

**RECEIVED**

OCT 27 2016

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**ORIGINAL**

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD HEALTH FACILITIES & SERVICES REVIEW BOARD

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

*E-060-16*

This Section must be completed for all projects.

**Facility/Project Identification**

Facility Name: Champaign SurgiCenter
Street Address: 1702 S Mattis Ave.
City and Zip Code: Champaign, IL 61821
County: Champaign      Health Service Area: HSA-4      Health Planning Area: D-1

**Applicant /Co-Applicant Identification**

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name (Co-Applicant): Champaign SurgiCenter, LLC
Address: 1702 S. Mattis Avenue Champaign, IL 61821
Name of Registered Agent: James C. Leonard, MD
Name of Chief Executive Officer: James C. Leonard, MD
CEO Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-3220

**Type of Ownership of Applicant/Co-Applicant**

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

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

**APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Primary Contact**

[Person to receive ALL correspondence or inquiries)

Name: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation Hospital
Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-8364
E-mail Address: Collin.Anderson@Carle.com
Fax Number:

**Additional Contact**

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 161 N. Clark Street, Suite 4200 Chicago, IL 60601
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

**Facility/Project Identification**

Facility Name: Champaign SurgiCenter		
Street Address: 1702 S Mattis Ave.		
City and Zip Code: Champaign, IL 61821		
County: Champaign	Health Service Area: HSA-4	Health Planning Area: D-1

**Applicant /Co-Applicant Identification**

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name (Co-Applicant): The Carle Foundation
Address: 611 West Park Street, Urbana IL, 61801
Name of Registered Agent: James C. Leonard, MD
Name of Chief Executive Officer: James C. Leonard, MD
CEO Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-3220

**Type of Ownership of Applicant/Co-Applicant**

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.

o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

**APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Primary Contact**

[Person to receive ALL correspondence or inquiries)

Name: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation Hospital
Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-8364
E-mail Address: Collin.Anderson@Carle.com
Fax Number:

**Additional Contact**

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 161 N. Clark Street, Suite 4200 Chicago, IL 60601
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

**Facility/Project Identification**

Facility Name: Champaign SurgiCenter		
Street Address: 1702 S Mattis Ave.		
City and Zip Code: Champaign, IL 61821		
County: Champaign	Health Service Area: HSA-4	Health Planning Area: D-1

**Applicant /Co-Applicant Identification**

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name (Co-Applicant): Carle Health Care Incorporated
Address: 611 West Park Street, Urbana IL, 61801
Name of Registered Agent: James C. Leonard, MD
Name of Chief Executive Officer: James C. Leonard, MD
CEO Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-3220

**Type of Ownership of Applicant/Co-Applicant**

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

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

**APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Primary Contact**

[Person to receive ALL correspondence or inquiries)

Name: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation Hospital
Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-8364
E-mail Address: Collin.Anderson@Carle.com
Fax Number:

**Additional Contact**

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 161 N. Clark Street, Suite 4200 Chicago, IL 60601
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**Post Permit Contact**

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960

Name: Collin Anderson
Title: Business Development & Regulatory Coordinator
Company Name: The Carle Foundation Hospital
Address: 611 West Park Street, Urbana IL, 61801
Telephone Number: 217-383-8364
E-mail Address: Collin.Anderson@Carle.com
Fax Number:

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: The Carle Foundation
Address of Site Owner: 611 West Park Street, Urbana IL, 61801
Street Address or Legal Description of Site: 1702 S Mattis Ave, Champaign, IL 61821
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Operating Identity/Licensee**

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Champaign SurgiCenter, LLC
Address: 1702 S. Mattis Avenue Champaign, IL 61821
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"><li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li><li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li></ul>
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Organizational Relationships**

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

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

**Flood Plain Requirements**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org). **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

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

**Historic Resources Preservation Act Requirements**

[Refer to application instructions.]

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

APPEND DOCUMENTATION AS **ATTACHMENT-6**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**DESCRIPTION OF PROJECT**

**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- Substantive
- Non-substantive

Certificate of Exemption for discontinuation

**2. Narrative Description**

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

Champaign SurgiCenter, LLC, Carle Health Care Incorporated and The Carle Foundation (the "Applicants") seek authority to discontinue in its entirety their existing ambulatory surgical treatment center ("ASTC") located at 1702 S. Mattis Avenue Champaign, IL 61821 (the "Existing ASTC"). Pursuant to an application that was filed concurrently with this one, they are also seeking to establish an ASTC to be located on the northeast corner of S. Staley Rd. and W. Curtis Rd. in Champaign, IL 61822 (the "Replacement ASTC")

Upon discontinuation, the license will be transferred to the Replacement ASTC. Accordingly, the discontinuation date is dependent upon occupancy of the Replacement ASTC, which is expected to be completed on or before June 30, 2019.

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**Project Costs and Sources of Funds**

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>	n/a	n/a	n/a
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	n/a	n/a	n/a
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

There are no capital costs associated with this closure.

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**Related Project Costs**

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

Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Purchase Price: \$ _____
Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.
Estimated start-up costs and operating deficit cost is \$ _____ n/a _____.

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>
Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): June 30, 2019
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <b>(Not Applicable)</b> <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies <input type="checkbox"/> Project obligation will occur after permit issuance.
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**State Agency Submittals**

Are the following submittals up to date as applicable: Not Applicable
<input checked="" type="checkbox"/> Cancer Registry
<input checked="" type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> All reports regarding outstanding permits
<b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b>

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**Cost Space Requirements (Not Applicable)**

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

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**Facility Bed Capacity and Utilization (Not Applicable)**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. **Include observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

<b>FACILITY NAME:</b>		<b>CITY:</b>			
<b>REPORTING PERIOD DATES:</b> <b>From:</b> <b>to:</b>					
<b>Category of Service</b>	<b>Authorized Beds</b>	<b>Admissions</b>	<b>Patient Days</b>	<b>Bed Changes</b>	<b>Proposed Beds</b>
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
<b>TOTALS:</b>					

**CERTIFICATION**

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

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

  
\_\_\_\_\_  
SIGNATURE

**James C. Leonard, MD**  
\_\_\_\_\_  
PRINTED NAME

**President and CEO**  
\_\_\_\_\_  
PRINTED TITLE

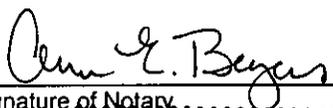
  
\_\_\_\_\_  
SIGNATURE

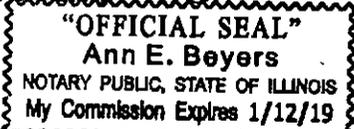
**John M. Snyder**  
\_\_\_\_\_  
PRINTED NAME

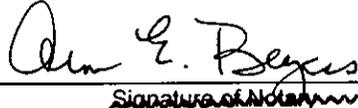
**Executive Vice President and System COO**  
\_\_\_\_\_  
PRINTED TITLE

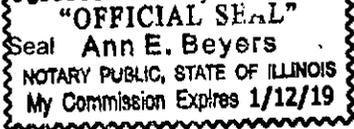
Notarization:  
Subscribed and sworn to before me  
this 21st day of October, 2016

Notarization:  
Subscribed and sworn to before me  
this 21st day of October, 2016

  
\_\_\_\_\_  
Signature of Notary

Seal  
  
"OFFICIAL SEAL"  
Ann E. Beyers  
NOTARY PUBLIC, STATE OF ILLINOIS  
My Commission Expires 1/12/19

  
\_\_\_\_\_  
Signature of Notary

Seal  
  
"OFFICIAL SEAL"  
Ann E. Beyers  
NOTARY PUBLIC, STATE OF ILLINOIS  
My Commission Expires 1/12/19

\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

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

*James C. Leonard*  
 SIGNATURE

James C. Leonard, MD  
 PRINTED NAME

President and CEO  
 PRINTED TITLE

*John M. Snyder*  
 SIGNATURE

John M. Snyder  
 PRINTED NAME

Executive Vice President and System COO  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 21<sup>st</sup> day of October, 2016

Notarization:  
 Subscribed and sworn to before me  
 this 21<sup>st</sup> day of October, 2016

*Ann E. Beyers*  
 Signature of Notary

Seal  
 "OFFICIAL SEAL"  
 Ann E. Beyers  
 NOTARY PUBLIC, STATE OF ILLINOIS  
 My Commission Expires 1/12/19

*Ann E. Beyers*  
 Signature of Notary

Seal  
 "OFFICIAL SEAL"  
 Ann E. Beyers  
 NOTARY PUBLIC, STATE OF ILLINOIS  
 My Commission Expires 1/12/19

\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

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

James C. Leonard  
SIGNATURE

**James C. Leonard, MD**  
PRINTED NAME

**President and CEO**  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 21st day of October, 2016

John M. Snyder  
SIGNATURE

**John M. Snyder**  
PRINTED NAME

**Executive Vice President and System COO**  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 21st day of October, 2016

Ann E. Beyers  
Signature of Notary

Seal  
"OFFICIAL SEAL"  
Ann E. Beyers  
NOTARY PUBLIC, STATE OF ILLINOIS  
My Commission Expires 1/12/19

\*Insert EXACT legal name of the applicant

Ann E. Beyers  
Signature of Notary

Seal  
"OFFICIAL SEAL"  
Ann E. Beyers  
NOTARY PUBLIC, STATE OF ILLINOIS  
My Commission Expires 1/12/19

## SECTION II. DISCONTINUATION

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

### Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

#### REASONS FOR DISCONTINUATION

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

#### IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility. **(Not Applicable)**
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination. **(Not Applicable)**

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

**SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS**

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

**Criterion 1110.230 – Background, Purpose of the Project, and Alternatives**

READ THE REVIEW CRITERION and provide the following required information:

**BACKGROUND OF APPLICANT**

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

**APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.**

**PURPOSE OF PROJECT (Not Applicable)**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

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

**NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.**

**APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.**

**ALTERNATIVES (Not Applicable)**

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
  - 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) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
  - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE (Not Applicable)**

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

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
  - c. The project involves the conversion of existing space that results in excess square footage.

**Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.**

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

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

**PROJECT SERVICES UTILIZATION:**

**This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.**

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

**A table must be provided in the following format with Attachment 15.**

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

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

**UNFINISHED OR SHELL SPACE: (Not Applicable)**

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF 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 areas proposed to occupy the shell space.
4. Provide:
  - a. Historical utilization for the area for the latest five-year period for which data are available; and
  - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**ASSURANCES: (Not Applicable)**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**SECTION V. - MASTER DESIGN AND RELATED PROJECTS (Not Applicable)**

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

**Criterion 1110.235(a) - System Impact of Master Design**

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities;
2. How the services proposed in future projects will improve access to planning area residents;
3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed; and
4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

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

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

1. The anticipated completion date(s) for the future construction or modernization projects; and
2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:
  - a. limitation on government funded or charity patients that are expected to continue;
  - b. restrictive admission policies of existing planning area health care facilities that are expected to continue;
  - c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.
3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:
  - a. historical service/beds utilization levels;
  - b. projected trends in utilization (include the rationale and projection assumptions used in such
  - c. projections);
  - d. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and anticipated changes in delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

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

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit;
2. The estimated project cost for the proposed projects and also for the total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT-1B, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**SECTION VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP (Not Applicable)**

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

**NOTE: For all projects involving a change of ownership THE COMPLETE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.**

**A. Criterion 1110.240(b), Impact Statement**

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered.
2. Who the operating entity will be.
3. The reason for the transaction.
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.
5. A cost-benefit analysis for the proposed transaction.

**B. Criterion 1110.240(c), Access**

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction.
2. The proposed admission policies for the facilities.
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.

**C. Criterion 1110.240(d), Health Care System**

Read the criterion and address the following:

1. Explain what the impact of the proposed transaction will be on the other area providers.
2. List all of the facilities within the applicant's health care system and provide the following for each facility.
  - a. the location (town and street address);
  - b. the number of beds;
  - c. a list of services; and
  - d. the utilization figures for each of those services for the last 12 month period.
3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.
4. Provide time and distance information for the proposed referrals within the system.
5. Explain the organization policy regarding the use of the care system providers over area providers.
6. Explain how duplication of services within the care system will be resolved.
7. Indicate what services the proposed project will make available to the community that are not now available.

APPEND DOCUMENTATION AS ATTACHMENT-19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD**

**SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA (Not Applicable)**

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

**(Not Applicable)**

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

**VIII. - 1120.120 - Availability of Funds**

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
		<b>TOTAL FUNDS AVAILABLE</b>

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

**Financial Viability Waiver**

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

**APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

**APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**X. 1120.140 - Economic Feasibility (Not Applicable)**

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

**A. Reasonableness of Financing Arrangements**

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
  - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
  - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

**B. Conditions of Debt Financing**

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

**C. Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

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

\* Include the percentage (%) of space for circulation

**D. Projected Operating Costs**

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD**

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

**E. Total Effect of the Project on Capital Costs**

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

**APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**XI. Safety Net Impact Statement**

**SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:**

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
Medicaid (revenue)	Year	Year	Year
Inpatient			

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

	Outpatient			
Total				

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

**XII. Charity Care Information (Not Applicable)**

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Coapplicant Identification including Certificate of Good Standing	29-31
2	Site Ownership	n/a
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	32-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36
5	Flood Plain Requirements	n/a
6	Historic Preservation Act Requirements	n/a
7	Project and Sources of Funds Itemization	n/a
8	Obligation Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	37-38
11	Background of the Applicant	39-46
12	Purpose of the Project	n/a
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
18	Master Design Project	n/a
19	Mergers, Consolidations and Acquisitions	n/a
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
21	Comprehensive Physical Rehabilitation	n/a
22	Acute Mental Illness	n/a
23	Neonatal Intensive Care	n/a
24	Open Heart Surgery	n/a
25	Cardiac Catheterization	n/a
26	In-Center Hemodialysis	n/a
27	Non-Hospital Based Ambulatory Surgery	n/a
28	Selected Organ Transplantation	n/a
29	Kidney Transplantation	n/a
30	Subacute Care Hospital Model	n/a
31	Children's Community-Based Health Care Center	n/a
32	Community-Based Residential Rehabilitation Center	n/a
33	Long Term Acute Care Hospital	n/a
34	Clinical Service Areas Other than Categories of Service	n/a
35	Freestanding Emergency Center Medical Services	n/a
	<b>Financial and Economic Feasibility:</b>	
36	Availability of Funds	n/a
37	Financial Waiver	n/a
38	Financial Viability	n/a
39	Economic Feasibility	n/a
40	Safety Net Impact Statement	47-48
41	Charity Care Information	n/a



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

CARLE HEALTH CARE INCORPORATED, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 01, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of OCTOBER A.D. 2016 .***

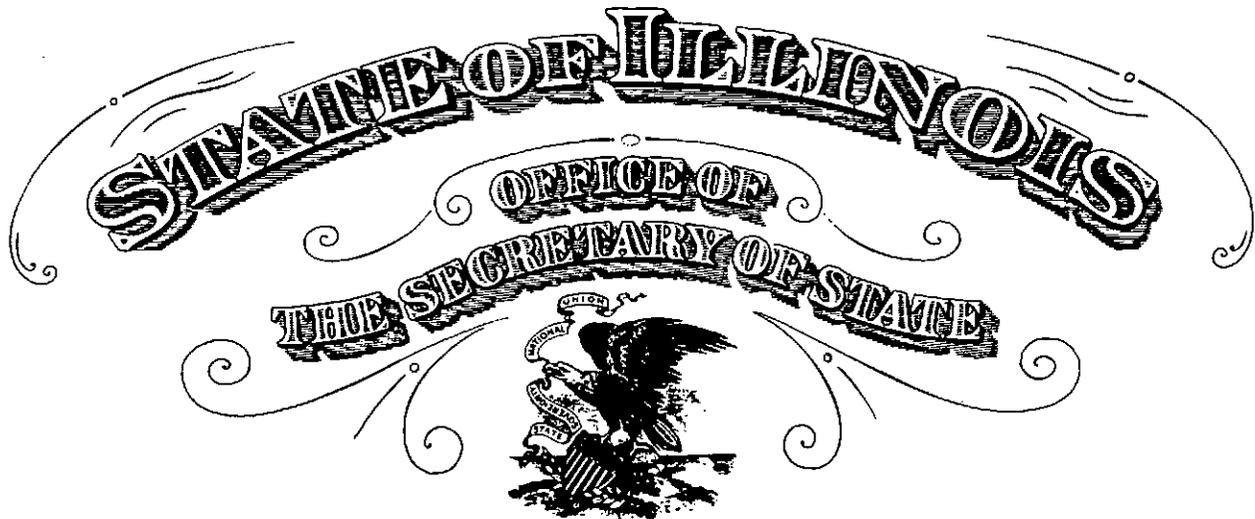


*Jesse White*

SECRETARY OF STATE

Authentication #: 1627901618 verifiable until 10/05/2017

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



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

CHAMPAIGN SURGICENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 06, 2004, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 2ND day of JUNE A.D. 2016 .***



Authentication #: 1615400962 verifiable until 06/02/2017  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

THE CARLE FOUNDATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1946, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 25TH day of JULY A.D. 2016 .***



*Jesse White*

SECRETARY OF STATE

Authentication #: 1620702344 verifiable until 07/25/2017

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

## **Partnership Information**

As depicted in Attachment- 4, The Carle Foundation (611 West Park Street, Urbana IL, 61801) indirectly through Carle Health Care Incorporated (611 West Park Street, Urbana IL, 61801) holds a 75% interest in Champaign SurgiCenter, LLC. Christie Clinic ASC, LLC (101 West University Avenue Champaign, IL 61820) holds a 25% interest.

Attachment-3



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

CARLE HEALTH CARE INCORPORATED, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 01, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

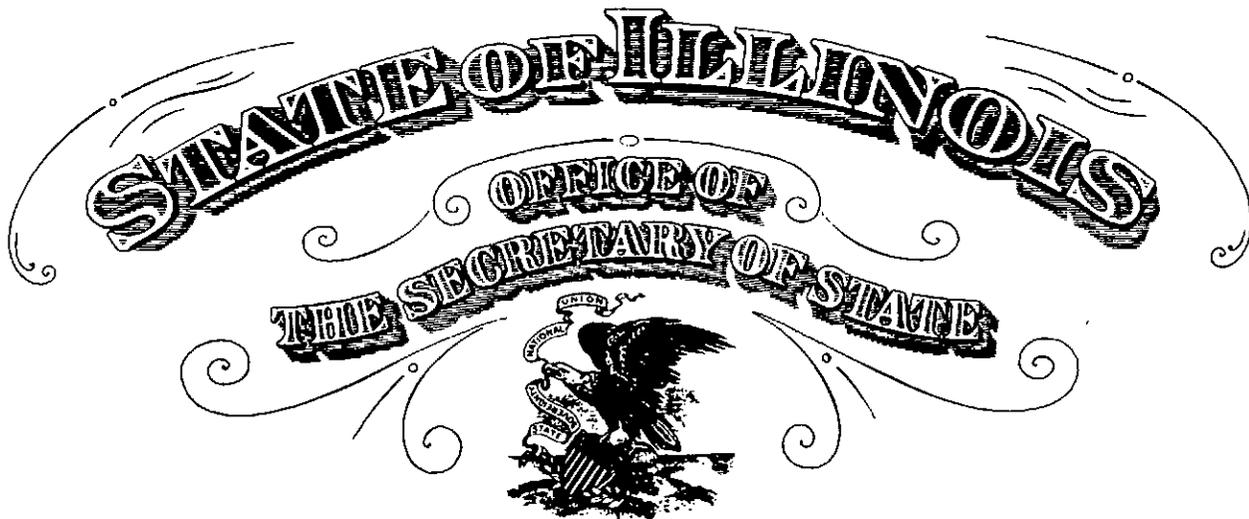
***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of OCTOBER A.D. 2016 .***



Authentication #: 1627901618 verifiable until 10/05/2017  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE

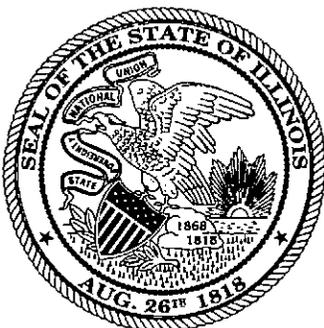


**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

CHAMPAIGN SURGICENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 06, 2004, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 2ND day of JUNE A.D. 2016 .***



*Jesse White*

SECRETARY OF STATE

Authentication #: 1615400962 verifiable until 06/02/2017  
Authenticate at: <http://www.cyberdriveillinois.com>



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

THE CARLE FOUNDATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1946, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 25TH day of JULY A.D. 2016 .***

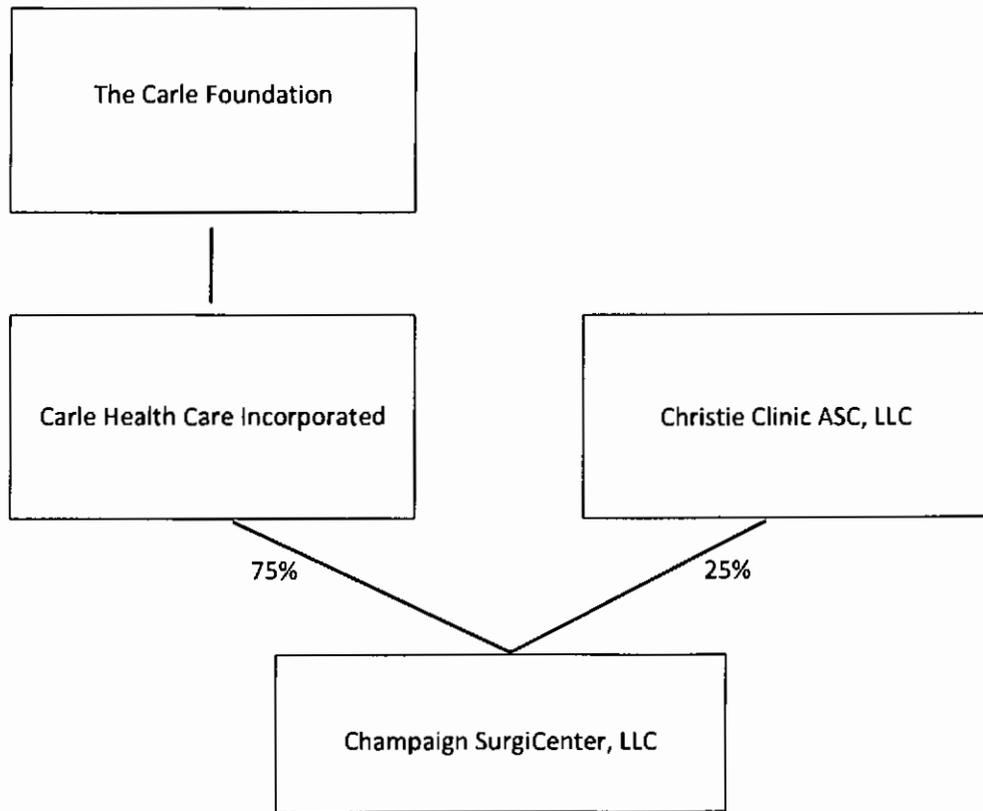


Authentication #: 1620702344 verifiable until 07/25/2017  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE

**Entity Chart**



## Section II, Discontinuation

### Criterion 1110.130(a), General

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

The Applicants seek authority from the Health Facilities and Services Review Board (the "State Board") to discontinue, in its entirety the existing five operating room ASTC located at 1702 S. Mattis Avenue Champaign, IL 61821 and to establish a new ASTC with eight operating rooms and one procedure room to be located at the northeast corner of S. Staley Rd. and W. Curtis Rd. in Champaign, IL 61822 (the "Replacement ASTC").

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

No other clinical services will be discontinued as a result of this project.

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

Anticipated discontinuation date: June 30, 2019

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

The vacated space within the existing ASTC will be backfilled with the following services that are currently housed in leased spaces:

- Carle Medical Supply
- Carle hospice, home care and home infusion

Moveable equipment which remains viable for the operation of the surgery center will be transferred to the Replacement ASTC.

**5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.**

Champaign SurgiCenter will retain its electronic medical records following the relocation.

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

This project is a relocation of the Existing ASTC and not a true discontinuation. The current operator will continue to submit all questionnaires and data required by HFSRB and IDPH going forward.

### Criterion 1110.130(b), Reasons for Discontinuation

This discontinuation is necessary to establish a new replacement ASTC to be located 3.9 miles away from the existing ASTC. As described in detail in the accompanying application for permit to establish the new ASTC, there are several benefits to doing so:

- Improve patient access by expanding the number of operating rooms.
- Increase capacity of the ASTC to allow certain procedures to shift from hospital operating rooms to a lower cost setting.
- Improve quality of care for patients in the geographic area served by Champaign SurgiCenter by addressing physical plant size limitations within the existing ASTC. Issues to be addressed include:
  - Configuration to allow one way flow of patients, staff and deliveries through the surgery center
  - Additional storage for large equipment
  - Separate space for interviewing patients during admission
  - A larger waiting room to accommodate individuals accompanying patients on their day of surgery

- Enable Carle to backfill the existing ASTC with other necessary services described above.
- Improve accessibility by relocating ASTC immediately adjacent to Interstate 57.

**Criterion 1110.130(c), Impact on Access**

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

The discontinuation of the Existing ASTC will not negatively impact access to care. To the contrary, it will improve access to high quality surgical procedures in a modern ASTC to residents of east central Illinois. As set forth above, the proposed project is for the discontinuation of an existing ASTC and the establishment of a replacement ASTC. No true discontinuation will occur as a result of the proposed project.



611 West Park Street, Urbana, IL 61801-2595 Phone: (217) 383-3311

Kathryn J. Olson, Chair  
Illinois Health Facilities and Services Review Board  
525 West Jefferson Street, 2nd Floor  
Springfield, Illinois 62761

**RE: Attachment 11 - Background of Applicant**

Dear Chair Olson:

The following information addresses the four points of the subject criterion 1110.230:

1. The health care facilities owned or operated by the applicants include:

**The Carle Foundation Hospital**

License Identification Number: 003798

Accreditation Identification Number: 119139-2012-AHC-USA-NIAHO

**Hoopeston Community Memorial Hospital, DBA Carle**

**Hoopeston Regional Health Center**

License Identification Number: 004200

Accreditation Identification Number: 128702-2012-AHC-USA-NIAHO

**Champaign SurgiCenter, LLC**

License Identification Number: 7002959

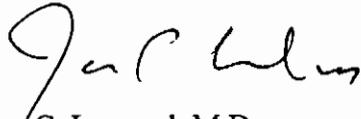
**Carle SurgiCenter – Danville**

License Identification Number: 7002439

2. Proof of current licensure and accreditation is attached.
3. No adverse action has been taken against the Applicants or any above facility, owner, or officer/director of the Applicants, nor does any such person have an adverse criminal or civil ruling, decision, etc. that would preclude them from owning and operating a health care facility.
4. This letter serves as authorization permitting the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information which the State Board or Agency finds pertinent to this subsection.

Attachment-11

Sincerely,

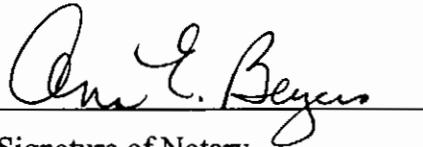


James C. Leonard, M.D.  
President and CEO

Attachments

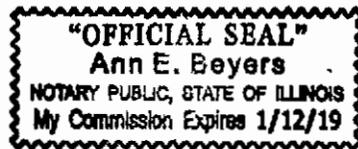
Notarization:

Subscribed and sworn to before  
me this 21<sup>st</sup> day of October, 2016.



Signature of Notary

seal





**Illinois Department of  
PUBLIC HEALTH**

HF109544

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**Nirav D. Shah, M.D., J.D.**  
**Director**

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2016		0003798
<b>General Hospital</b>		
<b>Effective: 01/01/2016</b>		

Exp. Date 12/31/2016

Lic Number 0003798

Date Printed 10/28/2015

**The Carle Foundation Hospital**  
**611 West Park Street**  
**Urbana, IL 61801**

**The Carle Foundation Hospital**  
**611 West Park Street**  
**Urbana, IL 61801**

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

FEE RECEIPT NO.

DISPLAY THIS PART IN A  
CONSPICUOUS PLACE



**Illinois Department of  
PUBLIC HEALTH**

HF110776

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

Nirav D. Shah, M.D., J.D.

Director

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	IC NUMBER
6/30/2017		0004200
<b>Critical Access Hospital</b>		
Effective: 07/01/2016		

Hoopeston Community Memorial Hospital  
701 East Orange Street  
Hoopeston, IL 60942

The face of this license has a colored background. Printed by Authority of the State of Illinois • PO #4012220 IBM 3/12

Exp. Date 6/30/2017

Lic Number 0004200

Date Printed 5/3/2016

Hoopeston Community Memorial Hosp  
701 East Orange Street  
Hoopeston, IL 60942

FEE RECEIPT NO.



**Illinois Department of  
PUBLIC HEALTH**

HF 109805

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**Nirav D. Shah, M.D., J.D.**

Director

Issued Under the authority of the Illinois Department of Public Health

EXPIRES	CATEGORY	J.D. NUMBER
1/31/2017	ALL	7002959

**Ambulatory Surgery Treatment Center**

Effective: 02/01/2016

**Champaign Surgicenter, LLC  
dba Carle Surgicenter  
1702 S. Mattis Avenue, Suite 120**

**Champaign, IL 61821**

This face of this license has a colored background printed by Authority of the State of Illinois, P.O. #401-2320-10M 9/12



**Illinois Department of  
PUBLIC HEALTH**

HF111221

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**Nirav D. Shah, M.D., J.D.**  
Director

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	L.D. NUMBER
7/31/2017		7002439
<b>Ambulatory Surgery Treatment Center</b>		
Effective: 08/01/2016		

Exp. Date 7/31/2017

Lic Number 7002439

Date Printed 6/30/2016

Carle Surgicenter  
2300 N. Vermilion  
Danville, IL 61832

Carle Surgicenter  
2300 N. Vermilion  
Danville, IL 61832-7499

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

FEE RECEIPT NO.

# CERTIFICATE OF ACCREDITATION

Certificate No.:  
181715-2015-AHC-USA-NIAHO

Initial date:  
6/29/2015

Valid until:  
6/29/2018

This is to certify that:

## **Carle Foundation Hospital**

611 W. Park St, Urbana, IL 61801

has been found to comply with the requirements of the:  
**NIAHO® Hospital Accreditation Program**

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:  
DNV GL - Healthcare  
Katy, TX



Patrick Morine  
Chief Executive Officer



October 14, 2015

Harry Brockus  
Chief Executive Officer  
Hoopeston Community Memorial Hospital  
d/b/a Carle Hoopeston Regional Health Center  
701 East Orange Street  
Hoopeston, IL 60942

Program: CAH  
CCN: 141316  
Survey Type: Medicare Recertification/DNV Reaccreditation  
Certificate #: 188047-2014-AHC-USA-NIAHO  
Survey Dates: September 1-2, 2015  
Accreditation Decision: Full accreditation  
Date Acceptable Plan of Correction Received: 10/12/2015  
Method of Follow-up: Acceptable Plan of Correction,  
Self-Attestation, Document Review  
Effective Date of Accreditation: 12/19/2015  
Expiration Date of Accreditation: 12/19/2018  
Term of Accreditation: Three (3) years

Dear Mr. Brockus:

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Hoopeston Community Memorial Hospital d/b/a Carle Hoopeston Regional Health Center is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485) and awarded full accreditation for a three (3) year term effective on the date referenced above. DNV GL Healthcare USA, Inc. is recommending your organization for continued deemed status in the Medicare Program.

This accreditation is applicable to all facilities operating under the above-referenced CCN number at the following address(es):

Hoopeston Community Memorial Hospital d/b/a Carle Hoopeston Regional Health Center -  
701 East Orange Street - Hoopeston, IL 60942

This accreditation requires an annual survey and the organization's continual compliance with the DNVHC Accreditation Process. Failure to complete these actions or otherwise comply with your Management System Certification/Accreditation Agreement may result in a change in your organization's accreditation status.

Congratulations on this significant achievement.

Sincerely,



Patrick Horine  
Chief Executive Officer  
cc: CMS CO and CMS RO V (Chicago)

## Safety Net Impact Statement

The Applicants seek to relocate and expand their Existing ASTC. No services are being eliminated. The Project will enhance the delivery of care at Champaign SurgiCenter, and is not expected to have any adverse impact on safety net services in the community or on the ability of any other health care provider to deliver services.

This Safety Net Impact Statement addresses the following requirements:

- 1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.**

The relocation of Champaign SurgiCenter will improve safety net services in the community by expanding capacity at an essential provider of these services. In 2015, Champaign SurgiCenter treated the most Medicaid and the most charity care patients of any ASTC in Health Service Area 004. Champaign SurgiCenter has the same Medicaid and charity care policies as Carle Foundation Hospital. As a result, in 2015, 18.7% of Champaign SurgiCenter's patients' primary payor source was Medicaid, while Charity Care accounted for another 9.1% of patients. The relocation of the ASTC will not impact its Medicaid and/or charity care policies. Patients seeing Carle providers in the Replacement ASTC will be eligible for the same charity care benefits that are available at the Existing ASTC.

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

The relocation of the ASTC will not adversely impact the ability of other providers or health care systems to serve patients seeking safety net services. The Applicants do not believe there will be any adverse impact on other providers or health care systems, as the Project is aimed at addressing the demand for services currently performed at the Existing ASTC and Carle Foundation Hospital.

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

The proposed project is for the discontinuation of an existing ASTC and the establishment of a replacement ASTC. No true discontinuation will occur. As a result, an analysis regarding how reduced services will impact the community is not applicable.

**Safety Net Impact Statements shall also include:**

- 1. For the three fiscal years prior to the application, the applicant must also provide certification describing the amount of charity care provided by the applicant;**
- 2. For the three fiscal years prior to the application, a certification of the amount of charity care provided to Medicaid patients;**
- 3. Any information the applicant believes is directly relevant to safety net services.**

## Safety Net Impact Statement

### 1. Charity Care Information

<b>Charity Care (# of patients)</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>
Inpatient	0	0	0
Outpatient	413	442	447
<b>Total</b>	<b>413</b>	<b>442</b>	<b>447</b>
<b>Charity Care (cost in dollars)</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>
Inpatient	\$0	\$0	\$0
Outpatient	\$442,535	\$441,812	\$384,564
<b>Total</b>	<b>\$442,535</b>	<b>\$441,812</b>	<b>\$384,564</b>

### 2. Medicaid Information

<b>Medicaid (# of patients)</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>
Inpatient	0	0	0
Outpatient	603	776	918
<b>Total</b>	<b>603</b>	<b>776</b>	<b>918</b>
<b>Medicaid (Revenue)</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>
Inpatient	0	0	0
Outpatient	\$218,354	\$817,211	\$1,553,709
<b>Total</b>	<b>\$218,354</b>	<b>\$817,211</b>	<b>\$1,553,709</b>