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:	AMITA Health Endoscopy Center Lincoln Park
Street Address:	331 West Surf Street Suite 506
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area: VI Health Planning Area: A-01

Legislators

State Senator Name:	Sara Feigenholtz
State Representative Name:	Margaret Croke

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

Exact Legal Name:	PCHC GI JV, L.L.C.
Street Address:	331 West Surf Street Suite 506
City and Zip Code:	Chicago, IL 60657
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:	John Baird
CEO Street Address:	2900 Lakeshore Drive
CEO City and Zip Code:	Chicago, IL 60657
CEO Telephone Number:	773/665-3972

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- X 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 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:	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

Facility/Project Identification

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Street Address:	331 West Surf Street Suite 506
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area: VI Health Planning Area: A-01

Legislators

State Senator Name:	Sara Feigenholtz
State Representative Name:	Margaret Croke

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. Impicciche
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

X	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.**
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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

Facility/Project Identification

Facility Name:	AMITA Health Endoscopy Center Lincoln Park
Street Address:	331 West Surf Street Suite 506
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area: VI Health Planning Area: A-01

Legislators

State Senator Name:	Sara Feigenholtz
State Representative Name:	Margaret Croke

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

Exact Legal Name:	Presence Chicago Hospitals Network
Street Address:	200 South Wacker Drive 12th 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 12th floor
CEO City and Zip Code:	Chicago, IL 60606
CEO Telephone Number:	855/692-6482

Type of Ownership of Applicants

X	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:	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

Facility/Project Identification

Facility Name:	AMITA Health Endoscopy Center Lincoln Park
Street Address:	331 West Surf Street Suite 506
City and Zip Code:	Chicago, IL 60657
County: Cook	Health Service Area: VI Health Planning Area: A-01

Legislators

State Senator Name:	Sara Feigenholtz
State Representative Name:	Margaret Croke

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 12th 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 12th floor
CEO City and Zip Code:	Chicago, IL 60606
CEO Telephone Number:	855/692-6482

Type of Ownership of Applicants

- [X] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] Sole Proprietorship
- [ ] Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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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 after the Project is Complete

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	331 APL RKC, LLC c/o Remedy Medical Properties Inc.
Address of Site Owner:	331 West Surf St. Suite 110 Chicago, IL 60657

Street Address or Legal Description of the Site: 331 West Surf St. Suite 506 Chicago, IL 60657

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:	PCHC GI JV, L.L.C.
Address:	331 West Surf St. Suite 506 Chicago, IL 60657

☐	Non-profit Corporation	☐	Partnership	
☐	For-profit Corporation	☐	Governmental	
X	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: same as above

Address:

X	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.

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 AMITA Health Endoscopy Center Lincoln Park.

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 ☐ Yes X 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. .

_____

_____

_____

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:

- 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 _____PCAC GI JV L.L.C._____

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

JOHN D. BAIRD

PRINTED NAME

BOARD CHAIR

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

SIGNATURE

SAMUEL F. CASTILLO

PRINTED NAME

SECRETARY / 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

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 __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

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

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 ___**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
Keith Parrott PRINTED NAME	PRINTED NAME
President 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);
- 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	_____ 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.
- X 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:**

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

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 ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

File Number 0840298-1

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PCAC GI JV, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 15, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* JANUARY *A.D.* 2022 .

Authentication #: 2201803538 verifiable until 01/18/2023
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6964-462-7

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

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

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 3128-198-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, 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 #: 2201303032 verifiable until 01/13/2023

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

ATTACHMENT 1

File Number 6964-462-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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 AMITA Health Endoscopy Center Lincoln Park site is owned by 331 APL RKC, LLC.

File Number 0840298-1

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PCAC GI JV, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 15, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

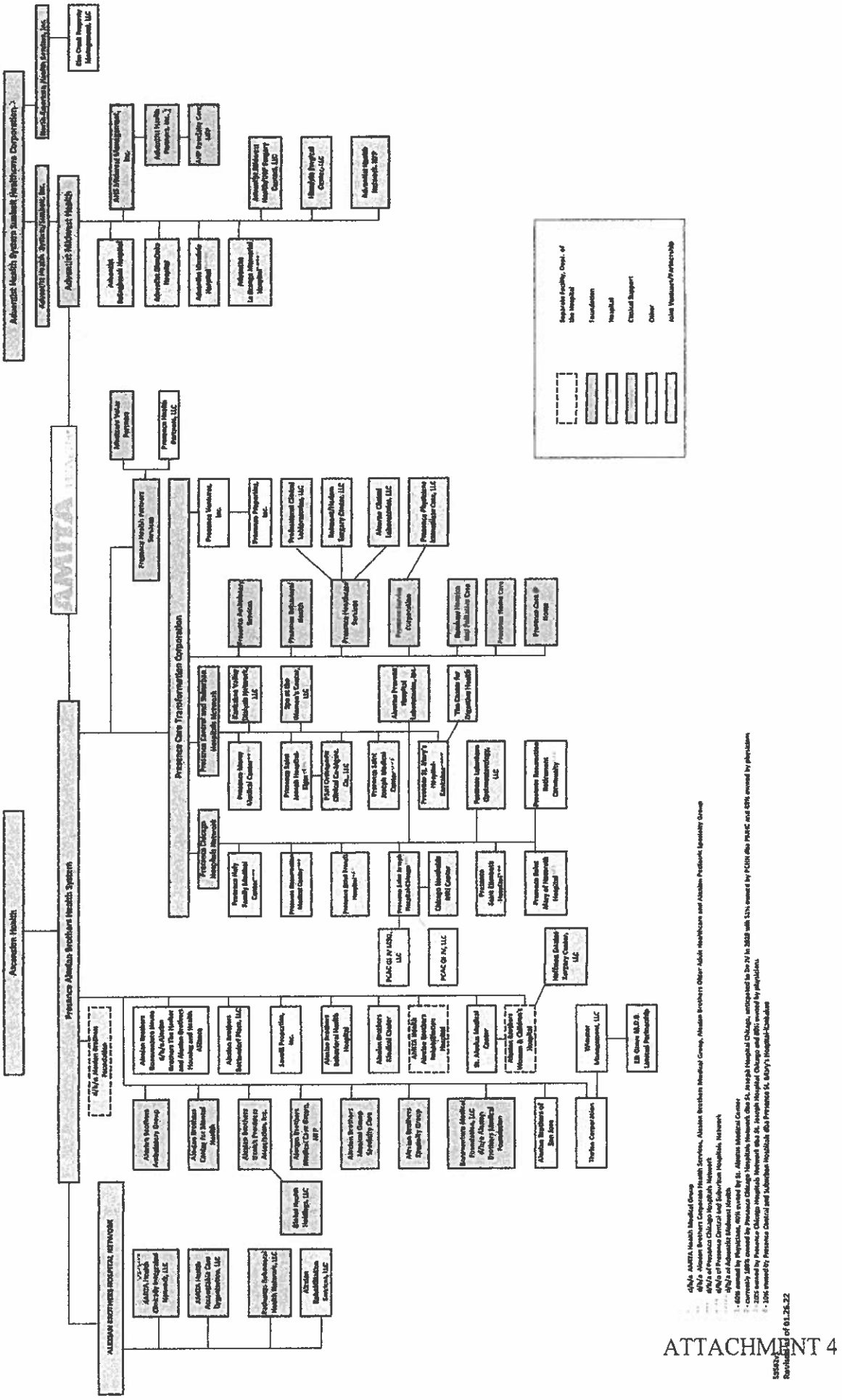
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* JANUARY *A.D.* 2022 .

Authentication #: 2201803538 verifiable until 01/18/2023
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STA

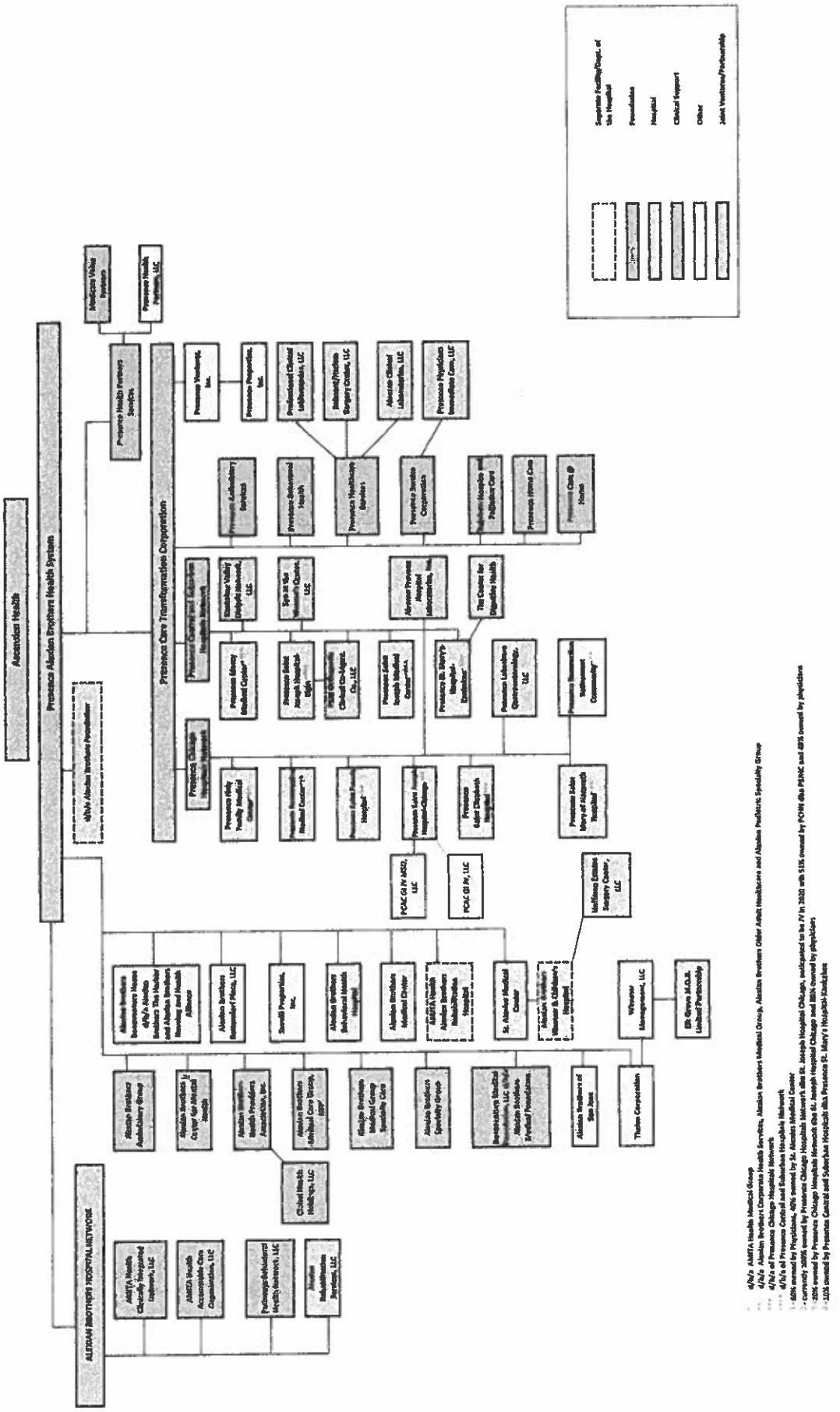
ATTACHMENT 3

CURRENT ORGANIZATIONAL CHART



ATTACHMENT 4

PROPOSED ORGANIZATIONAL CHART

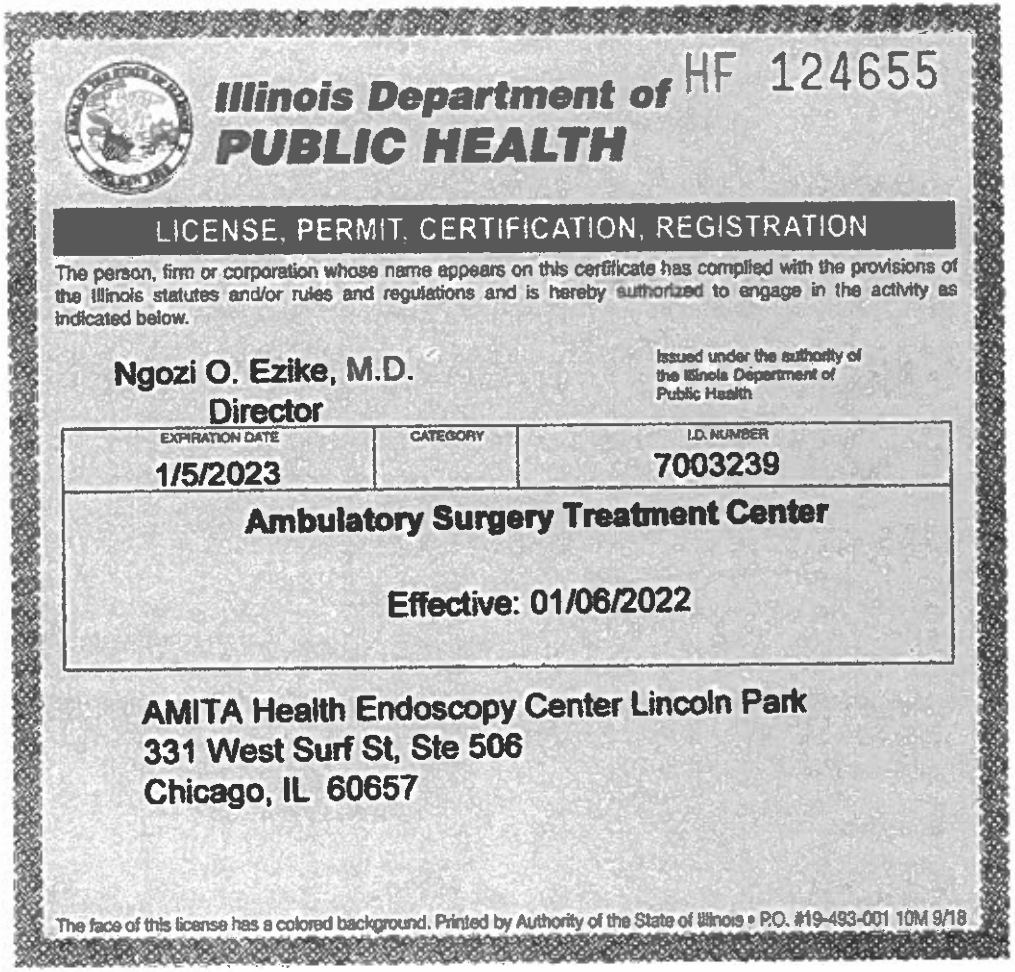


ATTACHMENT 4

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.



Illinois Department of PUBLIC HEALTH

HF 124655

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
1/5/2023		7003239

Ambulatory Surgery Treatment Center

Effective: 01/06/2022

AMITA Health Endoscopy Center Lincoln Park
331 West Surf St, Ste 506
Chicago, IL 60657

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/18

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 1/5/2023

Lic Number 7003239

Date Printed 1/11/2022

AMITA Health Endoscopy Center Linc

331 West Surf Street Suite 506
Chicago, IL 60657-7227

FEE RECEIPT NO.

ATTACHMENT 5

#E-021-22

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 Nurding 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

Ascension Health ASCs (Wholly Owned)

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

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

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 Sared Heart Rehabilitation Hospital
Ascension St. Francis Hospital

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 HEALTH HOSPITAL LISTING (Wholly Owr

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

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:

PCHC GI JV, LLC, the current and proposed licensee

Ascension Health, which currently has and will continue to have "ultimate control" over the licensee

Presence Chicago Hospitals Network d/b/a Presence Saint Joseph Hospital-Chicago, which holds a controlling interest in the ASTC

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 will be obligated prior to action being taken by the HFSRB on the requested Certificate of Exemption

Permit #21-017 addresses a modernization project at AMITA Health Resurrection Medical Center Chicago, and will be obligated prior to action being taken by the HFSRB on the requested Certificate of Exemption

Permit #21-018 addresses a modernization project at AMITA Health Saint Mary Hospital Chicago, and will be obligated prior to action being taken by the HFSRB on the requested Certificate of Exemption

Permit #21-020 addresses a modernization project at Alexian Brothers Medical Center, and will be obligated prior to action being taken by the HFSRB on the requested Certificate of Exemption

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.

A copy of the facility's quality assurance policies is attached as APPENDIX B.

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. The governing board consists of four directors appointed by the Class A Members and four Directors appointed by the Class B member (Presence Saint Joseph Hospital-Chicago). Class A Units are owned by Physician Interest Holders.

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 provided at the facility are anticipated to occur within 24 months of the proposed transaction. However, the ASTC is exploring potential changes in the facility's ownership structure to allow for new physician ownership; and if changes to the ownership structure that require the filing and approval of a Certificate of Exemption application are anticipated, that application will be prepared and filed consistent with Part 1130.

Current Status: *Active* **PolicyStat ID:** *3681281*

Presence Health

Origination:	*2/23/2014*
Effective:	*11/9/2017*
Last Approved:	*11/9/2017*
Last Revised:	*11/9/2017*
Next Review:	*11/8/2020*
Owner:	*Chris Westerkamp: Cwr-Contractor*
Policy Area:	*Finance*
References:	
Applicability:	*Presence Health System Wide - Hospitals*

Financial Assessment for Hospital Patients

I. PURPOSE

To promote the health and well-being of our communities, residents of communities served by Presence Health hospitals who have limited financial resources and no or insufficient health insurance coverage shall be eligible for discounted or free hospital services as set forth herein. The purpose of this Policy is to ensure that patients with limited financial means have access to needed hospital services.

II. KEY PRINCIPLES

A. **Eligibility for Financial Assistance Discounts; Maximum Charge Levels.** Hospital patients receiving emergency or other medically necessary care with Family Income of less than 600% of the federal poverty guidelines are eligible for Financial Assistance. System hospitals will apply presumptive eligibility criteria to facilitate prompt recognition of eligibility for financial assistance. Patients who qualify for Financial Assistance will not be charged more for emergency or medically necessary care than the amounts generally billed (AGB) to patients who have insurance coverage.

B. **Uninsured Patient Discounts**. Discounts on hospital charges are available to patients through an automatic 40% discount. Uninsured patient discounts are not considered Financial Assistance under this Policy.

C. **Hospital Financial Assistance Committees** are responsible for reviewing data on financial assistance granted by the hospital and considering special-circumstances exceptions to provide higher than the standard level of financial assistance discounts, or discounts to persons in need who otherwise would not be eligible for assistance.

III. DEFINITIONS

As used in this Policy:

A. **Amounts Generally Billed (AGB)** - means amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage. AGB refers to the amount due to the hospital after applicable insured discounts are applied.

B. **Application Period** - means the period during which Presence Health must accept and process an application for financial assistance under this Policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Presence Health provides the individual with a written notice that sets a deadline after which extraordinary collection actions (as defined in the System Hospital Billing and Collection for Uninsured and other Patients Policy) may be initiated.

APPENDIX A

C. **Automatic Uninsured Self-Pay Discount** means a discount of 40% in gross charges, automatically provided to all Uninsured Patients without requiring evidence of inability to pay. This discount is not considered Financial Assistance under this Policy.

D. **Catastrophic Discount** means a discount provided when the patient responsibility portion specific to medical care at Presence Health hospitals, even after payment by third-party payers, exceeds 15% of the patient's family annual gross income. This discount is intended to help patients and their families avoid bankruptcy or insolvency as a result of hospital costs and is considered Financial Assistance under this Policy.

E. **Exempt Assets** means the following forms of assets, which will not be considered in determining a patient's ability to pay or a financial need: the patient's primary residence; personal property exempt from judgment under Section 12-1001 of the Illinois Code of Civil Procedure; and any amounts held in a pension or retirement plan (exclusive of distributions and payments from such plans).

F. **Family** means the patient, his/her spouse (including a legal common law spouse) and his/her legal dependents claimed on filed tax returns or otherwise in accordance with Internal Revenue Service rules.

G. **Family Income** means the sum of a family's gross annual earnings and cash benefits from all sources before taxes, less payment made for child support. Sources of income include but are not limited to: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

H. **Financial Assistance** means the term used to refer to the value of free or discounted healthcare services provided to individuals who have been determined to be eligible for Financial Assistance under this Policy based on financial need.

I. **Financial Assistance Council** means a System council responsible for overseeing the implementation of this Policy. The Financial Assistance includes representation from the following areas: Mission, Finance and Legal Services.

J. **Hospital Financial Assistance Committee** means a team of hospital leaders that meets monthly to review data relating to Financial Assistance applications and determinations. The committee will consist of the hospital Chief Executive Officer, Chief Financial Officer (CFO), VP Mission Services, Revenue Integrity Director (or designee), Director of Case/Care Management, Patient Financial Counselor, or similar mix of responsible hospital leaders.

K. **Illinois Resident** means a person who currently lives in Illinois and who intends to remain living in Illinois indefinitely.

L. **Medically Necessary Service** means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A Medically Necessary service does not include: (1) non-medical services such as social and vocational services; or (2) elective cosmetic surgery (exclusive of plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity).

M. Medicare Cost to Charge Ratio - means the ratio determined by Medicare which calculates Presence Health overall cost to provide services compared to charges for services. This ratio will be used in calculating possible discounts for insured patients.

N. Presence Health Hospitals - means the following twelve (12) hospitals within the Presence Health System:

1. Presence Covenant Medical Center
2. Presence Holy Family Medical Center
3. Presence Mercy Medical Center
4. Presence Resurrection Medical Center

5. Presence Saint Francis Hospital
6. Presence Saint Joseph Hospital - Chicago
7. Presence Saint Joseph Hospital - Elgin
8. Presence Saint Joseph Medical Center
9. Presence Saints Mary and Elizabeth Medical Center (Presence Saint Mary of Nazareth Hospital and Presence Saint Elizabeth Hospital)
10. Presence St. Mary's Hospital
11. Presence United Samaritans Medical Center

O. **Presence Health, or System** means collectively, Presence Health Network and all affiliate entities of which Presence Health Network serves as the ultimate parent corporation.

P. **Uninsured Patient** means:

1. A patient of a hospital who is not covered under any commercial health insurance policy (including third party liability coverage) and is not a beneficiary or eligible to be covered by any governmental or other coverage program, including Medicare, Medicaid, TriCare, high deductible insurance, or other coverage agreements.
2. If a patient's insurance coverage is exhausted, or the patient's insurance does not cover medically necessary hospital services provided to the patient, the patient will be considered an Uninsured Patient for purposes of Financial Assistance and the Automatic Uninsured Self-Pay Discount will apply to these cases.

IV. REQUIRED PROCEDURES

A. **Identification of Potentially Eligible Patients**

1. **Offering Financial Assistance Information at Intake/Discharge.** All patients will be offered a plain language summary of this Policy as part of the intake or discharge process. In addition, any patient may request Financial Assistance information at any time.
2. **Financial Assistance Evaluation Prior to or After Admission/ Pre-Registration: Non-ED Patients.** When possible, prior to the admission or pre-registration, the hospital will conduct an appropriate pre-admissions/pre-registration interview with or for any patient other than one who has come to a hospital's Emergency Department, to determine eligibility for Financial Assistance. If a pre-admission/pre-registration interview is not possible, a Financial Assistance interview should be conducted upon admission or registration or as soon as possible thereafter.
3. **Evaluation of Financial Assistance Eligibility for Emergency Medical Treatment.** For patients who have come to the hospital's Emergency Department, the hospital's evaluation of payment ability to pay or eligibility for Financial Assistance should not take place until an appropriate medical screening has been provided, and in the case of patients determined to have an emergency medical condition, until after such condition has been stabilized.

B. **Presumptive Eligibility Criteria**

Any patient meeting any of the criteria set forth below will be considered presumptively eligible for Financial Assistance without further documentation requirements. In such situations, the patient is deemed to have a family income of 200% or less of the Federal Poverty Level, and therefore eligible for a 100% reduction from Medically Necessary hospital charges (i.e. full charity write off). Patients will receive a minimum of one statement to provide a summary of services and account information. Presumptive eligibility for 100% Financial Assistance will be made for patients meeting any of the following criteria:

1. Patient is homeless (with such status verified after review of available facts).

2. Patient is deceased with no estate.
3. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
4. Patient is currently eligible for Medicaid, but was not on a prior date of service or for non-covered services.
5. Patient is enrolled or covered by the Women, Infants and Children Nutrition Program (WIC).
6. Patient is enrolled or covered by the Supplemental Nutrition Assistance Program (SNAP) or Food Stamp Eligibility (LINK).
7. Patient is enrolled or covered by the Illinois Free Lunch and Breakfast Program (eligible for free and reduced price school meals).
8. Patient is enrolled or covered by the Low Income Home Energy Assistance Program (LIHEAP)
9. Patient or family is a qualified participant in an organized community-based program for providing access to medical care that accesses and documents limited low-income financial status criteria
10. Patient receives or qualifies for free care from a community clinic affiliated with the hospital or known to have eligibility standards substantially equivalent to that of the hospital under this Policy, and the community clinic refers the patient to the hospital for treatment or for a procedure.
11. Patient is a recipient of grant assistance for medical services.
12. Patient participates in state-funded prescription programs.
13. Patient or patient's family is enrolled in Illinois Housing Development Authority's Rental Housing Support Program.
14. Patient or patient's family has been determined by an independent third-party reporting agency to have family income of 200% or less than the Federal Poverty Level.
15. Patient or patient's family's inability to pay any portion of patient-liability amount has been verified by an independent third-party agency.

C. **Standard Determinations of Eligibility**

1. **Income Documentation**. Patients other than those determined to be presumptively eligible for Financial Assistance must provide at least one of the following forms of income documentation with their Financial Assistance application:
   a. A copy of the most recent Federal income tax return (preferred) or state income tax return;
   b. A copy of the most recent W-2 form and 1099 forms, or similar forms issued to members of partnerships, limited liability companies or other entities;
   c. Copies of two (2) most recent pay stubs;
   d. Written income verification from an employer if paid in cash; or
   e. One (1) other reasonable form of third party income verification deemed acceptable to the hospital
2. **Expectations of Patient Cooperation**. It is expected that patients will cooperate with the information gathering and assessment process in order to determine eligibility for Financial Assistance.
3. **Residency Requirement**. Financial Assistance and other patient discounts under this Policy will be provided to Illinois Residents and eligible visitors (as set forth in sub-section c below)
   a. **Proof of Residency**. Residency may be evidenced by any of the following:
      i. Any of the income documentation listed in Paragraph IV.B above
      ii. A valid state-issued identification card or driver's license;
      iii. A recent utility bill;

iv. A lease agreement (for housing);

v. A vehicle registration card

vi. Mail addressed to the patient at an Illinois address from a government or other credible source;

vii. A statement from a family member of the patient who resides at the same address and presents verification of residency; or

viii. A letter from a homeless shelter, transitional house or other similar facility verifying that the patient resides at the facility.

b. **Eligible Out-of-State Service Area Residents**. Patients who are residents (using the verification standards applicable to Illinois residents specified above) of an adjacent state who reside in an area of such state that falls within a Presence Health hospital's primary service area will be considered eligible for Financial Assistance for services provided at such System hospital (or other Presence Health hospitals to which the service area hospital refers the patient) on the same basis as IL residents. Notwithstanding the foregoing, patients who reside in Presence United Samaritans Medical Center's secondary services area of zip code 47932 will also be considered eligible for Financial Assistance for services provided at such hospital on the same basis as IL residents.

c. **Visitors Eligible for Financial Assistance**. Patients who are not residents of Illinois, but who state or verify that they did not come to Illinois for the primary purpose of receiving medical care will be evaluated for eligibility for Financial Assistance on the same basis as Illinois residents. Financial Assistance applications by all other non-Illinois residents, including those where the primary reason for the patient visit is not clear, must be reviewed by the hospital's Financial Assistance Committee for a determination of whether granting Financial Assistance is consistent with the purposes of this Policy, under the circumstances.

4. **Review of Applications with Special Circumstances**. The hospital Financial Assistance Committee will review patient accounts identified by a Financial Counselor that involve unique circumstances indicating financial need despite the absence of the standard eligibility criteria set forth in this Policy. The hospital Financial Assistance Committee may recommend to the Financial Assistance Council exceptions to this Policy for specific patients based on unusual or uncommon circumstances relating to financial need. The basis for all exception decisions must be documented and maintained in the account file and must be made consistently across the System.

   a. **Assets Consideration**. Assets will not be used for initial Financial Assistance eligibility, except to the extent the presence of substantial assets (other than Exempt Assets) indicates the existence of significant unreported additional sources of income that would show the patient's actual family income to be more than 600% of the Federal Poverty Level.

5. **Approval Authorities**. The hospital Business Office may approve Financial Assistance for amounts up to $25,000. A System Financial Assistance Manager may approve amounts greater than $25,000 but lower than $100,000. Amounts greater than $100,000 will be approved by the hospital's CFO; provided, however that amounts of $500,000 or greater must be reviewed by the hospital CFO and the System Chief Mission Officer. Approval amounts must be in compliance with this Policy.

D. **Eligibility Determination Process and Notification**

1. **Normal Processing Period**. Clear expectations as to the length of time required to review a financial assistance application and provide a decision to the patient should be communicated at the time of application. A written decision will be made within a reasonable time period after the hospital's receipt of the completed application, including, if applicable, the assistance for which the individual is eligible and the basis for this determination. Collection activity on the account will be suspended while the Financial Assistance application is pending.

2. **Incomplete Applications**. If an application is missing the minimum information or documentation

necessary for determination of Financial Assistance eligibility, Presence Health representatives will notify the patient in writing, specifying the additional information needed to complete the application. If the application remains incomplete for 45 days after such written notice, and after reasonable attempts to obtain the necessary documentation or equivalent information, collection actions may be taken or resumed.

3. **Denials; Patient Right to Appeal**. Patients will be notified of a denial of a financial assistance application in writing, including reason(s) for the denial, and appeal rights. If a patient disagrees with the Financial Assistance eligibility determination, including the extent of discount for which a patient is eligible, the patient may appeal in writing within 45 days after denial. System Patient Financial Services will review the appeal, and make a recommendation to the Financial Assistance Committee. Decisions reached will normally be communicated to the patient within 60 days, and reflect the Committee's final review. Collection activity will be suspended during the appeal process.
4. **Suspension of Collection Activities Pending Eligibility Determination**. When an application for Financial Assistance has been received, a note will be entered into the patient's account to suspend collection activity until the Financial Assistance process is completed. If the account has been placed with a collection agency, the agency will be notified to suspend collection efforts until a determination is made, with such notification documented in the account notes.
5. **Application of Catastrophic Discount**. The Catastrophic Discount will be available to patients who have medical expenses over a 12-month period for Medically Necessary Services from a Presence Health hospital that exceed 15% of the patient's family's annual gross income, even after payment by third-party payers. Any patient responsibility in excess of 15% will be written off to charity. Services that are not Medically Necessary will not be eligible for this discount.
6. **Change in Status Notifications**. If the patient with an outstanding bill or payment obligation has a change in his/her financial status that may result in eligibility for Financial Assistance or a higher Financial Assistance discount, the patient should promptly notify the Central Billing Office (CBO) or hospital designee. The patient may request a reevaluation and apply for Financial Assistance or a change in payment plan terms.
7. **Payment Arrangements for Balances Due**. After the Financial Assistance discount has been applied, any remaining patient balances will be eligible for payment arrangements in accordance with System Patient Financial Services policies. If a patient is unable to meet the payment arrangement guidelines due to special patient or family circumstances limiting the patient's payment ability, the Financial Counselor or similar representative may review and recommend additional Financial Assistance to the hospital Financial Assistance Committee for the Committee's review and recommendation.
8. **Application of Financial Assistance Discounts to Patient Accounts**. Once a Financial Assistance eligibility determination is made, the applicable discount will be applied to all of the patient's open (defined as open accounts receivable) or bad debt accounts for services prior to the approval date. Refunds will be provided to the extent of the approved Financial Assistance discount, on payments submitted within the Application Period.
9. **Re-application of Financial Assistance.** Approval for Financial Assistance will be available for up to twelve (12) months or within the calendar year of the approval date. Patients may be required to verify information that was provided on a prior application submitted more than 12 months before a Financial Assistance approval date.

E. **Uninsured Self-Pay Discount**

1. There is no application process for the patient to receive the Uninsured Self-Pay Discount. The discount is applied based on the account's self-pay/uninsured status.
2. Patients receiving pre-negotiated discounts (package pricing) for hospital services will not be eligible for the Uninsured Self-Pay Discount.

3. If a patient is subsequently approved for Financial Assistance, the Uninsured Self-Pay Discount will be reversed so that the full amount can be recognized as a charity discount.

F. **Financial Assistance Guidelines and Eligibility Criteria**

1. **General.** The Financial Assistance Guidelines and Eligibility Criteria below are designed to assure that patients with financial need are charged at a rate substantially less than insured patients, including the opportunity to receive 100% free care. The table below is used to determine the Financial Assistance discounts by tier for Uninsured Patients.

Eligibility Criteria			
Percentage of Poverty Guidelines	**Discount Percentage for Uninsured Patient (off Gross Charges)**	**Discount Percentage for Insured Patient (off Patient Balance)**	**Annual Maximum Catastrophic Patient Payment (% of Patient Family Income)**
Up to 200%	100%	100%	n/a
201-300%	90%	Discount equal to 100% of Medicare Cost to Charge Ratio	15%
301-400%	80%	Discount equal to 100 of Medicare Cost to Charge Ratio	15%
401-600%	75%	Determined on an exception basis	15%
Over 600%	Determined on an exception basis	Determined on an exception basis	Determined on an exception basis

2. **Annual Updates of Criteria Levels**. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the U.S. Department of Health and Human Services.

3. **Pre-Negotiated Rates Package Pricing**. Patients receiving pre-negotiated discounts (package pricing) for hospital services will not be eligible for Financial Assistance.

4. **Financial Assistance for Certain Crime Victims**. Individuals who are deemed eligible by the State of Illinois to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall first be evaluated for eligibility for Financial Assistance based on the Financial Assistance Guidelines and the Eligibility Criteria. Applications for reimbursement under such Crime Victims Funds will be made only to the extent of any remaining patient liability after the Financial Assistance eligibility determination is made.

5. **Financial Assistance for Insured Patients**. Financial Assistance in the form of 100% discounts (free care) are available for patient-liability amounts remaining after insurance payments, for insured patients who are Illinois residents with family gross income less than or up to 200% of the Federal Poverty guidelines. For insured patients with family gross income between 200% and 400% of the Federal Poverty guidelines, the expected patient payment will be the lesser of patient's out of pocket (OOP) liability reduced by 100% of the hospital's Medicare cost-to-charge ratio or the amount the patient would have been responsible for had they been uninsured. The amount of Financial Assistance will be determined once all third-party payment amounts have been identified. In addition, insured patients with high hospital bills may receive a Catastrophic Discount.

6. **Financial Assistance for Students.** Financial Assistance for verified full-time enrolled students with income of 200% or less of the Federal Poverty Level will be eligible for a 100% reduction from charges (i.e., full charity write-off).

7. **Timing of Financial Assistance Application**. A patient may apply for Financial Assistance at any time during the billing and collection process.

G. **Patient Responsibilities**

1. **Patients Potentially Eligible for Public Programs**. Patients who are identified as potentially eligible for healthcare coverage from a governmental program or other source will be referred to a Financial Counselor and expected to cooperate with efforts to determine their eligibility for coverage (e.g. Medicaid), prior to consideration for Financial Assistance. Such coverage eligibility efforts will be made at the hospital's expense, and will promote public policy goals by assuring eligible patients are covered by available health coverage programs.
2. **Verification**. It is the responsibility of the patient to provide any additional required supporting documentation to confirm Presumptive Eligibility determination. Patients will receive a minimum of one communication to provide any needed verifying documents. Financial assistance will not be denied based on the omission of information or documentation, if that information or documentation is not specifically required by this policy or by the Financial Assistance Application.

H. **Billing**

1. **No Bill May Be Issued Pending Processing of Financial Assistance Application**. If a partial Financial Assistance application is provided, no bill will be issued to an Uninsured Patient until 45 days after a reasonable attempt is made to obtain outstanding verifying documents. A reasonable attempt is defined as using available patient contact information, including current address, phone number, and email, to correspond with the patient for at least 45 days about outstanding documents and how eligibility might be obtained.
2. **Billing Statement**. When a patient is deemed eligible for Financial Assistance (not under presumptive eligibility), the hospital will provide the patient with a new billing statement indicating the amount owed after Financial Assistance. This billing statement will include the AGB for care provided and how that amount was determined.
3. **Amounts Generally Billed Percentages**
   a. Patients who are eligible for Financial Assistance shall not be billed more than AGB in the case of emergency or other medically necessary care, and shall be billed less than gross charges in the case of all other medical care covered under this Policy.
   b. The AGB for all Presence Health hospitals will be calculated annually, as the lowest AGB percentage of all System hospitals, using the "look-back" method. The "look-back" method requires determining the total amount received by System hospitals for Medicare fee-for-service and private health insurer allowed claims, divided by the gross charges for those claims for a 12-month period. The current AGB will be set forth by System Financial Patient Services as of the 120th day after the start of the calendar year. Individuals may obtain the specific AGB percentage and accompanying description of the calculation in writing and free of charge by contacting a financial counselor via the telephone numbers provided below.

I. **Collection Practices**. See the System Hospital Billing and Collection for Uninsured and other Patients Policy for additional information on billing and collection practices. Individuals may obtain a copy of such policy by contacting a financial counselor via the telephone numbers provided below.

J. **Patient Awareness of Policy and Availability of Financial Assistance**

1. **Signage**. Signs, placards or similar written notices regarding the availability of Financial Assistance will be visible in all hospitals at points of registration and other patient intake areas, to create awareness of the Financial Assistance program. At a minimum, signage will be posted in the emergency department, and the admission/patient registration area.

2. **Application Forms**. In addition to offering a copy of the plain language summary of this Policy as part of the intake or discharge process, Financial Assistance Applications and other forms used to determine a patient's eligibility for Financial Assistance will be made available at each hospital and provided at registration to all patients who are identified as uninsured or at other appropriate times or locations if the patient's uninsured status is determined after registration.
3. **Languages for Financial Assistance Policies and Notices**. All public information and/or forms regarding the provision of Financial Assistance will use languages that are appropriate for the hospital's service area in accordance with the state's Language Assistance Services Act. This Policy will be translated to and made available in those languages that constitute the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be affected or encountered by a Presence Health hospital.
4. **Notices on Hospital Bill/Invoice**. Patient bills, invoices or other summary of charges shall include a prominent statement (in English, Spanish and Polish) that patients who meet certain income requirements may qualify for Financial Assistance and information regarding how a patient may apply for consideration under this Policy.
5. **Policy Availability**. Upon request, any member of the public or state governmental body will be provided with a copy of this Policy. A summary of the Financial Assistance is available pursuant to this Policy and will be available on the Presence Health website in those languages that are appropriate for the Presence Health hospitals' service areas as set forth in **Section IV.J.3** above.
6. **List of Participating Providers**. Each Presence Health hospital will list all physicians and other providers who will apply hospital-determined Financial Assistance discounts for medically necessary hospital services provided at the hospital (**"501 (r) Provider Participation List"**). Presence Health will update the 501 (r) Provider Participation List quarterly.

V. IMPLEMENTATION FORMS AND OTHER DOCUMENTS

The following documents are available at the System website and internally at the webpage for Patient Financial Services under System Services/Finance:

A. Plain Language Summary of Financial Assistance Policy
B. Hospital Financial Assistance Program Cover Letter and Application
C. Room and Board Statement
D. Financial Assistance Policy Provider List
E. Amounts Generally Billed (AGB) Information
F. Federal Poverty Guidelines

VI. RELATED SYSTEM OR MINISTRY POLICIES

Hospital Billing and Collection for Uninsured and Other Patients Policy

VII. REFERENCES

Hospital Contact Information: Presence Health Hospital Physician Addresses and Financial Counselor Telephone Numbers_05.19.2017.docx

Website: http://www.presencehealth.org/for-hospitals

APPENDIX A

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
VP Revenue Cycle OPS	Curtis Haley: VP Revenue Cycle OPS	11/9/2017
VP Revenue Cycle OPS	Robert Lamont: System VP Finance Svc Delivery	10/24/2017
	La'Queela Angel: System Dir Pt. Payment/Exper	7/24/2017

Applicability

Presence Behavioral Health, Presence Health System, Presence Holy Family Medical Center, Presence Home Health, 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

Amita Health Endoscopy Center Lincoln Park

Quality Assessment & Performance Improvement Plan

In compliance with the Mission, Vision, and Values of this organization the purpose of our Quality Assessment & Performance Improvement Plan is to provide high quality of care to our patients. Our goal is to provide a planned, systematic and interdisciplinary (organization-wide) approach to identifying, measuring and assessing areas for improvement in clinical, administrative and managerial processes and outcomes.

The Quality Assessment & Performance Improvement Plan for this facility is a comprehensive program designed to objectively and systematically evaluate the quality and appropriateness of services provided, pursue opportunities to improve care, identify trends that warrant evaluation or action, modify processes to improve care in a continuous manner, and resolve identified problems using a multidisciplinary approach.

The Quality Assessment & Performance Improvement Plan implemented by the facility is one component of the facilitywide performance improvement program. The findings, conclusions drawn, recommendations made, actions taken, and the results/effectiveness of actions taken are communicated to the Board through the Quality Committee (QC). Quarterly reports of the performance improvement activities are presented to the Quality Committee (QC). All activities are reported to the Board on a quarterly basis.

The purpose of the Quality Assessment & Performance Improvement Plan of this organization is to carry out its mission. The facility will describe how it will plan, design, measure, assess, and improve its performance in-patient and organizational functions using the plan, do, check, act (PDCA) model.

Specific/key components within the facility's performance improvement program include:

a. Ongoing monitoring of performance measures to systematically assess and evaluate each department's performance in relation to appropriateness and quality of important aspects of care provided;
b. Systematic evaluation of care provided by personnel employed;
c. Ongoing evaluation, study and modification of processes within each department to continuously improve the services provided.
d. Opportunity for Improvement (OFI) form
e. Process Design
f. Performance Measurement
g. Performance Assessment
h. Performance Improvement

STRUCTURE:

In order to ensure that the organization approaches PI in a planned, systematic, organization-wide manner, the following structure has been created:

Quality Committee

This body is sometimes referred to as the Quality Improvement (QI) committee as well. This committee was designed to guide the direction of the organization's performance improvement projects. The committee members are a representation of clinical, non-clinical, administrative and medical staff members. They provide the following functions:

1. Improve the performance of the organization.
2. Review/coordinate performance improvement activities.
3. Ensure that measurement activities are complete, reliable, valid and accurate on an ongoing basis.
4. Identify performance improvement projects.

5. Prioritize performance improvement projects.
6. Review departmental reports of departmental indicators (quality control activities) that have been a variance for two consecutive quarters.
7. Act on information to improve organization performance.
8. Follow up the effectiveness of the actions taken over time.
9. Peer Review activities
10. Participation in external and internal performance benchmarking activities that allow for the comparisons of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals
11. Infection Control Activities
12. Risk Management/Incident Reporting Activities

COMPOSITION:

The Governing Board shall determine the composition of this council, (i.e., Safety Officer, Performance Improvement Coordinator). This council will be responsible for ensuring appropriate review and follow up of the ongoing activities pertaining to patient care.

Meetings will be held quarterly.

COMMUNICATION:

Cooperation and communication with the Owner, Medical Director, and staff providing continuous quality patient care.

PERFORMANCE IMPROVEMENT PROGRAM-EMPLOYEE ROLE:

Each employee of the facility has a direct role in the Quality Assessment & Performance Improvement Plan and the Performance Improvement process at the facility. By recognizing that each job task has the ability to affect the overall quality of the facility's activities, each employee comes to understand that every action has the capability to improve or lessen the quality of patient care. Performance Improvement is not the role of the supervisor, but the role of each individual employee.

PLAN:

The facility will identify methods for designing new processes and services and/ or the improvement of existing processes by the following criteria:

1. It is consistent with the organization's mission;
2. All resources have input in to the development of the plan;
3. Annual review of the plan and revisions are completed as necessary;
4. Approval from the Quality Committee and Governing Board;
5. Evaluation of high risk, high volume, or problem prone areas;
6. The needs and expectation of the patients, staff, community, medical staff, payors and others is considered;
7. Common practice guidelines, and up to date sources of information are used for improvement.

MEASUREMENT:

In measuring performance improvement projects, the collection of data is what forms the basis for determining the level of performance of the existing processing and outcomes resulting from these processes. The measurement must be completed in a systematic, relate to the performance, and be appropriate in scope.

Data is measured by:

1. Process (goal-directed, interrelated series of actions events, mechanisms, or steps) and outcomes;
2. Indicates are established for both quality and quantity;
3. Satisfaction of our customers and their expectations.

PERFORMANCE IMPROVEMENT GUIDELINES:

Facilitator responsibilities:

1. Neutral for the group process;
2. Provides structure;
3. Focuses the group's direction;
4. Acts as a liaison/ mediator for the meetings, and ends the meeting if there are problems such as:
    a. Verbal attacks of ideas and or persons;
    b. Argumentative discussions;
    c. Unwillingness to participate;
    d. Repeated side conversations.

This person should:

1. Create an environment for equal participation and involvement;
2. Uses effective communication skills;
3. Responsible to feedback from the group;
4. Encourages resolution of issues and to take action;
5. Gives feedback on the success of the project;
6. Provides education and problem-solving tools (conflict resolution, group development).

Facilitator qualities:

1. Ability to articulate;
2. Organized;
3. Sensitive to issues;
4. Tactful;
5. Confident;
6. Good listening skills;
7. Ability to paraphrase;
8. Patient;
9. Good teaching skills;
10. Effective written and verbal skills.

PROGRAM OBJECTIVES:

1. To systematically design, monitor, and evaluate the quality and effectiveness of patient care and organizational functions and processes;
2. To devise ways to improve and actively address identified problems;
3. To help staff improve the processes in which they are involved;
4. To encourage teamwork and establish communication strategies when problems or opportunities to improve services involve others;
5. To identify relationships between patient care, cost, and patient outcomes;
6. To promote a more effective and efficient utilization of our facility and the services we provide.

RESPONSIBILITIES:

Governance through the Quality Committee shall be responsible for the over sight of the Performance Improvement Plan and activities and is ultimately responsible for any corrective actions, monitoring plans, and follow-up activities which may be deemed necessary on the basis of review findings.

The Quality Control Coordinator and/or designee will serve as the facilitator of the Quality Council/Performance Improvement committee and is responsible for:

1. Organization and presentation of data;
2. Supervision of staff in carrying out the Performance Improvement Plan;
3. Following up on effectiveness of action;
4. Preparing a written report of the year's results for the Governing Board;
5. Documenting revisions to the Performance Improvement Plan.

Performance improvement activities will be addressed through the company's Quality Committee and will be comprised of individuals who perform various functions with the organization. The committee will meet quarterly and shall be responsible for:

1. Development and application of criteria;
2. Evaluation of data that influences important processes or outcomes related to patient care and organizational functions;
3. Identifying important problems and concerns;
4. Implementing measures to address and resolve problems and concerns;
5. Re-evaluating problems and concerns to determine whether corrective measures have been achieved and sustained to obtain the desired results.

Performance improvement problems identified shall be referred to the Quality Committee and the Governing Board.

Annually the Governing Board will review the Quality Assessment & Performance Improvement Plan.

PRIORITIES:

Priorities will be established by the Quality Committee and Governing Board based on the following:

1. *High Volume* (Care or service occurs frequently or affects large number of patients);
2. *High Risk* (Patients are potentially exposed to serious complications or are deprived of substantial benefits when care is not provided appropriately);
3. *Problem Prone* (Documented history of producing inappropriate variations in care/service);
4. *Regulatory Issue, or an area identified for on-going evaluation by and accreditation body, state or federal government or*
5. *An issue that has been identified through performance improvement activities.*

All changes made in priorities will be made by the Governing Board.

MODEL:

The Plan-Do-Check-Act cycle is the model to be used in carrying out Performance Improvement Activities.

PLAN

- An operational plan for testing the chosen improvement action is created;
- Data to monitor the process for improvement is determined;

DO

- Collect and analyze the data on the improvement process;
- Make improvement changes and take action when indicated and appropriate;

CHECK

- Establish decision/review points to determine the effectiveness of changes;
- Assess the effects of the improvements;
- Analyze the improvement results;

ACT

- Team meets on a regular basis to determine what was learned;
- Tests or actions re repeated if necessary to ensure process improvement;
- Communicate information to the Quality Committee and Leadership.

DATA COLLECTION:

Data that will be considered for collection to monitor performance includes the following:

1. Performance measures related to accreditation and other requirements;
2. Patient statistics;
3. Financial data;
4. Outcomes of processes and services;
5. Patient and family needs, expectations and satisfactions;
6. Staff views regarding performance improvement and improvement opportunities;
7. Operative and other procedures that place patients at risk;
8. Medical necessary and appropriateness of care (utilization management)
9. Risk management activities (environment of care and infection control)
10. Quality control activities.
11. Peer Review Activities
12. Data from external and internal performance benchmarking activities that allow for the comparisons of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. These can be defined by the organization.

Performance measurement indicators are essential for all data collection and are required when looking at statistical tools, such as control charts, Preto charts, histograms, and scatter diagrams. Statistical tools are especially helpful in comparing performance with historical patterns and assessing variation and stability.

Variation is inherent in very process and has two general types and causes.

Common cause variation is inherent in every process. A process that varies only because of common causes is considered "stable" and can be improved.

Special-cause variation arises from unusual circumstances or events that may be difficult to anticipate such as human error and mechanical malfunction. Special cause variation should be identified and eliminated; however, removing a special cause does not improve the basic level of performance as it only eliminates defective, atypical, defective or irregular performance.

The organization's Quality Assessment & Performance Improvement Plan shall use appropriate statistical quality control techniques. The assessment of the Quality Assessment & Performance Improvement Plan shall include at the minimum the following:

1. Comparison to data over time.
2. Comparison with practice guidelines in the literature and expert opinions.
3. Comparison to external and internal databases.
4. Comparison to company internal databases.

Intensive assessment will occur in the following cases:

1. When there is undesirable variation.
2. When there is a sentinel event that triggers concern.
3. When trends or patterns are identified in the assessment of data.
4. When the organization's performance varies from recognized standards.
5. When the organization wishes to improve an already good performance.

When assessment leads to issues concerning individual performance, the following shall occur:

1. The Medical Director will review licensed independent practitioner issues through its process of peer review.

2. The organization shall systematically improve its performance by improving existing and new processes.

Decisions to improve **existing** processes shall be based upon the following:

1. An undesirable change occurs.
2. It is part of an important function as defined by applicable accrediting bodies.
3. It is a required item for improvement by an accrediting body.
4. Consideration of the organization's mission, vision and/or priorities is impacted.

IMPLEMENTATION OF CHANGES:

The Quality Committee shall direct the implementation of changes that are worthwhile improvements, which were identified through its' plan.

These improvements shall have the following characteristics:

1. The effect of the improvement is assessed, and if there is success it is implemented organization wide as appropriate.

2. Improvement efforts shall be directed at processes, **not** individuals. However, if an individual has performance problems that he or she is unable or unwilling to improve, his or her clinical privileges or job assignment are modified, as indicated, or other appropriate action will be taken via medical staff peer review, or according to the contractual terms, or policies.

3. Improvement activities of a facility-wide nature shall utilize a systematic approach to redesigning current processes or acting on opportunities for incremental improvement.

4. Examples of different approaches that a company might utilize include FOCUS-PDCA, etc. The Governing Board is responsible for deciding which approach is to be used.

The improvement activities shall meet the following expectations:

1. It will consider the impact on the relevant dimensions of performance.
2. It shall set performance expectations of change.
3. It shall include adopting, or creating new measures of performance.
4. It will involve those individuals, professionals, and services closest to the improvement activity.

ASSESSMENT:

The goal for the assessment process is to compare the facility with itself, with others, with standards, and with best practices. Assessments may be derived from authoritative sources such as professional associations, clinical literature, historical documentation or internal consensus.

Two types of indicators may be utilized: sentinel-event indicators and aggregate-data indicators.

1. A sentinel event indicator identifies an individual event or occurrence that is significant and triggers further investigation and review. The threshold will be set at 0% or 100%. A sentinel event is important in triggering an event for evaluation and is useful in risk management to prevent future occurrences. When a threshold is not set at 0% or 100%, it may be necessary not only to look at the total data but also to break down it more by individual, event, or situation.
2. Aggregate-data indicators quantify a process or outcome that may be related to many causes and may occur frequently. Aggregated-data indicators are divided into two types: continuous variable indicators and rate-based indicators.

Continuous variable indicators: measures performance along a continuous scale (i.e., the number of patient visits; the number of surgical visits).

Rate based indicators: The value of each measurement is expressed as a proportion or as a ratio.

1. For a proportion, the number of occurrences is expressed in relationship to the entire group within which the occurrence could take place. The numerator is expressed as a subset of the denominator (i.e., the number of events/the number of surgeries).
2. For a ratio, the numerator and denominator measure different phenomena (i.e., the number of surgeries with infections/the number of number of surgeries).

ROOT CAUSE ANALYSIS:

Intensive assessment utilizing a Root Cause Analysis form is to be initiated whenever there is an undesirable variation in performance of the following:

1. Important single events, absolute levels, patterns or tends that vary significantly and undesirably from those expected;
2. Performance varies significantly and undesirably from other organizations;

3. Performance varies significantly and undesirably from recognized standards;
4. Operative procedures that place patients at risk;
5. When a sentinel event, as defined by Sentinel Event Policy (accreditation agencies) has occurred.

WHAT IS PDCA?

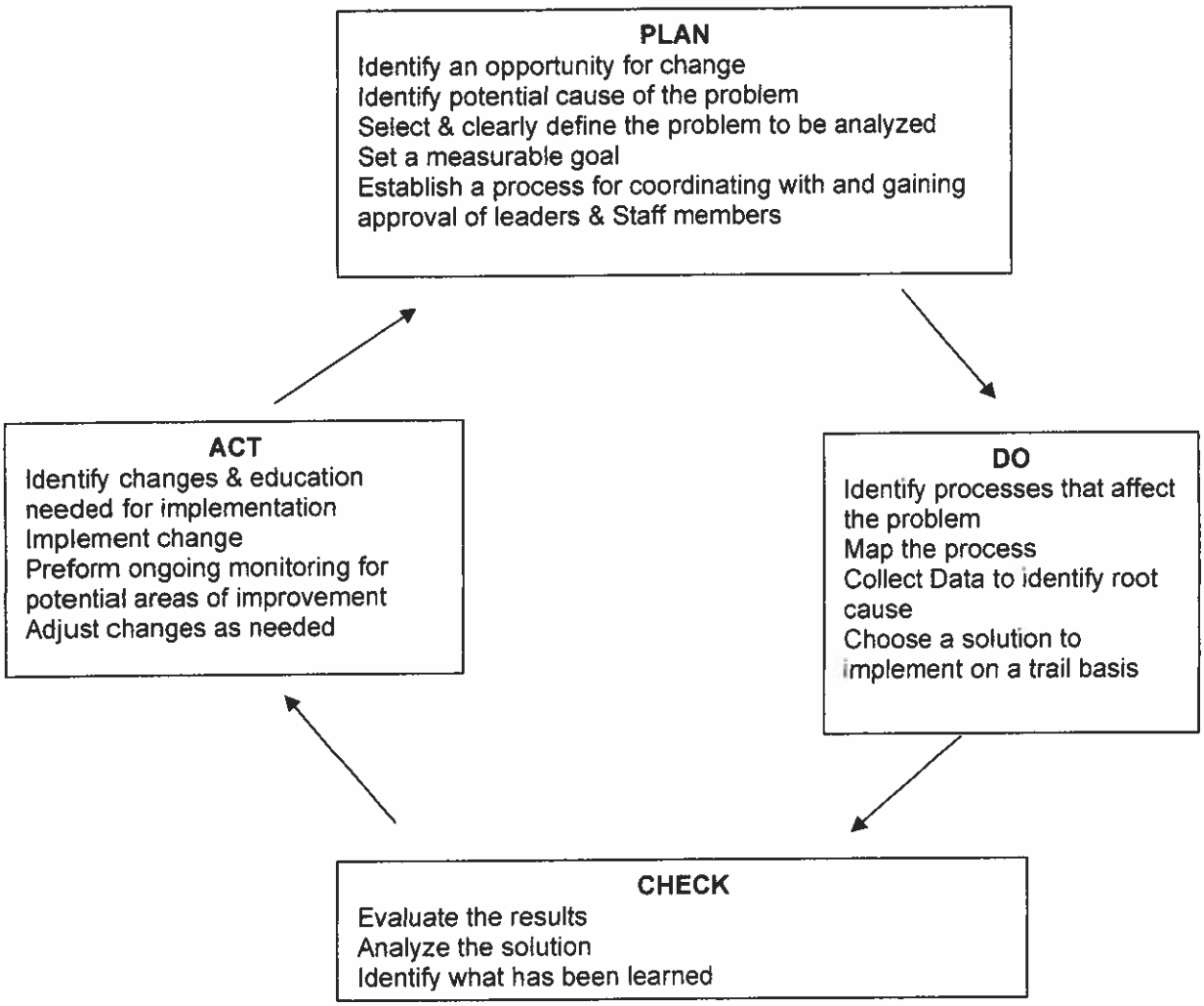
The PDCA cycle is used to test and implement the process of improving a function using these steps:

PLAN	understand, then propose an improvement, and finally decide how an improvement action will be tested and how data will be collected to determine what effect the action has.
Do	perform the test by implementing the action on a small scale.
Checks	analyze the effect of the action being taken.
Act.	fully implement the action, reassess it and sometimes even choose another action.

Amita Health Endoscopy Center Lincoln Park

Quality Assessment & Performance Improvement Plan

PDCA:



HESC QUALITY ASSURANCE PROGRAM

Policy The HESC Quality Assurance Program has been formulated to objectively and systematically monitor and evaluate the quality and appropriateness of all services, pursue opportunities to improve patient care and resolve identified problems.

Definition The term "Quality Assurance" refers to the identification, assessment, correction and monitoring of important aspects of patient care designed toenhance the quality of Health Maintenance Services consistent with achievable goals and within available resources.

Purpose The HESC Quality Assurance Program is established in consonance with the philosophy, mission and goals of the Center. It is the intent of the Center to provide care to all patients regardless of age, sex, race, national origin,handicap or financial capabilities.

I. Goals

a. To assure that services rendered to patients is of the appropriate level ofcontinuity and high quality.

b. To assure that treatment is consistent with the clinical impression or workingdiagnosis.

c. To assure that appropriate diagnostic procedures and/or consultations areobtained relative to a patient's condition.

d. To assure that Center's resources are used in the most efficient and effective manner possible.

e. To assure complete and accurate medical record documentation.

f. To assure compliance with the IDPH, CMS and AAAHC regulations for surgical centers.

g. To assure that the overall health needs of patients are met, including patient satisfaction.

II. Program Foundation: There are (4) key programs that are the foundation of the Quality Assurance Program.

a. The Quality Assessment & Improvement Program
b. The Infection Prevention Program
c. The Risk Management Program
d. The Medical Staff Credentialing Program

APPENDIX B

Assurance Program. Problems for study may be identified through, but not limited to, any of thefollowing means:

a. Compliance with rules, AAAHC standards and IDPH/CMS regulations governing the Center.
b. Compliance with policies and/or procedures established by the Center, including adherence to the staff Bylaw.
c. Known or suspected problem areas, as determined by the Center's Infection Control Program which focuses on the prevention, identification, and analysis of infections in the facility. Data is gathered on individual occurrences and trends. In addition, an ongoing monitoring evaluation process is in place.
d. Known or suspected problem areas, as determined by the Center's safety protocols which focus on the prevention, identification, and analysis of incidents in the facility. Individual occurrences and trends are addressed.
e. Known or suspected problem areas, as determined by the Center's Risk Management program which reviews all incidents that include but are not limited to, hospital transfers, medical errors, any ongoing or potential litigation, accidents, and clinical aspects of care.
f. Referral from Medical Director or Executive Director of known or suspected problem areas.
g. Referral from Center's medical staff or employees of known or suspected problem areas.
h. Patient complaints or grievances.

V. Assessment of Services: Assessment of the Center's delivery of services rendered is the next important step. Assessment methods are varied, but may include the following:

a. Formal medical audit.
b. The Center's Quality Studies.
c. Review of data from external sources, such as AAAHC standards or IDPH/CMS regulations.
d. Patient satisfaction surveys.
e. Review of corporate compliance data.
f. Quarterly variance reports
g. Quarterly peer review
h. Infection Control audits

III. Program Components There are four (4) basis program components of the Center's HESC Quality Assurance Program:

a. Problem Identification,
b. Assessment of patient services,
c. Correction of Identified Problems, and
d. Follow up Monitoring.

IV. Problem Identification: Identification of known or suspected problems in

i. Quarterly Medication and controlled substance audits and chart reviews

VI. Correction of Problems: Once problem areas have been studied and resultsassessed, appropriate action(s) is taken to resolve the problem. Corrective actions may include, but are not limited to, the following:

a. Revision of a policy or procedure consistent with problem resolution.
b. Continuing medical education of medical staff.
c. Education of employees regarding policies, procedures to streamline or improve the delivery of care.
d. Initiation or continuation of a formal quality study.

Such actions may be taken by the Medical Director or Director of Nursing for clinical problems and by the Executive Director, for administrative problems. Written documentation is be maintained and available for review.

VII. Reporting Relationships. The HESC Quality Assurance Program is comprehensive, coordinated and integrated in nature. The Executive Director, MedicalDirector, Director of Nursing, Qualified Consulting Committee (QCC) and the Board of Directors each review and participate in the HESC Quality Assurance Program.
a. Assessment results are reported quarterly to the QCC and the Board of Managers.
b. The results are shared with the employees at their staff meetings.

Roles

Executive Director is apprised of any findings relative to the management and operation of the Center. This includes frequent communication with the Director of Nursing, Medical Director and Board of Directors concerning the administration of policies and procedures designed to enhance or improve the quality of care at the Center.

Director of Nursing is the Center's chief nurse responsible for all clinical operations and is the Center's Infection Preventionist. She ensures that adequate and necessary staffing is provided to carry out the activities described in the Plan.

Medical Director:
a. To act in coordination and cooperation with the Director of Nursing and Executive Director in all matters of mutual concern.
b. To call, preside at, and be responsible for the agenda of the meetings of Qualified Consulting Committee.
c. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations and for implementations of sanctions where indicated.
d. Represent the views, policies, needs and grievances of the Medical Staff to the Board of Managers.
e. Interpret to the Medical Staff the policies given by the Board of Managers
f. Serve as a clinical liaison for the Center.

Qualified Consulting Committees: The QCC is the functional component of the HESC Quality Assurance Program and meets quarterly.

a. Establish and enforce standards for professional work in the Center;
b. Review development and content of the written policies and procedures of the Center, the procedures for granting privileges, and the quality of the surgical procedures performed; evidence of such review is be recorded in writing;
c. Granting "provisional" status to new Members pending action by the Board of Managers.
d. Reporting activities of the Qualified Consulting Committee to the Board of Managers.
e. To represent and to act on behalf of the staff as a whole, subject to such limitations as may be imposed by these Bylaws.
f. To recommend actions on medical administrative matters, long range plans, clinical budgets, and licensure/accreditation issues.
g. To act as the Infection Control, Medical Records and Tissue Review Committee.

h. To provide the clinical expertise necessary to maintain the Center's compliance with Medicare, licensure and the standards and requirements of any organization that accredits the Center.
i. To provide surveillance of the Center's infection potentials, to review and analyze actual infections, and recommend corrective programs to minimize infection hazards.
j. To maintain standards for hazardous waste management.
k. To authorize the Executive Director to take corrective action as necessary and appropriate to prevent infection problems.
l. To review surgical cases for indications for surgery and variations in pre and post-operative diagnoses.
m. To review reports on all tissues removed and submitted to the Pathologist for examination to verify the correlation (or lack of) between the pathology report and pre/post-operative diagnosis and operative procedure on a quarterly basis.
n. To recommend further quality studies or reviews to be performed and corrective actions to be taken.
o. Ensure that surgical procedures are not being performed at the Center if a patient's medical, surgical or psychiatric condition warrants treatment in a hospital setting.
p. To evaluate and analyze medical/surgical and nursing care to assure the quality and appropriateness of these services.
q. To review the medical/surgical necessity and appropriateness of procedures performed at the Center
r. To identify variances or problems to be assessed and recommend action to be taken for correction or follow up.

Board of Directors: The Board of Directors is responsible for the overall adoption and implementation of written policies and procedures governing the operationof the Center, including its HESC Quality Assurance Program. Assessment results and corrective actions taken is be documented and reported to the Board on a quarterly basis. The Board annually reviews the HESC Quality Assurance Program to ensure compliance with written rules and regulations.

QUALITY ASSESSMENT & IMPROVEMENT PROGRAM

I. PURPOSE

The purpose of The Quality Assessment & Improvement Program (QAIP) is to continuously improve the quality of patient care and service in a manner that is efficient, effective, and consistent with the mission, objectives, and goals of the Center.

II. Definitions:

A. An Incident includes any occurrence that is not consistent with the routine care or operation of the Center. Incidents may involve patients, visitors, employees and medical staff members.

B. An Adverse Incident incorporates an unexpected occurrence involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.

III. GOALS AND OBJECTIVES:

A. The goals of the Quality Assessment & Improvement Program are to:

1. Ensure optimal quality of care and appropriate utilization of resources through an effective mechanism for monitoring, evaluation and improving client care and service.
2. Meet requirements of laws, regulations of government agencies, and accreditation organizations.
3. Involve department staff in quality improvement process.
4. Provide information as indicated for performance management.

B. The objectives of the Quality Assessment & Improvement Program are to

1. Specify responsibility for QAIP activities.
2. Identify applicable laws, regulations, and standards.
3. Develop indicators of care, utilizing objective criteria to apply to all health care providers.
4. Perform an ongoing review of care given to clients regardless of payment Source.
5. Initiate action of identified problems and opportunities to improve care, and follow-up as indicated to assure resolution.
6. Develop operational linkages with related function within the center (ie. infection control, risk management, safety, ect.).
7. Provide education regarding the QAIP process.
8. Coordinate all QAIP activities so as to enhance communication, minimize duplicate of effort, and be cost-effective and consistent.

IV. AUTHORITY

The Board of Managers has ultimate responsibility for the center's activities, including quality assessment and improvement. Authority and accountability for Q.I. Program are delegated to the Administrator.

V. SCOPE OF PROGRAM

A. The Quality Assessment & Improvement Program will apply to all services and all clinical and business staff members who provide direct client care. This program will include, but not necessarily be limited to:

1. Physicians
2. Registered Nurses
3. Licensed Practical Nurses
4. CST
5. Business Office Staff

B. The QAIP will apply to all clients regardless of payment source. This program will include, but not necessarily be limited to:
   1. Medicare
   2. Private Insurance
   3. Private Pay
   4. Hardship/Self Pay

VI. COMMITTEE DEFINITION

A. The Quality Assessment & Improvement Committee will be composed of
   1. Administrator
   2. Qualified Consulting Committee Members

B. The Administrator will serve as committee chairman. Between meetings, the chairperson will have the authority to take action on issues that require immediate response. In the absence of the chairperson, the Medical Director will serve as chairperson.

C. The Committee will meet not less than quarterly unless otherwise specified

D. The committee is responsible for oversight of QAIP activities within the Center. Specific functions of the committee will include:
   1. Develop and revise indicators as necessary to adequately evaluate care provided by the department and meet or exceed external requirements.
   2. Review data summaries for all scheduled indicators, as well as information from other sources regarding the quality of care provided by the department.
   3. Initiate corrective action on identified problems and opportunities to improve care.
   4. Initiate follow-up as indicated to assure resolution.
   5. Develop educational programs based on needs identified through committee activities, and support department-wide education on continuous process improvement principles.
   6. Coordinate review activities in order to provide an objective comprehensive review, while reducing duplication of effort.
   7. Assure documentation and appropriate, timely reporting of all QAIP activities.
   8. Provide relevant findings from review for use in performance management.
   9. Evaluate the effectiveness of the Center's program at least annually.

VII. REVIEW PROCESS

The following process will be the basis for all defined QAIP review activities.

A. PLAN:
   1. Assign responsibility for monitoring and evaluation activities.
   2. Delineate the scope of care provided by the Center.
   3. Identify the most important aspects of care provided by the Center.
   4. Identify indicators (and appropriate clinical criteria) for monitoring the important aspects of care.
   5. Establish patterns or trends (thresholds where indicated) for the indicators that trigger evaluation of care.

B. DO:
   Monitor the important aspects of care by collection and organizing the data for each indicator.

C. CHECK:
   Evaluate care when patterns or trends noted in order to identify either opportunities to improve care or problem.

D. ACT:
   1. Take action to improve care delivery, process or correct identified problem.
   2. Assess the effectiveness of the actions and document the results. Take alternative actions if improvement was not achieved or if improvements were determined to be unsustainable.
   3. Communicate the results of the monitoring and evaluation process to relevant individuals, groups, or departments organization wide.

APPENDIX B

VIII. REPORTING MECHANISMS

A. Data summaries and other reports will be presented to the Center.
B. Pertinent information from Center QAIP Committee activities will be presented to the staff during staff meeting.
C. Summary reports are provided to the Board of Managers.
D. A summary report of patient/staff infections will be reported as defined by Hoffman Estates Surgery Center, LLC and on a quarterly basis.
E. All patient and employee incidents will be reported as defined by Hoffman Estates Surgery Center, LLC and on a quarterly basis.
F. Other risk management and safety issues will be reported as they occur.
G. The Center will comply with the required FASA quarterly reporting and IDPH annual reporting.

IX. CONFIDENTIALITY POLICY

A. Reports, minutes, and other data generated for use in the QAIP are protected from discovery.
B. Information required by law or authorized by Center's Medical Director will be provided by the following:
   1. A.A.A.H.C
   2. CDC, APIC, AORN
   3. IDPH and the IHFPB
   4. Illinois ASC Licensing Board
   5. Secretary of Health and Human Service
   6. Other licensing and regulatory agencies
C. The Administrator will maintain Department specific reports and minutes.
D. Provider and patient identification will be protected in all minutes and reports.

X. SCOPE OF THE QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM

A. Monitor and evaluate in a systemic fashion, the key aspects of patient care and service delivery for all disciplines and services, both clinical and administrative. Included in this step are the following:
   1. Review and evaluation of the quality and appropriateness of the admission process
   2. Review and evaluation of the quality and appropriateness of the assessment process.
   3. Review and evaluation of the quality and appropriateness of the plan of care.
   4. Review and evaluation of the quality and appropriateness of the patient progress in the intra operative phase.
   5. Review and evaluation of the quality and appropriateness of the discharge Process planning.
   6. Monitoring and evaluation of the quality and appropriateness of care for Medical Staff functions
B. The monitoring and evaluation activities are also utilized to integrate data concerning clinical performance into credential and privilege files. A summary of the quality assessment finding and actions is placed into these files. This summary is reviewed at the time of presentation for renewal of privileges and is considered as a part of the determination to recommend continued privilege status.
C. The Quality Improvement Plan will ensure that quality and appropriateness for applicable contracted services are also monitored and evaluated. This includes the following: Pathology Services - the quality and appropriateness of pathology services is timeliness and accuracy of pathological reports.
D. The Quality Improvement Plan also provides for the monitoring and evaluation of the following organizational wide functions.
   1. Infection Control - Focuses on the prevention, identification, and analysis of infections in the facility. Data is gathered on individual occurrences and trends. In addition, an ongoing monitoring evaluation process is in place. APPENDIX B

2. Safety - Focuses on the prevention, identification, and analysis of incidents in the facility. Individual occurrences and trends are addressed.
3. Risk Management - Reviews all incidents that include but are not limited to, hospital transfers, medical, safety, accidents, and clinical aspects of care (confidentiality, etc.).

HOFFMAN ESTATES SURGERY CENTER
UTILIZATION REVIEW WORKSHEET (Peer Review)

Patient No. _____ Diagnosis _____
Date Reviewed_____
Attending Practitioner _____
Surgery _____
Reviewing Practitioner _____
Age _____ Sex _____

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1. Do the pre-operative indications for surgery fulfill the criteria to justify surgery?
   YES _____ NO _____
   Comments:

2. Was the appropriate pre-operative treatment and evaluation performed?
   YES _____ NO _____
   Comments:

3. Were the ancillary services utilized consistent with the patient's need and the treatment provided?
   YES _____ NO _____
   Comments:

4. Does the pathology report (or Tissue Report) of the tissue removed (where appropriate) justify the surgery?
   YES _____ NO _____
   Comments:

5. Is the operative record consistent with the pre-operative evaluation and program of treatment?
   YES _____ NO _____
   Comments:

6. Does the chart provide complete documentation as to the appropriateness of care provided?
   YES _____ NO _____
   Comments:

Additional Comments:

Signature of Reviewing Practitioner: _____

APPENDIX B

HOFFMAN ESTATES SURGERY CENTER
QUALITY ASSESSMENT AND IMPROVEMENT INDICATOR

DEPARTMENT: _____ DATE: _____

1. QA and I Indicator: _____

2. Threshold for Evaluation: GOAL _____% ACTUAL _____%

3. Evaluation of Care: _____

   a. Conclusion and Recommendation:

   b. Action Taken:

4. Assessment of Actions and Improvements: _____

   a. Follow-up:

   b. Further follow-up indicated:

5. Communication of results:
   Further assessment is (needed/not needed) and (will/will not) be discussed at the next Committee meeting

Signature: _____

Date: _____

HOFFMAN ESTATES SURGERY CENTER
QUALITY INDICATORS

I.	Staff Indicators	
	a. Total Overtime Hours	< 40 per quarter
	b. % of Payroll to Net Revenue	< 23%
II.	Billing Performance	
	a. Days A/R Outstanding	<35
III.	Process Indicators	
	a. On-time Rate	>95%
IV.	Documentation Indicators	
	a. Medical Record Completion Rate	30 Business Days
V.	Satisfaction Indicators	
	a. Customer Satisfaction Rate	>or equal to 98%
VI.	Clinical Outcomes	<1%

CLINICAL OUTCOMES Per 1,000 Patient Encounters
Wrong Site/Side/Patient/Procedure/Implant
Medication Errors
PONV Requiring Intervention
Patient Burns
Patient/Visitor Falls
Prophylactic IV Antibiotic On-time
Post Surgical Wound Infection
Unscheduled Direct Transfer
Patient Deaths (day of or within 48 hours of discharge)
Admit to Hospital (within 48 hours of discharge)
Consent Variance / No H&P
Code Blue
Malignant Hyperthermia
Complictions