

**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:	Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center		
Street Address:	333 Madison Street		
City and Zip Code:	Joliet, IL 60435		
County:	Cook	Health Service Area:	IX Health Planning Area: A-13

**Legislators**

State Senator Name:	John Connor
State Representative Name:	Lawrence Walsh, Jr.

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

Exact Legal Name:	Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center		
Street Address:	333 Madison Street		
City and Zip Code:	Joliet, IL 60435		
Name of Registered Agent:	CT Corporation System		
Registered Agent Street Address:	208 South LaSalle Street, Suite 814		
Registered Agent City and Zip Code:	Chicago, IL 60604		
Name of Chief Executive Officer:	Dana Gilbert		
CEO Street Address:	200 South Wacker Drive 12 <sup>th</sup> Floor		
CEO City and Zip Code:	Chicago, IL 60606		
CEO Telephone Number:	855/692-6482		

**Type of Ownership of Applicants**

<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	
<ul style="list-style-type: none"> <li>Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>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.</li> </ul>	

**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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION**

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

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**Legislators**

State Senator Name:	John Connor
State Representative Name:	Lawrence Walsh, Jr.

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

Exact Legal Name:	Ascension Health
Street Address:	4600 Edmunson Road
City and Zip Code:	St. Louis, MO 63134
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Joseph R. Impicicche
CEO Street Address:	4600 Edmunson Road
CEO City and Zip Code:	St. Louis, MO 63134
CEO Telephone Number:	314/733-8000

**Type of Ownership of Applicants**

<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	

☐ 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.**

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Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**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**

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City and Zip Code:	Joliet, IL 60435		
County:	Cook	Health Service Area:	IX Health Planning Area: A-13

**Legislators**

State Senator Name:	John Connor
State Representative Name:	Lawrence Walsh, Jr.

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

Exact Legal Name:	Alexian Brothers-AHS Midwest Region Health Co. (operating as AMITA Health)
Street Address:	200 South Wacker Drive 12 <sup>th</sup> floor
City and Zip Code:	Chicago, IL 60606
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 South La Salle Street Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Keith Parrott
CEO Street Address:	200 South Wacker Drive 12 <sup>th</sup> floor
CEO City and Zip Code:	Chicago, IL 60606
CEO Telephone Number:	855/692-6482

**Type of Ownership of Applicants**

- |  |  |
|--|--|
| <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                             |  |
- 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.**

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Name:	Jacob M. Axel
Title:	President
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Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**Post Exemption 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:	Julie Roknich
Title:	Vice President, Senior Associate General Counsel
Company Name:	AMITA Health
Address:	2601 Navistar Drive Lisle, IL 60532
Telephone Number:	224/273-2320
E-mail Address:	Julie.Roknich@amitahealth.org
Fax Number:	

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center
Address of Site Owner:	333 Madison Street Joliet, IL 60435
Street Address or Legal Description of the Site:	333 Madison Street Joliet, IL 60435
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:	Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center		
Address:	333 Madison Street Joliet, IL 60435		
<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			

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

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

Exact Legal Name: same as above

Address:

X Non-profit Corporation  
☐ For-profit Corporation  
☐ Limited Liability Company  
☐ Other

☐ Partnership  
☐ Governmental  
☐ Sole Proprietorship

☐

- 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.

In 2014, Advent Health System Sunbelt Healthcare Corporation (“AdventHealth”) and Ascension Health entered into an affiliation agreement under which it joined certain management and operations of their Illinois hospitals and ASTCs (“Illinois Facilities”) under the joint operating company known as Alexian Brothers-AHS Midwest Regional Health Co., d/b/a “AMITA Health. In late 2021, AdventHealth and Ascension Health made the mutual decision to terminate the affiliation agreement, disaffiliate each of their Illinois Facilities from the AMITA Health system and wind up the affairs of AMITA Health (“the Disaffiliation”). Notwithstanding AMITA Health’s operation and management of the Illinois Facilities, at all times, ownership of the Illinois Facilities remained and will, after the Disaffiliation, remain with AdventHealth or Ascension Health, respectively. Specifically, the seventeen facilities under Presence Alexian Brothers Health System (formerly part of Presence Health and Alexian Brothers Health System) will continue to operate and will be organized under the umbrella of Presence Alexian Brothers Health System, and will continue to be clinically and operationally integrated with Ascension Health. The four AdventHealth hospitals will continue to operate under the Adventist Midwest Health umbrella and will continue to be clinically and operationally integrated with AdventHealth. The individual license holders will not change and ownership/control of the physical assets (buildings, equipment, etc.) of the individual facilities will not change.

The Illinois Facilities consist of the following, and Certificate of Exemption applications are being filed for each of the Illinois Facilities concurrently:

- Alexian Brothers Medical Center (located in Elk Grove Village)
- St. Alexius Medical Center (located in Hoffman Estates)
- Alexian Brothers Behavioral Health Hospital (located in Hoffman Estates)
- Presence Chicago Hospitals Network d/b/a Saint Joseph Hospital – Chicago
- Presence Chicago Hospitals Network d/b/a Presence Resurrection Medical Center
- Presence Chicago Hospitals Network d/b/a Presence Saint Mary of Nazareth Hospital
- Presence Chicago Hospitals Network d/b/a Presence Saint Elizabeth Hospital
- Presence Chicago Hospitals Network d/b/a Presence Holy Family Medical Center (located in Des Plaines)
- Presence Chicago Hospitals Network d/b/a Presence Saint Francis Hospital (located in Evanston)
- Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Hospital – Elgin
- Presence Central and Suburban Hospitals Network d/b/a Presence Saint Joseph Medical Center (located in Joliet)
- Presence Central and Suburban Hospitals Network d/b/a Presence St. Mary’s Hospital (located in Kankakee)
- Presence Central and Suburban Hospitals Network d/b/a Presence Mercy Medical Center (located in Aurora)
- Adventist Midwest Health d/b/a Adventist La Grange Memorial Hospital
- Adventist Midwest Health d/b/a Adventist Hinsdale Hospital
- Adventist Bolingbrook Hospital
- Adventist GlenOaks Hospital
- Hoffman Estates Surgery Center, LLC

- Belmont/Harlem Surgery Center, LLC (located in Chicago)
- Presence Lakeshore Gastroenterology, LLC d/b/a Des Plaines Endoscopy Center
- PCHC GI JV L.L.C. (assumed name: AMITA Health Endoscopy Center Lincoln Park)

This Certificate of Exemption application addresses the change of ownership of Presence Saint Joseph Medical Center.

Please refer to ATTACHMENT 6, Criterion 1130.520(b)(1)(C) Structure of Transaction, for a description of the proposed transaction.

**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: \$ _____		

**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 X. 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.

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**Anticipated exemption completion date** (refer to Part 1130.570): June 1, 2022

**State Agency Submittals**

Are the following submittals up to date as applicable:

X Cancer Registry

X APORS

X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

X 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:

- 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 manager 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 is filed on the behalf of Presence Central and Suburban Hospitals Network

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 TITLE

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_

Signature of Notary

Signature of Notary

Seal

Seal

\*Insert the EXACT legal name of the applicant

**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);
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- 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 Ascension Health

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.

Christine K. McCoy  
SIGNATURE

Christine K. McCoy  
PRINTED NAME

Secretary  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_

Signature of Notary

Seal

Matthew Jagger  
SIGNATURE

Matthew Jagger  
PRINTED NAME

Treasurer  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_

Signature of Notary

Seal

\*Insert the EXACT legal name of the applicant


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- 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 **Alexian Brothers-AHS Midwest Region Health Co., d/b/a AMITA Health**

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

Keith Parrott  
PRINTED NAME

President  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_

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

Seal

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_

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

Seal

\*Insert the EXACT legal name of the applicant

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- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf **Alexian Brothers-AHS Midwest Region Health Co., d/b/a AMITA Health**

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

G. Thor Thordarson  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

Treasurer  
PRINTED TITLE

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_

Notarization:

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_

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

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

Seal

Seal

\*Insert the EXACT legal name of the applicant

**SECTION II. BACKGROUND.****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**

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:**

<b>APPLICABLE REVIEW CRITERIA</b>	<b>CHOW</b>
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



APPLICABLE REVIEW CRITERIA	CHOW
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 <u>ATTACHMENT 6</u> , 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.**

<b>CHARITY CARE</b>			
	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Net Patient Revenue</b>	<b>\$178,512,880</b>	<b>\$325,513,520</b>	<b>\$335,673,407</b>
Amount of Charity Care (charges)	\$10,761,924*	\$37,789,179	\$51,581,340
Cost of Charity Care	\$7,242,178	\$6,140,944	\$9,389,750

\*six months of charges

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

File Number

5968-176-1



***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***

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, 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 13TH  
day of JANUARY A.D. 2022 .***

*Jesse White*

SECRETARY OF STATE

ATTACHMENT 1

# STATE OF MISSOURI



**John R. Ashcroft**  
**Secretary of State**

**CORPORATION DIVISION**  
**CERTIFICATE OF GOOD STANDING**

I, JOHN R. ASHCROFT, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

***ASCENSION HEALTH***  
***N00062003***

was created under the laws of this State on the 5th day of August, 1999, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 20th day of January, 2022.

  
Secretary of State



Certification Number: CERT-01202022-0113

ATTACHMENT 1

File Number

6964-462-7



***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***

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, 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 20TH day of JANUARY A.D. 2022 .***



Authentication #: 2202003506 verifiable until 01/20/2023

Authenticate at: <http://www.ilsos.gov>

*Jesse White*

SECRETARY OF STATE ATTACHMENT 1

SITE OWNERSHIP

With the signatures provided on the Certification pages of this Certificate of Exemption (“COE”) application, the applicants attest that the Presence Saint Joseph Medical Center site is owned by Presence Central and Suburban Hospitals Network.

File Number

5968-176-1



**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***

***PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, 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 13TH  
day of JANUARY A.D. 2022 .***

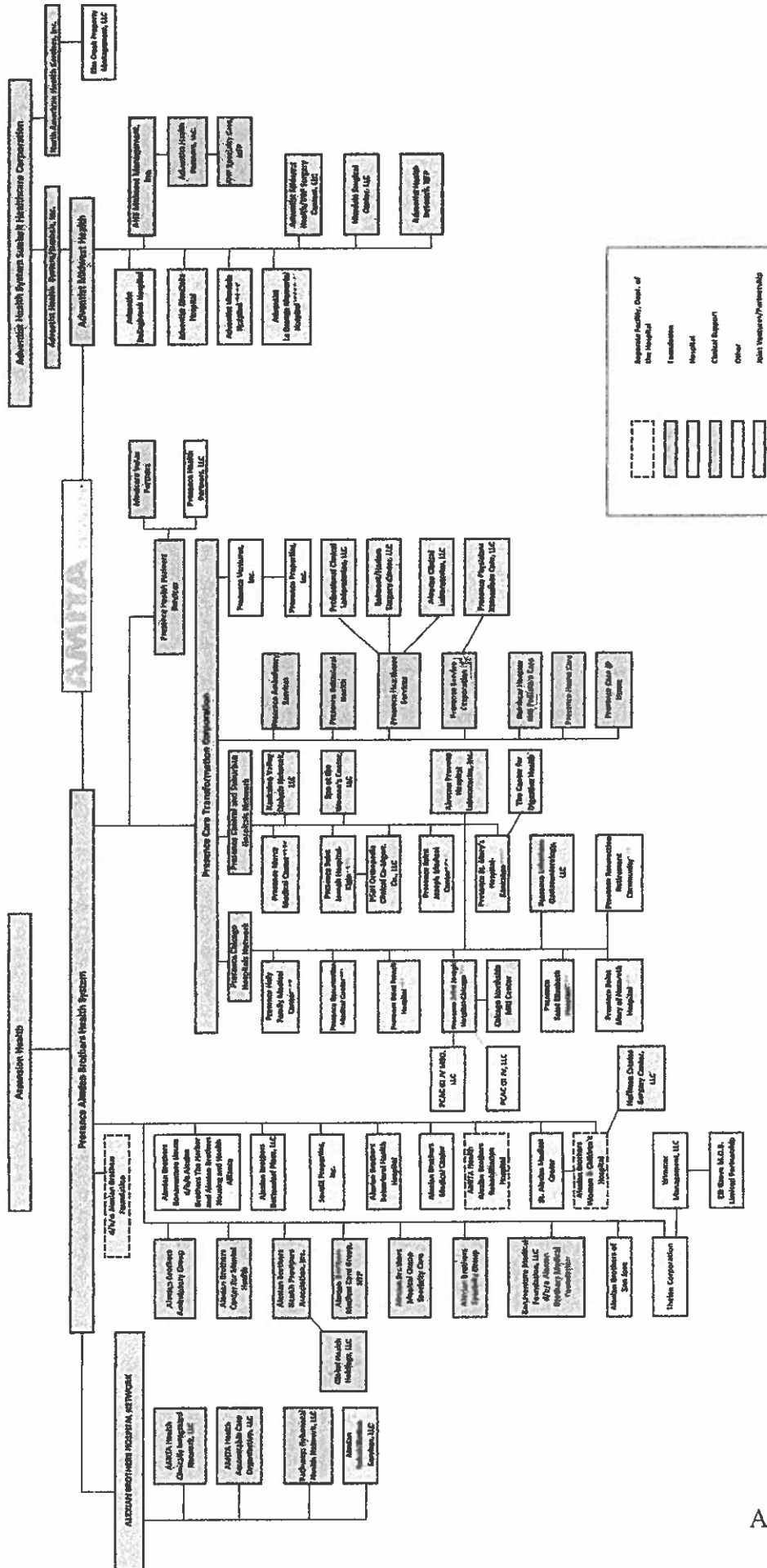
*Jesse White*

SECRETARY OF STATE

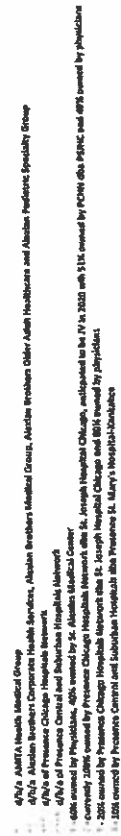
Authentication #: 2201303066 verifiable until 01/13/2023  
Authenticate at: <http://www.ilsos.gov>

ATTACHMENT 3

CURRENT ORGANIZATIONAL CHART








## BACKGROUND OF APPLICANT

With the signatures provided on the Certification pages of this Certificate of Need (“CON”) application, each of the applicants attest that, to the best of their knowledge, no adverse action has been taken against any Illinois health care facility owned and/or operated by them, during the three years prior to the filing of this Certificate of Exemption (“COE”) application. Further, with the signatures provided on the Certification pages of this COE application, each of the applicants authorize the Health Facilities and Services Review Board and the Illinois Department of Public Health access to any documents which it finds necessary to verify any information submitted, including, but not limited to official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

Attached is a list of the licensed health care facilities owned by Ascension Health.

 <b>Illinois Department of PUBLIC HEALTH</b>		HF 124105
<b>LICENSE, PERMIT, CERTIFICATION, REGISTRATION</b>		
<small>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.</small>		
<b>Ngozi O. Ezike, M.D.</b> <b>Director</b>		<small>Issued under the authority of the Illinois Department of Public Health</small>
<small>EXPIRATION DATE</small> <b>12/31/2022</b>	<small>CATEGORY</small> <b>General Hospital</b>	<small>I.D. NUMBER</small> <b>0004838</b>
<b>Effective: 01/01/2022</b>		
<b>Presence Central and Suburban Hospitals Network dba Presence Saint Joseph Medical Center 333 N Madison St  Joliet, IL 60435</b>		
<small>The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/19</small>		

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

Exp. Date 12/31/2022

Lic Number 0004838

Date Printed 10/22/2021

Presence Central and Suburban Hospi  
dba Presence Saint Joseph Medical C  
333 N Madison St  
Joliet, IL 60435

FEE RECEIPT NO.

Presence Central and Suburban  
Hospitals Network  
Presence St. Joseph Medical Center

Joliet, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the  
Hospital Accreditation Program

November 16, 2019

Accreditation is customarily valid for up to 36 months.

*David H. Perrott*

David Perrott, MD, DDS, MBA, FACS  
Chair, Board of Commissioners

ID #7364

Print/Reprint Date: 02/12/2020

*Mark R. Chassin*

Mark R. Chassin, MD, FACP, MPP, MPH  
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at [www.jointcommission.org](http://www.jointcommission.org).



## ASCENSION HEALTH HOSPITAL LISTING (Wholly Own by location

### ALABAMA

Ascension St. Vincent's Birmingham  
Ascension St. Vincent's East  
Ascension St. Vincent's Chilton  
Ascension St. Vincent's Blount  
Ascension St. Vincent's St. Clair

### BALTIMORE, MD

Ascension Saint Agnes Hospital

### BINGHAMTON, NY

Lourdes Hospital

### CHICAGO, IL

AMITA Health Mercy Medical Center  
AMITA Health Resurrection Medical Chicago  
AMITA Health Saints Mary and Elizabeth Medical Center, Saint Elizabeth Campus  
AMITA Health Saints Mary and Elizabeth Medical Center, Saint Mary Campus  
AMITA Health Holy Family Medical Center  
AMITA Health Saint Joseph Hospital, Elgin  
AMITA Health Alexian Brothers Medical Center Elk Grove Village  
AMITA Health Rehabilitation Hospital Elk Grove Village  
AMITA Health Saint Francis Hospital  
AMITA Health St. Alexium Medical Center Hoffman Estates  
AMITA Health Women & Children's Hospital Hoffman Estates  
AMITA Health Alexian Brothers Behavioral Health Hospital Hoffman Estates  
AMITA Health Saint Joseph Medical Center  
AMITA Health St. Mary's Hospital

### FLORIDA AND GULF COAST

Ascension Providence Hospital  
Ascension St. Vincent's Riverside  
Ascension St. Vincent's Southside  
Ascension St. Vincent's Clay County  
Ascension Sacred Heart Emerald Coast  
Ascension Sacred Heart Bay  
Ascension Sacred Heart Pensacola  
The Studer Family Children's Hospital at Ascension Sacred Heart  
Ascension Sacred Heart Gulf

### INDIANA

Ascension St. Vincent Anderson  
Ascension St. Vincent Avon  
Ascension St. Vincent Dunn

ATTACHMENT 5

Ascension St. Vincent Warrick  
 Ascension St. Vincent Clay  
 Ascension St. Vincent Carmel  
 Ascension St. Vincent Mercy  
 Ascension St. Vincent Evansville  
 St. Vincent Hospital for Women & Children  
 St. Vincent Rehabilitation Institute  
 Ascension St. Vincent Fishers  
 Peyton Manning Children's Hospital at Ascension St. Vincent  
 Ascension St. Vincent Heart Center  
 Ascension St. Vincent Hospital  
 Ascension St. Vincent Castleton  
 Ascension St. Vincent Indianapolis South  
 Ascension St. Vincent Seton Specialty Hospital  
 Ascension St. Vincent Stress Center  
 Ascension St. Vincent Women's Hospital  
 Ascension St. Vincent Kokomo  
 Ascension St. Vincent Orthopedic Hospital  
 Ascension St. Vincent Noblesville South  
 Ascension St. Vincent Jennings  
 Ascension St. Vincent Plainfield  
 Ascension St. Vincent Salem  
 Ascension St. Vincent Williamsport  
 Ascension St. Vincent Randolph

#### KANSAS

Ascension Via Christi Hospital (Manhattan)  
 Ascension Via Christi Hospital (Pittsburg)  
 Wamego Health Center  
 Ascension Via Christi St. Francis  
 Ascension Via Christi St. Joseph  
 Ascension Via Christi St. Teresa  
 Ascension Via Christi Rehabilitation Hospital  
 Ascension Via Christi Behavioral Health

#### MICHIGAN

Ascension Borgess Allegan Hospital  
 Ascension Brighton Center for Recovery  
 Ascension St. John Hospital  
 Ascension St. John Children's Hospital  
 Ascension Borgess-Lee Hospital  
 Ascension River District Hospital  
 Ascension Genesys Hospital  
 Ascension Borgess Hospital  
 Ascension Macomb-Oakland Hospital, Madison Heights Campus  
 Ascension Providence Hospital, Novi Campus  
 Ascension Borgess-Pipp Hospital  
 Ascension Providence Rochester Hospital  
 Ascension St. Mary's Hospital, Saginaw Campus  
 Ascension Providence Hospital, Southfield Campus  
 Ascension Standish Hospital

Ascension St. Joseph Hospital  
Ascension Macomb-Oakland Hospital, Warren Campus

OKLAHOMA

Ascension St. John Jane Phillips  
Ascension St. John Broken Arrow  
Ascension St. John Nowata  
Ascension St. John Owasso  
Ascension St. John Sapulpa  
Ascension St. John Medical Center

TENNESSEE

Ascension Saint Thomas Hickman  
Ascension Saint Thomas River Park  
Ascension Saint Thomas Rutherford  
Ascension Saint Thomas Behavioral Health Hospital  
Ascension Saint Thomas Hospital - Midtown  
Ascension Saint Thomas Hospital - West  
Ascension Saint Thomas DeKalb  
Ascension Saint Thomas Highlands  
Ascension Saint Thomas Stones River

TEXAS

Dell Seton Medical Center at The University of Texas  
Dell Children's Medical Center  
Ascension Seton Medical Center Austin  
Ascension Seton Northwest  
Ascension Seton Southwest  
Ascension Seton Shoal Creek  
Ascension Seton Bastrop  
Ascension Seton Highland Lakes  
Ascension Seton Hays  
Ascension Seton Edgar B. Davis  
Ascension Seton Williamson  
Ascension Seton Smithville  
Ascension Providence  
Ascension Providence DePaul Center

WISCONSIN

Ascension NE Wisconsin - St. Elizabeth Campus  
Ascension SE Wisconsin Hospital - Elmbrook Campus  
Ascension Calumet Hospital  
Ascension SE Wisconsin Hospital - Franklin Campus  
Ascension Wisconsin Hospital - Greenfield  
Ascension Wisconsin Hospital - Menomonee Falls  
Ascension Columbia St. Mary's Hospital Ozaukee  
Ascension SE Wisconsin Hospital - St. Joseph Campus  
Ascension Sacred Heart Rehabilitation Hospital  
Ascension St. Francis Hospital

Ascension NE Wisconsin - Mercy Campus  
Ascension All Saints Hospital - Wisconsin Avenue Campus  
Ascension All Saints Hospital - Spring Street Campus  
Ascension Wisconsin Hospital - Waukesha



**Ascension Health ASCs (Wholly Owned)**

St. Vincent's One Nineteen ASC  
Interventional Rehabilitation Center, LLC  
Founders Circle  
Maryland Surgeons Center of Columbia, LLC  
George Thomas Grace MD Surgery Center  
St. John North Macomb Surgery Center  
St. John Surgery Center ASC St. Clair Shores  
Mt Pleasant ASC  
Ascension SE Wisconsin at Mayfair Road

Alabama  
Florida  
Kansas  
Maryland  
Maryland  
Michigan  
Michigan  
Wisconsin  
Wisconsin

**Ascension Health SNFs (Wholly Owned)**

Ascension Living Carroll Manor	District of Columbia
Ascension Living St. Cathering Laboure Place	Florida
Ascension Casa Scalabrini	Illinois
Ascension Heritage Village	Illinois
Ascension Nazarethville Place	Illinois
Ascension Resurrection Life	Illinois
Ascension Resurrection Place	Illinois
Ascension Saint Anne Place	Illinois
Ascension Saint Benedict	Illinois
Ascension Saint Joseph Village	Illinois
Ascension Villa Franciscan	Illinois
Sacred Heart Village	Indiana
Via Christi Village - Hays Inc	Kansas
Via Christi Village Manhattan, Inc	Kansas
Via Christi Village Mclean Inc	Kansas
Via Christi Village Pittsburgh, Inc	Kansas
Via Christi Village Ridge	Kansas
Villa St. Joseph	Kansas
Borgess Gardens	Michigan
Ascension Living Sherbrooke Village	Missouri
Our Lady of Peace Nurning Care Residence	New York
Ascension Living Via Christi Village Ponca City	Oklahoma
Ascension Living Alexian Village Tennessee	Tennessee
Ascension Living Providence Village	Texas
St. Catherine Center	Texas
Alexian Village of Milwaukee	Wisconsin
Ascension Living - Lakeshore at Siena	Wisconsin
Franciscan Woods	Wisconsin
Wheaton Franciscan HC - Terrace at St. Franciscan	Wisconsin

REQUIREMENTS FOR EXEMPTIONS INVOLVING  
THE CHANGE OF OWNERSHIP OF A HEALTH CARE FACILITY  
SECTION 1130.520

**Criterion 1130.520(b)(1)(A) Names of the parties**

The parties named as an applicant are:

Presence Central and Suburban Hospitals Network, the current and proposed licensee Ascension Health, which currently has and will continue to have “ultimate control” over the licensee

Alexian Brothers-AHS Midwest Region Health Co. (operating as AMITA Health), which currently has certain designated “control” over the licensee through the Affiliation Agreement between Adventist Health System Sunbelt Healthcare Corporation and Ascension Health, with an original effective date of October 30, 2014.

**Criterion 1130.520(b)(1)(B) Background of the parties**

Provided in ATTACHMENT 1, as applicable, are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 5 are:

1. An identification of each applicant’s licensed health care facilities
2. The applicants’ authorization permitting the HFSRB and IDPH access to documents necessary to verify the information submitted

**Criterion 1130.520(b)(1)(C) Structure of transaction**

The transaction is structured as a mutual termination of the Affiliation Agreement between Adventist Health System Sunbelt Healthcare Corporation (“AdventHealth”) and Ascension Health (“Ascension Health”) with an original effective date of October 30, 2014 (the “Affiliation Agreement”), and wind up of the affairs of the joint operating company known as Alexian Brothers-AHS Midwest Regional Health Co. d/b/a “AMITA Health” (“AMITA”) formed pursuant to the Affiliation Agreement. The two (2) members of AMITA are Adventist Midwest Health (“AMH”), whose sole corporate member is Adventist Health System/Sunbelt Inc. and Presence Alexian Brothers Health System (“PABHS”), whose sole corporate member is Ascension Health. AdventHealth and Ascension Health will enter into an Agreement to Terminate Affiliation Agreement and Related Agreements (the “Disaffiliation Agreement”). AdventHealth and Ascension Health anticipate that their Disaffiliation Agreement will be signed and effective as of March 31, 2022.

Key points of the disaffiliation are:

1. There will be no impact on the ownership and control of the facility’s assets, which continue to remain with its original sponsor (Ascension Health).
2. There will be no impact on licensure. The facility’s license will not change and it will continue to hold the license.

3. The facility will continue to operate under the umbrella of Presence Alexian Brothers Health System and be clinically an operationally integrated with Ascension Health.

**Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction**

Please see Criterion 1130.520(b)(1)(A), above.

**Criterion 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 organization structure with a listing of controlling or subsidiary persons.**

Current and proposed organizational charts are provided in ATTACHMENT 4.

**Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred**

Not applicable, as no assets will change ownership. All assets are currently owned and will continue to be owned by Ascension Health.

**Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets**

The proposed transaction does not have a purchase price as the ownership of the facility's assets will not change.

**Criterion 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.**

Applicant Ascension Health holds seven Certificate of Need Permits:

Permit 20-012 addresses the establishment of an ASTC on the campus of AMITA Health Saint Joseph Hospital Chicago. Notification of project completion has been filed and a final cost report will be filed consistent with filing requirements.

Permit #20-043 addresses a modernization project at AMITA Health Mercy Medical Center Aurora, and has been obligated

Permit #21-013 addresses a modernization project at AMITA Health Saint Alexius Medical Center, and has been obligated

Permit #21-017 addresses a modernization project at AMITA Health Resurrection Medical Center Chicago, does not involve a HFSRB-designated "Category of Service", and will be obligated consistent with Section 1130

Permit #21-018 addresses a modernization project at AMITA Health Saint Mary Hospital Chicago, does not involve a HFSRB-designated "Category of Service", and will be obligated consistent with Section 1130

Permit #21-020 addresses a modernization project at Alexian Brothers Medical Center, does not involve a HFSRB-designated "Category of Service", and will be obligated consistent with Section 1130

Permit #21-023 addresses the establishment of an infusion therapy center in Romeoville, and has been obligated.

With the signatures in the certification section of this Certificate of Exemption application, the applicants affirm that each of the above-identified projects will be completed in accordance with all applicable provisions of Section 1130.

**Criterion 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 charity care 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.**

No changes to the charity care policy currently in effect are anticipated; and with the signatures in the certification section of this Certificate of Exemption application, the applicants affirm that the current charity care policy will remain in effect for, at minimum, a two-year period following the change of ownership transaction.

A copy of the charity care policy is attached as APPENDIX A.

**Criterion 1130.520(b)(4) A statement as to the anticipated benefits of the proposed changes in ownership to the community**

The disaffiliation of AMITA will allow Ascension to more nimbly meet the changing needs and expectations of the communities served by the facility in the rapidly evolving healthcare environment

**Criterion 1130.520(b)(5) The anticipated or potential cost savings, if any, that will result for the community and facility because of the change in ownership.**

To date, no anticipated savings have been quantified by the applicants.

**Criterion 1130.520(b)(6) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control.**

Ascension places great importance in quality control, and implements best practice models through its individual hospitals. Quality improvement mechanisms at the facility will not initially change, but will be evaluated against parallel programs used in other Ascension hospitals, with adjustments being made as appropriate to enhance clinical and non-clinical opportunities for improvement.

Due to the size of the facility's quality assurance plan, a copy of the plan will be made available upon request.

**Criterion 1130.520(b)(7) A description of the selection process that the acquiring entity will use to select the facility's governing body**

No change will be made to the selection process for the facility's governing body. Ascension determines appointments to the facility's board of directors.

**Criterion 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.**

While there may be a need for some changes in the future because of financial conditions in the health care industry, at this time, no changes to the scope of services or the levels of care provided at the facility are anticipated to occur within 24 months of the proposed transaction.

Current Status: Active

PolicyStat ID: 10964718



**Origination:** 7/6/2020  
**Effective:** 1/4/2022  
**Last Approved:** 1/4/2022  
**Last Revised:** 1/4/2022  
**Next Review:** 1/4/2023  
**Owner:** Richard Carter: Chief Finance Officer  
**Policy Area:** Finance  
**References:**  
**Applicability:** AMITA Health/Legacy Presence  
 System Wide-Hospitals

## Financial Assistance Policy - AMITA Health

### I. PURPOSE

The purpose of this Policy is to specify the requirements for administering Financial Assistance at AMITA Health System.

### II. POLICY

It is the policy of the organizations listed below this paragraph (each one being the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

This policy applies to each of the following Organizations within AMITA Health:

Adventist Bolingbrook Hospital  
 Adventist Glen Oaks Hospital  
 Adventist Hinsdale Hospital  
 Adventist LaGrange Hospital  
 Alexian Brothers Behavioral Health Hospital  
 Alexian Brothers Medical Center - Elk Grove  
 Holy Family Medical Center – Des Plaines  
 Mercy Medical Center - Aurora  
 Resurrection Medical Center  
 St. Francis Hospital - Evanston  
 Saint Joseph Hospital - Chicago  
 Saint Joseph Hospital - Elgin  
 Saint Joseph Medical Center - Joliet  
 Saints Mary and Elizabeth Medical Center  
 St. Alexius Medical Center - Hoffman Estates  
 St. Mary's Hospital - Kankakee

Employed Physician Practices

- A. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable

APPENDIX A

persons, and our commitment to distributive justice and stewardship.

- B. This policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.
- C. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

### III. DEFINITIONS

#### Policy-Specific Definitions

- A. **"501(r)"** means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- B. **"Amount Generally Billed" or "AGB"** means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- C. **"Community"** means the State of Illinois. To "live in the Community," for purposes of this Policy, means to be an Illinois resident – a person who lives in Illinois and who intends to remain living in Illinois indefinitely, but not someone who has relocated to Illinois for the purpose of receiving health benefits. A Patient will also be deemed to be a member of the Organization's Community if the emergency and medically necessary care the Patient requires is continuity of emergency and medically necessary care received at another AMITA Health facility where the Patient has qualified for financial assistance for such emergency and medically necessary care.
- D. **"Emergency Care"** means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.
- E. **"Medically Necessary Care"** means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- F. **"Organization"** means AMITA Health and the entities that are covered by this Financial Assistance Policy as set forth above in Section II.
- G. **"Patient"** means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.
- H. **"Presumptive Scoring"** means the use of third-party sources of information, which may include public records, or other objective and reasonable accurate means of assessing a patient's eligibility for financial assistance.



- I. "Uninsured Patient" means a patient who is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third-party liability.

## IV. REQUIRED PROCEDURES

A. Financial assistance described in this section is limited to Patients that live in the Community:

1. Patients with income less than or equal to 250% of the Federal Poverty Level income ("FPL"), will be eligible for 100% discount on the portion of the charges in which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an "Application") on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.
2. Subject to the other provisions of this Financial Assistance Policy, uninsured Patients with incomes above 250% of the FPL but not exceeding 600% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided. Patients with insurance and with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible, per the insurance plan's explanation of benefits. Such discounts shall apply after the Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

The sliding scale discount is as follows: (FPL – Federal Poverty Level Income)

Uninsured Patient Sliding Scale		%	Insured Patient Sliding Scale		%
0% - 250%	FPL	100%	0% - 250%	FPL	100%
251% - 300%	FPL	95%	251% - 300%	FPL	95%
301% - 400%	FPL	90%	301% - 400%	FPL	90%
401% - 600%	FPL	85%			

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 600% (for uninsured) and 400% (for insured) of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to health care providers within AMITA Health and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 600% (uninsured) and 400% (insured) of the FPL under Paragraph 2 above, if

APPENDIX A

such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

Additionally, for uninsured patients who qualify for a sliding-scale discount as set forth in Paragraph 2, collections over 12-month period shall be additionally capped at 20% of the patient's family income.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed 600% of such Patient's FPL amount may not be eligible for financial assistance.
5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.

Patients demonstrating one or more of the following criteria will be deemed presumptively eligible for a 100% charity care: homelessness, deceased with no estate, mental incapacitation with no one to act on patient's behalf, Medicaid eligibility, but not on date of service or for non-covered service, Medicaid enrollment in a different state where Organization is not and does not intend to become a participating provider, and Medicaid participation but exhaustion of any length of stay limits. Additional mandated categories include enrollment in the following programs: Women, Infants and Children Nutrition Program (WIC); Supplemental Nutrition Assistance Program (SNAP); Illinois Free Lunch and Breakfast Program; Low Income Home Energy Assistance Program (LIHEAP). Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria, and Receipt of grant assistance for medical services.

6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.
7. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
  - a. Appeals should be initially received by Patient Financial Services for review and follow up questions, if applicable.
  - b. A committee shall then meet on a monthly basis to review all appeals. The committee

## APPENDIX A

membership should include representation from Patient Financial Services, Mission Integration, Case Management/Social Services and Finance/CFO

Appeals shall be distributed to the committee members prior to the monthly committee meeting for review.

- c. A Patient Financial Services representative should be present at the committee meeting to discuss each case and provide additional input that the patient may have provided.
- d. The committee will review the applicant's FAP Application with special attention to additional information and points made by the applicant in the appeal process.
- e. The committee may approve, disapprove or table the appeal. The committee may table an appeal if additional information is required based on questions asked during the appeal discussion.
- f. Patient Financial Services will communicate in writing the outcome of the appeal to the Patient or family members.

**B. Other Assistance for Patients Not Eligible for Financial Assistance**

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

- 1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest-paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
- 2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

**C. Limitations on Charges for Patients Eligible for Financial Assistance**

- 1. Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r).
- 2. A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website, calling 888-693-2252, by email at [amitafinancialassistance@amitahealth.org](mailto:amitafinancialassistance@amitahealth.org), or in writing at:  
AMITA Health PFS  
Attention: Financial Assistance Department  
1000 Remington Blvd., Suite 110  
Bolingbrook, IL 60440

**D. Applying for Financial Assistance and Other Assistance**

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP

Application Instructions are available on the Organization's website or by calling 888-693-2252, by email at [amitafinancialassistance@amitahealth.org](mailto:amitafinancialassistance@amitahealth.org), or in writing at:

AMITA Health PFS

Attention: Financial Assistance Department

1000 Remington Blvd., Suite 110

Bolingbrook, IL 60440

The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

#### E. Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by calling 888-693-2252, by email at [amitafinancialassistance@amitahealth.org](mailto:amitafinancialassistance@amitahealth.org), or in writing at:

AMITA Health PFS

Attention: Financial Assistance Department

1000 Remington Blvd., Suite 110

Bolingbrook, IL 60440

#### F. Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

## V. REFERENCES

- A. Ascension Administrative Policy #600 – Financial Assistance for Those in Need
- B. Financial Assistance Application Form
- C. Plain Language Summary of the Financial Assistance Policy
- D. List of Providers Covered and Not Covered Under the Financial Assistance Policy
- E. Amounts Generally Billed

## Attachments

Financial Assistance Application Forms.docx

## Approval Signatures

Step Description	Approver	Date
Chief Financy Officer	Richard Carter: Chief Finance Officer	1/4/2022

## Applicability

AMITA Health Adventist Medical Center-Bolingbrook, AMITA Health Adventist Medical Center-GlenOaks, AMITA Health Adventist Medical Center-Hinsdale, AMITA Health Adventist Medical Center-LaGrange, AMITA Health Alexian Brothers Medical Center-Elk G, AMITA Health St. Alexius Medical Center, Hoffman E, AMITA Health System, Presence Health System, Presence Holy Family Medical Center, Presence Mercy Medical Center, Presence Resurrection Medical Center, Presence Saint Francis Hospital, Presence Saint Joseph Hospital - Chicago, Presence Saint Joseph Hospital - Elgin, Presence Saint Joseph Medical Center, Presence Saints Mary and Elizabeth Medical Center, Presence St. Mary's Hospital