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|  | **illinois health facilities and services review board****Change of ownership Exemption application****April 2021 Edition** |

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 **illinois health facilities and services review board**

**525 WEST JEFFERSON STREET, 2nd FLOOR**

**SPRINGFIELD, ILLINOIS 62761**

**(217) 782-3516**

**INSTRUCTIONS**

**GENERAL**

* The application for change of ownership (Application) must be completed for all change of ownership transactions.
* The persons preparing the application for exemption are advised to refer to the Illinois Health Facilities Planning Act, as well as the rules promulgated there under (77 Ill. Adm. Code 1130) for more information.
* Applicants should refer to 77 IAC 1130.140 for definitions of a change of ownership and control of a health care facility. Applicants should also refer to 77 IAC 1130.220(a) for information on who the applicant(s) should be.
* 77 IAC 1130.520(a) prohibits any person from acquiring or entering into an agreement to acquire an existing health care facility prior to receiving approval from the State Board.
* All applications for exemption for the change of ownership of a health care facility are subject to the opportunity for a public hearing and public hearing requirements (77 IAC 1130.520(c)).
* **The Application does not supersede any of the above-cited rules and requirements.**
* The Application is organized into several sections. Questions concerning completion of this form may be directed to Health Facilities and Services Review Board staff at (217) 782-3516.
* Copies of the Application form are available on the Health Facilities and Services Review Board website [www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb).

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**SPECIFIC**

* Use the Application as written and formatted.
* Complete and submit **ONLY** those Sections along with the required attachments that are applicable to the type of project proposed.
* **ALL APPLICABLE CRITERIA** for each applicable section must be addressed. **If a criterion is NOT APPLICABLE, label it as such and state the reason why**.
* **ALL PAGES ARE TO BE NUMBERED CONSECUTIVELY BEGINNING WITH PAGE 1 OF THE APPLICATION. DO NOT INCLUDE INSTRUCTIONS AS PART OF THE APPLICATION OR IN NUMBERING THE PAGES IN THE APPLICATION.**
* Unless otherwise stated, attachments for each Section should be appended after the last page of the Application.
* Begin each attachment on a separate 8 1/2" x 11" sheet of paper and print or type the attachment identification in the lower right-hand corner of each attached page.
* Information to be considered must be included with the applicable Section attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
* The Application must be signed by the authorized representative(s) of each applicant entity.
* Provide an original Application and one copy, both **unbound**.  **Label the copy** that contains the original signatures **original** **(put the label on the Application).**

|  |
| --- |
| **Failure to follow these requirements WILL result in the Application being declared incomplete. In addition, failure to provide certain required information (e.g., not providing a site for the proposed project or having an invalid entity listed as the applicant) may result in the Application being declared null and void.**  |

**ADDITIONAL REQUIREMENTS**

|  |
| --- |
| **CHARITY CARE INFORMATION** CHARITY CARE INFORMATION must be provided for **ALL** projects. **SEE SECTION IV** OF THE APPLICATION. |

|  |
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| **FEE**An application-processing fee of $2,500 MUST be submitted with the application. **The application will not be deemed complete and review will not be initiated until the entire processing fee is submitted.** **Payment may be made by check or money order and must be made payable to the Illinois Department of Public Health**. |

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| **APPLICATION SUBMISSION****Submit an original and one copy of all Sections** of the application, including all necessary attachments. **The original must contain original signatures in the certification portions of this form.**  Submit all copies to:  **Illinois Health Facilities and Services Review Board** **525 West Jefferson Street, 2nd Floor****Springfield, Illinois 62761**  |

**illinois health facilities and services review board**

**APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION**

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

**This Section must be completed for all projects.**

**Facility/Project Identification**

|  |
| --- |
| Facility Name: |
| Street Address: |
| City and Zip Code: |
| County: Health Service Area: Health Planning Area: |

**Legislators**

|  |
| --- |
| State Senator Name: |
| State Representative Name: |

**Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

|  |
| --- |
| Exact Legal Name: |
| Street Address: |
| City and Zip Code: |
| Name of Registered Agent: |
| Registered Agent Street Address: |
| Registered Agent City and Zip Code:  |
| Name of Chief Executive Officer: |
| CEO Street Address: |
| CEO City and Zip Code: |
| CEO Telephone Number: |

**Type of Ownership of Applicants**

|  |
| --- |
| [ ]  Non-profit Corporation [ ]  Partnership[ ]  For-profit Corporation [ ]  Governmental[ ]  Limited Liability Company [ ]  Sole Proprietorship [ ]  Other* Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
* Partnerships must provide the name of the state in which they are 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: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

**Additional Contact** [Person who is also authorized to discuss the Application]

|  |
| --- |
| Name: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

**Post Exemption Contact**

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

|  |
| --- |
| Name: |
| Title: |
| Company Name: |
| Address: |
| Telephone Number: |
| E-mail Address: |
| Fax Number: |

**Site Ownership after the Project is Complete**

[Provide this information for each applicable site]

|  |
| --- |
| Exact Legal Name of Site Owner: |
| Address of Site Owner: |
| Street Address or Legal Description of the Site:**Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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.** |

**Current Operating Identity/Licensee**

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

|  |
| --- |
| Exact Legal Name: |
| Address: |
| [ ]  Non-profit Corporation [ ]  Partnership[ ]  For-profit Corporation [ ]  Governmental[ ]  Limited Liability Company [ ]  Sole Proprietorship [ ]  Other |

**Operating Identity/Licensee after the Project is Complete**

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

|  |
| --- |
| Exact Legal Name: |
| Address: |
| [ ]  Non-profit Corporation [ ]  Partnership[ ]  For-profit Corporation [ ]  Governmental[ ]  Limited Liability Company [ ]  Sole Proprietorship [ ]  Other* Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
* 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.
* **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
 |
| **APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

**Organizational Relationships**

|  |
| --- |
| Provide (for each 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.** |

**Narrative Description**

|  |
| --- |
| In the space below, provide a brief narrative description of the change of ownership. 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.  |

**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 [ ]  Yes [ ]  No Purchase Price: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fair Market Value: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Project Status and Completion Schedules**

|  |
| --- |
| **Outstanding Permits:** Does the facility have any projects for which the State Board issued a permit that is not complete? Yes \_\_ No \_\_. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Anticipated exemption** **completion date** (refer to Part 1130.570): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**State Agency Submittals**

|  |
| --- |
| Are the following submittals up to date as applicable:[ ]  Cancer Registry[ ]  APORS[ ]  All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted[ ]  All reports regarding outstanding permits **Failure to be up to date with these requirements will result in the Application being deemed incomplete.** |

**CERTIFICATION**

|  |
| --- |
| The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:* in the case of a corporation, any two of its officers or members of its Board of Directors;
* in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
* 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);
* in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
* in the case of a sole proprietor, the individual that is the proprietor.
 |
| **This Application is filed on the behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****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 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 fee required for this application is sent herewith or will be paid upon request.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PRINTED NAME PRINTED NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PRINTED TITLE PRINTED TITLENotarization: Notarization:Subscribed and sworn to before me Subscribed and sworn to before methis \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Notary Signature of Notary Seal Seal\*Insert the EXACT legal name of the applicant |

[**SECTION II. BACKGROUND.**](http://www.ilga.gov/commission/jcar/admincode/077/077011100C02300R.html)

|  |
| --- |
| **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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application. Please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
4. 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.**
5. If, during a given calendar year, an applicant submits more than one Application, 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 was 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 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 5.**  |

**SECTION III. CHANGE OF OWNERSHIP (CHOW)**

|  |
| --- |
| **Transaction Type. Check the Following that Applies to the Transaction:*** Purchase resulting in the issuance of a license to an entity different from current licensee.
* Lease resulting in the issuance of a license to an entity different from current licensee.
* Stock transfer resulting in the issuance of a license to a different entity from current licensee.
* Stock transfer resulting in no change from current licensee.
* Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee.
* Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee.

 * Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity.
* Change of 50% or more of the voting members of a not-for-profit corporation’s board of directors that controls a health care facility’s operations, license, certification or physical plant and assets.
* Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility.
* Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee.
* Change of ownership among related persons resulting in a license being issued to an entity different from the current licensee
* Change of ownership among related persons that does not result in a license being issued to an entity different from the current licensee.
* Any other transaction that results in a person obtaining control of a health care facility’s operation or physical plant and assets and explain in “Narrative Description.”

  |

[**1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility**](http://www.ilga.gov/commission/jcar/admincode/077/077011300E05200R.html)

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

| **APPLICABLE REVIEW CRITERIA** | **CHOW** |
| --- | --- |
| 1130.520(b)(1)(A) - Names of the parties | X |
| 1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. | X |
| 1130.520(b)(1)(C) - Structure of the transaction | X |
| 1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction |  |
| 1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons. | X |
| 1130.520(b)(1)(F) - Fair market value of assets to be transferred. | X |
| 1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]  | X |
| 1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section | X |
| 1130.520(b)(3) -    If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction.  The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction | X |
| 1130.520(b)(4) - A statement as to the anticipated benefits of the proposed changes in ownership to the community | X |
| 1130.520(b)(5) -   The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership; | X |
| 1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control; | X |
| 1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body; | X |
| 1130.520(b)(9)-  A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition. | X |
| **APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

**SECTION IV. Charity Care Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 7.**

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

 |
| **APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.** |

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

| **INDEX OF ATTACHMENTS** **ATTACHMENT** **NO. PAGES**   |
| --- |
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| --- | --- | --- |
| 1 | Applicant Identification including Certificate of Good Standing |  |
| 2 | Site Ownership |  |
| 3 | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. |  |
| 4 | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.  |  |
| 5 | Background of the Applicant |  |
| 6 | Change of Ownership |  |
| 7 | Charity Care Information |  |

 |