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*](mailto: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