Capital Budget project must be completed in accordance with the time frames specified in the application for permit unless a renewal has been granted by the State Board. Alterations to a Master Plan or Capital Budget project are subject to the provisions of 77 Ill. Adm. Code 1130.750.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

SUBPART B: REVIEW CRITERIA – DISCONTINUATION

Section 1110.110 Introduction (Repealed)

~~When discontinuation as defined in Section 1110.120 is proposed, an application for permit is required. It is the intent of the State Board that all applications for permit for discontinuation be processed promptly. The review shall include opportunity for a public hearing.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.120 Discontinuation – Definition (Repealed)

~~"Discontinuation" means to cease operation of an entire health care facility or to cease operation of a category of service and is further defined in 77 Ill. Adm. Code 1130.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.130 Discontinuation – Review Criteria

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a) Information Requirements - Review Criterion
The applicant shall provide at least the following information:

1) Identification of the categories of service and the number of beds, if any, that are to be discontinued;

2) Identification of all other clinical services and types of medical equipment detailed in Appendix A (e.g., surgery, emergency department, diagnostic imaging, outpatient clinics, etc.) that are to be discontinued;

3) The anticipated date of discontinuation for each identified service or for the entire facility;

4) The anticipated use of the physical plant and equipment after discontinuation occurs;

5) The anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be retained;

6) For applications involving discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFPB or IDPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation and that the required information will be submitted no later than 60 days following the date of discontinuation.

b) Reasons for Discontinuation - Review Criterion
The applicant must document that the discontinuation is justified by providing data that verifies that one or more factors, such as, but not limited to, the following, exist with respect to each service being discontinued:

1) Insufficient volume or demand for the service indicated by utilization levels that have been below minimum or target occupancy or utilization levels specified in 77 Ill. Adm. Code 1100 or in this Subchapter a for a period of at least 24 consecutive months;

2) Lack of sufficient staff to adequately provide the service, indicated by a staffing vacancy rate in excess of 10% for licensed health care professionals (full-time equivalent positions) involved in the provision of the service for a period of at least 24 consecutive months;

3) The facility or the service is not economically feasible, and continuation impairs the facility's financial viability, indicated by operating deficits for the service and for the facility for a period of at least 24 consecutive months;

4) The facility or the service is not in compliance with licensing or certification standards, indicated by actions taken by governmental or professional certification agencies that document noncompliance, and the failure or inability of the applicant to correct life safety or other types of deficiencies.

c) Impact on Access - Review Criterion
The applicant shall document that the discontinuation of each service or of the entire facility will not have an adverse impact upon access to care for residents of the facility's market area. The applicant shall provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination. Factors that indicate an adverse impact upon access to service for the population of the facility's market area include, but are not limited to, the following:

1) The service will no longer exist within 45 minutes travel time of the applicant facility;

2) Discontinuation of the service will result in creating or increasing a shortage of beds or services, as calculated in the Inventory of Health Care Facilities;

3) Facilities or a shortage of other categories of service at determined by the provisions of 77 Ill. Adm. Code 1100 or other Sections of this Part.

HFPB NOTE: The facility's market area is defined by those zip code areas that account for at least 50% of the facility's admissions. The applicant must document that a written request for an impact statement was received by all

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existing or approved health care facilities (that provide the same services as those proposed for discontinuation) located within 45 minutes travel time of the applicant facility. The request for an impact statement must be received by the facilities at least 30 days prior to submission of the application for permit. The applicant's request for an impact statement must include at least the following: the anticipated date of discontinuation of the service; the total number of patients that have received care or the number of treatments that have been provided (as applicable) for the latest 24 month period; whether the facility being contacted has or will have available capacity to accommodate a portion or all of the applicant's experienced caseload; and whether any restrictions or limitations preclude providing service to residents of the applicant's market area. The request shall allow 15 days after receipt for a written response from the contacted facility. Failure by an existing or approved facility to respond to the applicant's request for an impact statement within the prescribed 15-day response period shall constitute a non-rebuttable assumption that the discontinuation will not have an adverse impact for that facility.

~~a) The applicant must provide the following:~~

~~1) the reasons for the discontinuation;~~

~~2) the anticipated or actual date of discontinuation or the date the last person was or will be discharged or treated, as applicable;~~

~~3) 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;~~

~~4) a closure plan indicating the process used to provide alternative services or facilities for the patients prior to or upon discontinuation; and~~

~~5) the anticipated use of the physical plant and equipment after discontinuation has occurred and the anticipated date of such use.~~

~~b) Each application for discontinuation will be analyzed to determine:~~

~~1) that the stated reasons for the proposed discontinuation are valid and are of such a nature to warrant discontinuation;~~

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~~2)~~ ~~that the discontinuation project will not adversely affect the services needed by the planning area as calculated in the appropriate Appendix of this Subchapter;~~

~~3)~~ ~~that the discontinuation project will not have an adverse affect on the health delivery system by creating demand for services which cannot be met by existing area facilities;~~

~~4)~~ ~~that the discontinuation project is in the public interest and would not cause planning area residents unnecessary hardship by the limitation of access to needed services including the effect of the proposed discontinuation on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, the elderly and other underserved groups to obtain needed health care;~~

~~5)~~ ~~that (in every project for discontinuation except the discontinuation of a total health care facility) the anticipated use to which the physical plant and equipment will be put once the discontinuation takes place and the date such action will occur is appropriate.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART C: GENERAL PURPOSE, MASTER DESIGN, AND FACILITY CONVERSION - INFORMATION REQUIREMENTS AND~~CHANGES OF OWNERSHIP~~ REVIEW CRITERIA

Section 1110.210 Introduction

a) This Subpart contains all General Purpose and Scope, Master Design, and Facility Conversion Information Requirements and Review Criteria that apply in total or in part to all projects, with the exception of projects solely involving "Discontinuation".

b) Each required point of information is intended to provide HFPB with an overview of the need for a proposed project. HFPB shall consider a project's conformance with the applicable information requirements contained in this Subpart, as well as a project's conformance with all applicable review criteria indicated in subsection (c), to determine whether sufficient project need has been documented to issue a Certificate of Need (CON) permit.

c) The review criteria to be addressed (as required) are contained in the following Parts and Subparts:

1) Subpart C, Section 1110.232 contains review criteria concerning "Project Scope and Size", "Utilization" and "Unfinished Shell Space", and Section 1110.3030 contains review criteria concerning "Clinical Service Areas Other Than Categories of Service";

2) Subparts F through AE of this Part contain service specific review criteria that shall be addressed, as applicable, to the Category of Service included in a proposed project;

3) Subpart AF contains review criteria pertaining to financial and economic feasibility;

4) 77 Ill. Adm. Code 1130 contains the CON procedural requirements that may be applicable to a proposed project; and

5) *An application for a permit or exemption shall be made to HFPB upon forms provided by HFPB. This application shall contain such information as HFPB deems necessary*. [20 ILCS 3960/6] The application shall include affirmative evidence on which the Director may make the findings required under this Section and upon which HFPB may make its decision on the approval or denial of the permit or exemption.

d) Definitions for Subpart C and Subparts F through AE (service specific) are contained in the Act and in 77 Ill. Adm. Code 1100.220.

~~This Subpart C contains all General, Master Design, and Changes of Ownership Review Criteria that apply in total or in part to all projects except discontinuation and certain non substantive projects.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.220 Definitions – General Review Criteria (Repealed)

~~a)~~ ~~"Board Certified or Board Eligible Physician" means a physician who has satisfactorily completed an examination (or is "eligible" to take such examination)~~

in a medical specialty and has taken all of the specific training requirements for certification by a specialty board. For purposes of this definition, "medical specialty" shall mean a specific area of medical practice by health care professionals. A listing of specialty boards may be found in Appendix A of this Part.

b) "Health Services" means diagnostic, treatment or rehabilitative services which are grouped, for purposes of review, into clinically related Categories of Service based upon level or type of support functions, equipment or treatment provided to patients/residents. Categories of Service, when established or discontinued, are subject to review regardless of cost.

c) "Level of Care" means a specific degree of, type of, or approach to patient/resident care within a defined category of service.

d) "Surgery" means a category of service pertaining to the performance of any type of surgical operation(s). Surgical areas include but are not limited to:

1) Operating Rooms;

2) Nurses Station;

3) Nurses' Lockers and Lounge;

4) Doctor's Lockers and Lounge;

5) Scrub Areas;

6) General Storage Space;

7) Linen Storage Area;

8) Circulation Space;

9) Patient Holding Area; and

10) Recovery.

~~e)~~ ~~"Distinct Unit" means a physically distinct area comprising all beds served by a nursing station in which a particular category of service is provided and which utilizes a nursing staff assigned exclusively to the distinct area.~~

~~f)~~ ~~"DRG" means diagnostic related groups utilized in the Medicare program for health care reimbursement.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.230 Project Purpose, Background and Alternatives - Information Requirements~~General Review Criteria~~

The information requirements contained in this Section are applicable to all projects except projects that are solely for discontinuation. An applicant shall document the *qualifications, background, character and financial resources to adequately provide a proper service for the community* and also demonstrate that the project promotes the *orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of facilities* or service. [20 ILCS 3960/2]

a) Background of Applicant – Information Requirements

1) An applicant must demonstrate that it is fit, willing and able, and *has the qualifications, background and character, to adequately provide a proper standard of health care service for the community*. [20 ILCS 3960/6] In evaluating the fitness of the applicant, HFPB shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. A health care facility is considered "owned or operated" by every person or entity that, within the three years preceding the filing of the application, owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity (refer to 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

2) Examples of facilities owned or operated by an applicant include:

A) The applicant, Partnership ABC, owns 60% of the shares of Corporation XYZ, which manages the Good Care Nursing Home under a management agreement. The applicant, Partnership ABC, owns or operates Good Care Nursing Home.

B) The applicant, Healthy Hospital, a corporation, is a subsidiary of Universal Health, the parent corporation of Healthcenter Ambulatory Surgical Treatment Center (ASTC), its wholly-owned subsidiary. The applicant, Healthy Hospital, owns and operates Healthcenter ASTC.

C) Dr. Wellcare is the applicant. His wife is the director of a corporation that owns a hospital. The applicant, Dr. Wellcare, owns or operates the hospital.

D) Drs. Faith, Hope and Charity own 40%, 35% and 10%, respectively, of the shares of Healthfair, Inc., a corporation, that is the applicant. Dr. Charity owns 45% and Drs. Well and Care each own 25% of the shares of XYZ Nursing Home, Inc. The applicant, Healthfair, Inc., owns and operates XYZ Nursing Home, Inc.

3) The applicant shall submit the following information:

A) A listing of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, as applicable;

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

C) Authorization permitting HFPB and Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide the authorization shall constitute an

abandonment or withdrawal of the application without any further action by HFPB.

4) If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed to update and/or clarify data.

b) Purpose of the Project – Information Requirements
The applicant shall document that the project will provide health services that improve the health care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other, per the applicant's definition.

1) The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided should include, but is not limited to, existing identification of problems or issues that need to be addressed, including:

A) The area's demographics or characteristics (e.g., rapid area growth rate, increased aging population, higher or lower fertility rates) that may affect the need for services in the future;

B) The population's morbidity or morality rates;

C) The incidence of various diseases in the area;

D) The population's financial ability to access health care (e.g., financial hardship, increased number of charity care patients, changes in the area population's insurance or managed care status);

E) The physical accessibility to necessary health care (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).

2) The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).

3) The applicant shall detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific time frames that relate to achieving the stated goals.

4) For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.

c) Alternatives to the Proposed Project – Information Requirements
The applicant shall document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

1) Alternative options that shall be addressed include, but are not limited to:

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

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Other considerations.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

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

~~a) Location – Review Criterion~~

~~An applicant who proposes to establish a new health care facility or a new category of service or who proposes to acquire major medical equipment that is not located in a health care facility and that is not being acquired by or on behalf of a health care facility must document the following:~~

~~1) that the primary purpose of the proposed project will be to provide care to the residents of the planning area in which the proposed project will be physically located. Documentation for existing facilities shall include patient origin information for all admissions for the last 12 months. Patient origin information must be presented by zip code and be based upon the patient's legal residence other than a health care facility for the last six months immediately prior to admission. For all other projects for which referrals are required to support the project, patient origin information for the referrals is required. Each referral letter must contain a certification by the health care worker physician that the representations contained therein are true and correct. A complete set of the referral letters with original notarized signatures must accompany the application for permit.~~

~~2) that the location selected for a proposed project will not create a maldistribution of beds and services. Maldistribution is typified by such factors as: a ratio of beds to population (population will be based upon the most recent census data by zip code), within 30 minutes travel time under normal driving conditions of the proposed facility, which exceeds one and one half times the State average; an average utilization rate for the last 12 months for the facilities providing the proposed services within 30 minutes travel time under normal driving conditions of the proposed project which is below the Board's target occupancy rate; or the lack of a~~

~~sufficient population concentration in an area to support the proposed project.~~

~~b)~~ ~~Background of Applicant – Review Criterion~~

~~1)~~ ~~The applicant shall demonstrate that it is fit, willing and able, and *has the qualifications, background and character to adequately provide a proper standard of health care service for the community*. [20 ILCS 3960/6] In evaluating the fitness of the applicant, the State Board shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.~~

~~2)~~ ~~For purposes of this subsection:~~

~~A)~~ ~~"Adverse action" means conviction of any felony or any misdemeanor involving fraud or dishonesty; any supervision, probation, suspension, revocation, termination, or denial of a license or certificate or registration; imposition of a conditional license; termination or suspension from participation in any program involving payment authorized under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, as amended; or denial, suspension, revocation or termination of accreditation by an nationally recognized organization.~~

~~B)~~ ~~A health care facility is considered "owned or operated" by every person or entity which, within the three years preceding the filing of the application, owns, directly or indirectly, an ownership interest as specified in this subsection (b)(2).~~

~~C)~~ ~~"Ownership interest" means any legal or equitable interest, including any interest arising from a lease or management agreement, which gives rise to participation in profits or losses, or which gives rise to the exercise or implementation of any decision-making authority respecting the operations or finances of the health care facility.~~

~~i)~~ ~~In the case of an individual, "ownership interest" includes any interest owned or exercised, directly or indirectly, by or for the individual's spouse or children.~~

~~ii)~~ ~~In the case of a partnership, "ownership interest" includes any interest owned or exercised, directly or indirectly, by or for any general partner, and the partnership is considered to be owned by all of its general partners.~~

~~iii)~~ ~~In the case of a limited liability company, "ownership interest" includes any interest owned, directly or indirectly, by or for any member or partner, and the limited liability company is considered to be owned by all of its members or partners.~~

~~iv)~~ ~~In the case of an estate, "ownership interest" includes any interest owned or exercised, directly or indirectly, by any beneficiary, and the estate is considered to be owned by all of its beneficiaries.~~

~~v)~~ ~~In the case of a trust, "ownership interest" includes any interest owned or exercised, directly or indirectly, by any beneficiary, and the trust is considered to be owned by all of its beneficiaries.~~

~~vi)~~ ~~In the case of a corporation, "ownership interest" includes any interest owned, directly or indirectly, by or for any principal shareholder, member, director or officer, and the corporation is considered to be owned by its principal shareholders, members, directors and officers.~~

~~D)~~ ~~"Principal shareholder" means:~~

~~i)~~ ~~In the case of a corporation having 30 or more shareholders, a person who, directly or indirectly, beneficially owns, holds or has the power to vote 5% or more of any class of securities issued by the corporation.~~

ii) In the case of a corporation having fewer than 30 shareholders, a person who, directly or indirectly, beneficially owns, holds or has the power to vote 50% or more of any class of securities issued by the corporation, or any member of any group of five or fewer shareholders which, directly or indirectly, beneficially own, hold or have the power to vote 80% or more of any class of securities issued by the corporation.

E) If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity.

3) Examples of facilities owned or operated by the applicant:

A) The applicant, Partnership ABC, owns 60% of the shares of Corporation XYZ which manages the Good Care Nursing Home under a management agreement. The applicant, Partnership ABC, owns or operates Good Care Nursing Home.

B) The applicant, Healthy Hospital, a corporation, is a subsidiary of Universal Health, the parent corporation of Healthcenter ASTC, its wholly-owned subsidiary. The applicant, Healthy Hospital, owns and operates Healthcenter ASTC.

C) Dr. Wellcare is the applicant. His wife is the director of a corporation which owns a hospital. The applicant, Dr. Wellcare, owns or operates the hospital.

D) Drs. Faith, Hope and Charity own 40%, 35%, and 10%, respectively, of the shares of Healthfair, Inc., a corporation, which is the applicant. Dr. Charity owns 45% and Drs. Well and Care each own 25% of the shares of XYZ Nursing Home, Inc. The applicant, Healthfair, Inc., owns and operates XYZ Nursing Home, Inc.

4) Documentation to be submitted shall include:

A) A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable;

B) proof of current licensure and, if applicable, certification and accreditation of all health care facilities owned or operated by the applicant;

C) a certification from the applicant listing any adverse action taken against any facility owned or operated by the applicant during the three years prior to the filing of the application;

D) authorizations 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 (b)(4) or to obtain any additional documentation or information which the State Board or IDPH finds pertinent to this subsection (b)(4). Failure to provide the authorization shall constitute an abandonment or withdrawal of the application without any further action by the State Board.

5) If during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior application may be utilized to fulfill the data requirements of this Part. In these cases, applicant must state that the information has been previously provided to IDPH, cite the project for the prior application, and certify that no changes have occurred regarding the information which has been previously provided.

6) In addition to documentation submitted by the applicant, the State Board and IDPH shall review the official records of IDPH, other State agencies, and, where applicable, those of other states, respecting licensure and certification, and shall review the records of nationally recognized accreditation organizations to determine compliance with the requirements of this subsection (b).

c) Alternatives to the Proposed Project – Review Criterion. The applicant must document that the proposed project is the most effective or least costly alternative. Documentation shall consist of a comparison of the proposed project to

~~alternative options. Such a comparison must address issues of cost, patient access, quality, and financial benefits in both the short and long term. If the alternative selected is based solely or in part on improved quality of care, the applicant shall provide empirical evidence including quantifiable outcome data that verifies improved quality of care. Alternatives must include, but are not limited to: purchase of equipment, leasing or utilization (by contract or agreement) of other facilities, development of freestanding settings for service and alternate settings within the facility.~~

~~d)~~ ~~Need For the Project – Review Criterion. The project must be needed.~~

~~1)~~ ~~If the State Board has determined need pursuant to Part 1100, the proposed project shall not exceed additional need determined unless the applicant meets the criterion for a variance.~~

~~2)~~ ~~If the State Board has not determined need pursuant to Part 1100, the applicant must document that it will serve a population group in need of the services proposed and that insufficient service exists to meet the need. Documentation shall include but not be limited to:~~

~~A)~~ ~~area studies (which evaluate population trends and service use factors);~~

~~B)~~ ~~calculation of need based upon models of estimating need for the service (all assumptions of the model and mathematical calculations must be included);~~

~~C)~~ ~~historical high utilization of other area providers; and~~

~~D)~~ ~~identification of individuals likely to use the project.~~

~~3)~~ ~~If the project is for the acquisition of major medical equipment that does not result in the establishment of a category of service, the applicant must document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.~~

~~e)~~ ~~Size of Project – Review Criterion. The applicant must document that the size of a proposed project is appropriate.~~

~~1)~~ ~~The proposed project cannot exceed the norms for project size found in Appendix B of this Part unless the additional square footage beyond the norm can be justified by one of the following:~~

~~A)~~ ~~the proposed project requires additional space due to the scope of services provided;~~

~~B)~~ ~~the proposed project involves an existing facility where the facility design places impediments on the architectural design of the proposed project;~~

~~C)~~ ~~the proposed project involves the conversion of existing bed space and the excess square footage results from that conversion; or~~

~~D)~~ ~~the proposed project includes the addition of beds and the historical demand over the last five year period for private rooms has generated a need for conversion of multiple bed rooms to private usage.~~

~~2)~~ ~~When the State Board has established utilization targets for the beds or services proposed, the applicant must document that in the second year of operation the annual utilization of the beds or service will meet or exceed the target utilization. Documentation shall include, but not be limited to, historical utilization trends, population growth, expansion of professional staff or programs (demonstrated by signed contracts with additional physicians) and the provision of new procedures which would increase utilization.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.234 Project Scope and Size, Utilization and Unfinished/Shell Space - Review Criteria

a) Size of Project – Review Criterion
The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix B, unless the additional GSF can be justified by documenting one of the following:

1) Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

2) The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

3) The project involves the conversion of existing bed space that results in excess square footage.

b) Project Services Utilization - Review Criterion
This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFPB has not established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100. The applicant shall document that, in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in Appendix B.

c) Unfinished or Shell Space - Review Criterion
If the project includes unfinished space (i.e., shell space) that is to meet an anticipated future demand for service, the applicant must document that the amount of shell space proposed for each department or area is justified, and that such space will not exceed the GSF standards of Appendix B unless the amount of space is mandated by a governmental or certification agency. The applicant shall provide the following information:

1) The total gross square footage of the proposed shell space;

2) The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;

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

A) Requirements of governmental or certification agencies; or

B) Experienced increases in the historical occupancy or utilization of those departments, areas or functions proposed to occupy the shell space. The applicant shall provide the historical utilization for the

department, area or function for the latest five-year period for which data are available, and, based upon the average annual percentage increase for that period, project the future utilization of the department, area or function through the anticipated date when the shell space will be placed into operation.

d) Assurances
The applicant shall submit the following:

1) Verification that the applicant will submit to HFPB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at that time or the categories of service involved;

2) The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3) The anticipated date when the shell space will be completed and placed into operation.

(Source: Added at 32 Ill. Reg. _____, effective _____)

SUBPART D: REVIEW CRITERIA RELATING TO ALL PROJECTS INVOLVING ESTABLISHMENT OF ADDITIONAL BEDS OR SUBSTANTIAL CHANGE IN BED CAPACITY

Section 1110.310 Introduction (Repealed)

~~Subpart D contains all Bed Related Review Criteria. These criteria apply only to projects proposing the addition of inpatient beds to a Category of Service and are utilized in addition to the General Review Criteria outlined in Subpart C.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.320 Bed Related Review Criteria (Repealed)

~~a)~~ ~~Establishment of Additional Hospitals – Review Criterion. A proposed general hospital to be located within a Metropolitan Statistical Area (M.S.A.*) must contain a minimum of 100 MS beds.~~

~~AGENCY NOTE: *M.S.A.'s are defined and named in the U.S. Bureau of the Census publication, Metropolitan Statistical Areas: 1984, available from the U.S. Government Printing Office, Washington, D.C. 20402.~~

~~b)~~ ~~Allocation of Additional Beds – Review Criterion. The applicant proposing to establish a category of service must document that access to the service will be improved. Documentation shall consist of at least one of the following:~~

~~1)~~ ~~the proposed service is not available within the planning area;~~

~~2)~~ ~~existing facilities have restricted admission policies resulting in access limitations;~~

~~3)~~ ~~existing service providers are experiencing occupancy levels in excess of the category of service target levels;~~

~~4)~~ ~~the travel time to existing service providers is excessive (exceeds 45 minutes) for area residents to be served by the project.~~

~~c)~~ ~~Addition of Beds to Existing Facilities – Review Criterion~~

~~1)~~ ~~The applicant must document that the addition of beds is necessary. Documentation shall consist of evidence that:~~

~~A)~~ ~~existing inpatient bed services over the latest 12 month period have averaged at or above the target occupancy; or~~

~~B)~~ ~~when occupancy levels over that period fall below the target occupancy the services affected cannot be converted to provide the needed bed space due to architectural or programmatic considerations.~~

~~2)~~ ~~An applicant proposing to add beds while operating an acute care service (for purposes of this subsection, acute care services means: M-S, OB, Pediatrics, ICU, Acute Mental Illness, and Burn services) must document the appropriateness of the length of stay in existing services. Documentation shall consist of a comparison of patient length of stay with other providers within the planning area. An applicant whose existing services have a length of stay longer than that of other area providers must~~

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~~document that the severity or type of illness treated at the applicant facility is greater.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

SUBPART E: MODERNIZATION REVIEW CRITERIA

Section 1110.410 Introduction (Repealed)

~~Subpart E contains all Modernization Review Criteria. These criteria apply only to modernization projects and are utilized in addition to the General Review Criteria outlined in Subpart C.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.420 Modernization Review Criteria (Repealed)

~~a)~~ ~~Modernization of Beds – Review Criterion. The applicant must document that the number of beds proposed in each category of service affected does not exceed the number of beds needed to support the facility's utilization in each service proposed at the appropriate modernization target as found in Part 1100. (Utilization shall be based upon the latest 12 month period for which data are available.)~~

~~b)~~ ~~Modern Facilities – Review Criterion. The applicant must document that the proposed project meets one of the following:~~

~~1)~~ ~~The proposed project will result in the replacement of equipment or facilities which have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out-of-service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.~~

~~2)~~ ~~The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training, or other support services to meet the requirements of existing services or services previously approved to be added or expanded. Documentation shall consist of but is not limited to: historical utilization data, evidence of changes in industry standards,~~

~~changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.~~

~~c)~~ ~~Major Medical Equipment – Review Criterion~~
~~Proposed projects for the acquisition of major medical equipment must document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

SUBPART F: CATEGORY OF SERVICE REVIEW CRITERIA – MEDICAL/SURGICAL, OBSTETRIC, PEDIATRIC AND INTENSIVE CARE

Section 1110.510 Introduction (Repealed)

~~Subpart F contains Review Criteria which pertain to the Medical/Surgical, Obstetric, Pediatric and Intensive Care categories of service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.520 Medical/Surgical, Obstetric, Pediatric and Intensive Care – Definitions (Repealed)

~~a)~~ ~~Medical/Surgical~~

~~1)~~ ~~"Medical Surgical Service" means a category of service pertaining to the medical surgical care performed at the direction of a physician in behalf of patients by physicians, dentists, nurses and other professional and technical personnel. For purposes of this Subchapter, the medical surgical category of service includes such subcategories of service as medical, surgical, ophthalmology, intermediate intensive care, tuberculosis, gynecology (outside obstetric (OB) department), research, eyes-ears-nose and throat, orthopedic, neurology, cardio-thoracic-vascular, trauma, inpatient renal dialysis, special care units, substance abuse/addiction treatment, dental and urology. The medical surgical category of service does not include the following categories of service and their subcategories:~~

A) Obstetric Service;

B) Pediatric Service;

C) Intensive Care Service;

D) Rehabilitation Service;

E) Acute Mental Illness Treatment Service;

F) Neonatal Intensive Care Service;

G) Burn Treatment Service;

H) General Long-Term Care Categories of Service; and

I) Specialized Long-Term Care Categories of Service.

2) "Medical Surgical Unit" means an assemblage of inpatient beds and related facilities in which medical-surgical services are provided to a defined and limited class of patients according to their particular medical care needs.

b) Obstetrics

1) "Combined Maternity and Gynecological Unit" means an entire facility or a distinct part of a facility which provides both a program of maternity care (as defined in subsection (b)(3) below) and a program of obstetric gynecological care (as defined in subsection (b)(5) below) and which is designed, equipped, organized and operated in accordance with the requirements of the Hospital Licensing Act [210 ILCS 85].

2) "Fertility Rate" means projections of population fertility based upon resident birth occurrence as provided by IDPH.

3) "Maternity Care" means a subcategory of obstetric service related to the medical care of the patient prior to and during the act of giving birth either to a living child or to a dead fetus and to the continuing medical care of

~~both patient and newborn infant under the direction of a physician in behalf of the patient by physicians, nurses, and other professional and technical personnel.~~

~~4)~~ ~~"Maternity Facility or Unit" means an entire facility or a distinct part of a facility which provides a program of maternity and newborn care and which is designed, equipped, organized, and operated in accordance with the requirements of the Hospital Licensing Act.~~

~~5)~~ ~~"Obstetric Gynecological Care" means a subcategory of obstetric service where medical care is provided to clean gynecological, surgical, or medical cases which are admitted to a postpartum section of an obstetric unit in accordance with the requirements of the Hospital Licensing Act.~~

~~6)~~ ~~"Obstetric Service" means a category of service pertaining to the medical or surgical care of maternity and newborn patients or medical or surgical cases which may be admitted to a postpartum unit.~~

~~c)~~ ~~Pediatrics~~

~~1)~~ ~~"Designated Pediatric Beds" means beds within the facility which are primarily used for pediatric patients and are not a component part of a distinct pediatric unit as defined in subsection (c)(2) below.~~

~~2)~~ ~~"Pediatric Facility or Distinct Pediatric Unit" means an entire facility or a distinct unit of a facility, where the nurses' station services only that unit, which provides a program of pediatric service and is designed, equipped, organized and operated to render medical surgical care to the 0-14 age population.~~

~~3)~~ ~~"Pediatric Service" means a category of service for the delivery of treatment pertaining to the non intensive medical surgical care of a pediatric patient (0-14 years in age) performed at the direction of a physician in behalf of the patient by physicians, dentists, nurses, and other professional and technical personnel.~~

~~d)~~ ~~Intensive Care~~

~~1)~~ ~~"Intensive Care Service" means a category of service providing the coordinated delivery of treatment to the critically ill patient or to patients requiring continuous care due to special diagnostic considerations requiring extensive monitoring of vital signs through mechanical means and through direct nursing supervision. This service is given at the direction of a physician in behalf of patients by physicians, dentists, nurses, and other professional and technical personnel. The intensive care category of service includes the following subcategories; medical Intensive Care Unit (ICU), surgical ICU, coronary care, pediatric ICU, and combinations of such ICU. This category of service does not include intermediate intensive or coronary care and special care units which are included in the medical surgical category of service.~~

~~2)~~ ~~"Intensive Care Unit" means a distinct part of a facility which provides a program of intensive care service and which is designed, equipped, organized and operated to deliver optimal medical care for the critically ill or for patients with special diagnostic conditions requiring specialized equipment, procedures and staff, and which is under the direct visual supervision of a qualified professional nurses' staff. Effective February 15, 2003, the repeal of 77 Ill. Adm. Code 1110.1010, 1110.1020 and 1110.1030, the beds and corresponding utilization for the Burn Treatment category of service will be included in the Intensive Care category of service.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.530 Medical/Surgical, Obstetric, Pediatric and Intensive Care – Review Criteria

a) Introduction

1) This Section applies to projects involving the following categories of hospital bed services: Medical/Surgical; Obstetrics; Pediatrics; and Intensive Care. Applicants proposing to establish, expand or modernize a category of hospital bed service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA

Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Bed Category of Service
	(b)(5) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e)(1) -	Staffing Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Expansion of Existing Services	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(4) -	Planning Area Need – Service Demand – Expansion of Existing Bed Category of Service
	(e)(1) -	Staffing Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & (3) -	Documentation
	(d)(4) -	Occupancy
	(f) -	Performance Requirements

2) If the proposed project involves the replacement of a hospital or service onsite, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (g) (Assurances).

3) If the proposed project involves the replacement of a hospital or service on a new site, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".

4) If the proposed project involves the replacement of a hospital or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing category of bed service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of hospital bed service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility) for the last six months immediately prior to admission.

3) Service Demand – Establishment of Bed Category of Service
The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of hospital bed service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals
An applicant proposing to establish a bed category of service or establish a new hospital shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address, and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Demand – Expansion of Existing Bed Category of Service
The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years;

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical

percentage of applicant market share within a 24-month period after project completion;

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth: If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist; and

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

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

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

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bedrooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm Code 1100.

e) Staffing Availability - Review Criterion

1) An applicant proposing to establish a new hospital or to add beds to an existing hospital shall document that a sufficient supply of personnel will be available to staff the total number of beds proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care

workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

f) Performance Requirements

1) Bed Capacity Minimum

A) Medical-Surgical
The minimum bed capacity for a medical-surgical category of service within a Metropolitan Statistical Area (MSA) is 75 beds.

B) Obstetrics

i) The minimum unit size for a new obstetric unit within an MSA is 20 beds.

ii) The minimum unit size for a new obstetric unit outside an MSA is 7 beds.

C) Intensive Care: The minimum unit size for an intensive care unit is 4 beds.

D) Pediatrics: The minimum size for a pediatric unit within an MSA is 16 beds.

E) New Hospital: The minimum bed capacity for the establishment of a new acute care hospital within an MSA, except for federally designated critical access hospitals, is 75 beds.

2) Length of Stay

A) An applicant proposing to add beds to an existing acute care bed service (Med/Surg, OB, Pediatrics and ICU) shall document that the average length of stay (ALOS) for the subject service is consistent with the planning area's 3-year ALOS.

B) Documentation shall consist of the 3-year ALOS for all hospitals within the planning area, as reported in the Annual Hospital Questionnaire.

C) An applicant whose existing services have an ALOS exceeding 125% of the ALOS for area providers shall document that the severity or type of illness treated at the applicant facility is significantly higher than the planning area average. Documentation from CMMS or other objective records shall be provided.

D) An applicant whose existing services have an ALOS that is lower than the planning area ALOS shall submit an explanation as to the reasons for the divergence.

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

~~a) Unit Size – Review Criterion~~

~~1) Obstetrics~~

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A) The minimum unit size for a new obstetric unit within a Metropolitan Statistical Area is 20 beds.

B) The minimum unit size for a new obstetric unit outside a Metropolitan Statistical Area is 7 beds.

2) Intensive Care. The minimum unit size for an intensive care unit is 4 beds.

3) Pediatrics. The minimum size for a pediatric unit within a Metropolitan Statistical Area is 16 beds.

b) Variances to Bed Need – Review Criterion. The applicant must document one or more of the following.

1) High Occupancy Variance

A) The applicant must document that the applicant facility has experienced high occupancy. Documentation shall consist of evidence that the historical average annual occupancy rate has equaled or exceeded the target occupancy for the prior 24-month period.

B) The applicant must also document that the number of beds proposed will not exceed the number needed to reduce the facility's high occupancy to the target occupancy, or if the number of beds proposed exceeds the number of beds justified by the applicant's historical workload, then projections may be used. Utilization projections must be based upon the following:

i) projections shall be based upon population projections from the U.S. Bureau of the Census;

ii) projections shall be for a maximum period of 5 years from the date the application is submitted;

iii) projections shall be zip code and age-specific; and

~~iv) projections shall be based upon the applicant's service area as defined by historical patient origin, and shall not include projected changes in market share.~~

~~The projections provided must also demonstrate that the proposed number of beds will not exceed the number of beds needed to meet the target occupancy rate over the next 5 years.~~

~~2) Medically Underserved Variance~~

~~A) The applicant must document that access to the proposed service is restricted in the planning area as documented by:~~

~~i) the absence of the service within the planning area;~~

~~ii) limitations on governmentally funded or charity patients;~~

~~iii) restrictive admission policies of existing providers;~~

~~iv) the area population and existing care system exhibit indicators of median care problems such as an average family income level below the State average poverty level, high infant mortality or designation as a Health Manpower Shortage Area; or~~

~~v) the project will provide service for a portion of the population who must currently travel over 45 minutes to receive service.~~

~~B) Documentation shall consist of location and utilization of other planning area service providers; patient location information and all applicable time-travel studies; a certification of waiting times and scheduling or admission restrictions that exist in area providers; and an assessment of area population characteristics which would indicate an access problem.~~

~~C) The applicant must also document that the number of beds proposed will not exceed the number needed at the target~~

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~~occupancy rate to meet the health care needs of the population identified as having restricted access.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART G: CATEGORY OF SERVICE REVIEW CRITERIA – COMPREHENSIVE PHYSICAL REHABILITATION

Section 1110.610 Introduction (Repealed)

~~Subpart G contains Review Criteria which pertain to the Comprehensive Physical Rehabilitation category of service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.620 Comprehensive Physical Rehabilitation--Definitions (Repealed)

~~a)~~ ~~"Comprehensive Physical Rehabilitation" means a category of service provided in a comprehensive physical rehabilitation facility providing the coordinated interdisciplinary team approach to physical disability under a physician licensed to practice medicine in all its branches, who directs a plan of management of one or more of the classes of chronic disabling disease or injury. Comprehensive physical rehabilitation must include but is not limited to the services of: elements as specified in the federal regulations defining "a rehabilitation unit - distinct part" (42 CFR 405.471(i) (1986)). Comprehensive physical rehabilitation services can only be provided by a comprehensive physical rehabilitation facility.~~

~~b)~~ ~~"Comprehensive Physical Rehabilitation Facility" means a distinct bed unit of a hospital or a special referral hospital which provides a program of comprehensive physical rehabilitation and which is designed, equipped, organized and operated to deliver inpatient rehabilitation services; and which is licensed by the Department of Public Health under the "Hospital Licensing Act" or is a facility operated or maintained by the State or a state agency.~~

~~c)~~ ~~There are two types of comprehensive physical rehabilitation facilities:~~

~~1)~~ ~~Freestanding comprehensive physical rehabilitation facility means a specialty hospital dedicated to the provision of comprehensive rehabilitation; and~~

~~2)~~ ~~Hospital/based comprehensive physical rehabilitation facility means a distinct unit, located in a hospital, dedicated to the provision of comprehensive physical rehabilitation.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.630 Comprehensive Physical Rehabilitation Beds - Review Criteria

a) Introduction

1) This Section applies to projects involving the Comprehensive Physical Rehabilitation (CPR) category of service. Applicants proposing to establish, expand or modernize CPR shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA
Establishment of Services or Facility	(b)(1) - Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) - Planning Area Need – Service to Planning Area Residents
	(b)(3) - Planning Area Need – Service Demand - Establishment of Bed Category of Service
	(b)(5) - Planning Area Need - Service Accessibility
	(c)(1) - Unnecessary Duplication of Services
	(c)(2) - Maldistribution
	(c)(3) - Impact of Project on Other Area Providers
	(e)(1) - Staffing Availability
	(f) - Performance Requirements
	(g) - Assurances
Expansion of Existing Services	(b)(2) - Planning Area Need – Service to Planning Area Residents

	(b)(4) -	Planning Area Need – Service Demand – Expansion of Bed Category of Service
	(e)(1) -	Staffing - Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & (3) -	Documentation
	(d)(4) -	Occupancy
	(f) -	Performance Requirements

2) If the proposed project involves the replacement of a hospital or service on-site, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (g) (Assurances).

3) If the proposed project involves the replacement of a hospital or service on a new site, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".

4) If the proposed project involves the replacement of a hospital or service (on-site or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population

served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing category of bed service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of hospital bed service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility) for the last six months immediately prior to admission.

3) Service Demand – Establishment of Bed Category of Service
The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals:

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of hospital bed service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

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B) Projected Referrals
An applicant proposing to establish a category of bed service or establish a new hospital shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients whom the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Demand – Expansion of Bed Category of Service
The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide

documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth
If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care

coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist; and

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

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1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

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

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

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing

1) Availability - Review Criterion

A) An applicant proposing to establish a new hospital or to add beds to an existing hospital shall document that a sufficient supply of personnel will be available to staff the total number of beds proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

B) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

C) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

D) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

2) Personnel Qualifications
The applicant shall document that personnel possessing proper credentials in the following categories are available to staff the service:

A) Medical Director – Medical direction of the facility shall be vested in a physician who is a doctor of medicine licensed to practice in all of its branches and who has had three years of post-graduate specialty training in the medical management of inpatients requiring rehabilitation services.

B) Rehabilitation Nursing – Supervisors, for all nurses participating as part of the rehabilitation team, must be available on staff and shall have documented education in rehabilitation nursing and at least one year of rehabilitation nursing experience.

C) Allied Health – The following allied health specialists shall be available on staff:

i) Physical Therapist – Graduate of a program in physical therapy approved by the American Physical Therapy Association is licensed to practice in the State of Illinois.

ii) Occupational Therapist – Registered by the American Occupational Therapy Association or graduate of an approved educational program, with the experience needed for registration. Educational programs are approved by the American Medical Association's Council on Medical Education in collaboration with the American Occupational Therapy Association. The therapist shall be licensed to practice in the State of Illinois.

iii) Social Worker.

D) Other Specialties – The following personnel shall be available on staff or on a consulting basis:

i) Speech Pathologist;

ii) Psychologist;

iii) Vocational Counselor or Specialist;

iv) Dietitian;

v) Pharmacist;

vi) Audiologist; and

vii) Prosthetist and Orthotist.

E) Documentation shall consist of:

i) Medical Director
Curriculum Vitae of Medical Director

ii) Other Personnel

- Letters of interest from potential employees
- Applications filed with the applicant for a position
- Signed contracts with required staff
- Narrative explanation of how other positions will be filled

f) Performance Requirements

1) Bed Capacity Minimum

A) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.

B) The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.

2) Length of Stay

A) An applicant proposing to add beds to an existing freestanding comprehensive rehabilitation facility or an existing comprehensive rehabilitation unit shall document that the average length of stay (ALOS) for the subject service is consistent with the planning area's three-year ALOS.

B) Documentation shall consist of the three-year ALOS for all hospitals within the planning area, as reported in the Annual Hospital Questionnaire.

C) An applicant whose existing services have an ALOS exceeding 125% of the ALOS for area providers shall document that the severity or type of illness treated at the applicant facility is significantly higher than the planning area average. Documentation shall be provided from CMMS or other objective records.

D) An applicant whose existing services have an ALOS that is lower than the planning area ALOS shall submit an explanation as to the reasons for the divergence.

g) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

~~a) Facility Size – Review Criterion~~

~~1) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.~~

~~2) The minimum hospital unit size for comprehensive physical rehabilitation is 15 beds.~~

~~b) Access Variance to Bed Need – Review Criterion~~

~~1)~~ ~~The applicant must document that access to the proposed service is restricted in the planning area as documented by:~~

~~A)~~ ~~the absence of the service within the planning area;~~

~~B)~~ ~~limitations on governmentally funded or charity patients;~~

~~C)~~ ~~restrictive admission policies of existing providers; or~~

~~D)~~ ~~the project will provide service for a portion of the population who must currently travel over 45 minutes to receive service.~~

~~2)~~ ~~The applicant must also document that the number of beds proposed will not exceed the number needed to meet the health care needs of the population identified as having restricted access at the target occupancy rate.~~

~~c)~~ ~~Staffing Requirements – Review Criterion~~

~~1)~~ ~~The applicant must document that personnel possessing proper credentials in the following categories are available to staff the service:~~

~~A)~~ ~~Medical Director – Medical direction of the facility shall be vested in a physician who is a doctor of medicine licensed to practice in all of its branches and who has had three year of post-graduate specialty training in the medical management of inpatients requiring rehabilitation services.~~

~~B)~~ ~~Rehabilitation Nursing – Supervisors, for all nurses participating as part of the rehabilitation team, must be available on staff and shall have documented education in rehabilitation nursing and at least one year of rehabilitation nursing experience.~~

~~C)~~ ~~Allied Health – The following allied health specialists must be available on staff:~~

~~i)~~ ~~Physical Therapist – Graduate of a program in physical therapy approved by the American Physical Therapy Association.~~

~~ii) Occupational Therapist – Registered by the American Occupational Therapy Association or graduate of an approved educational program, with the experience needed for registration. Educational programs are approved by the American Medical Association's council on Medical Education in collaboration with the American Occupational Therapy Association.~~

~~iii) Social Worker~~

~~D) Other Specialties – The following personnel must be available on staff or on a consulting basis:~~

~~i) Speech Pathologist;~~

~~ii) Psychologist;~~

~~iii) Vocational Counselor or Specialist;~~

~~iv) Dietician;~~

~~v) Pharmacist;~~

~~vi) Audiologist;~~

~~vii) Prosthetist and Orthotist; and~~

~~viii) Dentist.~~

~~2) Documentation shall consist of:~~

~~A) letters of interest from potential employees;~~

~~B) applications filed with the applicant for a position;~~

~~C) signed contracts with required staff; or~~

~~D) a narrative explanation of how other positions will be filled.~~

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NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART H: CATEGORY OF SERVICE REVIEW CRITERIA – ACUTE MENTAL ILLNESS AND CHRONIC MENTAL ILLNESS

Section 1110.710 Introduction (Repealed)

~~Subpart H contains Review Criteria which pertain to the Acute Mental Illness category of service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.720 Acute Mental Illness – Definitions (Repealed)

~~"Acute Mental Illness" means a crisis state or an acute phase of one of more specific psychiatric disorders in which a person displays one or more specific psychiatric symptoms of such severity as to prohibit effective functioning in any community setting. Persons who are acutely mentally ill may be admitted to an acute mental illness facility or unit under the provisions of the Mental Health and Developmental Disabilities Code [405 ILCS 5] which determines the specific requirements for admission by age and type of admission.~~

~~"Acute Mental Illness Facility or Unit" means a facility or a distinct unit in a facility which provides a program of acute mental illness treatment service (as defined below) and which is designed, equipped, organized, and operated to deliver inpatient and supportive acute mental illness treatment services; and which is licensed by the Department of Public Health under the Hospital Licensing Act [210 ILCS 85] or is a facility operated or maintained by the State or a State agency.~~

~~"Acute Mental Illness Treatment Service" means a category of service which provides a program of care for those persons suffering from acute mental illness. Such services are provided in a highly structured setting in a distinct psychiatric unit of a general hospital, in a private psychiatric hospital, or in a state-operated facility, to individuals who are severely mentally ill and in a state of acute crisis, in an effort to stabilize the individual and either effect his quick placement in a less restrictive setting or to reach a determination that extended treatment is~~

~~needed. Acute mental illness is typified by an average length of stay of 45 days or less for adults and 60 days or less for children and adolescents.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.730 Acute Mental Illness – Review Criteria

a) Introduction

1) This Section applies to projects involving Acute Mental Illness (AMI) and Chronic Mental Illness (CMI). Applicants proposing to establish, expand or modernize AMI and CMI categories of service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Bed Category of Service
	(b)(5) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e) -	Staffing Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Expansion of Existing Services	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(4) -	Planning Area Need – Service Demand – Expansion of Bed Category of Service
	(e) -	Staffing Availability
	(f) -	Performance Requirements

	(g) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & (3) -	Documentation
	(d)(4) -	Occupancy
	(f) -	Performance Requirements

2) If the proposed project involves the replacement of a hospital or service onsite, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (g) (Assurances).

3) If the proposed project involves the replacement of a hospital or service offsite, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".

4) If the proposed project involves the replacement of a hospital or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

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A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing category of bed service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of hospital bed service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility), for the last six months immediately prior to admission.

3) Service Demand – Establishment of Bed Category of Service
The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of hospital bed service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals
An applicant proposing to establish a new bed category of service or establish a new hospital shall submit the following:

i) Physician referral and/or DHS-funded mental health provider (59 Ill. Adm. Code 132) letters that attest to the total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician and/or DHS-funded mental health provider will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's and/or mental health provider's documented historical caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Patient Type
The applicant shall identify the type of patients that will be served by the project by providing the clinical conditions anticipated (e.g., eating disorder, borderline personality disorder, dementia) and age groups (e.g., childhood, adolescent, geriatric) targeted.

4) Service Demand – Expansion of Bed Category of Service
The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service,

as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) an estimated number of patients the physician will refer to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth
If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as

experienced within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions

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The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area

providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

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

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

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, bed and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing Availability - Review Criterion

1) An applicant proposing to establish a new hospital or to add beds to an existing hospital shall document that a sufficient supply of personnel will be available to staff the total number of beds proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide

documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

f) Performance Requirements

1) Bed Capacity Minimum

A) The minimum unit size for a new AMI unit within an MSA is 20 beds.

B) The minimum unit size for a new AMI unit outside an MSA is 10 beds.

2) Length of Stay

A) An applicant proposing to add beds to an existing bed service shall document that the average length of stay (ALOS) for the subject service is consistent with the planning area's three-year ALOS .

B) Documentation shall consist of the three-year ALOS for all hospitals within the planning area, as reported in the Annual Hospital Questionnaire.

C) An applicant whose existing services have an ALOS exceeding 125% of the ALOS for area providers shall document that the severity or type of illness treated at the applicant facility is significantly higher than the planning area average. Documentation shall be provided from CMS or other objective records.

D) An applicant whose existing services have an ALOS lower than the planning area ALOS shall submit an explanation as to the reasons for the divergence.

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and

maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

~~a)~~ ~~Unit Size – Review Criterion. The minimum unit size for acute mental illness beds is 20 beds for facilities within a metropolitan statistical area. The minimum unit size for acute mental illness beds is 10 beds for facilities within nonmetropolitan statistical areas.~~

~~b)~~ ~~Supportive Mental Health Services – Review Criterion. The applicant must document that the proposed project is or will be a component of an integrated community mental health system, as indicated by the existence of formal multi-institutional service agreements with non-hospital providers. The formal agreements must include:~~

~~1)~~ ~~A specific process for linking of patients to needed aftercare services;~~

~~2)~~ ~~A specific process for the exchange of information concerning the patient; and~~

~~3)~~ ~~Designated staff members or points of contact between the facilities and/or professionals.~~

~~c)~~ ~~Variance to Bed Need – Review Criterion~~

~~1)~~ ~~High Occupancy – The applicant must document that the number of beds proposed will not exceed the number needed to reduce the facility's high occupancy to the target occupancy.~~

~~2)~~ ~~Access – The applicant must document that the proposed project will be providing the acute mental illness category of service that is not readily accessible to the general population of the given planning area. Factors affecting accessibility include, but are not limited to:~~

~~A)~~ ~~Restrictive admission policies by facilities currently providing the service in the area; and/or~~

~~B)~~ ~~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 service.~~

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~~In addition, the applicant must provide documentation that the proposed project will achieve, within the first year of operation, the target occupancy for the service and that there is an available number of patients needing the facility's services to meet this level.~~

~~Type of Admissions – Review Criterion. The applicant must document that the acute mental illness service will annually achieve the target occupancy beginning in the second year of operation. Documentation shall consist of statistical evidence that there is an available number of patients suffering from psychiatric disorders as referenced in the Diagnostic and Statistical Manual of Mental Disorders, IV Edition (1980), DMS-111, American Psychiatric Association, which would utilize the acute mental illness service.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART O: CATEGORY OF SERVICE REVIEW CRITERIA – IN-CENTER HEMODIALYSIS~~CHRONIC RENAL DIALYSIS~~

Section 1110.1410 Introduction (Repealed)

~~Subpart O contains Review Criteria which pertain to the Chronic Renal Dialysis category of service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.1420 Chronic Renal Dialysis Service – Definitions (Repealed)

~~"Acute Dialysis" is dialysis given on an intensive care, inpatient basis to patients suffering from (presumably reversible) acute renal failure, or to patients with chronic renal failure with serious complications.~~

~~"Chronic Renal Dialysis" is a category of service in which dialysis is performed on a regular long-term basis in patients with chronic irreversible renal failure. The maintenance and preparation of patients for kidney transplantation (including the immediate post-operative period and in case of organ rejection) or other acute~~

~~conditions within a hospital does not constitute a chronic renal dialysis category of service.~~

~~"Dialysis" is a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane. The two types of dialysis which are recognized in classical practice are hemodialysis and peritoneal dialysis.~~

~~"Hematocrit" means a measure of the packed cell volume of red blood cells expressed as a percentage of total blood volume.~~

~~"Hemodialysis" is a type of dialysis that involves the use of artificial kidney through which blood is circulated on one side of a semipermeable membrane while the other side is bathed by a salt dialysis solution. The accumulated toxic products diffuse out of the blood into the dialysate bath solution. The concentration and total amount of water and salt in the body fluid is adjusted by appropriate alternations in composition of the dialysate fluid.~~

~~"Peritoneal Dialysis" is a type of dialysis in which the dialysate fluid is injected slowly into the peritoneum, causing dialysis of water and waste products to occur through the peritoneal sac which acts as a semipermeable membrane. The fluid and waste, after accumulating for a period of time (1 hour), is drained from the abdomen and the process is repeated. This procedure is much slower than hemodialysis, requiring the patient to be immobilized for a long period of time.~~

~~"Renal Dialysis Facility" means a freestanding facility or a unit within an existing health care facility that furnishes routine chronic dialysis service(s) to chronic renal disease patients. Such types of services are: self-dialysis, training in self-dialysis, dialysis performed by trained professional staff and chronic maintenance dialysis including peritoneal dialysis.~~

~~"Self-Care Dialysis Training" is a program which trains Chronic Renal Disease patients or their helpers, or both, to perform self-care dialysis.~~

~~"Self-Dialysis" or "Self-Care Dialysis" is maintenance dialysis performed by a trained patient at home or in a special facility with or without the assistance of a family member or other helper.~~

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~~"Urea" means the chief product of urine and the final product of protein metabolism in the body.~~

~~"Urea Reduction Ratio (URR)" means the amount of blood cleared of urea during dialysis. It is reflected by the ratio of the measured level of urea before dialysis and urea remaining after dialysis. The larger the URR, the greater the amount of urea removed during the dialysis treatment.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.1430 In-Center Hemodialysis Projects~~Chronic Renal Dialysis~~ – Review Criteria

a) Introduction

1) This Section applies to projects involving the In-Center Hemodialysis category of service. Applicants proposing to establish, expand or modernize a category of service shall comply with the applicable subsections of this Section as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Station Category of Service
	(b)(5) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e) -	Staffing
	(f) -	Support Services
	(g) -	Minimum Number of Stations
	(h) -	Continuity of Care

	(j) -	Assurances
Expansion of Existing Services	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(4) -	Planning Area Need – Service Demand – Expansion of Stations Category of Service
	(e)(1) -	Staffing - Availability
	(f) -	Support Services
	(j) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & (3) -	Documentation
	(f) -	Support Services

2) If the proposed project involves the relocation of an existing facility or service, the applicant shall comply with the requirements listed in subsection (a)(1) for "Establishment of Services or Facility", as well as requirements in Section 1110.130 (Discontinuation) and subsection (i) (Relocation of Facilities).

3) If the proposed project involves the replacement of a facility or service (onsite or new site), the number of stations being replaced shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional stations can be justified per the criteria for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the number of stations to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of stations to be established for each category of service is in conformance with the projected station deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of stations proposed shall not exceed the number of the projected deficit, to meet the health care needs of the

population served, in compliance with the utilization standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add stations shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add stations to an existing category of service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility), for the last six months immediately prior to admission.

3) Service Demand – Establishment of Station Category of Service
The number of stations proposed to establish a new category of service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new facility, the applicant shall submit projected referrals:

A) Historical Referrals

i) If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.

ii) Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient facility.

B) Projected Referrals
An applicant proposing to establish a category of service or establish a new hospital, shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Demand – Expansion of Stations Category of Service
The number of stations to be added for each category of service is necessary to reduce the facility's experienced high utilization and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual utilization rate that has equaled or exceeded utilization standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject service, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient facility, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth
If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of stations being established or added for the subject category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

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

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

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of station service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, stations and services characterized by such factors as, but not limited to:

A) A ratio of stations to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the utilization standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of a category of service, the applicant shall document that the areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the relocation or modernization of a category of service or facility shall meet or exceed the utilization standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing

1) Availability

A) An applicant proposing to establish a new facility or to add beds to an existing facility shall document that a sufficient supply of personnel will be available to staff the total number of stations proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

B) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

C) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

D) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be

obtained to operate the proposed project, in accordance with licensing requirements.

2) Qualifications

A) Medical Director – Medical direction of the facility shall be vested in a physician who has completed a board-approved training program in nephrology and has at least 12 months experience providing care to patients receiving dialysis.

B) Registered Nurse – The nurse responsible for nursing services in the unit shall be a registered nurse (RN) who meets the practice requirements of the State of Illinois and has at least 12 months experience in providing nursing care to patients on maintenance dialysis.

C) Dialysis Technician – This individual shall meet all applicable State of Illinois requirements (see 210 ILCS 62, the End Stage Renal Disease Facility Act). In addition, the applicant shall document its requirements for training and continuing education.

D) Dietitian – This individual shall be a registered dietitian with the Commission on Dietetic Registration, meet the practice requirements of the State of Illinois (see the Dietetic and Nutrition Services Practice Act [225 ILCS 30]) and have a minimum of one year of professional work experience in clinical nutrition as a registered dietitian.

E) Social Worker – The individual responsible for social services shall have a Master's of Social Work and meet the State of Illinois requirements (see 225 ILCS 20, the Clinical Social Work and Social Work Practice Act).

3) Documentation shall consist of:

A) Medical Director
Curriculum vitae of Medical Director, including a list of all in-center hemodialysis facilities where the position of Medical Director is held.

B) All Other Personnel

i) Letters of interest from potential employees;

ii) Applications filed with the applicant for a position;

iii) Signed contracts with required staff; or

iv) A narrative explanation of how other positions will be filled.

4) Training
The applicant proposing to establish an in-center hemodialysis category of service shall document that an ongoing program of training in dialysis techniques for nurses and technicians will be provided at the facility.

5) Staffing Plan
The applicant proposing to establish an in-center hemodialysis category of service shall document that at least one RN will be on duty when the unit is in operation and will maintain a ratio of at least one direct patient care provider to every four patients.

6) Medical Staff
The applicant shall provide a letter certifying whether the facility will or will not maintain an open medical staff.

f) Support Services – Review Criterion
An applicant proposing to establish an in-center hemodialysis category of service must submit a certification from an authorized representative that attests to each of the following:

1) Participation in a dialysis data system;

2) Availability of support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric and social services; and

3) Provision of training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training provided at the proposed

facility, or the existence of a signed, written agreement for provision of these services with another facility.

g) Minimum Number of Stations
The minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

1) Four dialysis stations for facilities outside an MSA;

2) Eight dialysis stations for a facility within an MSA.

h) Continuity of Care
An applicant proposing to establish an in-center hemodialysis category of service shall document that a signed, written affiliation agreement or arrangement is in effect for the provision of inpatient care and other hospital services. Documentation shall consist of copies of all such agreements.

i) Relocation of Facilities – Review Criterion
This criterion may only be used to justify the relocation of a facility from one location in the planning area to another in the same planning area and may not be used to justify any additional stations. A request for relocation of a facility requires the discontinuation of the current category of service at the existing site and the establishment of a new category of service at the proposed location. The applicant shall document the following:

1) That the existing facility has met the utilization targets detailed in 77 Ill. Adm. Code 1100.630 for the latest 12-month period for which data is available; and

2) That the proposed facility will improve access for care to the existing patient population.

j) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the utilization standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

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~~a)~~ ~~Data System – Review Criterion. An applicant proposing to establish a renal dialysis facility must document that a chronic renal dialysis data system exists or will be established. This criterion shall not be applicable to existing renal dialysis facilities that are relocating or adding stations.~~

~~b)~~ ~~Minimum Size of Renal Dialysis Center or Renal Dialysis Facilities – Review Criterion. The minimum facility size for establishment of a renal dialysis facility is:~~

~~1)~~ ~~three dialysis stations within the facility in areas not included in an MSA or in an MSA of less than 500,000 people;~~

~~2)~~ ~~six dialysis stations in MSA's of over 500,000 population.~~

~~c)~~ ~~Variance to Station Need – Review Criterion~~
~~An applicant proposing to establish a renal dialysis facility or to add stations when no need for additional stations exists in the planning area must document one of the following:~~

~~1)~~ ~~a new facility will improve access in a geographic area that is within 30 minutes travel time of the proposed facility site as evidenced by documentation that verifies:~~

~~A)~~ ~~all existing renal dialysis facilities in the area are operating at or in excess of the target utilization level for the latest 12 month period for which data is available; and~~

~~B)~~ ~~a sufficient number of patients is experiencing an access problem to justify the proposed number of stations at the minimum utilization level detailed in 77 Ill. Adm. Code 1100; and~~

~~C)~~ ~~the caseload at all existing renal dialysis facilities in the area will not be adversely affected; or~~

~~2)~~ ~~additional stations are needed to reduce high utilization of an existing facility as evidenced by documentation that verifies that the number of proposed stations will reduce the facility's experienced utilization level for the latest 12 month period for which data is available to the minimum utilization level detailed in 77 Ill. Adm. Code 1100.~~

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~~d)~~ ~~Support Services – Review Criterion. The applicant proposing to establish a renal dialysis facility must document that clinical and pathological laboratory services, blood bank, nutrition, rehabilitation, psychiatric and social services, and self-care dialysis support services, will be available. Documentation shall consist of a narrative as to how such services will be provided. This criterion shall not be applicable to existing renal dialysis facilities that are relocating or adding stations.~~

~~e)~~ ~~Affiliation Agreements – Review Criterion. The applicant proposing to establish a renal dialysis facility must document that a written affiliation agreement or arrangement is in effect for the provision of inpatient care and other hospital services. Documentation shall consist of copies of all such agreements. This criterion shall not be applicable to existing renal dialysis facilities that are relocating or adding stations.~~

~~f)~~ ~~Self-Care and Home Dialysis Training – Review Criterion. The applicant proposing to establish a renal dialysis facility must document that self-care dialysis, self-care instruction, home dialysis and home training will be provided at the applicant facility or that a written agreement with another facility for the provision of these services exists. Documentation shall consist of a certification that services are provided by the applicant or copies of all agreements for provision of such services. This criterion shall not be applicable to existing renal dialysis facilities that are relocating or adding stations.~~

~~g)~~ ~~Relocation of Facilities – Review Criterion. This criterion may only be used to justify the relocation of a facility from one location in the planning area to another in the same planning area and may not be used to justify any additional stations. The applicant must document the following:~~

~~1)~~ ~~that the existing facility has met the occupancy targets detailed in 77 Ill. Adm. Code 1100.630 for the latest 12 month period for which data is available;~~

~~2)~~ ~~that the proposed facility will improve access for care to the existing patient population; and~~

~~3)~~ ~~that the existing facility needs to be replaced in order to comply with Section 1110.420(b).~~

~~h)~~ ~~Addition of Stations – Review Criterion. This criterion applies to an existing facility which proposes the addition of stations at the existing site. The applicant must document the following:~~

~~1)~~ ~~that the existing facility has met the occupancy targets set forth in 77 Ill. Adm. Code 1100.630 for the latest 12 month period for which data is available;~~

~~2)~~ ~~that the proposed project will not adversely impact the workload at any other existing facility within 30 minutes travel time of the applicant facility; and~~

~~3)~~ ~~that a need for additional stations exists in the planning area based upon the update to the Inventory of Health Care Facilities in effect at the time of State Board consideration; or that the proposed project is in conformance with the variance set forth in subsection (c) of this Section.~~

~~i)~~ ~~Quality of Care – Review Criterion. The applicant must demonstrate the following:~~

~~1)~~ ~~that greater than 65% of its patients achieve a urea reduction ratio (URR) of 0.65 or better; and~~

~~2)~~ ~~that greater than 65% of its patients achieve a hematocrit level of 31% or better.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART R: CATEGORY OF SERVICE REVIEW CRITERIA – GENERAL LONG TERM~~LONG-TERM~~ CARE

Section 1110.1710 Introduction (Repealed)

~~Subpart R contains Review Criteria which pertain to the General Long-Term Care category of service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

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Section 1110.1720 General Long Term~~Long-Term~~ Care – Definitions (Repealed)

~~a)~~ ~~"General Long-Term Care" means a classification of categories of service that provides inpatient levels of care primarily for convalescent or chronic disease adult patients/residents who do not require specialized long-term care services.~~

~~b)~~ ~~The General Long-Term Care Classification includes the nursing category of service. The nursing category of service provides inpatient treatment for convalescent or chronic disease patients/residents and includes the skilled nursing level of care and/or the intermediate nursing level of care (both as defined in IDPH's Long-Term Care Facilities Minimum Standards, Rules and Regulations).~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.1730 General Long Term~~Long-Term~~ Care – Review Criteria

a) Introduction

1) This Section applies to projects involving General Long Term Care. Applicants proposing to establish, expand or modernize General Long Term Care category of service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Bed Category of Service
	(b)(5) -	Planning Area Need - Service Accessibility
	(e)(1) -	Unnecessary Duplication of Services
	(e)(2) -	Maldistribution
	(e)(3) -	Impact of Project on Other Area Providers
	(g) -	Staffing Availability

	(h) -	Facility Size
	(i) -	Community Related Functions
	(j) -	Zoning
	(k) -	Assurances
Expansion of Existing Services	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(4) -	Planning Area Need – Service Demand – Expansion of Bed Category of Service
	(g) -	Staffing Availability
	(h) -	Facility Size
	(k) -	Assurances
Category of Service Modernization	(f)(1) -	Deterioriated Facilities
	(f)(2) & (3) -	Documentation
	(f)(4) -	Utilization
	(h) -	Facility Size
	(i) -	Community Related Functions
	(j) -	Zoning
Continuum of Care - Establishment or Expansion	(c)(1) & (2) -	Description of Continuum of Care Components
	(c)(3) -	Documentation
	(g) -	Staffing Availability
	(h) -	Facility Size
	(i) -	Community Related Functions
	(j) -	Zoning
	(k) -	Assurances
Defined Population - Establishment or Expansion	(d)(1) -	Description of Defined Population to be Served
	(d)(2) -	Documentation of Need
	(g) -	Staffing Availability
	(h) -	Facility Size
	(i) -	Community Related Functions
	(j) -	Zoning
	(k) -	Assurances

2) If the proposed project involves the replacement of a facility or service onsite, the applicant shall comply with the requirements listed in

subsection (a)(1) for "Category of Service Modernization" plus subsection (k) (Assurances).

3) If the proposed project involves the replacement of a facility or service on a new site, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".

4) If the proposed project involves the replacement of a facility or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing category of bed service shall provide patient origin information for all admissions

for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of bed service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility), for the last six months immediately prior to admission.

3) Service Demand – Establishment of Bed Category of Service
The number of beds proposed to establish a new category of bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new long term care (LTC) facility, the applicant shall submit projected referrals.

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of bed service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient LTC facility.

B) Projected Referrals
An applicant proposing to establish a bed category of service or establish a new LTC facility, shall submit the following:

i) Hospital referral letters that attest to the number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the hospital will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of

referrals cannot exceed the hospital's experienced LTC caseload;

iii) Each referral letter shall contain the Chief Executive Officer's notarized signature, the typed or printed name of the hospital, and the hospital's address; and

iv) Verification by the hospital that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Demand – Expansion of Bed Category of Service
The number of beds to be added at an existing facility is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient facility, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) Hospital referral letters that attest to the hospital's total number of patients (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients whom the hospital will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the hospital's documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

iii) Each referral letter shall contain the hospital Chief Executive Officer's notarized signature, the typed or printed name of the hospital, and the hospital's address; and

iv) verification by the hospital that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Long Term Care Questionnaire.

c) Continuum of Care
The applicant proposing a continuum of care project shall provide the following:

1) The project will provide a continuum of care for a geriatric population that includes independent living and/or congregate housing (such as unlicensed apartments, high rises for the elderly and retirement villages) and related health and social services. The housing complex shall be on the same site as the health facility component of the project.

2) Such a proposal shall be for the purposes of and serve only the residents of the housing complex and shall be developed either after the housing complex has been established, or as a part of a total housing construction

program, provided that the entire complex is one inseparable project, that there is a documented demand for the housing, and that the licensed beds will not be built first, but will be built concurrently with or after the residential units.

3) The applicant shall provide the following:

A) That the proposed number of beds is needed. Documentation shall consist of a list of available patients/residents needing the proposed project. The proposed number of beds shall not exceed one licensed LTC bed for every five apartments or independent living units;

B) Provision in the facility's written operational policies assuring that a resident of the retirement community who is transferred to the LTC facility will not lose his/her apartment unit or be transferred to another LTC facility solely because of the resident's altered financial status or medical indigency; and

C) That admissions to the long term care unit will be limited to current residents of the independent living units and/or congregate housing.

d) Defined Population
The applicant proposing a project for a defined population shall provide the following:

1) The applicant shall document that the proposed project will service a defined population group of a religious, fraternal or ethnic nature from throughout the entire health service area or from a larger geographic service area (referred to in this subsection (d) as the GSA) proposed to be served and that includes, at a minimum, the entire health service area in which the facility is or will be physically located.

2) The applicant shall document each of the following:

A) A description of the proposed religious, fraternal or ethnic group proposed to be served;

B) The boundaries of the GSA;

C) The number of individuals in the defined population who live within the proposed GSA, including the source of the figures;

D) That the proposed services do not exist in the GSA where the facility is or will be located;

E) That the services cannot be instituted at existing facilities within the GSA in sufficient numbers to accommodate the group's needs. The applicant shall specify each proposed service that is not available in the GSA's existing facilities and the basis for determining why that service could not be provided.

F) That at least 85% of the residents of the facility will be members of the defined population group. Documentation shall consist of a written admission policy insuring that the requirements of this subsection (d)(2)(F) will be met.

G) That the proposed project is either directly owned, sponsored or affiliated with the religious, fraternal or ethnic group that has been defined as the population to be served by the project. The applicant shall provide legally binding documents that prove ownership, sponsorship or affiliation.

e) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

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

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

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area facilities that are currently (during the latest 12-month period) operating below the occupancy standards.

f) Category of Service Modernization

1) If the project involves modernization of a category of hospital facility bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or facility shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

g) Staffing Availability - Review Criterion

1) An applicant proposing to establish a new category of service or to add beds to an existing category of service shall document that a sufficient supply of personnel will be available to staff the total number of beds proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those facilities located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced

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a staffing shortage with respect to the categories of services proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

h) Performance Requirements - Facility Size
The maximum size of a general long term care facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c - Long-Term Care Facilities) over a two-year period of time.

i) Community Related Functions – Review Criterion
The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from such organizations.

j) Zoning – Review Criterion

The applicant shall document one of the following:

1) The property to be utilized has been zoned for the type of facility to be developed;

2) Zoning approval has been received; or

3) A variance in zoning for the project is to be sought.

k) Assurances

1) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

2) For beds that have been approved based upon representations for continuum of care (subsection (c)) or defined population (subsection (d)), the facility shall provide assurance that it will maintain admissions limitations as specified in those subsections for the life of the facility. To eliminate or modify the admissions limitations, prior approval of HFPB will be required.

~~a) Facility Size – Review Criterion. The maximum size of a general long-term care facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c) (Long-Term Care Facilities) over a 2-year period of time.~~

~~b)~~ ~~Community Related Functions – Review Criterion. The applicant must document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from such organizations.~~

~~c) Zoning – Review Criterion. The applicant must document one of the following:~~

1) the property to be utilized has been zoned for the type of facility to be developed;

2) zoning approval has been received; or

3) a variance in zoning for the project is to be sought.

d) Variances to Computed Nursing Care Bed Need – Review Criterion

1) Defined Population Variance.

A) The applicant must document that the proposed project will service a defined population group of a religious, fraternal or ethnic nature from throughout the entire health service area or from a larger geographic area (hereinafter referred to as the GA) proposed to be served and which includes, at a minimum, the entire health service area in which the facility is or will be physically located. Documentation shall consist of the following:

i) a description of the proposed religious, fraternal or ethnic group proposed to be served;

ii) the boundaries of the GA; and

iii) the number of individuals in the defined population which lives within the proposed GA, including the source of the figures.

B) In addition, the applicant must document each of the following:

i) the proposed services do not exist in the GA where the facility is or will be located; and

ii) the services cannot be instituted at existing facilities within the GA in sufficient number to accommodate the group's needs. The applicant must enumerate each specific service the proposed facility will provide which could not be provided in any of the existing facilities in the GA; the

basis for determining why such service could not be provided.

C) The application must document that the proposed number of beds is needed based upon the target occupancy rate. Documentation shall consist of an identification of the defined population volume; the patient origin of the proposed patients; and a rationale for the utilization projections.

D) The applicant must document that at least 85% of the residents of the facility will be members of the defined population group. Documentation shall consist of written admission policy which insures that the requirements of this subsection will be met.

E) The applicant must document that the proposed project is either directly owned, sponsored or affiliated with the religious, fraternal or ethnic group that has been defined as the population to be served by the project. The applicant must provide legally-binding documents which prove ownership, sponsorship or affiliation.

2) Continuum of Care Variance

A) The applicant must document that the project will provide a continuum of care for a geriatric population which includes independent living and/or congregate housing (such as unlicensed apartments, high rises for the elderly, and retirement villages) and related health and social services. Such housing complex must be on the same site as the health facility component of the project. Such a proposal must be for the purposes of and serve only the residents of the housing complex and may be developed in one of the following ways:

i) The proposal may be developed after the housing complex has been established; or

ii) The proposal may be developed as a part of a total housing construction program, provided that, the entire complex is one inseparable project and that there is a documented demand for the housing and that the licensed beds will not

~~be built first, but will be built concurrently with or after the residential units.~~

~~B)~~ ~~The applicant must also document the following:~~

~~i)~~ ~~That the proposed number of beds are needed. Documentation shall consist of a list of available patients/residents needing the proposed project. The proposed number of beds may not exceed one licensed long-term care bed for every five apartments or independent living units; and~~

~~ii)~~ ~~That its written policies of operation provide that if a resident of the retirement community is transferred to the long-term care unit, the resident will not lose his or her apartment unit or be transferred to another long-term care facility solely because of the resident's altered financial status or medical indigency.~~

~~e)~~ ~~Staffing – Review Criterion~~
~~Applicants must document that the supply of manpower currently available in the area is sufficient to meet the health service needs in that area. Documentation should include, but is not limited to, letters from employment services in the area indicating the number of potential health care employees on their rolls; letters from local health departments, in whose jurisdiction the applicant is located, indicating the availability of personnel in the planning area; actual applications for employment on file with the applicant; and surveys performed by persons other than the applicant regarding the availability of manpower.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART X: CATEGORY OF SERVICE REVIEW CRITERIA – SELECTED ORGAN TRANSPLANTATION

Section 1110.2310 Introduction (Repealed)

~~Subpart X contains review criteria which pertain to the selected organ transplantation category of service. These review criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

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(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2320 Selected Organ Transplantation – Definitions (Repealed)

~~a)~~ ~~The selected organ transplantation service means a category of service relating to the surgical transplantation of any of the following human organs: heart, lung, heart-lung, liver, pancreas, or intestine and small bowel. It does not include bone marrow or cornea transplants.~~

~~b)~~ ~~A selected organ transplantation center means a hospital which provides staffing and other adult or pediatric medical and surgical specialty services required for the care of a transplant patient.~~

~~c)~~ ~~"Teaching Institution" for the purpose of this Subpart means a hospital having a major relationship with a medical school as defined and listed in the current "Directory of Residency Training Programs" developed by the American Medical Association, 535 Dearborn, Chicago, Illinois 60610 and the National Organ Procurement and Transplantation Network.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2330 Selected Organ Transplantation – Review Criteria

a) Introduction

1) This Section applies to projects involving the following category of service: Selected Organ Transplantation. Applicants proposing to establish or modernize this category of service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Category

		of Service
	(b)(4) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e) -	Staffing Availability
	(f) -	Surgical Staff
	(g) -	Collaborative Support
	(h) -	Support Services
	(i) -	Performance Requirements
	(j) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & 3 -	Documentation
	(d)(4) -	Utilization
	(i) -	Performance Requirements
	(j) -	Assurances

2) If the proposed project involves the replacement of a facility or service on site, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (j) (Assurances).

3) If the proposed project involves the relocation of an existing facility or service, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility", as well as requirements in Section 1110.130 (Discontinuation) and Section 1110.1430(i) (Relocation of Facilities).

4) If the proposed project involves the replacement of a hospital or service (onsite or new site), the number of key rooms being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years.

b) Planning Area Need - Review Criterion

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The applicant shall document that the proposed category of service is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)
No formula need for this category of service has been established.

2) Service to Planning Area Residents
Applicants proposing to establish this category of service shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable) for each category of service included in the project.

3) Service Demand – Establishment of Category of Service
The establishment of this category of service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for this category of service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals
An applicant proposing to establish this category of service shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period

after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Accessibility
The establishment of this category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

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v) For purposes of this subsection (b)(4) only, all services within the three-hour normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

A) A list of all zip code areas that are located, in total or in part, within three hours normal travel time of the project's site;

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

C) The names and locations of all existing or approved health care facilities located within three hours normal travel time from the project site that provide this category of service.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

B) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of this category of service, the applicant shall document that the inpatient areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the utilization standards for the category of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing Availability - Review Criterion

1) An applicant proposing to establish this category of service shall document that a sufficient supply of personnel will be available to staff the proposed project. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care

workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

f) Surgical Staff – Review Criterion
The applicant shall document that the facility has at least one transplant surgeon certified in the applicable specialty on staff and that each has had a minimum of one year of training and experience in transplant surgery, post-operative care, long term management of organ recipients and the immunosuppressive management of transplant patients. Documentation shall consist of curricula vitae of transplant surgeons on staff and certification by an authorized representative that the personnel with the appropriate certification and experience are on the hospital staff.

g) Collaborative Support – Review Criterion
The applicant shall document collaboration with experts in the fields of hepatology, cardiology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, anesthesiology, physical therapy and rehabilitation medicine. Documentation of collaborate involvement shall include, but not be limited to, a plan of operation detailing the interaction of the transplant program and the stated specialty areas.

h) Support Services – Review Criterion
An applicant shall submit a certification from an authorized representative that

attests to each of the following:

1) Availability of on-site access to microbiology, clinical chemistry, radiology, blood bank and resources required to monitor use of immunosuppressive drugs;

2) Access to tissue typing services; and

3) Ability to provide psychiatric and social counseling for the transplant recipients and for their families.

i) Performance Requirements

1) The applicant shall document that the proposed category of service will be provided at a teaching institution.

2) The applicant shall document that the proposed category of service will be performed in conjunction with graduate medical education.

3) The applicant shall provide proof of membership in the Organ Procurement and Transplantation Network (OPTN) and a federally designated organ procurement organization (OPO).

j) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

~~a) Establishment of a Program – Review Criterion~~

~~1) The applicant must document the following:~~

~~A) the applicant is a teaching institution; and~~

~~B) the transplantation program will be performed in conjunction with graduate medical education.~~

2) Documentation shall consist of a written agreement between the applicant and the medical school detailing the relationship of the transplantation program to graduate medical education.

b) Physical Facilities – Review Criterion. The applicant must document sufficient operating and recovery room resources, intensive care resources and personnel to operate the transplant program as reflected in the norms found in Appendix B of this Part.

c) Access to Donor Organs – Review Criterion. The applicant must document access to donor organs. This must be accomplished by membership in the National Organ Procurement and Transplantation Network and in a Regional Organ Procurement Agency.

d) Recipient Selection – Review Criterion. The applicant must provide a copy of its procedures for selecting transplant candidates and distribution of organs.

e) Surgical Staff – Review Criterion. The applicant must document that the facility has on staff transplant surgeon(s) certified in the applicable specialty and that each has had a minimum of one year of training and experience in transplant surgery, post operative care, long term management of organ recipients and the immunosuppressive management of transplant patients. Documentation shall consist of certification by the hospital administrator that the personnel with the appropriate certification and experience are on the hospital staff.

f) Collaborative Support – Review Criterion. The applicant must document collaboration with experts in the fields of hepatology, cardiology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, anesthesiology, physical therapy, and rehabilitation medicine. Documentation of collaborate involvement shall include, but not be limited to, a plan of operation detailing the interaction of the transplant program and the stated specialty areas.

g) Ancillary Services – Review Criterion. The applicant must document on site access to microbiology, clinical chemistry, radiology, blood bank and resources required to monitor use of immunosuppressive drugs. The applicant must also have access to tissue typing services and be able to provide psychiatric and social counseling for the transplant recipient and for their families.

~~h)~~ ~~Data – Review Criterion. The applicant must document that information on finances (cost and charges) and patient outcomes will be provided to the Department of Public Health.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART Y: CATEGORY OF SERVICE REVIEW CRITERIA – KIDNEY TRANSPLANTATION

Section 1110.2410 Introduction (Repealed)

~~Subpart Y contains Review Criteria which pertain to the Kidney Transplantation category of service. These review criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2420 Kidney Transplantation – Definitions (Repealed)

~~a)~~ ~~Kidney Transplantation is a category of service which involves the surgical replacement of a nonfunctioning human kidney with a donor kidney in order to restore renal function to the patient.~~

~~b)~~ ~~Kidney Transplantation Center means a hospital which directly furnishes transplantation and other medical and surgical specialty services required for the care of the kidney transplant patient, including inpatient dialysis furnished directly or under arrangement.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2430 Kidney Transplantation – Review Criteria

a) Introduction

1) This Section applies to projects involving the following category of service: Kidney Transplantation. Applicants proposing to establish or modernize this category of service shall comply with the applicable subsections of this Section, as follows:

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PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Category of Service
	(b)(4) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e) -	Staffing Availability
	(f) -	Surgical Staff
	(g) -	Support Services
	(h) -	Performance Requirements
	(i) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & 3 -	Documentation
	(d)(4) -	Occupancy
	(h) -	Performance Requirements

2) If the proposed project involves the replacement of a facility or service onsite, the applicant shall comply with the requirements listed in subsection (a)(i) for "Category of Service Modernization" plus subsection (i) (Assurances).

3) If the proposed project involves the relocation of an existing facility or service, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility", as well as requirements in Section 1110.130 (Discontinuation) and Section 1110.1430(i) (Relocation of Facilities).

4) If the proposed project involves the replacement of a facility or service (onsite or new site), the number of beds shall be replaced on a 1:1 basis. If

the applicant proposes to add beds to the replacement service or facility, the applicant shall also comply with the requirements listed in subsection (a)(1) for "Expansion of Existing Services".

b) Planning Area Need - Review Criterion
The applicant shall document that the proposed category of service is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)
No formula need for this category of service has been established.

2) Service to Planning Area Residents
Applicants proposing to establish this category of service shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

3) Service Demand – Establishment of Category of Service
The establishment of this category of service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for this category of service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals
An applicant proposing to establish this category of service shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have

received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

4) Service Accessibility
The establishment of this category of service is necessary to improve access for planning area residents. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level,

high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(4) only, all services within the three-hour normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Hospital Questionnaire.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

A) A list of all zip code areas that are located, in total or in part, within three hours normal travel time of the project's site;

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

C) The names and locations of all existing or approved health care facilities located within three hours normal travel time from the project site that provide this category of service.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

B) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of this category of service, the applicant shall document that the areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing Availability - Review Criterion

1) An applicant proposing to establish a new category of service shall document that a sufficient supply of personnel will be available to staff the proposed project. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of services proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

f) Surgical Staff – Review Criterion
The applicant shall document that the facility has at least one transplant surgeon certified in the applicable specialty on staff and that each has had a minimum of one year of training and experience in transplant surgery, post-operative care, long-term management of organ recipients and the immunosuppressive management of transplant patients. Documentation shall consist of curricula vitae of transplant surgeons on staff and certification by an authorized representative that the personnel with the appropriate certification and experience are on the hospital staff.

g) Support Services – Review Criterion
The applicant must document that the following are available on premises: laboratory services, social services, dietetic services, self-care dialysis support services, inpatient dialysis services, pharmacy and specialized blood facilities (including tissue typing). The applicant must also document participation of the center in a recipient registry. Documentation shall consist of a certification as to the availability of such services and participation in a recipient registry.

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h) Performance Requirements
The applicant shall document that:

1) The proposed category of service will be provided at a teaching institution;

2) The proposed category of service will be performed in conjunction with graduate medical education;

3) The applicant renal transplantation center has membership in the Organ Procurement and Transplantation Network (OPTN) and a federally designated organ procurement organization (OPO); and

4) The subject renal transplantation center is performing 25 or more transplants per year.

i) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

~~a) Establishment of Facilities – Review Criterion. The applicant must document that each existing renal transplantation center is serving a population base of more than two million people with the performance of 25 or more transplants per year and that an unserved population of at least two million people exists within three hours travel time. Documentation shall consist of travel time studies involving all existing service providers.~~

~~b) Kidney Transplantation Center – Review Criterion. The applicant must document that the following are available on premises: laboratory services, social services, dietetic services and self-care dialysis support services, inpatient dialysis services, pharmacy, specialized blood facilities (including tissue typing). The applicant must also document participation of the center in a recipient registry. Documentation shall consist of a certification as to the availability of such services and participation in a recipient registry.~~

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~~c)~~ ~~Affiliation Agreements – Review Criterion. The applicant must document that the transplantation center is a teaching institution (see Section 1110.2320(c)).~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART Z: CATEGORY OF SERVICE REVIEW CRITERIA – SUBACUTE CARE HOSPITAL MODEL

Section 1110.2510 Introduction

a) Subpart Z of this Part contains review criteria that~~which~~ pertain to the subacute care hospital model category of service. Definitions pertaining to this Subpart are contained in the Act, in 77 Ill. Adm. Code 1100 and 1130, and in the Alternative Health Care Delivery Act [210 ILCS 3]. The subacute care hospital model category of service is a demonstration program that~~which~~ is authorized by the Alternative Health Care Delivery Act [210 ILCS 3]. These subacute care hospital model review criteria are utilized in addition to the applicable review criteria of Subparts C and AF ~~General Review Criteria contained in Subpart C of this Part and in addition to the Financial and Economic Feasibility Review Criteria contained in 77 Ill. Adm. Code 1120~~. This Subpart also contains the methodology the State Board shall utilize in evaluating competing applications, if any, for the establishment of any subacute care hospital models.

b) A facility at any time may be caring for subacute patients. A permit must be obtained to establish a subacute care hospital model. Existing hospitals and long-term care facilities providing subacute care are not required to obtain a permit *provided, however, that the facilities shall not hold themselves out to the public as subacute care hospitals* (Section 15 of the Alternative Health Care Delivery Act [210 ILCS 3/15]). Establishment of a subacute care hospital model category of service occurs when a facility holds itself out to the general public as a subacute care hospital. In such instances failure to obtain a permit will result in the application of sanctions as provided for in the Illinois Health Facilities Planning Act [20 ILCS 3960].

c) As the purpose of the demonstration project is to evaluate the subacute care hospital model for quality factors, access and the impact on health care costs, each applicant approved for the category of service will be required to periodically submit data necessary for evaluating the model's effectiveness.

d) Applications received for the subacute care hospital model shall be deemed complete upon receipt by IDPH. Due to the comparative nature of the subacute care hospital model review, applicants will not be allowed to amend the application or provide additional supporting documentation during the review process. The application as submitted to IDPH shall serve as the basis for all standard and prioritization evaluation.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2520 Subacute Care Hospital Model-Definitions (Repealed)

~~a)~~ ~~"Subacute Care Hospital" *is a designated site which provides medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. The average length of stay for patients treated in subacute care hospitals shall not be less than 20 days, and for individual patients, the expected length of stay at the time of admission shall not be less than 10 days. A subacute care hospital is either a freestanding building or a distinct physical and operational entity within a hospital or nursing home building. A subacute care hospital shall only consist of beds currently existing in licensed hospitals or skilled nursing facilities.* (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35])~~

~~b)~~ ~~"Subacute Care" means the provision of *medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. Subacute care includes physician supervision, registered nursing, and physiological monitoring on a continual basis.* (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35])~~

~~c)~~ ~~"Subacute Care Hospital Model" means a category of service for the provision of subacute care.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2540 Subacute Care Hospital Model – HFPB~~State Board~~ Review

a) State Board Evaluation. The State Board shall evaluate each application for the subacute care hospital model category of service based upon compliance with the

conditions set forth in subsections (b), (c) and (d) of this Section.

b) State Board Prioritization of Hospital Applications

1) All hospital applications for each planning area shall be rank ordered based on points awarded as follows:

A) Compliance with all applicable review criteria of Subpart C ~~of this Part (General Review Criteria)~~ – 10 Points.

B) Compliance with all review criteria of Section 1110.2530 (Subacute Care Hospital Model Review Standards) – 10 Points.

C) Compliance with all applicable review criteria of Subpart AF~~77 Ill. Adm. Code 1120 (Financial Review Criteria)~~ – 10 Points.

D) In rural areas an applicant shall be awarded 25 Points if documentation is provided that the subacute care hospital model will provide the necessary financial support for the facility to provide continued acute care services. The~~Such~~ documentation shall consist of:

i) Factors within the facility or area ~~that, within the next two years,~~ will prevent the facility from complying with the minimum financial ratios established in Subpart AF~~Part 1120 concerning facility financial viability (a current ratio exceeding 1.5, a net margin percentage greater than 3%, a percent debt to total capitalization ratio of less than 80% and a projected debt service coverage ratio greater than 1.5)~~ within the next two years; and

ii) Historical documentation that the facility has failed to comply with the minimum financial ratios ~~referenced above,~~ in each of the last three calendar years; and

iii) Projected revenue from the:

• subacute hospital care model and the positive impact of that~~such~~ revenue on the financial position

of the applicant facility. The applicant must explain how thesuch revenue will impact the facility's financial position such that the facility will comply with the financial viability ratios of Subpart AFPart 1120 referenced above; or iv)Projected revenue from the

• subacute hospital model will be sufficient to operate thesuch subacute care hospital care model in compliance with the financial viability ratios of Subpart AFPart 1120 referenced above, or that the applicant facility has entered into a binding agreement with another institution thatwhich guarantees the financial viability of the subacute hospital care model in accordance with the ratios established in Subpart AFPart 1120 referenced above for a period of at least five (5) years, regardless of the financial ratios of the applicant facility.

E) Location in a medically underserved area (as defined by the Department of Health and Human Services (Section 332 of the Public Health Service Act) (42 USCU.S.C. 254E) as a health professional shortage area) – 3 Points.

F) A multi-institutional system arrangement exists for the referral of subacute patients where the applicant facility serves as the receiving facility for thesuch a system. A multi-institutional system consists of a network of licensed hospitals and long-term care facilities located within the planning area and within 60 minutes travel time of the applicant thatwhich are inter-related by contractual agreement thatwhich provides for an exclusive best effort arrangement concerning the transfer of patients between facilities. Best effort arrangement means that the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred only to the applicant facility. – 1 Point per each additional facility in the multi-institutional system, to a maximum of 10 Pointsten points.

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G) The existence of Medicare and Medicaid certification at the applicant facility and historic volume at the applicant facility. The following point allocation will be applied:

i) In the last calendar or fiscal year Medicare/Medicaid patient days were between 10% and 25% of total facility patient days – 2 Points.

ii) In the last calendar or fiscal year Medicare/Medicaid patient days were between 26% and 50% of total facility patient days – 4 Points.

iii) In the last calendar or fiscal year Medicare/Medicaid patient days exceeded 50% of total facility patient days – 6 Points.

H) If, in each of the last five calendar years, the applicant facility documents a case mix consisting of: ventilator cases, head trauma cases, rehabilitation patients including spinal cord injuries, amputees and patients with orthopaedic problems requiring subacute care or patients with multiple complex diagnoses that ~~which~~ included physiological monitoring on a continual basis, of such magnitude that if placed in the proposed subacute facility these patients would have constituted an annual occupancy exceeding 75% in each past year. If a multi-institutional system, as defined in subsection (b)(1)(F) of this Section, has an exclusive best efforts agreement, then each of the cases listed in this subsection (b)(1)(H) from such signatory facilities may be counted in computing the 75% annual occupancy threshold~~.~~ – 5 Points.

I) The applicant institution has documented that, during the last calendar year, at least 25% of all patient days of the applicant facility were reimbursed through contractual relationships with preferred provider organizations or HMOs ~~HMO's.~~ – 3 Points.

J) If the applicant institution, over the last five calendar year period, has been issued a notice of revocation of license from IDPH ~~the Department of Public Health~~ or has been decertified from the federal Title XVIII or XIX programs~~.~~ – Loss of 25 Points.

K) The applicant institution is accredited by the Joint Commission on Accreditation of Healthcare Organizations – 3 Points and 1 additional Point if accreditation is "with commendation~~.~~".

L) Staff support for the subacute care hospital model:

i) Full time Medical Director~~medical director~~ exclusively for the model – 1 Point,

ii) Physical therapist, 2 full-time equivalents (FTEs~~FTE's~~) or more – 1 Point,

iii) Occupational therapist, 1 FTE or more – 1 Point,

iv) Speech therapist, 1 FTE or more – 1 Point.

M) In areas where competing applications have been filed, 3 Points will be allocated to the applicant with the lowest positive mean net margin over the last three fiscal years. Each applicant must submit copies of the audited financial reports of the applicant facility for the latest three fiscal years.

2) Required Point Totals – Hospital Applications
A hospital application for the development of a subacute care hospital model must obtain a minimum of 50 points for approval. The applicant within the planning area receiving the most points shall be granted the permit for the category of service if the minimum point total has been exceeded. In the case of tie scores, HFPB ~~the State Board~~ shall base its decision on considerations relating to location, scope of service and access.

c) State Board Prioritization – Long-term Care Facilities

1) All long-term care applications for each planning area shall be rank ordered based on points awarded as follows:

A) Compliance with all applicable review criteria of Subpart C ~~(General Review Criteria)~~ – 10 Points

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B) Compliance with all review criteria of Section 1110.2530 (Subacute Care Hospital Model Review Criteria) – 10 Points

C) Compliance with all applicable review criteria of Subpart AF~~Part 1120 (Financial and Economic Review Criteria)~~ – 10 Points

D) The applicant has had an Exceptional Care Contract with the Illinois Department of Healthcare and Family Services~~Public Aid~~ for at least two years in the past four years~~.~~ – 3 Points

E) Location in a medically underserved area (as defined by the federal Department of Health and Human Services (Section 332 of the Public Health Service Act) (42 USC~~U.S.C.~~ 254E) as a health professional shortage area) – 3 Points

F) The existence of Medicare and Medicaid certification at the applicant facility and historic volume at the facility. The following point allocation will be applied:

i) In the last calendar year or fiscal year Medicare/Medicaid patient days were between 10% and 25% of total facility patient days~~.~~ – 3 Points

ii) In the last calendar or fiscal year Medicare/Medicaid patient days were between 26% and 50% of total facility patient days~~.~~ – 6 Points

iii) In the last calendar or fiscal year Medicare/Medicaid patient days exceeded 50% of total facility patient days~~.~~ – 9 Points

G) If in each of the last two calendar years the applicant institution documents a casemix consisting of: ventilator cases, head trauma cases, rehabilitation patients including stroke cases, spinal cord injury, amputees and patients with orthopaedic problems requiring subacute care or patients with multiple complex diagnoses that~~which~~ included physiological monitoring on a continual basis, of such magnitude that, if placed in the proposed subacute facility,

these patients would have constituted an annual occupancy exceeding 50% in each past year. If a multi-institutional system, as defined in subsection (c)(1)(M) of this Section, has an exclusive best efforts agreement, then each of the cases listed in this subsection (c)(1)(G) from such signatory facilities may be counted in computing the 50% annual occupancy threshold. – 5 Points

H) The applicant has documented that, during the last calendar year, at least 20% of all patient days of the applicant facility were reimbursed through contractual relationships with preferred provider organizations or HMOs ~~HMO's.~~ – 3 Points

I) If the applicant, over the last five year period, has been issued a notice of revocation of license from IDPH ~~the Department of Public Health~~ or decertified from the federal Title XVIII or XIX programs. – Loss of 25 Points

J) Staff support for the subacute care hospital model:

i) Full time Medical Director ~~medical director~~ exclusively for the model. – 1 Point

ii) Physical therapist, 2 FTEs ~~full-time equivalents (FTE's)~~ or more. – 1 Point

iii) Occupational therapist, 1 FTE or more. – 1 Point

iv) Speech therapist, 1 FTE or more – 1 Point.

K) In areas where competing applications have been filed, 3 Points will be allocated to the application with the lowest positive mean net margin over the last three fiscal years. Each applicant must submit copies of the audited financial reports of the applicant facility for the latest three fiscal years.

L) The applicant institution is accredited by the Joint Commission on Accreditation of Healthcare Organizations – 3 Points and 1 additional Point if accreditation is "with commendation.".

M) A multi-institutional system arrangement exists for the referral of subacute patients where the applicant facility serves as the receiving facility for thesuch a system. A multi-institutional system consists of a network of licensed hospitals and long-term care facilities located within the planning area and within 60 minutes travel time of the applicant thatwhich are inter-related by contractual agreement thatwhich provides for an exclusive best effort arrangement concerning the transfer of patients between facilities. 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. – 1 Point per each additional facility in the multi-institutional system to a maximum of 10 Pointsten points.

2) A long-term application for the development of a subacute care hospital model must obtain a minimum of 50 Pointspoints for approval. The applicant within the planning area receiving the most points shall be granted the permit for the category of service if the minimum point total has been exceeded. In the case of tie scores, HFPBthe State Board shall base its selection on considerations relating to location, scope of service and access.

d) HFPBState Board Prioritization of Previously Licensed Hospital Applications in Chicago

1) All applications for sites previously licensed as hospitals in Chicago shall be rank ordered based upon points awarded as follows:

A) Compliance with all applicable review criteria of Subpart C of this Part (General Review Criteria) – 10 Points.

B) Compliance with all review criteria of Section 1110.2530 (Subacute Care Hospital Model Review Standards) – 10 Points.

C) Compliance with all applicable review criteria of Subpart AD77 Ill. Adm. Code 1120 (Financial Review Criteria) – 10 Points.

D) Documentation that the proposed number of beds will be utilized at an occupancy rate of 75% or more within two years after permit

approval. Documentation shall consist of historical subacute caseload from one or more referral facilities where such caseload would in the future be transferred to the subacute model for care, anticipated caseload from physician referrals to the unit and demographic studies projecting the need for subacute service within the primary market of the proposed subacute hospital care model~~.~~ – 10 Points

2) Required Point Totals – Previously Licensed Hospitals
The applicant within the planning area receiving the most points shall be granted the permit for the category of service. In the case of tie scores, HFPB ~~the State Board~~ shall base its selection on considerations relating to location, scope of service and access.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART AA: CATEGORY OF SERVICE REVIEW CRITERIA – POSTSURGICAL RECOVERY CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section 1110.2610 Introduction

a) Subpart AA of this Part contains review criteria that~~which~~ pertain to the postsurgical recovery care center alternative health care model category of service. Definitions pertaining to this Subpart are contained in the Act, in 77 Ill. Adm. Code 1100 and 1130, and in the Alternative Health Care Delivery Act [210 ILCS 3]. The postsurgical recovery care center alternative health care model category of service is a demonstration program that~~which~~ is authorized by the Alternative Health Care Delivery Act. These postsurgical recovery care center alternative health care model review criteria are utilized in addition to the applicable review criteria of Subparts C and AD~~General Review Criteria contained in Subpart C of this Part and in addition to the Financial and Economic Feasibility Review Criteria contained in 77 Ill. Adm. Code 1120~~. This Subpart also contains the methodology HFPB~~the State Board~~ shall utilize in evaluating competing applications, if any, for the establishment of any postsurgical recovery care center alternative health care models.

b) A postsurgical recovery care center alternative health care model must obtain a CON~~certificate of need~~ permit to establish the category of service prior to receiving a license for the service. Failure to obtain a~~such~~ permit will result in the

application of sanctions as provided for in the Illinois Health Facilities Planning Act [20 ILCS 3960].

c) As the purpose of the demonstration project is to evaluate the model for quality factors, access and the impact on health care cost, each applicant approved for the category of service will be required to periodically submit data necessary for evaluating the model's effectiveness. All data requests of this type shall be a component of the semi-annual progress reports required of all permit holders. Data collected shall be provided to IDPH ~~the Department of Public Health~~ and the Illinois State Board of Health for use in their evaluation of the model.

d) Applications received for the postsurgical recovery care center alternative health care model shall be deemed complete upon receipt by IDPH~~the State Agency~~. All postsurgical recovery care center alternative health care models for the purposes of review shall be considered the establishment of a category of service rather than an addition of beds. ~~Therefore, the 60 day review requirement of 77 Ill. Adm. Code 1130.610(b) for bed projects shall not apply to applications of this type.~~ Due to the comparative nature of the postsurgical recovery care center alternative health care model review applicants will not be allowed to amend the application or provide additional supporting documentation during the review process prior to the initial HFPB~~State Board~~ decision. The application, as submitted to IDPH, shall serve as the basis for all standard and prioritization evaluation.

~~e) Applications received for the postsurgical recovery care center alternative health care model must be received by IDPH between 8:30 and 5:00 p.m.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2620 Postsurgical Recovery Care Center Alternative Health Care Model – Definitions (Repealed)

~~a) "Postsurgical Recovery Care Center" *is a designated site which provides postsurgical recovery care for generally health patients undergoing surgical procedures that require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting.* Such a center may be either freestanding or a defined unit of an ambulatory surgical treatment center or hospital. The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 72 hours. (Section 35 of the Alternative Health Care~~

~~Delivery Act [210 ILCS 3/35])~~

~~b)~~ ~~"Postsurgical Recovery Care Center Alternative Health Care Model" means a category of service for the provision of postsurgical recovery care within a postsurgical recovery care center.~~

~~c)~~ ~~"Surgical Referral Site" means an ambulatory surgical treatment center or hospital in which surgery will be performed and the surgical patient then transferred to the recovery care center.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2640 Postsurgical Recovery Care Center Alternative Health Care Model – HFPB~~State Board~~ Review

a) HFPB~~State Board~~ Evaluation~~.~~
HFPB~~The State Board~~ shall evaluate each application for the postsurgical recovery care center alternative health care model category of service (refer to 77 Ill. Adm. Code 1100.750(c) for development restrictions) based upon compliance with the conditions set forth in subsection (b) ~~below~~.

b) HFPB~~State Board~~ Prioritization

1) An application for the category of service must meet the development restrictions specified in 77 Ill. Adm. Code 1100.750(c).

2) All applications for each planning area shall be rank ordered based on points awarded as follows:

A) Compliance with all applicable review criteria of Subpart C ~~of this Part (General Review Criteria)~~ – 10 Points.

B) Compliance with all review criteria of Section 1110.2630 (Postsurgical Recovery Care Center Alternative Health Care Model Review Standards) – 10 Points.

C) Compliance with all applicable review criteria of Subpart AD~~77 Ill. Adm. Code 1120 (Financial Review Criteria)~~ – 10 Points.

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D) Location in a medically underserved area (as defined by the federal Department of Health and Human Services (Section 332 of the Public Health Service Act) as a health professional shortage area) – 3 Points.

E) To ensure~~insure~~ that the model evaluates a wide range of surgical cases, an applicant shall be awarded an additional point for each designated surgical specialty area beyond the required three areas from which patients are referred to the postsurgical recovery care center ~~(refer to Section 1110.2630(c) for surgical specialties)~~.

F) Historical Medicare and Medicaid surgical revenue at the surgical referral sites. 10% to 25%~~Ten to twenty-five percent~~ – 3 Points, 26% to 50%~~twenty-six to fifty percent~~ – 6 Points and over 50%~~fifty percent~~ – 9 Points

G) Accreditation of the applicant facility or facilities by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Healthcare (AAAHC)~~.~~ – 3 Points~~.~~

3) A postsurgical recovery care center alternative health care model must obtain a minimum of 30 Points~~points~~ to be considered for approval. Competing applications within a planning area that~~which~~ have obtained the points necessary for permit consideration shall be evaluated by the HFPB~~State Board~~ to determine which application best implements the goals of the Health Facilities Planning Act and the Alternative Health Care Delivery Act.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART AB: CATEGORY OF SERVICE REVIEW CRITERIA – CHILDREN'S COMMUNITY-BASED HEALTH~~RESPITE~~ CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section 1110.2710 Introduction

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a) Subpart AB of this Part contains review criteria thatwhich pertain to the Children's Community-Based Health Respite Care Center Alternative Health Care Model category of service. Definitions pertaining to this Subpart are contained in the Act, in 77 Ill. Adm. Code 1100 and 1130, and in the Alternative Health Care Delivery Act [210 ILCS 3]. The Children's Community-Based HealthRespite Care Center Alternative Health Care Model category of service is a demonstration program thatwhich is authorized by the Alternative Health Care Delivery Act. These Children's Community-Based HealthRespite Care Center Alternative Health Care Model review criteria are utilized in addition to the General Review Criteria contained in Subpart C of this Part and in addition to the applicable review criteria of Subparts C and ADFinancial and Economic Feasibility Review Criteria contained in 77 Ill. Adm. Code 1120. This Subpart also contains the methodology HFPBthe State Board shall utilize in evaluating competing applications, if any, for the establishment of any Children's Respite Care Alternative Health Care Models. *The provisions of the Act concerning children's respite care centers shall not apply to any facility licensed under the Hospital Licensing Act, the Nursing Home Care Act, or the University of Illinois Hospital Act that provides respite care services to children* (Section 15 of the Alternative Health Care Delivery Act [210 ILCS 3/15]).

b) A Children's Community-Based HealthRespite Care Center Alternative Health Care Model must obtain a certificate of need permit to establish the category of service prior to receiving a license for the service. Failure to obtain asuch permit will result in the application of sanctions as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960].

c) As the purpose of the demonstration project is to evaluate the model for quality factors, access and the impact on health care costs, each applicant approved for the category of service will be required to periodically submit data necessary for evaluating the model's effectiveness. Data collected shall be provided to IDPHthe Department of Public Health and the Illinois State Board of Health for use in their evaluation of the model.

d) Applications received for the Children's Community-Based HealthRespite Care Center Alternative Health Care Model shall be deemed complete upon receipt by HFPBthe State Agency. All Children's Community-Based HealthRespite Care Center Alternative Health Care Models for purposes of review shall be considered the establishment of a category of service rather than the addition of beds. Therefore, the 60-day review requirement of 77 Ill. Adm. Code 1130.610(b) for

~~bed projects shall not apply to applications of this type.~~ Due to the comparative nature of the Children's Community~~-~~Based Health~~Respite~~ Care Center Alternative Health Care Model review, applicants will not be allowed to amend the application or provide additional supporting documentation during the review process prior to the initial HFPB~~State Board~~ decision. The application, as submitted to HFPB~~the State Agency~~, shall serve as the basis for all standard and prioritization evaluations.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2720 Children's Respite Care Center Alternative Health Care Model – Definitions (Repealed)

~~a)~~ ~~"Children's Respite Care Alternative Health Care Model" means a category of service for the provision of respite care to medically frail or technologically dependent children within a children's respite care center. Children cannot exceed age 18 and length of stay must be 14 days or less.~~

~~b)~~ ~~"Children's Respite Care Center" means a facility physically separate and apart from any other facility licensed by the Department of Public Health under the Alternative Health Care Delivery Act or any other Act and which is established and designed to provide a home-like environment to medically frail/technologically dependent children who are placed within the facility for short durations in order to provide a respite for the caregiver(s). The facility must provide *at a minimum, out-of-home respite care, hospital to home training for families and caregivers; short term transitional care to facilitate placement and training for foster care parents; parent and family support groups* (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35]).~~

~~c)~~ ~~"Medically Frail or Medically Fragile Child" means a child who requires a particular medical device to compensate for the use of a body function and who must be constantly assessed and monitored and have the necessary health care readily available to avert death or further disability.~~

~~d)~~ ~~"Out-of-Home Respite Care" means care provided in a facility setting to a clinically stable individual whose medical condition does not require major diagnostic procedures or therapeutic interventions and who normally receives such care in a home environment for the purposes of providing a respite to the caregiver from the responsibilities of providing such care.~~

~~e)~~ ~~"Short Term Transitional Care" means care provided to an individual on an interim basis to allow for the training of the home caregiver or to allow the relocation of the patient from one care environment to another.~~

~~f)~~ ~~"Technologically Dependent or Technology Dependent Child" means a child who has a chronic health related condition and whose survival and quality of life is dependent upon medical technology whether it be mechanical, biological or technical.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2730 Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model – Review Criteria

a) Admission Policies – Review Criterion
The applicant shall~~must~~ document that the Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model will not restrict admissions due to age, race, diagnosis, or source of payment. Documentation shall consist of copies of all admission policies to be in effect at the facility and a signed statement that no restrictions on admissions due to these~~the~~ factors ~~indicated above~~ will occur.

b) Staffing – Review Criterion
The applicant shall~~must~~ document that the children's community-based health~~respite~~ care center will have a Medical Director~~medical director~~ who has expertise in chronic diseases of children. The applicant must also provide a staffing plan that will provide for nursing coverage as required by licensure. Documentation shall consist of: identification of the number and type of staff positions dedicated to the model; how special staffing circumstances will be handled; and identification of the facility Medical Director~~medical director~~ and a description of his or her responsibilities.

c) Mandated Services – Review Criterion
The applicant shall~~must~~ document that the children's community-based health~~respite~~ care center has the capability of providing the minimum range of services required under the Act, as referenced in Section 1110.2720(b). Documentation shall consist of a narrative explaining how ~~such~~ services will be provided.

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d) Acute Care Backup – Review Criterion
The applicant shall~~must~~ document that an agreement has been signed with an acute care facility for the referral of emergency patients. The acute care facility shall ~~must~~ be located within 15 minutes travel time of the children's community-based health~~respite~~ care center and have an organized pediatric department.

e) Patient Screening/Emergency Care – Review Criterion
The applicant shall~~must~~ document that an admission protocol will be established for the screening of potential residents for the severity of medical conditions associated with the required care for the child. Facilities of this type are not intended to provide diagnosis or treatment or care to the chronic child whose medical condition would warrant placement in a facility when more sophisticated medical intervention is required. Documentation shall include a narrative description of all protocols developed for the medical screening of potential admissions. The applicant shall~~must~~ also document that, for each child admitted, a care plan has been developed that~~which~~ identifies the medical needs of the child and identifies a physician who~~that~~ can be contacted in case of emergency. The applicant shall~~must~~ submit a copy of the facility's protocols dealing with the required components of individual care plans and how emergency situations will be handled.

f) Education – Review Criterion
The applicant shall~~must~~ document that children who participate in educational programs will continue to receive ~~such~~ services during their stay at the facility. Documentation shall detail who has the responsibility for maintaining these services and how ~~such~~ services will be provided.

g) Age Specific Needs – Review Criterion
The needs of the medically frail child differ due to medical condition and to the age of the patient. The applicant shall~~must~~ document that, if the center will admit children of all age groups, ~~that~~ the appropriate staff expertise exists to deal with the care needs of all age groups admitted to the facility. Documentation shall consist of a narrative description of staff expertise as it pertains to the specific care needs required of the various age groups that will be admitted.

h) Project Costs – Review Criterion

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An applicant shall~~must~~ document that the project cost to establish a~~such~~ model will not exceed $800,000. Documentation shall be based on Subpart AD~~the Part 1120 financial~~ data submissions that~~which~~ detail the itemized costs of the project.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2740 Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model – HFPB~~State Board~~ Review

a) HFPB~~State Board~~ Evaluation~~.~~
HFPB~~The State Board~~ shall evaluate each application for the Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model category of service (refer to 77 Ill. Adm. Code 1100.760(c) for development restrictions) based upon compliance with the conditions set forth in subsection (b).

b) HFPB~~State Board~~ Prioritization

1) An application for the category of service shall~~must~~ meet the development restrictions specified in 77 Ill. Adm. Code 1100.760(c).

2) All applications for each planning area shall be evaluated by HFPB~~the State Board~~ and awarded points as follows:

A) Compliance with all applicable review criteria of Subpart C~~General Review Criteria~~ – 10 Points~~.~~

B) Compliance with all review criteria of Section 1110.2730 (Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model Review Criteria) – 10 Points~~.~~

C) Compliance with all applicable review criteria of Subpart AD~~77 Ill. Adm. Code 1120 (Financial Review Criteria)~~ – 10 Points~~.~~

D) Location of the proposed model in a residential community under single family or group home zoning requirements – 5 Points~~.~~

E) Location in a health professional shortage area (as defined by the federal Department of Health and Human Services (Section 332 of

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the Public Health Service Act~~,~~ (42 USC 254(e))) – 3 Points~~.~~

3) A proposed Children's Community~~-~~Based Health~~Respite~~ Care Center Alternative Health Care Model shall~~must~~ comply with the development restrictions specified in 77 Ill. Adm. Code 1100.760(c) and shall~~must~~ obtain a minimum of 20 Points~~points~~ to be considered for approval. Competing applications within a planning area that~~which~~ have obtained the points necessary for permit consideration shall be evaluated by HFPB~~the State Board~~ to determine which application best implements the goals of the Health Facilities Planning Act and the Alternative Health Care Delivery Act, including the extent to which the model will provide care in a home-like environment and be located in a residential community.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2750 Children's Community-Based Health~~Respite~~ Care Center Alternative Health Care Model – Project Completion

a) Since the purpose for establishment of this category of service is to evaluate the alternative delivery model for effectiveness, such projects are not complete until such time as the model is evaluated and the decision made to adopt or not adopt the model as an ongoing licensed level of service separate from an alternative delivery model. A permit will not be required of a Children's Respite Care Alternative Health Care Model which proposes to cease participation in the demonstration program. If the facility proposes to discontinue the model, written notice containing the reasons for the discontinuation must be received by HFPB~~the State Board~~ at least 90 days prior to the anticipated discontinuation. The project shall be considered abandoned as of the date IDPH~~the Agency~~ receives notice of the actual discontinuation or the date the last patient is discharged, whichever is later and the facility should be removed from the inventory.

b) All assurances for service presented in the application shall be in effect until the demonstration program has been completed, unless altered pursuant to the approval of HFPB~~the State Board~~.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART AC: CATEGORY OF SERVICE REVIEW CRITERIA –

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COMMUNITY-BASED RESIDENTIAL REHABILITATION CENTER
ALTERNATIVE HEALTH CARE MODEL

Section 1110.2810 Introduction

a) Subpart AC of this Part contains review criteria that pertain to the community-based residential rehabilitation center category of service. Definitions pertaining to this Subpart are contained in the Act, in 77 Ill. Adm. Code 1100 and 1130, and in the Alternative Health Care Delivery Act [210 ILCS 3]. The community-based residential rehabilitation category of service is a demonstration program that is authorized by the Alternative Health Care Delivery Act ~~[210 ILCS 3]~~.

b) As the purpose of the demonstration project is to evaluate the community-based residential rehabilitation model for quality factors, access and the impact on health care costs, the model approved for the category of service will be required to periodically submit data necessary for evaluating the model's effectiveness. Data collected shall be provided to IDPH~~the Department of Public Health~~ and the Illinois State Board of Health for use in their evaluation of the model.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 1110.2820 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Definitions (Repealed)

~~a)~~ ~~"Community-Based Residential Rehabilitation Center" *is a designated site that provides rehabilitation or support, or both, for persons who have experienced severe brain injury, who are medically stable, and who no longer require acute rehabilitative care or intense medical or nursing services. The average length of stay in a community-based residential rehabilitation center shall not exceed 4 months.* [210 ILCS 3/35]~~

~~b)~~ ~~Community-Based Residential Rehabilitation" *services include, but are not limited to, case management, training and assistance with activities of daily living, nursing consultation, traditional therapies (physical, occupational, speech), functional interventions in the residence and community (job placement, shopping, banking, recreation), counseling, self-management strategies, productive activities, and multiple opportunities for skill acquisition and practice throughout the day.* [210 ILCS 3/35]~~

~~c)~~ ~~"Model" means a category of service for the provision of community based residential rehabilitation care and services.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 1110.2830 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Review Criteria

a) Staffing – Review Criterion
The applicant shall~~must~~ furnish a detailed staffing plan that provides: staff qualifications; identification of the number and type of staff positions dedicated to the model; how special staffing circumstances will be handled; staffing patterns for the proposed community-based residential rehabilitation center; and the manner in which non-dedicated staff services will be provided.

b) Mandated Services – Review Criterion
The applicant shall~~must~~ document that the community-based residential rehabilitation center has the capability of providing the minimum range of services required under the Alternative Health Care Delivery Act [210 ILCS 3/35]~~Act as referenced in Section 1110.2820(b)~~. Documentation shall consist of a narrative of how ~~such~~ services will be provided.

c) Unit Size – Review Criterion
The applicant shall~~must~~ document the number and location of all beds in the model. The applicant shall~~must~~ also document that the number of community-based residential rehabilitation beds shall not exceed 12 beds in any one residence, as defined in Section 35 of the Alternative Health Care Delivery Act ~~[210 ILCS 3/35]~~. No community-based residential rehabilitation center alternative health care delivery model shall exceed 100 beds.

d) Utilization – Review Criterion
The applicant shall~~must~~ document that the target utilization for this model (as defined at 77 Ill. Adm. Code 1100.770(c)) will be achieved by the second year of the model's operation. Documentation shall include, but not be limited to, historical utilization trends, population growth, expansion of professional staff or programs and the provision of new procedures that increase utilization.

e) Background of Applicant – Review Criterion
The applicant shall~~must~~ demonstrate experience in providing the services required

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by the model. Additionally, the applicant shall~~must~~ document that the programs provided in the~~this~~ 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.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART AD: CATEGORY OF SERVICE REVIEW CRITERIA – LONG TERM ACUTE CARE HOSPITAL BED PROJECTS

Section 1110.2930 Long Term Acute Care Hospital Bed Projects – Review Criteria

a) Introduction

1) This Section applies to projects involving the following categories of hospital bed services: Long Term Acute Care Hospital (LTACH). Applicants proposing to establish, expand or modernize a category of hospital bed service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
Establishment of Services or Facility	(b)(1) -	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(b)(2) -	Planning Area Need – Service to Planning Area Residents
	(b)(3) -	Planning Area Need – Service Demand - Establishment of Bed Category of Service
	(b)(5) -	Planning Area Need - Service Accessibility
	(c)(1) -	Unnecessary Duplication of Services
	(c)(2) -	Maldistribution
	(c)(3) -	Impact of Project on Other Area Providers
	(e) -	Staffing Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Expansion of Existing Services	(b)(2) -	Planning Area Need – Service to

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		Planning Area Residents
	(b)(4) -	Planning Area Need – Service Demand – Expansion of Bed Category of Service
	(e) -	Staffing Availability
	(f) -	Performance Requirements
	(g) -	Assurances
Category of Service Modernization	(d)(1) -	Deterioriated Facilities
	(d)(2) & 3 -	Documentation
	(d)(4) -	Occupancy
	(f) -	Performance Requirements

2) If the proposed project involves the replacement of a hospital or service on-site, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (g) (Assurances).

3) If the proposed project involves the replacement of a hospital or service on a new site, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".

4) If the proposed project involves the replacement of a hospital or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".

5) If the proposed project involves the conversion of existing acute care beds to LTACH services, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility", as well as requirements in subsection (b)(6) (Conversion of Existing General Acute Care Beds).

b) Planning Area Need - Review Criterion
The applicant shall document that the number of LTACH beds to be established or added is necessary to serve the planning area's population, based on the following:

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1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of LTACH beds to be established is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of LTACH beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing category of bed service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 75% of admissions were residents of the area. For all other projects, applicants shall document that at least 75% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing category of hospital bed service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility), for the last six months immediately prior to admission.

3) Service Demand – Establishment of Bed Category of Service
The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

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A) Historical Referrals
If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of hospital bed service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals
An applicant proposing to establish a bed category of service or establish a new hospital shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing LTACH facilities located in the area or had a length of stay of over 25 days in a general acute care hospital and were considered to be LTACH candidates, annually over the latest two year period prior to submission of the application; and an estimate as to the number of patients that will be referred to the applicant's facility;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Type of Patients

The applicant shall identify the type of patients that will be served by the project by providing the anticipated diagnosis (by DRG classification) for anticipated admissions to the facility. The applicant shall also indicate the types of service (e.g., ventilator care, etc.) to be provided by the project.

4) Service Demand – Expansion of Bed Category of Service
The number of beds to be added for each category of service is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years.

B) Projected Referrals
The applicant shall provide the following:

i) Physician referral letters that attest to the number of patients (by zip code of residence) that have received care at existing LTACH facilities located in the area or had a length of stay of over 25 days in a general acute care hospital and were considered to be LTACH candidates, during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period

after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

iii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

C) Projected Service Demand – Based on Rapid Population Growth If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:

i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;

ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;

iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;

iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;

v) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a

period of time equal to or in excess of the projection horizon;

vi) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and

vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPB.

5) Service Accessibility
The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions
The applicant shall document that at least one of the following factors exists in the planning area:

i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the 45-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

B) Supporting Documentation
The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

i) The location and utilization of other planning area service providers;

ii) Patient location information by zip code;

iii) Independent time-travel studies;

iv) A certification of waiting times;

v) Scheduling or admission restrictions that exist in area providers;

vi) An assessment of area population characteristics that document that access problems exist;

vii) Most recently published IDPH Hospital Questionnaire.

6) Conversion of Existing General Acute Care Beds – Review Criterion
An applicant proposing to establish a Long-Term Acute Care Hospital category of service through the conversion of existing general acute care beds shall:

A) Address Section 1110.130 for discontinuation of categories of service;

B) Identify modifications in scope of services or elimination of clinical service areas, not covered in Section 1110.130 (e.g., Emergency Department Classification, Surgical Services, Outpatient Services, etc.);

C) Submit a statement as to whether the following clinical service areas are to be available to the general population (non-LTACH): operating rooms, surgical procedure rooms, diagnostic services, therapy services (physical, occupational, speech, respiratory) and other outpatient services; and

D) Document that changes in clinical service areas will not have an adverse impact upon the health care delivery system. An applicant shall document that a written request for information on any adverse impact was received by all hospitals within the 45-minute normal travel time, and that the request included a statement that a written response be provided to the applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute a non-rebuttable assumption that the existing facility will be adversely impacted.

c) Unnecessary Duplication/Maldistribution - Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

A) A list of all zip code areas that are located, in total or in part, within 45 minutes normal travel time of the project's site;

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

C) The names and locations of all existing or approved health care facilities located within 45 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

d) Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

B) Non-compliance with licensing or life safety codes;

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH CMMS inspection reports; and

B) Joint Commission on Accreditation of Healthcare Organizations reports.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

A) Copies of maintenance reports;

B) Copies of citations for life safety code violations; and

C) Other pertinent reports and data.

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing Availability - Review Criterion

1) An applicant proposing to establish a new hospital or to add beds to an existing hospital shall document that a sufficient supply of personnel will be available to staff the total number of beds proposed. Sufficient staff availability shall be based upon evidence that, for the latest 12-month period prior to submission of the application, those hospitals located in zip code areas that are, in total or in part, within one hour normal travel time of the applicant facility's site have not experienced a staffing shortage with respect to the categories of service proposed by the project.

2) A staffing shortage is indicated by an average annual vacancy rate of more than 10% for budgeted full-time equivalent staff positions for health care workers who are subject to licensing by the Department of Financial and Professional Regulation.

3) An applicant shall document that a written request for this information was received by all existing facilities within the zip code areas, and that the request included a statement that a written response be provided to the

applicant no later than 15 days after receipt. Failure by an existing facility to respond to the applicant's request for information within the prescribed 15-day response period shall constitute an assumption that the existing facility has not experienced staffing vacancy rates in excess of 10%. Copies of any correspondence received from the facilities shall be included in the application.

4) If more than 25% of the facilities contacted indicated an experienced staffing vacancy rate of more than 10%, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

f) Performance Requirements

1) Bed Capacity Minimum
An applicant shall document that the project will result in a facility capacity of at least 50 Long Term Acute Care Hospital beds located in an MSA and 25 Long Term Acute Care Hospital beds in a non-MSA.

2) Length of Stay

A) An applicant proposing to add beds to an existing service shall document that the average length of stay (ALOS) for the subject service is consistent with the planning area's 3-year ALOS.

B) Documentation shall consist of the 3-year ALOS for all hospitals within the planning area (as reported in the Annual Hospital Questionnaire).

C) An applicant whose existing services have an ALOS exceeding 125% of the ALOS for area providers shall document that the severity or type of illness treated at the applicant facility is significantly higher than the planning area average. Documentation shall be provided from CMMS or other objective records.

D) An applicant whose existing services have an ALOS lower than the planning area ALOS shall submit an explanation as to the reasons for the divergence.

3) Be certified by Medicare as a Long-Term Acute Care Hospital within 12 months after the date of project completion.

g) Assurances
The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, within 30 months of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

(Source: Added at 32 Ill. Reg. _____, effective _____)

SUBPART AE: CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE – REVIEW CRITERIA

Section 1110.3030 – Clinical Service Areas Other Than Categories of Service - Review Criteria

a) Introduction

1) These criteria are applicable only to those projects or components of projects (including major medical equipment), concerning Clinical Service Areas (CSAs) that are not "Categories of Service", but for which utilization standards are listed in Appendix B, including:

A) Surgery

B) Emergency Services and/or Trauma

C) Ambulatory Care Services (organized as a service)

D) Diagnostic and Interventional Radiology/Imaging (by modality)

E) Therapeutic Radiology

F) Laboratory

G) Pharmacy

H) Occupational Therapy/Physical Therapy

I) Major Medical Equipment

2) The applicant shall also comply with requirements of the review criterion in Section 1110.234(a) (Size of Project), as well as all other applicable requirements in 77 Ill. Adm. Code 1100, 1110 and 1130. Applicants proposing to establish, expand or modernize CSAs shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA
New Services or Facility or Equipment	(b) - Need Determination - Establishment
Service Modernization	(c)(1) - Deteriorated Facilities and/or (c)(2) - Necessary Expansion PLUS (c)(3)(A) - Utilization - Major Medical Equipment or (c)(3)(B) - Utilization - Service or Facility

3) If the proposed project involves the replacement of a facility or service onsite, the applicant shall comply with the requirements listed in subsection (a)(2) for "Service Modernization".

4) If the proposed project involves the replacement of a facility or service on a new site, the applicant shall comply with the requirements of subsection (a)(2) for "New Services or Facility or Equipment".

5) Projects involving the replacement of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B.

6) The number of key rooms proposed in a replacement or modernization project shall be justified by the historical utilization for each of the latest two years, per utilization standards cited in Appendix B.

b) Need Determination - Establishment
The applicant shall describe how the need for the proposed establishment was determined by documenting the following:

1) Service to the Planning Area Residents

A) Either:

i) The primary purpose of the proposed project is to provide care to the residents of the planning area in which the proposed service will be physically located; or

ii) If the applicant service area includes a primary and secondary service area that expands beyond the planning area boundaries, the applicant shall document that the primary purpose of the project is to provide care to residents of the service area; and

B) Documentation shall consist of strategic plans or market studies conducted, indicating the historical and projected incidence of disease or health conditions, or use rates of the population. The number of years projected shall not exceed the number of historical years documented. Any projections and/or trend analyses shall not exceed 10 years.

2) Service Demand
To demonstrate need for the proposed CSA services, the applicant shall document one or more of the indicators presented in subsections (b)(2)(A) through (D). For any projections, the number of years projected shall not exceed the number of historical years documented. Any projections and/or trend analyses shall not exceed 10 years.

A) Referrals from Inpatient Base
For CSAs that will serve as a support or adjunct service to existing inpatient services, the applicant shall document a minimum two-

year historical and two-year projected number of inpatients requiring the subject CSA.

B) Physician Referrals
For CSAs that require physician referrals to create and maintain a patient base volume, the applicant shall document patient origin information for the referrals. The applicant shall submit original signed and notarized referral letters, containing certification by the physicians that the representations contained in the letters are true and correct.

C) Historical Referrals to Other Providers
If, during the latest 12-month period, patients have been sent to other area providers for the proposed CSA services, due to the absence of those services at the applicant facility, the applicant shall submit verification of those referrals, specifying: the service needed; patient origin by zip code; recipient facility; date of referral; and physician certification that the representations contained in the verifications are true and correct.

D) Population Incidence
The applicant shall submit documentation of incidence of service based upon IDPH statistics or category of service statistics.

3) Impact of the Proposed Project on Other Area Providers
The applicant shall document that, within 24 months after project completion, the proposed project will not:

A) Lower the utilization of other area providers below the utilization standards specified in Appendix B.

B) Lower, to a further extent, the utilization of other area providers that are currently (during the latest 12-month period) operating below the utilization standards.

4) Utilization
Projects involving the establishment of CSAs shall meet or exceed the utilization standards for the services, as specified in Appendix B. If no utilization standards exist in Appendix B, the applicant shall document its

anticipated utilization in terms of incidence of disease or conditions, or historical population use rates.

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities
The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

2) Necessary Expansion
The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

3) Utilization

A) Major Medical Equipment
Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

B) Service or Facility
Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c)(2) (Necessary Expansion).

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C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

(Source: Added at 32 Ill. Reg. _____, effective _____)