Illinois Critical Access Hospital Network

*2020 Flex Grant Reporting Form*

***Outpatient Services Award***

|  |
| --- |
| **Hospital:** |
| **Person Completing Report:** |
| **Date of Report:** | **Phone:** |
| **Authorized Signature:** |

*Please complete the following information and return with accompanying budget evaluation form to Laura S. Fischer at* *lfischer@icahn.org* *no later than* ***July 31, 2020.***

|  |
| --- |
| 1. **Which category did you use the funds for:**

[ ]  Outpatient case management[ ]  Telemedicine or mobile health[ ]  Electronic Medical Record for outpatient rehab and home health service[ ]  Fitness, Health & Wellness Services[ ]  Aquatic Therapy[ ]  Concussion Management Services[ ]  Cardiac Rehab Services[ ]  Pulmonary Rehab Services[ ]  Laboratory Outreach Services[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Describe your grant program/project and how it was implemented.** **Did this program/project do the following:**1) Strengthen existing services [ ]  Yes [ ]  No [ ]  Not Applicable 2) Improve operations [ ]  Yes [ ]  No [ ]  Not Applicable 3) Add new services to your facility [ ]  Yes [ ]  No [ ]  Not Applicable 4) Improve outpatient services [ ]  Yes [ ]  No [ ]  Not Applicable  |
| 1. **Explain how you achieved the outcomes defined in the application for this grant. If outcomes were not achieved, explain what factors kept you from achieving them**.

|  |  |
| --- | --- |
| Short term outcomes (less than 6 months) |  |
| 1.  |  |
| 2  |  |
|  |  |
| Long term outcomes (6 months or greater) |  |
| 1. |  |
| 2. |  |
| 3. |  |

 |
| **3. Were there any changes to the planning process for the program/project?** [ ]  Yes [ ]  No**If yes, please describe**. |
| 1. **Explain how you measured the success of the program/project.**

|  |  |
| --- | --- |
| Measure 1 |  |
| Measure 2 |  |
| Measure 3 |  |
| Measure 4 |  |

**Was there an increase in patients using the service**? [ ]  Yes [ ]  No If no, why not?**Was there overall satisfaction with the service**? [ ]  Yes [ ]  No If no, why not?**Did the service improve your market share**? [ ]  Yes [ ]  No If no, why not?**Was patient care improved in the identified setting**? [ ]  Yes [ ]  No If no, why not?   |
| 1. **Please describe any changes to the original budget request and the reasons for the change**.
 |
| 1. **Please describe any changes to the original timeline or deliverables. Explain the reason(s) for the change. Describe in detail the plans for the completion of the project.**
 |
| 1. **Was an audit completed of the Organization’s most recent fiscal year-end by an independent Certified Public Accountant**?

[ ]  Yes [ ]  No**If an audit was completed, what type of audit opinion was issued on the financial statements**? [ ]  Unqualified [ ]  Qualified [ ]  Adverse |
| 1. **Was a single audit completed of the Organization’s most recent fiscal year-end? (A single audit is required if more than $500,000 of federal funding is expended in a given fiscal year.)**

[ ]  Yes [ ]  No**If a single audit was completed, did the Organization have any findings or questioned costs**?[ ]  Yes [ ]  No**If findings or questioned costs were in existence, please attach the single audit package for ICAHN’s review.** |

***Budget Evaluation***

**Did you receive your grant award funds?** [ ]  Yes [ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Grant Amount Received** | **Applicant Contribution** | **Total** |
| Consultant’s Fees |  |  |  |
| Contracted Services  |   |   |   |
| Communications/Marketing |   |   |   |
| Education/Training |   |   |   |
| Equipment/Supplies |  |   |   |
| Hardware/Software |   |   |   |
| **Total** |  |  |  |

**Budget Narrative** (Please provide detail of the amounts listed in budget evaluation section above.) **No food expenses are allowed.**

Consultant Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software