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

SUBPART B: REVIEW CRITERIA – DISCONTINUATION

Section

SUBPART C: GENERAL PURPOSE, MASTER DESIGN, AND FACILITY CONVERSION − INFORMATION REQUIREMENTS AND REVIEW CRITERIA

Section

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

Section

SUBPART E: MODERNIZATION REVIEW CRITERIA

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

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

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

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

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

SUBPART K: CATEGORY OF SERVICE REVIEW CRITERIA – BURN TREATMENT

SUBPART L: CATEGORY OF SERVICE REVIEW CRITERIA – THERAPEUTIC RADIOLOGY

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

SUBPART N: CATEGORY OF SERVICE REVIEW CRITERIA – CARDIAC CATHETERIZATION

SUBPART O: CATEGORY OF SERVICE REVIEW CRITERIA – IN-CENTER HEMODIALYSIS

SUBPART P: CATEGORY OF SERVICE REVIEW CRITERIA – NON-HOSPITAL BASED AMBULATORY SURGERY

Section

SUBPART Q: CATEGORY OF SERVICE REVIEW CRITERIA – COMPUTER SYSTEMS

Section

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

Section

SUBPART S: CATEGORY OF SERVICE REVIEW CRITERIA – SPECIALIZED LONG-TERM CARE

Section

SUBPART T: CATEGORY OF SERVICE REVIEW CRITERIA – INTRAOPERATIVE MAGNETIC RESONANCE IMAGING

Section

SUBPART U: CATEGORY OF SERVICE REVIEW CRITERIA – HIGH LINEAR ENERGY TRANSFER (L.E.T.)

Section
1110.2010 Introduction (Repealed)
1110.2020 High Linear Energy Transfer (L.E.T.) – Definitions (Repealed)
1110.2030 High Linear Energy Transfer (L.E.T.) – Review Criteria (Repealed)

SUBPART V: CATEGORY OF SERVICE REVIEW CRITERIA – POSITRON EMISSION TOMOGRAPHIC SCANNING (P.E.T.)

Section
1110.2110 Introduction (Repealed)
1110.2120 Positron Emission Tomographic Scanning (P.E.T.) – Definitions (Repealed)
1110.2130 Positron Emission Tomographic Scanning (P.E.T.) – Review Criteria (Repealed)

SUBPART W: CATEGORY OF SERVICE REVIEW CRITERIA – EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

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

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

Section

SUBPART AB: CATEGORY OF SERVICE REVIEW CRITERIA – CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section

SUBPART AC: CATEGORY OF SERVICE REVIEW CRITERIA – COMMUNITY-BASED RESIDENTIAL REHABILITATION CENTER ALTERNATIVE HEALTH CARE MODEL

Section

SUBPART AD: CATEGORY OF SERVICE REVIEW CRITERIA − LONG TERM ACUTE CARE HOSPITAL BED PROJECTS

SUBPART AE: CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE – REVIEW CRITERIA

SUBPART AG: CATEGORY OF SERVICE REVIEW CRITERIA − FREESTANDING EMERGENCY CENTER MEDICAL SERVICES

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. 12332, effective July 18, 2008; amended at 33 Ill. Reg. 3312, effective February 6, 2009.

SUBPART A: GENERAL APPLICABILITY AND PROJECT CLASSIFICATION

Section 1110.10 Introduction and Applicability

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.20 Projects Required to Obtain a Permit (Repealed)

(Source: Repealed at 16 Ill. Reg. 16108, effective October 2, 1992)

Section 1110.30 Processing and Reviewing Applications (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.40 Classification of Projects and Applicable Review Criteria

When an application for permit has been received by HFPB, 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 those construction or modification projects that affect the inpatient operation of a health care facility and are necessary because 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 with the following review criteria:

A) Documentation has been provided that verifies the existence of one or both of the conditions specified in subsection (a)(1)(A) or (B); and

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

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

3) Further detail concerning the process for emergency applications is provided in 77 Ill. Adm. Code 1130.610.

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.

Type of Project	Applicable Review Criteria
Discontinuation of category of service or facility	Section 1110.130 and 77 Ill. Adm. Code 1120

Facility conversion (e.g., change of ownership, merger or consolidation)	Sections 1110.230, 1110.240, and 77 Ill. Adm. Code 1120
Long-term care for the Developmentally Disabled (Adults and Children) Categories of Service	Sections 1110.230, 1110.234, 1110.1830, and 77 Ill. Adm. Code 1120
Acute Care Beds Certified for Extended Care Category of Service as defined by the Centers for Medicare and Medicaid Services (42 CFR 405.471 (1987))	Sections 1110.230, 1110.234, and 77 Ill. Adm. Code 1120
In-Center Hemodialysis Category of Service	Sections 1110.230, 1110.234, 1110.1430, and 77 Ill. Adm. Code 1120
Projects intended solely to provide care to patients suffering from Acquired Immunodeficiency Syndrome (AIDS) or related disorders	Sections 1110.230, 234, and 77 Ill. Adm. Code 1120
Master design projects	Sections 1110.230, 1110.234, 1110.235, 77 Ill. Adm. Code 1120 and Sections pertaining to any category of service proposed in the Master Plan Projects
Outpatient clinical service areas	Sections 1110.230, 1110.234, and 77 Ill. Adm. Code 1120
Fitness centers	Sections 1110.230, 1110.234, and 77 Ill. Adm. Code 1120
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.

d) Classification Appeal

Appeal of any classification may be made to HFPB at the next scheduled meeting following the date of the Executive Secretary's determination.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.60 Master Design Projects (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.65 Master Plan or Capital Budget Projects (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART B: REVIEW CRITERIA – DISCONTINUATION

Section 1110.110 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.120 Discontinuation – Definition (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.130 Discontinuation – Review Criteria

These criteria pertain to categories of service and facilities, as referenced in 77 Ill. Adm. Code 1130.

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 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 shall document that the discontinuation is justified by providing data that verifies that one or more of the following factors (and other factors, as applicable) exist with respect to each service being discontinued:

1) Insufficient volume or demand for the service;

2) Lack of sufficient staff to adequately provide the service;

3) The facility or the service is not economically feasible, and continuation impairs the facility's financial viability;

4) The facility or the service is not in compliance with licensing or certification standards.

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, which is described in 77 Ill. Adm. Code 1100.70 and found on HFPB's website;

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, for purposes of this Section, is 45 minutes travel time. The applicant must document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those 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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART C: GENERAL PURPOSE, MASTER DESIGN, AND FACILITY CONVERSION − INFORMATION REQUIREMENTS AND REVIEW CRITERIA

Section 1110.210 Introduction

a) This Subpart contains all Information Requirements and Review Criteria that apply in total or in part to all projects, (with the exception of projects solely involving "Discontinuation"), including:

1) Project Purpose, Background of Applicant and Alternatives − Information Requirements;

2) Project Scope and Size, Utilization and Unfinished/Shell Space Review Criteria;

3) Additional General Review Criteria for Master Design and Related Projects Only; and

4) Conversions (Changes of Ownership, Mergers, and Consolidations).

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) 77 Ill. Adm. Code 1120 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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.220 Definitions – General Review Criteria (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.230 Project Purpose, Background and Alternatives − Information Requirements

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 qualifications, background and character 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 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 shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of such information include:

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 mortality 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 shall be addressed. Examples of alternative options include:

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, as available.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.235 Additional General Review Criteria for Master Design and Related Projects Only

a) System Impact of Master Plan – Review Criterion. The applicant must document that the proposed master plan or future construction or modification project(s) will have a positive impact on the health care delivery system of the planning area in terms of improved access, long term institutional viability, and availability of services. Documentation shall address:

1) the availability of alternative health care facilities within the planning area and the impact the applicant's proposed future project(s) will have on the utilization of such facilities;

2) how the services proposed in the applicant's future project(s) will improve access to area residents;

3) what the potential impact on area residents would be if the proposed services were not to be replaced or developed; and

4) the anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreement between the applicant and other providers which will result in

the transfer of patients to the applicant's facility.

b) Master Plan or Related Future Projects – Review Criterion
The applicant must document that all beds and services to be developed pursuant to the master design project must be needed and that access to each service will be improved as a result of the proposed master plan or the construction or modification project(s). The applicant must indicate an anticipated completion date(s) for the future construction or modification projects, and document:

1) that:

A) the proposed number of beds and services to be developed pursuant to the master design project must be consistent with the bed or service need determination of 77 Ill. Adm. Code 1100; or

B) if bed or service need determinations do not support the proposed number of beds and services, there are existing factors that support the need for such development at the time of project completion. Such factors include but are not limited to:

i) limitations on governmental funded or charity patients that are expected to continue;

ii) restrictive admission policies of existing planning area health care facilities that are expected to continue;

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

2) Utilization of the proposed beds and services will meet or exceed the utilization targets established in 77 Ill. Adm. Code 1100 within two years after completion of the future construction or modification project(s). Documentation shall include:

A) historical service/bed utilization levels;

B) projected trends in utilization including the rationale and projection assumptions used in such projections;

C) anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would

support utilization projections; and

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

c) Relationship to Previously Approved Master Design Projects – Review Criterion

1) The applicant must document that any construction or modification project submitted pursuant to an approved master design project is consistent with the approved design permit. When such construction or modification represents a single phase of a multiple phase master plan, the applicant must document that the proposed phase is consistent with the approved master plan, and that any elements which will be utilized to support additional phases are justified under the approved master design permit. Documentation shall consist of:

A) schematic architectural plans for all construction or modification approved in the master design permit;

B) the estimated project cost for the proposed project and also for the total construction/modification project approved in the master design permit;

C) an item by item comparison of the construction elements (i.e., site, number of buildings, number of floors, etc.) in the proposed project to the approved master design permit; and

D) a comparison of proposed beds and services to those approved under the master design permit.

2) Approval of a proposed construction or modification project that is but one phase in a multiple phase project does not obligate approval or positive findings on construction or modification projects in future phases. 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.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.240 Changes of Ownership, Mergers and Consolidations

a) Introduction. The review criteria contained in this Section are designed to

evaluate the impact on the health care system for applicants for permit involving mergers, consolidations or changes of ownership as defined in 77 Ill. Adm. Code 1130. These criteria are in addition to other applicable criteria.

b) Impact Statement – Review Criterion. The applicant must submit an impact statement which details any proposed changes in the beds or services currently offered, who the anticipated operating entity will be, the reason for the transaction, any anticipated additions or reductions in employees, and a cost/benefit analysis of the transaction. The statement must reflect at least a two-year period following the date of the change of ownership, merger or consolidation.

c) Access – Review Criterion. The applicant must document any changes which may result in the restriction of patient admissions and document that no reductions in access to care will result from the transaction. Documentation shall consist of a written certification that the admission policies of the facilities involved will not become more restrictive and the submission of both the current formal admission policies of all institutions involved and the anticipated policy following completion of the project.

d) Health Care System – Review Criterion

1) The applicant must document that:

A) the applicant's care system will not restrict the use of other area care providers; or

B) the project improves access to services previously unavailable in the community because of the structure of the applicant's care system.

2) Documentation must detail the current and proposed relationship with those health care or health related organizations which are to be owned (in whole or in part), affiliated, operated, or under management contract with the applicant and provide the following:

A) all care system service providers and services offered including location, types of services, number of beds, and utilization levels for provided services over the last 12-month period; and

B) the proposed relationship of the project to the care system. Data should include where referrals for categories of service not available at the proposed project will be made, how duplication of

services will be resolved, time and travel factors involving referrals within the care system and any organization policies concerning the use of care system providers over other area providers.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

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

Section 1110.310 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.320 Bed Related Review Criteria (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART E: MODERNIZATION REVIEW CRITERIA

Section 1110.410 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.420 Modernization Review Criteria (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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

Section 1110.510 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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 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 Category of Service
	(e)(1) − Staffing Availability
	(f) − Performance Requirements
	(g) − Assurances
Category of Service Modernization	(d)(1) − Deteriorated 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 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).

3) Service Demand – Establishment of Bed Category of Service
The number of beds 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 hospital, the applicant shall submit projected referrals. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C):

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 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 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.

C) Project 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.

4) Service Demand – Expansion of Existing 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 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; 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

f) Performance Requirements − Bed Capacity Minimum

1) Medical-Surgical
The minimum bed capacity for a medical-surgical category of servicewithin a Metropolitan Statistical Area (MSA) is 100 beds.

2) Obstetrics

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

B) The minimum unit size for a new obstetric unit outside an MSA is 4 beds.

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

4) Pediatrics
The minimum size for a pediatric unit within an MSA is 4 beds.

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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

Section 1110.610 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.620 Comprehensive Physical Rehabilitation--Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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 CPR
	(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 CPR
	(e)(1) − Staffing − Availability
	(f) − Performance Requirements
	(g) − Assurances
Comprehensive Physical Rehabilitation Modernization	(d)(1) − Deteriorated 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 "Comprehensive Physical Rehabilitation 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 CPR 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 CPR service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

3) Service Demand – Establishment of Comprehensive Physical Rehabilitation
The number of beds proposed to establish CPR 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. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

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 CPR or to 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.

C) Projected Service Demand − Based on Rapid Population Growth
If a projected demand for services 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.

4) Service Demand – Expansion of Comprehensive Physical Rehabilitation
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 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; 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 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) Comprehensive Physical Rehabilitation Modernization

1) If the project involves modernization of a CPR 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of

interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

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 − 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).

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 − Bed Capacity Minimums

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 16 beds.

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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

Section 1110.710 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.720 Acute Mental Illness – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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 AMI and/or CMI
	(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 AMI and/or CMI
	(e) − Staffing Availability
	(f) − Performance Requirements
	(g) − Assurances
Category of Service Modernization	(d)(1) − Deteriorated 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 "AMI and/or CMI 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

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 AMI and/or CMI 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 AMI and/or CMI service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

3) Service Demand – Establishment of AMI and/or CMI
The number of beds proposed to establish a new AMI and/or CMI 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. The applicant shall document subsection (b)(3)(A) and subsection (b)(3)(B) or (C).

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 AMI and/or CMI 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) 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. Applicants proposing to use zip code data to define the project market area shall indicate the sources of that information;

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) Projection 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.

D) 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 AMI and/or CMI 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
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.

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) AMI and/or CMI Modernization

1) If the project involves modernization of an AMI and/or CMI 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

f) Performance Requirements − Bed Capacity Minimums

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

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

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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

Section 1110.810 Introduction (Repealed)

(Source: Repealed at 24 Ill. Reg. 6075, effective April 7, 2000)

Section 1110.820 Substance Abuse/Addiction Treatment – Definitions (Repealed)

(Source: Repealed at 24 Ill. Reg. 6075, effective April 7, 2000)

Section 1110.830 Substance Abuse/Addiction Treatment – Review Criteria (Repealed)

(Source: Repealed at 24 Ill. Reg. 6075, effective April 7, 2000)

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

Section 1110.910 Introduction

Subpart J contains Review Criteria which pertain to the Neonatal Intensive 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 Subpart D.

(Source: Amended at 16 Ill. Reg. 16108, effective October 2, 1992)

Section 1110.920 Neonatal Intensive Care – Definitions

"Neonatal Intensive Care" means a level of care providing constant and close medical coordination, multi-disciplinary consultation and supervision to those neonates with serious and life threatening developmental or acquired medical and surgical problems which require highly specialized treatment and highly trained nursing personnel.

"Neonatal Intensive Care Service" means a category of service providing treatment of the infant for problems identified in the neonatal period which warrant intensive care. An intensive neonatal care service must include a related obstetric service for care of the high-risk mother (except when the facility is dedicated to the care of children).

"Neonatal Intensive Care Unit" means a distinct part of a facility which provides a program of intensive neonatal care and which is designed, equipped, and operated

to deliver medical and surgical care to high-risk infants.

"Neonatologist" means a physician who is certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Pediatricians.

"Perinatal Center" means a referral facility intended to care for the high-risk patient before, during or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services. Such a center shall be a university or university-affiliated facility responsible for the administration and implementation of the Department of Human Services' regionalized perinatal health care program including continuing education for health professions.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.930 Neonatal Intensive Care – Review Criterion

a) Staffing – Review Criterion

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

A) Full-time Neonatal Director – a neonatologist as defined in Section 1110.920.

B) Full-time Subspecialty Obstetrical Director – an obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of Maternal and Fetal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Obstetricians and Gynecologists.

C) Other neonatologists and obstetricians sufficient in number to serve the projected number of maternal and neonatal patients to be served by the facility and to ensure adequate back-up to the neonatal and obstetrical directors so that there will be continuity of patient care and consultation.

D) Full-time Nurse-Director of the obstetric-newborn nursing service who is experienced in perinatal nursing, and preferably holds a master's degree.

E) Other nurses adequate in number to serve the projected number of maternal and neonatal patients to be served by the facility.

F) Board-Certified Anesthesiologist with training in maternal, fetal and neonatal anesthesia (24-hour availability).

G) One or more licensed social workers.

H) Respiratory therapists with experience in neonatal care and adequate in number to ensure availability of a minimum of one respiratory therapist for every four patients on mechanical ventilators.

I) Registered dietician with experience in perinatal nutrition.

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.

b) Letter of Agreement – Review Criterion. The applicant must document that a letter of agreement with the regional perinatal center for neonatal intensive care services has been signed. Such letter of agreement must fulfill the conditions for such letters found in the Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) and be approved by the Department of Human Services. A copy of the letter shall serve as documentation.

c) Need for Additional Beds – Review Criterion

1) The applicant must document that the proposed neonatal intensive care beds are needed. Bed need may be documented by any of the following:

A) no neonatal intensive care services exist within the planning area;

B) that for each of the last two years for which data is available, the yearly occupancy rate for the service at the affiliated perinatal center has exceeded the target occupancy rate;

C) existing providers of the service within the planning area cannot provide care to a patient caseload due to a limitation on funding for care providing; or

D) that for each of the last two years for which data is available, the yearly occupancy rate for the service at the applicant facility has exceeded the target occupancy rate.

d) Obstetric Service – Review Criterion. The applicant must document the availability within the facility of an obstetric service capable of providing care to high-risk mothers. Documentation must include a detailed assessment of obstetric service capability. This requirement does not apply to a facility dedicated to the care of children.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

SUBPART K: CATEGORY OF SERVICE REVIEW CRITERIA – BURN TREATMENT

Section 1110.1010 Introduction (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1020 Burn Treatment – Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1030 Burn Treatment – Review Criteria (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

SUBPART L: CATEGORY OF SERVICE REVIEW CRITERIA – THERAPEUTIC RADIOLOGY

Section 1110.1110 Introduction (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1120 Therapeutic Radiology – Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1130 Therapeutic Radiology – Review Criteria (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

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

Section 1110.1210 Introduction

a) Subpart M contains Review Criteria which pertain to the Open Heart Surgery 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.

b) Open heart surgical procedures performed on an emergency basis due to a complication occurring during a cardiac catheterization procedure shall not constitute establishment of the open heart surgery category of service when reported to the agency within 30 days of occurrence.

(Source: Amended at 16 Ill. Reg. 16108, effective October 2, 1992)

Section 1110.1220 Open Heart Surgery – Definitions

a) Cardiac Surgeon means a physician eligible or Board certified by the American Board of Thoracic Surgery.

b) Cardiac Surgery Room means a physically identifiable room(s) adequately staffed and equipped for the performance of open and closed heart surgery, and extracorporeal bypass.

c) Cardiological Team means the designated specialists and support personnel who consistently work together in the performance of open heart surgery.

d) Cardiovascular Surgical Procedures means any surgical procedure dealing with the heart, coronary arteries and surgery of the great vessels.

e) Cardiovascular Surgical Services means the programs, equipment and staff dealing with the surgery of the heart, coronary arteries and great vessels.

f) Closed Heart Surgery means any cardiovascular surgical procedures which do not include the use of a heart/lung pump.

g) Extracorporeal Circulation (Bypass) means the circulation of blood outside the

body, as through a heart/lung apparatus for carbon dioxide-oxygen exchange.

h) Open Heart Surgery means a category of service which utilizes any form of cardiac surgery which requires the use of extracorporeal circulation and oxygenation. The use of a pump during the procedure distinguishes "open heart" from "closed heart" surgery.

i) Pump Procedures means the utilization of a heart/lung pump in surgery to perform the work of the heart and lungs. Included in these procedures are Myocardiac Revascularization, Aortic and Mitral Valve Replacement, Ventricular Aneurysm Repairs, Pulmonary Valvuoplasty, and all other procedures utilizing a cardiac pump.

(Source: Amended at 16 Ill. Reg. 16108, effective October 2, 1992)

Section 1110.1230 Open Heart Surgery – Review Criteria

a) Peer Review – Review Criterion. The applicant must document the mechanism for peer review of an open heart surgery program.

b) Establishment of Open Heart Surgery – Review Criterion. The applicant must document that a minimum of 200 open heart surgical procedures will be performed during the second year of operation or that 750 cardiac catheterizations were performed in the latest 12 month period for which data is available. Anticipated open heart surgical volume must be documented by historical referral volume of at least 200 patients directly referred following catheterization at the applicant facility to other institutions for open heart surgery for each of the last two years.

c) Unnecessary Duplication of Services – Review Criterion. The applicant must document that the volume of any existing service within 90 minutes travel time from the applicant will not be reduced below 350 procedures annually for adults and 75 procedures annually for pediatrics. Documentation shall consist of proof of contact of all facilities within 90 minutes travel time currently providing open heart surgery to determine the projected impact the project will have on existing open heart surgery volume.

d) Support Services – Review Criterion. The applicant must document that the following support services and facilities are immediately available on a 24-hour basis and how such services will be mobilized in the case of emergencies.

1) Surgical and cardiological team appropriate for age group served.

2) Cardiac surgical intensive care unit.

3) Emergency room with full-time director, staffed 24 hours for cardiac emergencies with acute coronary suspect surveillance area and voice communication linkage to the ambulance service and the coronary care unit.

4) Catheterization-angiographics laboratory services.

5) Nuclear medicine laboratory.

6) Cardiographics laboratory, electrocardiography including exercise stress testing, continuous electrocardiograph (ECG) monitoring and phonocardiography.

7) Echocardiography service. This may or may not be a part of the cardiographics laboratory.

8) Hemotology laboratory.

9) Microbiology laboratory.

10) Blood gas and electrolyte laboratory with microtechniques for pediatric patients.

11) Electrocardiographic laboratory.

12) Blood bank and coagulation laboratory.

13) Pulmonary function unit.

14) Installation of pacemakers.

15) Organized cardiopulmonary resuscitation team or capability.

16) Preventive maintenance program for all biomedical devices, electrical installations, and environmental controls.

17) Renal Dialysis.

e) Staffing – Review Criterion

1) The applicant must document that a cardiac surgical team will be

established. Such a team must be composed of at least the following:

A) Two cardiac surgeons (at a minimum, one of which must be certified and the other qualified by the American Board of Thoracic Surgery) with special competence in cardiology, including cardiopulmonary anatomy, physiology, pathology, and pharmacology; extracorporeal perfusion technique; and interpretation of catheterization angiographic data.

B) Operating room nurse personnel (Registered Nurse (RN), Licensed Practical Nurse (LPN), Surgical Technician). The nurse to patient ratio for the ICU module of open heart surgery patient care should be no less than one nurse per one patient in the immediate recovery phase and one nurse per two patients thereafter.

C) Anesthesiologists (Board certified by the American Board of Anesthesiology).

D) Adult Cardiologists (Board certified by the American Board of Internal Medicine with subspecialty certification in cardiology).

E) Physician who is Board certified in anatomic and clinical pathology, with special expertise in microbiology, bloodbanking, lab aspects of blood coagulation, blood gases, and electrolytes.

F) Pump technician, or operator of the extracorporeal pump oxygenator, who should have in-depth experience on the active cardiac surgical service that includes perfusion physiology, mechanics of pump operation, sterile technique, and use of monitoring equipment, whether he/she be a physician, nurse or technician.

G) Radiologic Technologist experienced in angiographic principles and catheterization procedure techniques who is experienced in the usage, operation and care of all catheterization equipment.

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.

(Source: Amended at 16 Ill. Reg. 16108, effective October 2, 1992)

SUBPART N: CATEGORY OF SERVICE REVIEW CRITERIA – CARDIAC CATHETERIZATION

Section 1110.1310 Introduction

Subpart N contains Review Criteria which pertain to the Cardiac Catherterization 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.

Section 1110.1320 Cardiac Catheterization – Definitions

a) "Adult Catheterization" means the cardiac catheterization of patients 15 years of age and older.

b) "Cardiac Catheterization Category of Service" means for the purposes of this Subpart the performance of catheterization procedures which due to safety and quality considerations are preferably performed within a cardiac catheterization laboratory or special procedure room. Procedures which do not require the use of such specialized settings such as: pericardiocentesis, myocardial biopsy, cardiac pacemaker insertion or replacement, right heart catherterization with a flow-directed catheter (e.g., Swan-Ganz catheter), intra-aortic balloon pump assistance with intra-aortic balloon catheter placement, certain types of electrophysiology, arterial pressure or blood gas monitoring, fluoroscopy, and cardiac ultrasound are not recognized as procedures which under this Subchapter would in and of themselves qualify a facility as having a cardiac catheterization category of service.

c) "Dedicated Cardiac Catheterization Laboratory" means a distinct laboratory which is staffed, equipped and operated solely for the provision of cardiac catheterization.

d) "Examination" is defined as all cardiac diagnostic procedures (angiographic and physiologic studies) performed on a patient during one session in the laboratory.

e) "Pediatric Catheterization" means the cardiac catheterization of patients below the age of 15.

f) "Special Procedures Laboratory with a Cardiac Catheterization Service" means a

laboratory which has the equipment, staff, and support services required to provide cardiac catheterization and in which catheterizations are routinely performed. The laboratory is also utilized for other procedures not directly related to cardiac catheterization.

Section 1110.1330 Cardiac Catheterization – Review Criteria

a) "Peer Review" – Review Criteria
Any applicant proposing the establishment or modernization of a cardiac catheterization unit shall detail in its application for permit the mechanism for adequate peer review of the program. Peer review teams will evaluate the quality of studies and related morbidity and mortality of patients and also the technical aspects of providing the services such as film processing, equipment maintenance, etc.

b) "Establishment or Expansion of Cardiac Catheterization Service" – Review Criteria
There shall be not additional adult or pediatric catheterization categories of service started in a health planning area unless:

1) the standards as outlined in 77 Ill. Adm. Code 1100.620 are met; unless

2) in the circumstances where area programs have failed to meet those targets, the applicant can document historical referral volume in each of the prior three years for cardiac catheterization in excess of 400 annual procedures (e.g., certification of the number of patients transferred to other service providers in each of the last three years).

c) "Unnecessary Duplication of Services" – Review Criteria

1) Any application proposing to establish cardiac catheterization services must indicate if it will reduce the volume of existing facilities below 200 catheterizations.

2) Any applicant proposing the establishment of cardiac catheterization services must contact all facilities currently providing the service within the planning area in which the applicant facility is located, to determine the impact the project will have on the patient volume at existing services.

d) "Modernization of Existing Cardiac Catheterization Equipment" – Review Criteria
No proposed project for the modernization of existing equipment providing cardiac catheterization services will be approved unless the applicant documents

that the minimum utilization standards (as outlined in 77 Ill. Adm. Code 1100.620) are met.

e) "Support Services" – Review Criteria

1) Any applicant proposing the establishment of a dedicated cardiac catheterization laboratory must document the availability of the following support services;

A) Nuclear medicine laboratory.

B) Echocardiography service.

C) Electrocardiography laboratory and services, including stress testing and continuous cardiogram monitoring.

D) Pulmonary Function unit.

E) Blood bank.

F) Hematology laboratory - coagulation laboratory.

G) Microbiology laboratory.

H) Blood Gas laboratory.

I) Clinical pathology laboratory with facilities for blood chemistry.

2) These support services need not be in operation on a 24 hour basis but must be available when needed.

f) "Laboratory Location" – Review Criteria
Due to safety considerations in the event of technical breakdown it is preferable to group laboratory facilities. Thus in projects proposing to establish additional catheterization laboratories such units must be located in close proximity to existing laboratories unless such location is architecturally infeasible.

g) "Staffing" – Review Criteria
It is the policy of the State Board that if cardiac catheterization services are to be offered that a cardiac catheterization laboratory team be established. Any applicant proposing to establish such a laboratory must document that the following personnel will be available:

1) Lab director board-certified in internal medicine, pediatrics or radiology with subspecialty training in cardiology or cardiovascular radiology.

2) A physician with training in cardiology and/or radiology present during examination with extra physician backup personnel available.

3) Nurse specially trained in critical care of cardiac patients, knowledge of cardiovascular medication, and understanding of catheterization equipment.

4) Radiologic technologist highly skilled in conventional radiographic techniques and angiographic principles, knowledgeable in every aspect of catheterization instrumentation, and with thorough knowledge of the anatomy and physiology of the cardiovascular system.

5) Cardiopulmonary technician for patient observation, handling blood samples and performing blood gas evaluation calculations.

6) Monitoring and recording technician for monitoring physiologic data and alerting physician to any changes.

7) Electronic radiologic repair technician to perform systematic tests and routine maintenance; must be immediately available in the event of equipment failure during a procedure.

8) Darkroom technician well trained in photographic processing and in the operation of automatic processors used for both sheet and cine film.

h) "Continuity of Care" – Review Criteria
Any applicant proposing the establishment, expansion or modernization of a cardiac catheterization service must document that written transfer agreements have been established with facilities with open-heart surgery capabilities for the transfer of seriously ill patients for continuity of care.

i) "Multi-Institutional Variance" – Review Criteria

1) A variance to the establishment requirements of 1110.1330(b), "Establishment or Expansion of Cardiac Catheterization Service" shall be granted if the applicant can demonstrate that the proposed new program is necessary to alleviate excessively high demands on an existing operating program's capacity.

2) Each of the following must be documented:

A) That the proposed unit will be affiliated with the existing operating program. This must be documented by written referral agreements between the facilities, and documentation of shared medical staff;

B) That the existing operating program provides open heart surgery;

C) That initiation of a new program at the proposed site is more cost effective, based upon a comparison of charges, than expansion of the existing operating program;

D) That the existing operating program currently operates at a level of more than 750 procedures annually per laboratory; and

E) That the proposed unit will operate at the minimum utilization target occupancy and that such unit will not reduce utilization in existing programs below target occupancy (e.g., certification of the number of patients transferred to other service providers in each of the last three years and market studies developed by the applicant indicating the number of potential catheterization patients in the area served by the applicant).

3) The existing operating program cannot utilize its volume of patient procedures to justify a second affiliation agreement until such time as the operating program is again operating at 750 procedures annually per laboratory and the affiliate is operating at 400 procedures per laboratory.

(Source: Amended at 11 Ill. Reg. 7333, effective April 1, 1987)

SUBPART O: CATEGORY OF SERVICE REVIEW CRITERIA – IN-CENTER HEMODIALYSIS

Section 1110.1410 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.1420 Chronic Renal Dialysis Service – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.1430 In-Center Hemodialysis Projects – 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 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 In-Center Hemodialysis
	(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 In-Center Hemodialysis
	(e)(1) − Staffing − Availability
	(f) − Support Services
	(j) − Assurances
In-Center Hemodialysis Modernization	(d)(1) − Deteriorated 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 in-center hemodialysis 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 in-center hemodialysis 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 in-center hemodialysis service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

3) Service Demand – Establishment of In-Center Hemodialysis Service
The number of stations proposed to establish a new in-center hemodialysis 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 The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

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
The applicant shall provide physician referral letters that attest to:

i) The physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

ii) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

iii) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience.

The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iv) An estimated number of existing patients who are not expected to continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);

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

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

vii) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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.

4) Service Demand – Expansion of In-Center Hemodialysis 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 in-center hemodialysis 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

i) The applicant shall provide physician letters that attest to:

- the physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

- the number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

- an estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. 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;

ii) 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;

iii) The physician shall verify that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

iv) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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 an in-center hemodialysis 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 (JCAHO) 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 in-center hemodialysis or a facility shall meet or exceed the utilization standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

e) Staffing

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

1) 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).

2) 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.

3) 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.

4) 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.

5) 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:

1) 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; and

2) An applicant proposing to expand or relocate in-center hemodialysis stations will achieve and maintain compliance with the following adequacy of hemodialysis outcome measures for the latest 12-month period for which data are available:

≥ 85% of hemodialysis patient population achieves area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II .1.2.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART P: CATEGORY OF SERVICE REVIEW CRITERIA – NON-HOSPITAL BASED AMBULATORY SURGERY

Section 1110.1510 Introduction

Subpart P contains Review Criteria which pertain to the Non-Hospital Based Ambulatory Surgery 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.

Section 1110.1520 Non-Hospital Based Ambulatory Surgery – Definitions

"Ambulatory Surgical Treatment Center" means any institution, place or building required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act [210 ILCS 5].

"Non-Hospital Based Ambulatory Surgery" means a category of service relating to surgery that is performed at ambulatory surgical treatment centers on patients that arrive and are discharged the same day. Ambulatory surgery as the provision of surgical services may require anesthesia or a period of post-operative observation or both on a patient whose inpatient stay is not anticipated as being medically necessary.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.1530 Non-Hospital Based Ambulatory Surgery – Projects Not Subject to This Part

The specific criteria of this Part will not apply to hospital projects that will provide ambulatory surgical service and that will be operated in accordance with the provisions of the Hospital Licensing Act.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.1540 Non-Hospital Based Ambulatory Surgery – Review Criteria

a) "Scope of Services Provided" – Review Criterion
Any applicant proposing to establish a non-hospital based ambulatory surgical category of service must detail the surgical specialties that will be provided by the proposed project and whether the project will result in a limited specialty or multi-specialty ambulatory surgical treatment center (ASTC).

1) The applicant must indicate which of the following surgical specialties will be provided at the proposed facility:

A) Cardiovascular

B) Dermatology

C) Gastroenterology

D) General/Other (includes any procedure that is not included in the other specialties)

E) Neurological

F) Obstetrics/Gynecology

G) Ophthalmology

H) Oral/Maxillofacial

I) Orthopaedic

J) Otolaryngology

K) Plastic

L) Podiatry

M) Thoracic

N) Urology

2) The applicant must indicate which of the following type of ASTC will result from the proposed project:

A) Limited specialty ASTC, which provides one or two of the surgical specialties listed in this Section; or

B) Multi-specialty ASTC, which provides at least three of the surgical specialties listed in this Section. In order to be approved as a multi-specialty ASTC, the applicant must document that at least 250 procedures will be performed in each of at least three of the surgical specialties listed in this Section.

AGENCY NOTE: A permit is required for the addition of a surgical specialty by a limited specialty ASTC. Pursuant to information on file with the Agency's licensing program on March 1, 1995, the State Board has classified all existing and approved ASTCs as either limited specialty or multi-specialty..

b) "Target Population" – Review Criterion
Because of the nature of ambulatory surgical treatment, the State Board has not established geographic services areas for assessing need. Therefore, an applicant must define its intended geographic service area and target population. However, the intended geographic service area shall be no less than 30 minutes and no greater than 60 minutes travel time (under normal driving conditions) from the facility's site.

c) "Projected Patient Volume" – Review Criterion

1) The applicant must provide documentation of the projected patient volume for each specialty to be offered at the proposed facility. Documentation must include physician referral letters which contain the following information:

A) the number of referrals anticipated annually for each specialty;

B) for the past 12 months, the name and location of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility;

C) a statement by the physician that the information contained in the referral letter is true and correct to the best of his/her information and belief; and

D) the typed or printed name and address of the physician, his/her specialty and his/her notarized signature.

2) Referrals to health care providers other than ambulatory surgical treatment centers (ASTC) or hospitals will not be included in determining projected patient volume. The applicant shall provide documentation demonstrating that the projected patient volume as evidenced by the physician referral letters is from within the geographic service area defined under subsection (b).

d) "Treatment Room Need Assessment" – Review Criterion

1) Each applicant proposing to establish or modernize a non-hospital based ambulatory surgery category of service must document that the proposed number of operating rooms are needed to serve the projected patient volume. Documentation must include the average time per procedure for the target population including an explanation as to how this average time per procedure was developed. The following formula can be applied in determining treatment room need:

$$\text{Required Treatment Rooms} = \frac{\text{Hrs. of Surgery/Yr.*}}{\text{250 Days/Yr. x 7.5 Hrs./Day x .80**}}$$

(*Hours of surgery includes cleanup and setup time and will be based on

the projected volume)
(**80% is the desired occupancy rate)

2) There must be a need documented for at least one fully utilized (1,500 hours) treatment room for a new facility to be established. Also, utilizing the formula the application must document the need for each treatment room proposed.

e) "Impact on Other Facilities" – Review Criterion
An applicant proposing to change the specialties offered at an existing ASTC or proposing to establish an ASTC must document the impact the proposal will have on the outpatient surgical capacity of all other existing ASTCs and hospitals within the intended geographic service area and that the proposed project will not result in an unnecessary duplication of services or facilities. Documentation shall include any correspondence from such existing facilities regarding the impact of the proposed project, and correspondence from physicians intending to refer patients to the proposed facility. Outpatient surgical capacity will be determined by the Agency, utilizing the latest available data from the Agency's annual questionnaires, and will be the number of surgery rooms for ASTCs and the number of equivalent outpatient surgery rooms for hospitals. Equivalent outpatient surgery rooms for hospitals are determined by dividing the total hours of a hospital's outpatient surgery by 1,500 hours.
In addition to documentation submitted by the applicant, the State Agency shall review utilization data from annual questionnaires submitted by such health care facilities and data received directly from health facilities located within the intended geographic service area, including public hearing testimony.

f) Establishment of New Facilities – Review Criterion
Any applicant proposing to establish an ambulatory surgical treatment center will be approved only if one of the following conditions exists:

1) There are no other ASTCs within the intended geographic service area of the proposed project under normal driving conditions; or

2) All of the other ASTCs and hospital equivalent outpatient surgery rooms within the intended geographic service area are utilized at or above the 80% occupancy target; or

3) The applicant can document that the facility is necessary to improve access to care. Documentation shall consist of evidence that the facility will be providing services which are not currently available in the geographic service area, or that existing underutilized services in the geographic service area have restrictive admission policies; or

4) The proposed project is a co-operative venture sponsored by two or more persons at least one of which operates an existing hospital. The applicant must document:

A) that the existing hospital is currently providing outpatient surgery services to the target population of the geographic service area;

B) that the existing hospital has sufficient historical workload to justify the number of operating rooms at the existing hospital and at the proposed ASTC based upon the Treatment Room Need Assessment methodology of subsection (d) of this Section;

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

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

g) Charge Commitment – Review Criterion
In order to meet the purposes of the Act which are to *improve the financial ability of the public to obtain necessary health services and to establish a procedure designed to reverse the trends of increasing costs of health care*, the applicant shall include all charges except for any professional fee (physician charge). [20 ILCS 3960/2] The applicant must provide a commitment that these charges will not be increased, at a minimum, for the first two years of operation unless a permit is first obtained pursuant to 77 Ill. Adm. Code 1130.310(a).

h) Change in Scope of Service – Review Criterion
Any applicant proposing to change the surgical specialties currently being provided by adding one or more of the surgical specialties listed under subsection (a) of this Section must document one of the following:

1) that there are no other facilities (existing ASTCs or hospitals with outpatient surgical capacity) within the intended geographic service area which provide the proposed new specialty; or

2) that the existing facilities (existing ASTCs or hospitals with outpatient surgical capacity) within the intended geographic service area of the applicant facility are operating at or above the 80% occupancy target; or

3) that the existing programs are not accessible to the general population of the geographic service area in which the applicant facility is located.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

SUBPART Q: CATEGORY OF SERVICE REVIEW CRITERIA – COMPUTER SYSTEMS

Section 1110.1610 Introduction (Repealed)

(Source: Repealed at 11 Ill. Reg. 7333, effective April 1, 1987)

Section 1110.1620 Computer Systems – Definitions (Repealed)

(Source: Repealed at 11 Ill. Reg. 7333, effective April 1, 1987)

Section 1110.1630 Computer Systems – Review Criteria (Repealed)

(Source: Repealed at 11 Ill. Reg. 7333, effective April 1, 1987)

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

Section 1110.1710 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.1720 General Long Term Care – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.1730 General 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 General Long Term Care
	(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 General Long Term Care
	(g) −	Staffing Availability
	(h) −	Facility Size
	(k) −	Assurances
General Long Term Care Modernization	(f)(1) −	Deteriorated 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 general long term care 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 general long term care 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 general long term care service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

3) Service Demand – Establishment of General Long Term Care
The number of beds proposed to establish a new general long term care 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. The applicant shall document subsection (b)(3)(A) and subsection (b)(3)(B) or (C).

A) Historical Referrals
If the applicant is an existing facility and is proposing to establish this category of service, the applicant shall document the number of referrals to other facilities, for each proposed 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 LTC facility.

B) Projected Referrals
An applicant proposing to establish a 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 referral resources, and the referral resource'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.

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 prospective residents have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including completed applications that could not be accepted due to lack of the subject service and documentation from referral sources, with identification of those patients by initials and date.

B) Projected Referrals
The applicant shall provide the following:

i) Letters from referral sources (hospitals, physicians, social services and others) that attest to total number of prospective residents (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. Referral sources shall verify their projections and the methodology used;

ii) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources' 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 referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and

iv) Verification by the referral sources that the prospective resident 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.

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

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 a waiting list;

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 (JCAHO) 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

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART S: CATEGORY OF SERVICE REVIEW CRITERIA – SPECIALIZED LONG-TERM CARE

Section 1110.1810 Introduction

Subpart S contains Review Criteria which pertain to the Specialized 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. These review criteria shall apply to all specialized long-term care projects in the review process, at the time they become effective, and to all subsequent applications relating to specialized long-term care.

(Source: Amended at 18 Ill. Reg. 2993, effective February 10, 1994)

Section 1110.1820 Specialized Long-Term Care--Definitions

"Specialized Long-Term Care" means a classification consisting of categories of service which provides inpatient care primarily for children (ages 0 through 21) or inpatient care for adults who require specialized treatment and care because of mental or developmental disabilities. The Specialized Long-Term Care Classification includes the following Categories of Services:

Chronic Mental Illness (M.I.) Category of Service. The Chronic Mental Illness (M.I.) Category of Service includes levels of care provided to severely mentally ill clients in a structured setting in a psychiatric unit of a general hospital, in a private psychiatric hospital, or in a state-operated facility primarily in order to facilitate the improvement of their functioning level, to prevent further deterioration of their functioning level, or, in some instances to maintain their current level of functioning.

Long-Term Care for the Developmentally Disabled (Adult) Category of Service. This Category of Service includes levels of care for Developmentally Disabled adults as defined in the Illinois Mental Health and Developmental Disabilities Code (including those facilities licensed as ICF/DD or Intermediate Care Facilities for the Developmentally Disabled) which provide an integrated, individually-tailored program of services for developmentally disabled adults and which provides an active, aggressive,

and organized program of services directed toward achieving measurable behavioral and learning objectives.

Long-Term Care for the Developmentally Disabled (Children) Category of Service. This Category of Service includes levels of care for Developmentally Disabled Children and is limited to those residents ages 0 through 21 years and whose condition meets the definition of "Developmental Disabilities" (as defined in the Illinois Mental Health and Developmental Disabilities Code).

Long-Term Medical Care for Children Category of Service. The Long-Term Medical Care For Children Category of Service includes long-term medical services which are provided to those patients/residents ages 0-18 years and which provides for residents suffering from chronic medical disabilities.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.1830 Specialized Long-Term Care – Review Criteria

a) Facility Size – Review Criterion. The maximum unit size is 100 beds, unless the project is for a State-operated facility or for the long-term medical care for children Category of Service.

b) Community Related Functions – Review Criterion. The applicant must document the written endorsement of community groups including the following:

1) a detailed description of the steps taken to inform and receive input from the public, including those community members who live in close proximity to the proposed facility's location;

2) endorsements from social service, social, and economic organizations; and

3) support from municipal officials and other elected officials representing the area in which the proposed facility is located.

c) Availability of Ancillary and Support Programs – Review Criterion. An applicant proposing the establishment of an ICF/DD facility of 16 beds or fewer must document that the community has the necessary support services available to provide care to the proposed facility's residents. Such documentation must include:

1) a copy of the letter, sent by certified mail, return receipt requested, to each

of the day programming programs in the area informing them of the proposed project and requesting their comments regarding the impact of the proposed project upon their programs. The applicant shall also provide copies of the responses received from these letters;

2) a description of the transportation services available to the proposed residents;

3) a description of the specialized services, other than day programming, available to the proposed residents;

4) a description of the availability of community activities for the proposed facility's residents, e.g., movie theaters, bowling alleys, etc.; and

5) documentation of the availability of a community workshop to serve the residents.

d) Recommendations from State Departments -- Review Criterion. An applicant proposing a facility for the developmentally disabled must document contact with the Department of Human Services and the Department of Public Aid. Documentation must include proof that a request has been submitted to each Department requesting that each Department determine the project's consistency with the long-range goals and objectives of the Department and requesting the identification of individuals in need of the service. The Departments' responses should address, on both a Statewide and a planning area basis, whether the proposed project meets the Department's planning objectives regarding the size, type, and number of beds proposed, whether the project conforms or does not conform to each Department's plan, and how the project assists or hinders each Department in achieving its planning objectives. Such a request must be made by certified mail return receipt requested and must occur within a 60-day period prior to the submission of this application.

e) Long-Term Medical Care for Children Category of Service (Only) – Review Criterion. The applicant must document the following:

1) the planning area served by the facility and the size of the specialized population ages 0-18 years to be served within that geographic area. Documentation must include, but is not limited to, any reports or studies showing the points of origin of patients/residents admitted to the facility, preferably for the latest 12 month period for which data is available;

2) identification of the special programs and/or services to be provided or currently offered by the applicant and the relationship of such programs to

the needs of the specialized population (as outlined above);

3) insufficient service capability currently exists to meet this need; and

4) the number of beds in the proposed project is needed by providing documentation that the proposed project will achieve, within the first year of operation, an occupancy of at least 90 percent.

f) Zoning – Review Criterion. The applicant must document that:

1) the property to be utilized has been zoned for the type of facility to be developed; or

2) zoning approval has been received; or

3) a certificate of need is required by the local zoning authority before zoning can be approved. Such documentation shall include a letter from the appropriate zoning official indicating that such a requirement exists.

g) Establishment of Chronic Mental Illness – Review Criterion. Documentation shall consist of a narrative statement detailing the scope of system changes which have brought about the need for the project and historical utilization of facilities involved. The applicant must document that:

1) all beds will be operated by the State of Illinois;

2) the resident population and type of resident/patient served has changed, necessitating the establishment or expansion of services in order to meet the needs of the facility's residents;

3) the project represents redistribution of existing beds from another facility due to closure of the facility or unit; and

4) admissions from the general public have increased over the last two-year period and the expansion is necessary in order to adequately serve the residents of the facility and the general public.

h) Establishment of Beds, Developmentally Disabled (Adult) Category of Service – Review Criterion. Any proposed project to establish a facility of 16 beds or fewer must be located in a planning area where a need for additional beds is calculated using the formula shown in 77 Ill. Adm. Code 1100.670, unless the applicant can document compliance with the requirements for a variance to the computed bed need in subsection (i) of this Section.

i) Variance to Computed Bed Need for Establishment of Beds, Developmentally Disabled (Adult) Category of Service, for Placement of Residents From Department of Human Services (DHS) Operated Beds – Review Criterion. The applicant must document all of the following:

1) That each of the residents proposed to be served:

A) currently resides in a DHS-operated facility and has at least one interested family member residing in the proposed planning area; or has an interested family member who resides out-of-state within 15 miles of the proposed planning area boundary; or

B) has resided in a DHS-operated facility physically located in the proposed project's planning area for at least the last 2 years, and the consent of the resident's legal guardian has been obtained for the relocation.

2) All of the existing 16-bed or fewer facilities in the planning area are occupied at or above the 93% target occupancy rate or such facilities have refused to accept residents referred from DHS-operated facilities. Documentation of each refusal must include the following:

A) a letter from DHS stating the number of times in the last 12 months the facility or facilities have refused to accept referrals of DHS-operated facility residents, including the name of the facility, the date of the refusal, and the reason(s) cited for such refusals, if any;

B) a copy of the letter, sent by certified mail return receipt requested, to each of the underutilized facilities in the area asking if they accept referrals from DHS-operated facilities, listing the dates of each past refusal, and requesting an explanation of the basis for the refusal in each instance;

C) copies of the responses to the above letters; and

D) a letter from DHS indicating that each of the residents to be referred to the proposed facility have been refused admission at all of the other 16-bed or fewer facilities in the planning area.

3) That the proposed relocation of a resident will result in cost savings to the State.

4) That the facility will only accept future referrals from the DHS-operated facility in the planning area if a bed is available.

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

j) State Board Consideration of Public Hearing Testimony – Review Criterion. If public hearing testimony is presented that indicates that one or more facilities in the planning area have available beds, and are willing to accept DHS referrals, IDPH shall notify DHS and request that DHS contact the facility or facilities and attempt to place residents in such beds, thereby reducing the need for the proposed additional beds. DHS shall notify IDPH of the results of these placement efforts within 45 days after the date of IDPH advice. If DHS' response is not received by IDPH within the specified time period, IDPH shall assume that the patients were placed appropriately and that the need for such additional beds no longer exists. If the existing facility(ies) refuses to accept such referrals, IDPH shall be notified by DHS of the refusal and of any rationale for the refusal provided to DHS by the refusing facility. This material shall then be forwarded to the Board for its consideration. The review period set forth in 77 Ill. Adm. Code 1130.610(b) may be extended by IDPH for a period not to exceed 60 days.

(Source: Amended at 23 Ill. Reg. 2987, effective March 15, 1999)

SUBPART T: CATEGORY OF SERVICE REVIEW CRITERIA – INTRAOPERATIVE MAGNETIC RESONANCE IMAGING

Section 1110.1910 Introduction (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1920 Intraoperative Magnetic Resonance Imaging – Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.1930 Intraoperative Magnetic Resonance Imaging – Review Criteria (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

SUBPART U: CATEGORY OF SERVICE REVIEW CRITERIA – HIGH LINEAR ENERGY TRANSFER (L.E.T.)

Section 1110.2010 Introduction (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.2020 High Linear Energy Transfer (L.E.T) – Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.2030 High Linear Energy Transfer (L.E.T.) – Review Criteria (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

SUBPART V: CATEGORY OF SERVICE REVIEW CRITERIA – POSITRON EMISSION TOMOGRAPHIC SCANNING (P.E.T.)

Section 1110.2110 Introduction (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.2120 Positron Emission Tomographic Scanning (P.E.T.) – Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.2130 Positron Emission Tomographic Scanning (P.E.T.) – Review Criteria (Repealed)

(Source: Repealed at 27 Ill. Reg. 2916, effective February 21, 2003)

SUBPART W: CATEGORY OF SERVICE REVIEW CRITERIA – EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

Section 1110.2210 Introduction (Repealed)

(Source: Repealed at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.2220 Extracorporeal Shock Wave Lithotripsy – Definitions (Repealed)

(Source: Repealed at 23 Ill. Reg. 2987, effective March 15, 1999)

Section 1110.2230 Extracorporeal Shock Wave Lithotripsy – Review Criteria (Repealed)

(Source: Repealed at 23 Ill. Reg. 2987, effective March 15, 1999)

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

Section 1110.2310 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2320 Selected Organ Transplantation – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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) − Deteriorated 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
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;

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, as applicable to cited restrictions, 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART Y: CATEGORY OF SERVICE REVIEW CRITERIA – KIDNEY TRANSPLANTATION

Section 1110.2410 Introduction (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2420 Kidney Transplantation – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

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:

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) −	Deteriorated 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff

members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

f) Surgical Staff – Review Criterion
The applicant shall document that the facility has at least one kidney 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.

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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

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 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 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 Subpart C and 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 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2520 Subacute Care Hospital Model-Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2530 Subacute Care Hospital Model – Review Criteria

a) Distinct Unit – Review Criterion
The applicant must document that the proposed unit or health care facility will be primarily self-contained, physically distinct and have nursing staff dedicated to service within only that unit. Auxiliary personnel and contracted professional personnel must be available for care of unit patients but need not be dedicated to providing service to only the subacute care hospital model. Documentation shall include a physical layout of the unit detailing travel patterns to ancillary and support services and to patient and visitor access, a detailed summary of all shared services and how costs for such services will be allocated between the model and the hospital or long-term care facility. Also, the applicant must provide a detailed staffing plan which includes staff qualifications, staffing patterns for the proposed subacute care hospital and the manner in which non-dedicated staff services will be provided.

b) Contractual Relationship – Review Criterion
The applicant must document the capability to handle cases of complications, emergencies, or exigent circumstances.

1) An applicant must document, for a model to be located in a currently licensed long-term care facility, the capability through the existence of a contractual relationship (which includes a transfer agreement) with a general acute care hospital.

2) An applicant must document, for a model to be located on a designated site previously licensed as a hospital (Section 1100.740(c)), capability through the existence of a contractual arrangement (transfer agreement) with a general acute care hospital.

3) An applicant must document, for a model to be located in a licensed hospital, that the emergency capability continues to exist in accordance with the requirements of hospital licensure.

c) Unit Size – Review Criterion
The applicant must document that the number of subacute care beds proposed will equal or exceed the minimum number established for the planning area. The minimum subacute care hospital unit size is 10 beds in rural planning areas (as

defined in 77 Ill. Adm. Code 1100.720(a)) and 30 beds in all other planning areas.

(Source: Added at 18 Ill. Reg. 8455, effective July 1, 1994)

Section 1110.2540 Subacute Care Hospital Model – HFPB 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 – 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 77 Ill. Adm. Code 1120 – 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 documentation shall consist of:

i) Factors within the facility or area will prevent the facility from complying with the minimum financial ratios established in 77 Ill. Adm. Code 1120 within the next two years; and

ii) Historical documentation that the facility has failed to comply with the minimum financial ratios in each of the last three calendar years; and

iii) Projected revenue from the:

- subacute hospital care model and the positive impact of that revenue on the financial position of

the applicant facility. The applicant must explain how the revenue will impact the facility's financial position such that the facility will comply with the financial viability ratios of 77 Ill. Adm. Code 1120; or

- subacute hospital model will be sufficient to operate the subacute care hospital care model in compliance with the financial viability ratios of 77 Ill. Adm. Code 1120, or that the applicant facility has entered into a binding agreement with another institution that guarantees the financial viability of the subacute hospital care model in accordance with the ratios established in 77 Ill. Adm. Code 1120 for a period of at least five 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 USC 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 the 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 that are inter-related by contractual agreement that 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 be transferred only to the applicant facility – 1 Point per each additional facility in the multi-institutional system, to a maximum of 10 Points.

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 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 – 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 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 exclusively for the model – 1 Point,

ii) Physical therapist, 2 full-time equivalents (FTEs) 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 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 – 10 Points

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 77 Ill. Adm. Code 1120 – 10 Points

D) The applicant has had an Exceptional Care Contract with the Illinois Department of Healthcare and Family Services 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 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 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 – 3 Points

I) If the applicant, over the last five year period, has been issued a notice of revocation of license from IDPH 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 exclusively for the model – 1 Point

ii) Physical therapist, 2 FTEs 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 the 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 that are inter-related by contractual agreement that 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 Points.

2) A long-term 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 shall base its selection on considerations relating to location, scope of service and access.

d) HFPB 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 – 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 77 Ill. Adm. Code 1120 – 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 shall base its selection on considerations relating to location, scope of service and access.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2550 Subacute Care Hospital 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 discontinuation permit will not be required of a facility holding a subacute care hospital model permit if the facility elects to discontinue the model but retain licensed subacute care beds. The subacute care hospital model project shall be considered complete as of the date the Agency is notified of the discontinuation. If during the course of the model evaluation period an approved provider of the subacute hospital care model elects to discontinue the category of service, a replacement provider of the same type may be approved by the State Board. If a need for an additional subacute care hospital model exists, applications shall be approved in accordance with Section 1110.2540. Any alteration to the subacute care hospital model during the life of the permit is

subject to State Board review.

b) All assurances and charges for service presented in the application shall be in effect for the life of the permit unless altered pursuant to the approval of the State Board.

c) A subacute care hospital model shall have 24 months from the date of permit issuance to become operational. Failure to begin operation in this time period shall result in the permit becoming null and void.

(Source: Amended at 20 Ill. Reg. 14785, effective November 15, 1996)

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 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 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 Subpart C and 77 Ill. Adm. Code 1120. This Subpart also contains the methodology HFPB 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 permit to establish the category of service prior to receiving a license for the service. 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 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 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. 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. 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 decision. The application, as submitted to IDPH, shall serve as the basis for all standard and prioritization evaluation.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2620 Postsurgical Recovery Care Center Alternative Health Care Model – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2630 Postsurgical Recovery Care Center Alternative Health Care Model – Review Criteria

a) Need/Unit Size – Review Criterion
The applicant must specify the number of beds to be in the proposed postsurgical recovery care center. The applicant must also document that the proposed number of beds is justified (utilizing the 80% occupancy target) based upon the anticipated number of patients who will utilize the service. Documentation shall consist of: patient identification numbers, ICD 9 Code or procedure type, patient length of stay and surgical referral site for each inpatient surgical case which occurred in surgical referral sites over the last twelve month period that could have received surgical recovery services within the model if it had been available.

b) Staffing – Review Criterion
The applicant must document that the postsurgical recovery care center will be a separate and distinct (physically separate and identifiable) facility and have a dedicated nursing staff (i.e., that staff members working a shift are assigned only to cover the model), a medical director and 24 hour seven days a week on call physician coverage by a physician licensed to practice medicine in all of it branches. The on-call physician must be able to be physically present at the model within 15 minutes upon request. Documentation shall consist of: physical layout of the center (i.e., design drawings), identification of the number and type of staff positions dedicated to the model, identification of the facility medical director including a signed commitment to the facility by that person stating a willingness to hold such a position and evidence that the required physician coverage will be accomplished.

c) Patient Mix – Review Criterion
The applicant must document that the postsurgical recovery care center is capable of providing recovery care to patients receiving a wide variety of surgical procedures. For the purposes of this rule the following specialties (listing not inclusive of all surgical procedures that can recover in the model) shall be recognized: general surgery; eyes-ears-nose and throat; orthopedic; plastic surgery; ophthalmology; urology; obstetric-gynecology; and gastro-enterology. The applicant must document that anticipated referrals would result in admissions coming from at least three of these surgical specialties and that each of the three specialty groups represents a minimum of 10% of facility admissions totaling at least 30%. Documentation shall consist of a detailed listing of the types of surgical procedures which will be performed for which recovery care will be provided and the protocols as to how recovery care will be given to each type of surgical patient with details concerning how patient safety will be assured.

d) Travel Time/Patient Transfer – Review Criterion
The applicant must document that the model will be located no farther than 30 minutes travel time by medical transport from all surgical referral sites. Documentation shall consist of identification of all surgical referral sites and the time travel distance to the recovery care center. The applicant must also document who will have the responsibility for the transfer of patients from the surgical site to the postsurgical recovery care center and provide all transfer protocols which must demonstrate the safe transfer of the surgical patients to the postsurgical recovery care center from each surgical referral site.

e) On Site Emergency Care – Review Criterion
The applicant must document that the postsurgical recovery care center will have the capability to provide on-site emergency services sufficient to stabilize a patient for transfer to an acute care facility. Documentation shall consist of all protocols established for the treatment of emergency patients and the requirements established by the model for the education of staff in emergency procedures. Each postsurgical recovery care center must document that a crash cart is available on site and that staff trained in cardiac defibrillation are available at all times.

(Source: Added at 19 Ill. Reg. 2991, effective March 1, 1995)

Section 1110.2640 Postsurgical Recovery Care Center Alternative Health Care Model – HFPB Review

a) HFPB Evaluation
HFPB 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).

b) HFPB 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 – 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 77 Ill. Adm. Code 1120 – 10 Points.

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 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.

F) Historical Medicare and Medicaid surgical revenue at the surgical referral sites. 10% to 25% – 3 Points, 26% to 50% – 6 Points and over 50% – 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 to be considered for approval. Competing applications within a planning area that have obtained the points necessary for permit consideration shall be evaluated by the HFPB to determine which application best implements the goals of the Health Facilities Planning Act and the Alternative Health Care Delivery Act.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2650 Postsurgical Recovery 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 discontinuation permit will not be required of a facility holding a postsurgical recovery care center alternative health care model permit if the facility elects to discontinue the model. The postsurgical recovery care center alternative health care model project shall be considered complete as of the date the Agency receives notice of the discontinuation. If a need for an additional model exists applications shall be approved in accordance with Section 1110.2640. Any alteration, discontinuation or abandonment to the approved category of service during the life of the permit is subject to State Board review.

b) All assurances and charges for service presented in the application shall be in effect for the life of the permit unless altered pursuant to the approval of the State Board. Charges may be annually adjusted for inflation not to exceed the growth in the health care component of the Consumer Price Index.

c) A postsurgical recovery care center alternative health care model shall have a period of eighteen months from the date of permit issuance to become operational. Failure to begin operation in this time period shall result in the permit becoming null and void.

(Source: Added at 19 Ill. Reg. 2991, effective March 1, 1995)

SUBPART AB: CATEGORY OF SERVICE REVIEW CRITERIA – CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section 1110.2710 Introduction

a) Subpart AB of this Part contains review criteria that pertain to the Children's Community-Based Health 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 Health Care Center Alternative Health Care Model category of service is a demonstration program that is authorized by the Alternative Health Care Delivery Act. These Children's Community-Based Health 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 Subpart C and 77 Ill. Adm. Code 1120. This Subpart also contains the methodology HFPB 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 Health 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 a 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 IDPH and the Illinois State Board of Health for use in their evaluation of the model.

d) Applications received for the Children's Community-Based Health Care Center Alternative Health Care Model shall be deemed complete upon receipt by HFPB. All Children's Community-Based Health 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. Due to the comparative nature of the Children's Community-Based Health 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 decision. The application, as submitted to HFPB, shall serve as the basis for all standard and prioritization evaluations.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2720 Children's Respite Care Center Alternative Health Care Model – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2730 Children's Community-Based Health Care Center Alternative Health Care Model – Review Criteria

a) Admission Policies – Review Criterion
The applicant shall document that the Children's Community-Based Health 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 factors will occur.

b) Staffing – Review Criterion
The applicant shall document that the children's community-based health care center will have a 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 and a description of his or her responsibilities.

c) Mandated Services – Review Criterion
The applicant shall document that the children's community-based health 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 services will be provided.

d) Acute Care Backup – Review Criterion
The applicant shall document that an agreement has been signed with an acute care facility for the referral of emergency patients. The acute care facility shall be located within 15 minutes travel time of the children's community-based health care center and have an organized pediatric department.

e) Patient Screening/Emergency Care – Review Criterion
The applicant shall 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 also document that, for each child admitted, a care plan has been developed that identifies the medical needs of the child and identifies a physician who can be contacted in case of emergency. The applicant shall 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 document that children who participate in educational programs will continue to receive services during their stay at the facility. Documentation shall detail who has the responsibility for maintaining these services and how 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 document that, if the center will admit children of all age groups, 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
An applicant shall document that the project cost to establish a model will not exceed $800,000. Documentation shall be based on 77 Ill. Adm. Code 1120 data submissions that detail the itemized costs of the project.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2740 Children's Community-Based Health Care Center Alternative Health Care Model – HFPB Review

a) HFPB Evaluation
HFPB shall evaluate each application for the Children's Community-Based Health 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 Prioritization

1) An application for the category of service shall 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 and awarded points as follows:

A) Compliance with all applicable review criteria of Subpart C – 10 Points

B) Compliance with all review criteria of Section 1110.2730 (Children's Community-Based Health Care Center Alternative Health Care Model Review Criteria) – 10 Points

C) Compliance with all applicable review criteria of 77 Ill. Adm. Code 1120 – 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 the Public Health Service Act (42 USC 254(e))) – 3 Points

3) A proposed Children's Community-Based Health Care Center Alternative Health Care Model shall comply with the development restrictions specified in 77 Ill. Adm. Code 1100.760(c) and shall obtain a minimum of 20 Points to be considered for approval. Competing applications within a planning area that have obtained the points necessary for permit consideration shall be evaluated by HFPB 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 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2750 Children's Community-Based Health 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 at least 90 days prior to the anticipated discontinuation. The project shall be considered abandoned as of the date IDPH 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.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART AC: CATEGORY OF SERVICE REVIEW CRITERIA – 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.

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 and the Illinois State Board of Health for use in their evaluation of the model.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2820 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Definitions (Repealed)

(Source: Repealed at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2830 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Review Criteria

a) Staffing – Review Criterion
The applicant shall 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 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]. Documentation shall consist of a narrative of how services will be provided.

c) Unit Size – Review Criterion
The applicant shall document the number and location of all beds in the model. The applicant shall 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. No community-based residential rehabilitation center alternative health care delivery model shall exceed 100 beds.

d) Utilization – Review Criterion
The applicant shall 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 demonstrate experience in providing the services required by the model. Additionally, the applicant shall document that the programs provided in the model have been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Brain Injury Community-Integrative Program for at least three of the last five years.

(Source: Amended at 33 Ill. Reg. 3312, effective February 6, 2009)

Section 1110.2840 Community-Based Residential Rehabilitation Center Alternative Health Care Model – State Board Review

In order for an application for the community-based residential rehabilitation center alternative health care model to be approved, the applicant must comply with all criteria established in 77 Ill. Adm. Code 1110.2830. Competing applications within a planning area that comply with all

criteria shall be evaluated by the State Board to determine which application best implements the goals of the Health Facilities Planning Act and the Alternative Health Care Delivery Act.

(Source: Added at 24 Ill. Reg. 6075, effective April 7, 2000)

Section 1110.2850 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Project Completion

a) Since the purpose for the establishment of this category of service is to evaluate the alternative 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 Community-Based Residential Rehabilitation Alternative Health Care Model that 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 the State Board at least 90 days prior to the anticipated discontinuation. The project shall be considered abandoned as of the date the Agency receives notice of the actual discontinuation or the date the last client is discharged, whichever is later, and the facility should be removed from the inventory.

b) After obtaining its initial certificate of need, a community-based residential rehabilitation center alternative health care delivery model must obtain an additional certificate of need from the State Board before increasing the bed capacity of the center as mandated by Section 35(b) of the Act [210 ILCS 3/35(b)].

c) 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 the State Board.

d) A community-based residential rehabilitation center alternative health care model shall have a period of 12 months from the date of permit issuance to become operational. Failure to begin operation in this time period shall result in the permit becoming null and void.

(Source: Added at 24 Ill. Reg. 6075, effective April 7, 2000)

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 Long Term Acute Care Hospital (LTACH) services. Applicants proposing to establish, expand or modernize an LTACH 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)(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 Category of Service
	(e) − Staffing Availability
	(f) − Performance Requirements
	(g) − Assurances
Category of Service Modernization	(d)(1) − Deteroriated 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:

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 LTACH 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 LTACH service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

3) Service Demand – Establishment of LTACH 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. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

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 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, and name and location of the recipient hospital.

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 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) 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.

D) 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 not 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) LTACH Modernization

1) If the project involves modernization of an LTACH category of 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 (JCAHO) 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
The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

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 33 Ill. Reg. 3312, effective February 6, 2009)

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).

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 33 Ill. Reg. 3312, effective February 6, 2009)

SUBPART AG: CATEGORY OF SERVICE REVIEW CRITERIA – FREESTANDING EMERGENCY CENTER MEDICAL SERVICES

Section 1110.3210 Introduction

No person shall construct, modify, or establish a freestanding emergency center in Illinois, or acquire major medical equipment or make capital expenditures in relation to such a facility in excess of the capital expenditure minimum, as defined by the *Act, without first obtaining a permit from the State Board in accordance with criteria, standards, and procedures adopted by the State Board for freestanding emergency centers that ensure the availability of and community access to emergency medical services.* [20 ILCS 3960/5.1a]

(Source: Added at 32 Ill. Reg. 12332, effective July 18, 2008)

Section 1110.3230 Freestanding Emergency Center Medical Services − Review Criteria

a) Introduction

1) These criteria are applicable only to those projects or components of projects involving the freestanding emergency center (FEC) medical services (FECMS) category of service. In addition, the applicant shall address other applicable requirements in this Part, as well as those in 77

Ill. Adm. Code 1100 and 1130. Applicants proposing to establish, expand or modernize an FECMS category of service shall comply with the applicable subsections of this Section, as follows:

Project Type	Required Review Criteria
Establishment of Service	(b)(1) − Planning Area Need – 77 Ill. Adm. Code 1100 Formula Calculation
	(b)(2) − Service to Area Residents
	(b)(3) − Service Demand for Establishment
	(b)(4) − Service Accessibility
	(c)(1) − Unnecessary Duplication of Services
	(c)(2) – Maldistribution
	(c)(3) − Impact on Other Providers
	(c)(4) − Request for Data from Other Providers
	(e) − Staffing Availability
Expansion of Existing Service	(b)(2) − Service to Area Residents
	(e) − Staffing Availability
Category of Service Modernization	(d)(1) − Deteriorated Facilities
	(d)(2) − Documentation
	(d)(3) − Additional Documentation

2) If the proposed project involves the replacement of an FEC facility on site, the applicant shall comply with the requirements listed in subsection (a)(1) for Category of Service Modernization.

3) If the proposed project involves the replacement of the FEC facility on a new site, the applicant shall comply with the requirements listed in subsection (a)(1) for Establishment of Service.

4) All projects shall meet or exceed the utilization standards for the service, as specified in 77 Ill. Adm. Code 1100.

5) All projects for an FEC must comply with the licensing requirements established in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50/32.5], including the requirements that the proposed FEC is located:

A) *in a municipality with a population of 75,000 or fewer inhabitants;*

B) *within 20 miles of the hospital that owns or controls the FEC; and*

C) *within 20 miles of the Resource Hospital affiliated with the FEC as part of the EMS system* (Section 32.5(a) of the Emergency Medical Services (EMS) Systems Act).

6) The applicant shall certify that it has reviewed, understands and plans to comply with all of the following requirements:

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

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

b) Area Need – Establishment or Expansion of Service

1) 77 Ill. Adm. Code 1100 Formula Calculation
No formula need calculation has been established for the FECMS category of service.

2) Service to Area Residents
Applicants proposing to establish or expand an FECMS category of service shall document that the primary purpose of the project will be to provide necessary health care to the residents of the geographic service area (GSA), which is defined as 30 minutes travel time from the proposed FEC site.

A) For projects to establish an FECMS category of service, the applicant shall document that at least 50% of the projected patient volume will be residents of the GSA described in subsection (b)(2). Documentation shall consist of patient origin data, as follows:

i) Letters from authorized representatives of hospitals or other FEC facilities that are part of the Emergency Medical Services (EMS) System for the defined GSA, including patient origin data by zip code. If letters are submitted as documentation, a certification in each letter, by the authorized representative, that the representations contained in the letter are true and correct. A complete set of the letters with original notarized signatures shall accompany the application for permit; or

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

B) An applicant proposing to expand an FECMS category of service shall provide patient origin information for all patients served at the existing FEC facility for the last 12-month period, verifying that at least 50% of patients served were residents of the GSA, as defined in subsection (b)(2). The applicant shall submit patient origin information by zip code, based upon the patient's legal residence.

3) Service Demand − Establishment of FECMS Category of Service
The applicant shall document that establishment of an FECMS category of service is necessary to accommodate the service demand experienced annually by the existing GSA (as defined in subsection (b)(2)) hospitals over the latest two-year period.

A) Historical Utilization
The applicant shall document the annual number of ED patients that have received care at facilities that are located in the applicant's defined GSA for the latest two-year period prior to submission of the application;

B) Projected Utilization
The applicant shall document:

i) the estimated number of patients anticipated to receive services at the proposed FEC. The anticipated number cannot exceed the documented historical caseload of all hospitals that are located in the applicant's defined GSA.

ii) if applicable, the estimated number of patients anticipated to receive services at the proposed FEC, based upon rapid population growth in the applicant facility's existing market area.

C) Projected Service Demand – Documentation Parameters

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

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

iii) The number of years projected shall not exceed the number of historical years documented;

iv) 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;

v) 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

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

4) Service Accessibility
The proposed project to establish or expand an FECMS category of service is necessary to improve access for GSA 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 GSA:

i) The absence of ED services within the GSA;

ii) The area population and existing care system exhibit indicators of medical care problems, such as 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;

iii) All existing emergency 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 GSA service providers;

ii) Patient location information by zip code;

iii) Travel-time studies;

iv) A certification of waiting times;

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

vi) An assessment of GSA population characteristics that documents 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 (in total or in part) that are located within 30 minutes normal travel time of the project's site;

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

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

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified facilities within the Normal Travel Time have an excess supply of ED treatment stations 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 ED within 30 minutes travel time of the applicant's site that is below the utilization standard established pursuant to 77 Ill. Adm. Code 1100; or

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

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

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

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

4) The applicant shall document that a written request was received by all existing facilities that provide ED service located within 30 minutes travel time of the project site asking the number of treatment stations at each facility, historical ED utilization, and the anticipated impact of the proposed project upon the facility's ED utilization. The request shall include 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 will not experience an adverse impact in utilization from the project. Copies of any correspondence received from the facilities shall be included in the application.

d) Category of Service Modernization

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

A) High cost of maintenance;

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

C) Changes in standards of care; or

D) Additional space for diagnostic or therapeutic purposes.

2) Documentation shall include the most recent:

A) IDPH 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.

e) Staffing Availability − Review Criterion

1) An applicant proposing to establish an FECMS category of service shall document that a sufficient supply of personnel will be available to staff the service. Sufficient staff availability shall be based upon evidence that for the latest 12-month period prior to submission of the application, those hospitals or FECs 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 such 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% percent, the applicant shall provide documentation as to how sufficient staff shall be obtained to operate the proposed project, in accordance with licensing requirements.

(Source: Added at 32 Ill. Reg. 12332, effective July 18, 2008)

Section 1110.APPENDIX A Medical Specialty Eligibility/Certification Boards

The following is a listing of the "Medical Specialty" boards currently providing "certification of competence" in special fields. Such certification is a function of the primary boards listed, assisted by subspecialty boards or committees (if any).

1. American Board of Allergy and Immunology.

2. American Board of Anesthesiology.

3. American Board of Colon and Rectal Surgery.

4. American Board of Dermatology.

5. American Board of Emergency Medicine.

6. American Board of Family Practice.

7. American Board of Internal Medicine.
   Subspecialty Boards:

   (A) Cardiovascular Disease (Subspecialty Board);

   (B) Subspecialty Committee on Endocrinology and Metabolism;

   (C) Subspecialty Board on Gastroenterology;

   (D) Subspecialty Committee on Hematology;

   (E) Subspecialty Committee Infectious Disease;

   (F) Subspecialty Committee on Medical Oncology;

   (G) Subspecialty Committee on Nephrology;

   (H) Subspecialty Board on Pulmonary Disease; and

   (I) Subspecialty Committee on Rheumatology.

8. American Board of Neurological Surgery.

9. American Board of Nuclear Medicine (Conjoint Board of the American Boards of Internal Medicine, Pathology and Radiology, and sponsored by the Society of

Nuclear Medicine).

10. American Board of Obstetrics and Gynecology.

11. American Board of Opthamology.

12. American Board of Orthopaedic Surgery.

13. American Board of Otolaryngology.

14. American Board of Pathology (Special Certification in Blood Banking offered since 1972).

15. American Board of Pediatrics.
Subspecialty Boards:

    (A) Sub-Board of Pediatric Cardiology;

    (B) Subspecialty Committee of Pediatric Endocrinology;

    (C) Sub-Board of Pediatric Hematology-Oncology;

    (D) Sub-Board of Neonatal-Perinatal Medicine; and

    (E) Sub-Board of Pediatric Nephrology.

16. American Board of Physical Medicine and Rehabilitation.

17. American Board of Plastic Surgery.

18. American Board of Preventive Medicine.

19. American Board of Psychiatry and Neurology (Special Certification offered in Psychiatry; Neurology; Child Psychiatry; and Neurology with Special Competence in Child Neurology).

20. American Board of Radiology.

21. American Board of Surgery.

22. American Board of Thoracic Surgery.

23. American Board of Urology.

An excellent source document containing the Eligibility Requirements for certification by each of these boards, as well as a listing of certified M.D.'s (Diplomates) by state, is the "Directory of Medical Specialists" (complied for the American Board of Medical Specialties by Marquis Who's Who, Inc. of Chicago, Illinois). This two volume set not only lists the certification requirements and Diplomates, but includes the following items by specialty: Board Officers; Historical Review; Purpose and Functions; General Requirements; Training Requirements; Operative Experience Criteria; Criteria for Credit; Credit for Foreign Education; Applications; Exams Written/Oral; Re-Exams; Fees; Appeals; Certification; Recertifications; Revocation of Certification; and Rules and Regulations for Examination Qualifications.

Section 1110.APPENDIX B State and National Norms

The following norms are established for gross square footage by department and/or utilization of medical equipment. NOTE: Gross Square Footage indicated as gft^2.

Department	State Norms
Acute Mental Illness Beds	586 gft^2/Bed (Psych)
Ambulatory Care	4.1 Clinic Visits/gft^2 or 667 gft^2/Treatment Room (based upon 2,000 visits per room)
Ambulatory Surgical Treatment Centers	2,750 gft^2/Treatment Room (based upon 1,500 hours of surgery per room
Cardiac Catheterization	1,596 gft^2/Laboratory
Central Sterile Supply	18 gft^2/Bed (Total)
Conversion of Hosp. Acute Care Beds to Skilled Care	429 gft^2/Bed (Total)
Diagnostic Radiology	1,386 gft^2/Procedure Room or 5.5 Procedures/gft^2 (based upon 6,500 procedures/general x-ray room, 2,000 visits per mammography room, 2,000 visits per ultrasound room, 400 procedures per angiography room, and 2,000 visits per special procedures room (computerized tomography, multi-directional tomography, etc.))
Emergency Room	744.6 gft^2/Treatment Room (based upon 2,000 per treatment room per year) or 3.1 visits per gft^2
Hemodialysis	470 gft^2/Room
ICF/DD Facilities – 16 or less	369 gft^2/Bed (Total)
ICF/DD Facilities Over 16 Beds)	564 gft^2/Bed (Total)
Intensive Care Beds	603 gft^2/Bed (ICU)

Laboratory (includes blood bank)	225 gft^2/Full-Time Equivalent or 36 gft^2/Bed (Total)
Labor-Delivery-Recovery	23 gft^2/Bed or 4.6 gft^2/Procedure or 1975 gft^2/Needed Delivery Room (based upon 750 Live Births/Delivery Room)
LDRP	1,119 gft^2/Bed
Medical-Surgical Beds	401 gft^2/Bed (M-S)
MRI	3,400 gft^2/unit (2,000 visits per MRI)
Neonatal-High Risk Beds	355 gft^2/Bed (Neo)
Newborn Nursery	152 gft^2/Bed (Obstetrics)
Nuclear Medicine	2.9 Procedures/gft^2 or 1,135 gft^2/Treatment Room or 11.7 gft^2/Bed (Total) (based upon 2,000 visits per piece of equipment)
Nursing Care Facilities	414 gft^2/Bed (Total)
Obstetric Beds	476 gft^2/Bed (OB)
Occupational Therapy	4.3 gft^2/Bed (Total less ICU and OB)
Pediatric Beds	420 gft^2/Bed (Ped)
Pharmacy	12.0 gft^2/Bed (Total)
Physical Therapy	7.5 Treatments/gft^2 or 23 gft^2/Bed (M-S, Peds, Rehab, Burn and LTC)
Recovery (Surgical)	180 gft^2/Recovery Station (based upon maximum of 4 stations per needed operating room)
Rehabilitation Beds	588 gft^2/Bed (Rehab)
Respiratory Therapy	20.5 Procedures/gft^2 or 8.9 gft^2/Bed
Speech Pathology/Audiology	1.8 gft^2/Bed (Total)

Surgery	2,078 gft^2/Surgical Room (based upon 1,500 hours of surgery per operating room per year)

The State Board shall periodically evaluate the norms to determine if revisions should be made. Any revisions shall be promulgated in accordance with the provisions of the Illinois Administrative Procedure Act [5 ILCS 100].

(Source: Amended at 27 Ill. Reg. 2916, effective February 21, 2003)

Section 1110.APPENDIX C Statutory Citations for all State and Federal Laws and Regulations Referenced in Chapter 3

"Ambulatory Surgical Treatment Center Act" [210 ILCS 5]

Renal Disease Treatment Act [410 ILCS 430]

Developmental Disability Prevention Act [410 ILCS 250]

"Hospital Licensing Act" [210 ILCS 85]

"Illinois Administrative Procedure Act" [5 ILCS 100]

"Illinois Health Facilities Planning Act [20 ILCS 3960]

"Mental Health and Developmental Disabilities Code" [405 ILCS 5]

"National Health Planning and Resources Development Act of 1974" (P.L. 93-641) (42 U.S.C. 300K)

"Nursing Home Care Act [210 ILCS 45]

"Social Security Act – Title XVIII" (42 U.S.C. 1395)

"Social Security Act – Title XIX" (42 U.S.C. 1396)

"Social Security Amendments of 1982" (P.L. 92-603) (42 U.S.C. 1329)

(Source: Amended at 20 Ill. Reg. 4734, effective March 22, 1996)