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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Presence Lakeshore Gastroenterology, LLC d/b/a Des Plaines Endoscopy Center
Street Address:	150 N. River Road
City and Zip Code:	Des Plaines, IL 60016
County: Cook	Health Service Area: VII Health Planning Area: 031

Legislators

State Senator Name:	Laura Murphy
State Representative Name:	Martin Moylan

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

Exact Legal Name:	Presence Lakeshore Gastroenterology, LLC
Street Address:	150 North River Road
City and Zip Code:	Des Plaines, IL 60016
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:	Mani Mahdavian
CEO Street Address:	150 North River Road
CEO City and Zip Code:	Des Plaines, IL 60016
CEO Telephone Number:	847/787-1099

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
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Street Address:	150 N. River Road
City and Zip Code:	Des Plaines, IL 60016
County: Cook	Health Service Area: VII Health Planning Area: 031

Legislators

State Senator Name:	Laura Murphy
State Representative Name:	Martin Moylan

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

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E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

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

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
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Street Address:	150 N. River Road
City and Zip Code:	Des Plaines, IL 60016
County: Cook	Health Service Area: VII Health Planning Area: 031

Legislators

State Senator Name:	Laura Murphy
State Representative Name:	Martin Moylan

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

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Title:	President
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Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

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

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
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Facility/Project Identification

Facility Name:	Presence Lakeshore Gastroenterology, LLC d/b/a Des Plaines Endoscopy Center
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City and Zip Code:	Des Plaines, IL 60016
County: Cook	Health Service Area: VII Health Planning Area: 031

Legislators

State Senator Name:	Laura Murphy
State Representative Name:	Martin Moylan

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
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- [ ] Governmental
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- 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.

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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:	

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:	Presence Chicago Hospitals Network
Address of Site Owner:	200 South Wacker Drive 12th floor Chicago, IL 60606

Street Address or Legal Description of the Site: 150 N. River Road Des Plains, IL 60016

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Current Operating Identity/Licensee

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

Exact Legal Name:	Presence Lakeshore Gastroenterology, LLC
Address:	150 N. River Road Des Plaines 60016

☐	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 Presence lakeshore Gastroenterology, L.L.C..

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 Presence Lakeshore Gastroenterology, LLC

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

Mani Mahdavian
PRINTED NAME

Chairman
PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

Darcy Lorentzen
PRINTED NAME

Vice-Chairman
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 applican:

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 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

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- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of *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
_____	G. Thor Thordarson
PRINTED NAME	PRINTED NAME
_____	Treasurer
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

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.

SECTION IV.CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 7.

CHARITY CARE			
	2018	2019	2020
Net Patient Revenue	**$647,653**	**$4,245,900**	**$3,082,386**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

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

File Number 0513910-4

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 LAKESHORE GASTROENTEROLOGY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 29, 2015, 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* 13TH *day of* JANUARY *A.D.* 2022 .

Authentication #: 2201303288 verifiable until 01/13/2023
Authenticate at: http://www.ilsos.gov

Jesse White

SECRETARY OF STATE

ATTACHMENT1

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

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 Presence Lakeshore Gastroenterology, LLC site is owned by Presence Chicago Hospitals Network.

File Number 0513910-4

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 LAKESHORE GASTROENTEROLOGY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 29, 2015, 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.

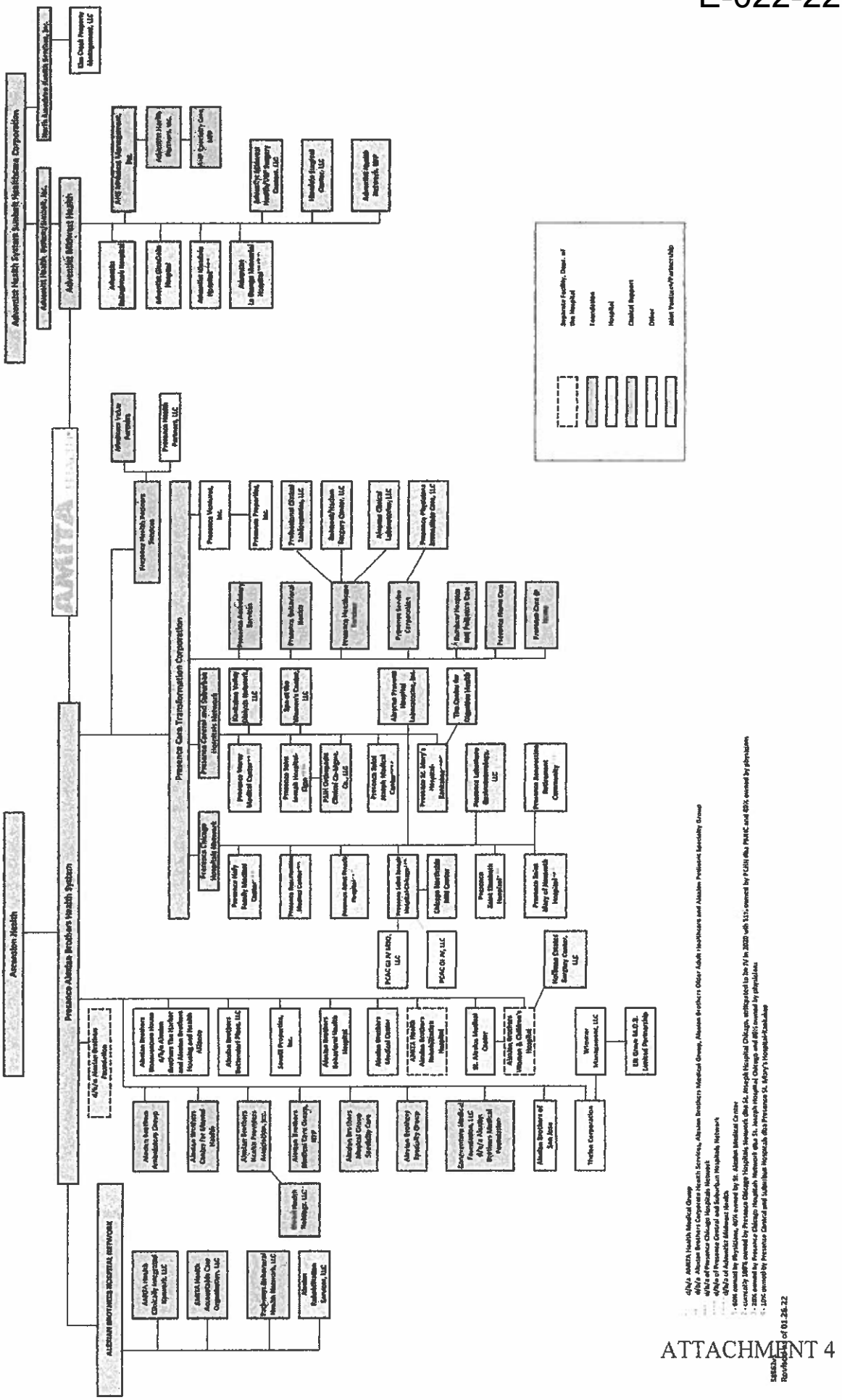
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 13TH *day of* JANUARY *A.D.* 2022 .

Authentication #: 2201303288 verifiable until 01/13/2023
Authenticate at: http://www.ilsos.gov

Jesse White
SECRETARY OF STATE

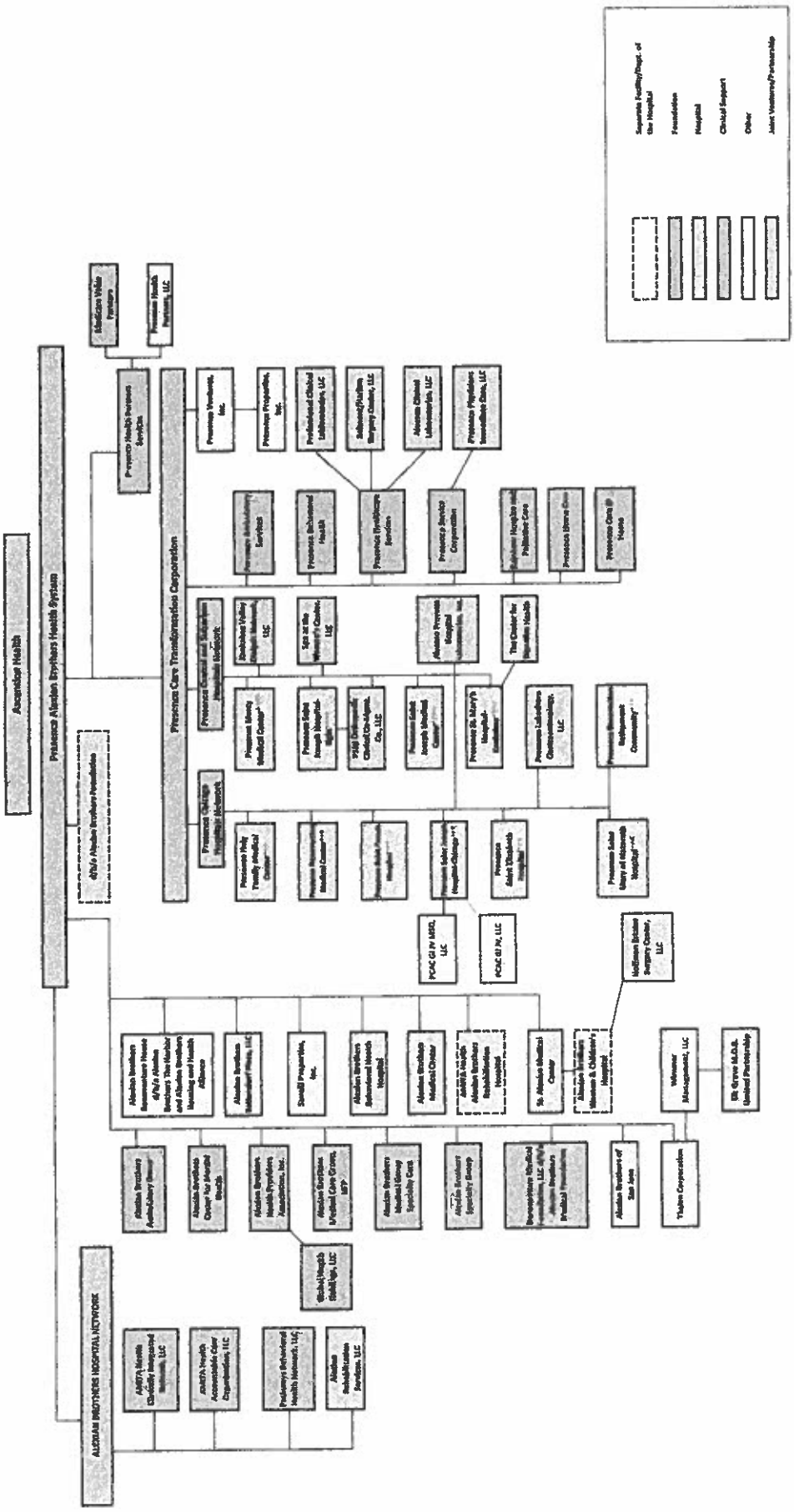
ATTACHMENT 3

CURRENT ORGANIZATIONAL CHART



ATTACHMENT 4

PROPOSED ORGANIZATIONAL CHART

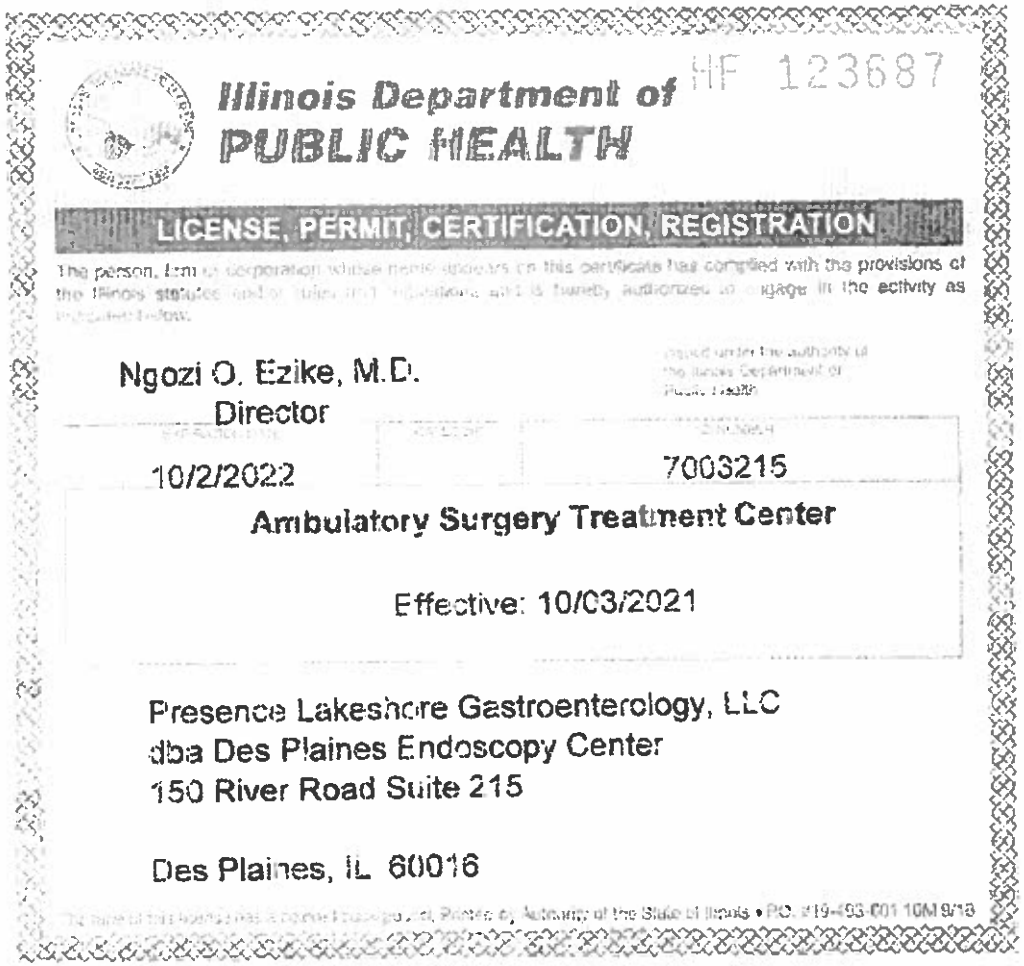


ATTACHMENT 4

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 123687

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	CERTIFICATE	LICENSE #
10/2/2022		7003215

Ambulatory Surgery Treatment Center

Effective: 10/03/2021

Presence Lakeshore Gastroenterology, LLC
dba Des Plaines Endoscopy Center
150 River Road Suite 215

Des Plaines, IL 60016

This form is issued by the Illinois Department of Public Health by authority of the State of Illinois • PO #19-493-001 10M 9/19

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 10/2/2022

Lic Number 7003215

Date Printed 8/31/2021

Presence Lakeshore Gastroenterology
dba Des Plaines Endoscopy Center
150 River Road Suite 215
Des Plaines, IL 60016-1272

FEE RECEIPT NO.

resence Lakeshore Gastroenterology LLC

E-022-22

Des Plaines, IL

has been Accredited by

The Joint Commission

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

Ambulatory Health Care Accreditation Program

March 27, 2021

Accreditation is customarily valid for up to 36 months.

ine Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #610164
Print/Reprint Date: 05/19/2021

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

int Commission is an independent, not-for-profit national body that oversees the safety and quality of health c
ervices provided in accredited organizations. Information about accredited organizations may be provided dir
oint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation perform
lual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

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

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

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

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

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

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

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

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

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

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

Ascension Health ASCs (Wholly Owned)

St. Vincent's One Nineteen ASC	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 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

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

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

The parties named as an applicant are:

Presence Lakeshore Gastroenterology, 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 Holy Family Medical Center, 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 has been obligated

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

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

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

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

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

Criterion 1130.520(b)(3) If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the charity care policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.

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

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

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

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

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

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

Criterion 1130.520(b)(6) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control.
Ascension places great importance in quality control, and implements best practice models through its individual hospitals. Quality improvement mechanisms at the facility will not initially change, but will be evaluated against parallel programs used in other Ascension hospitals, with adjustments being made as appropriate to enhance clinical and non-clinical opportunities for improvement.

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 body consists of three persons elected by LSGLDI Investments, LLC and three persons appointed by Presence Holy Family Medical Center.

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.

CHARITY CARE

Procedure
It is the policy of the Des Plaines Endoscopy Center to accept and treat all patients regardless of their ability to pay. Charges are billed to patients for all services rendered.

Policy Statement
Charity Care will be considered for patients who are experiencing financial hardship and/or have incurred excessive medical expenses and lacks the ability to pay; or may be struggling with their financial responsibilities.

Procedure
The Surgical Center may request that the patient first seek public benefits. Upon verification of denial for public assistance, the Surgical Center will extend consideration.

1. Patients seeking financial assistance should contact the Business Office. The patient or guarantor must complete Surgical Center's Financial Worksheet with supporting documentation as requested within 10 (ten) days.

2. Financial Worksheets completed and returned to the Surgical Center administrator within the allotted time frame will be evaluated for approval or denial by the Surgical Center administrator.

3. A patient will be considered for charity care, if criteria are met, based on poverty income level as established by the U.S. Department of Health and Human Services (revised annually).

4. The Surgical Center may deny assistance if the patient or guarantor has assets such as saving accounts, investments, or other available funds or does not furnish all requested information.

5. This consideration process is by application only and the applications are available upon request by calling the Billing Office at 833-222-0436.

6. The Surgical Center will notify the patient, in writing, as to the outcome of the application for charity care within 14 (fourteen) days of receipt of completed application.

7. Should the patient not qualify for charity care, or should there be a remaining balance after existing charges are reduced, the Surgical Center will offer the patient a payment plan.

8. For approved applications, existing charges will be adjusted appropriately by business office staff as directed by the administrator.

2022 Poverty Guidelines and Reduced Rates

Family Size	100% if income below:	50% if income below:	25% if income below:
1	$25,853	$27,926	$35,186
2	$34,898	$37,826	$47,660
3	$43,943	$47,726	$60,134
4	$52,988	$57,626	$72,608
5	$62,033	$67,526	$85,082
6	$71,078	$77,426	$97,556
7	$80,123	$87,326	$110,030
8	$89,168	$97,226	$122,504

DES PLAINES ENDOSCOPY CENTER
Financial Worksheet

The patient will need to complete a financial worksheet (see attachment B) and provide the following additional documentation with proof of income:

A. Income tax return (most recent year)
B. Forms from Medicaid or other State funded medical assistance
C. Social Security benefits

Additionally, the patient should provide documentation for any of the following circumstances that may also contribute to financial hardship:

A. Bankruptcy
B. Catastrophic situation (death, disability, divorce)
C. Any other circumstances that would support why paying said medical bills would cause further financial hardship.

Please return all documentation along with the completed Financial Worksheet to:

Des Plaines Endoscopy Center
Business Office
6128 S Lyncrest Ave
Sioux Falls SD 57108
PHONE 833-222-0436
FAX # 605-274-6186

All information relating to financial hardship requests will be kept confidential. If any of the information given proves to be inaccurate, we will promptly reevaluate your financial status and take the action necessary to collect on your account.

APPENDIX A

Account#_____

FINANCIAL WORKSHEET
Attachment B
DES PLAINES ENDOSCOPY CENTER

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip:_____

Telephone: _____ Cell Phone: _____

Responsible Party/Guarantor: _____

(complete information below if different from patient information)

Address: _____ City: _____ State: ____ Zip:_____

Telephone: _____ Cell Phone: _____

GENERAL INFORMATION

Patient/Guarantor employer: _____
Spouse's employer: _____
Name/age of dependent children: _____

MONTHLY GROSS INCOME

Wages/unemployment/work comp/social security, etc:

Patient/Guarantor: $_____

Spouse: $_____

Alimony or child support: $_____

Public Assistance: $_____

Retirement/Pension (all sources): $_____

All Other income (explain below): $_____

TOTAL: $_____

Have you applied for Medical Assistance? County _____ Medicaid_____
(This is a requirement to be considered for financial assistance)

APPENDIX A

MONTHLY EXPENSES
Please list creditors. (use back of this sheet for additional information)

Mortgage/Rent:	$_____
Auto loan:	$_____
Home/Auto Insurance:	$_____
Utilities (electric, phone, gas, water):	$_____
Food/clothing:	$_____
Credit card (list individually on back of form if necessary):	$_____
Loan payments (Bank, credit company, school loans):	$_____
Health/Dental Insurance:	$_____
Child care:	$_____
Child Support:	$_____
Medical Fees (dentist, physician, hospital, etc):	$_____
Collection Agency:	$_____
Auto related expenses:	$_____
TOTAL:	**$**_____

Total monthly income: **$**_____

Total monthly expenses: **$**_____

Total Monthly Discretionary Income: **$**_____

We MUST have a copy of your last year Income Tax Return. If your parents claim you, provide a copy of their tax return. W-2's or payroll stubs may be requested as additional information.

Remarks:

_____

_____

PLEASE RETURN WITHIN 10 BUSINESS DAYS

I acknowledge that the above information is true and accurate and that this application is made to allow DES PLAINES ENDOSCOPY CENTER to determine your eligibility for reduced out of pocket health care costs. I understand that verification of information may be made as necessary.

Signature of patient _____ Date_____
(parent or legal guardian if patient is a minor)

Internal Office use only
APPROVED DENIED Notification Sent:

APPENDIX A

Authorized Signature: _____Date_____

SUBJECT: PERFORMANCE IMPROVEMENT PLAN

The Center's management and staff are committed to developing and carrying out an ongoing performance improvement program. Experience has proven that quality cannot be assured, but it can be monitored continuously and improved effectively through a concerted effort by all individuals. Performance Improvement is a dynamic process that focuses on the evaluation of patient outcomes to determine methods of improving care.

An emphasis on performance improvement is a link among all medical and clinical personnel providing patient care and the numerous individuals involved in the care to achieve a standard of excellence in an objective and comprehensive manner that will benefit patients.

GLOSSARY:

Aspects of care:	Clinical activities that involve a high volume of patients, entail a high degree of risk for patients or tend to produce problems for staff or patients
Concurrent:	A study that begins with a current manifestation and links this effect to occurrences at the same point in time, related to care in progress
High risk:	Patients at risk if the aspect of care is not provided correctly and in a timely manner
High volume:	The aspect of care that occurs frequently or affects a large number of patients
Indicator:	Well defined measurable objective statements related to the structure, process or outcomes of care
Occurrence screens:	Data that are utilized to identify individual variations in care which are reviewed and confirmed by peer review and used to identify trends/patterns
Outcomes:	The intended or realistically expected correction of the patient's problem by a certain point in time
Standard:	A criterion used by general agreement to determine whether something is as it should be. An agreed upon level of excellence. An established norm determined by opinion, authority, research and/or theory
Threshold:	Preestablished level or point at which intensive evaluation of care or practice is indicated for the monitoring activity for the purpose of setting realistic goals for performance improvement.

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OBJECTIVES

Objectives of the program are

1. To improve overall patient care and services through systematic monitoring and evaluation;
2. To ensure continuing improvement by putting into effect an ongoing, comprehensive, and a workable program;
3. To involve all levels of staff in the improvement process;
4. To provide higher quality care and services at lower costs;
5. To utilize indicators and related thresholds;
6. To routinely collect data related to the indicators and compare the level of performance with the thresholds for evaluation;
7. To collect data on sentinel and rate-based indicators based on important aspects of care and/or services that reflect structure, process and outcomes;
8. To monitor and evaluate important aspects of care when the thresholds for evaluation have been reached; and,
9. To ensure identification and solution of problems.

A Performance Improvement/Medical Advisory Committee shall be established which shall meet at least once per calendar quarter. Documentation of the committee activities will be presented to the Governing Body for review.

PURPOSE

The purpose of the committee is as follows:

1. Develop mechanisms necessary to detect and identify performance which is inconsistent with the standards of the center;
2. Collect data to determine that standards are being met;
3. Recommend corrective action which will bring performance into compliance with standards; and
4. Plan follow-up studies to evaluate the effectiveness of corrective actions.

MEMBERSHIP

The committee members shall include:

Medical Director
Administrative and clinical director(s)
At least one other physician
Center personnel as desired and appropriate

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RESPONSIBILITIES

The Governing Body has the overall responsibility for developing, maintaining and supporting the ongoing, comprehensive program. The Medical Director is responsible for monitoring the program.

The committee is charged with the following quality assurance and performance improvement activities:

1. Assures the provision of quality patient care by requiring and supporting the establishment and maintenance of an effective Performance Improvement program
2. Monitors, coordinates and integrates all committee activities and ensures participation of all disciplines. The committee receives all reports regarding but not limited to, infection control, patient transfers, tissue review, medical records review, safety and fire, medication handling and storage, risk management, and patient safety.
3. Monitors and evaluates the quality and appropriateness of patient care and clinical performance and identifies variances or problems to be assessed. The Performance Improvement/ recommends actions to be taken for correction and follow up or directs the appropriate committee or individual(s) to take necessary action. Actions taken are then reported back to the Committee.
4. Reports at least quarterly to the Governing Body. A surgery center manager is responsible for providing the Committee report/minutes to the Governing Body.

COMMITTEE MEMBER FUNCTIONS

Functions of Committee Members

1. The Medical Director and administrative manager have the following functions and responsibilities:
   a. Develops and ensures implementation of the Performance Improvement Program using input from all levels of staff;
   b. Participates with the clinical staff in the identification of clinical functions and indicators and in the establishment of thresholds for evaluation;
   c. Serves as primary coordinator and director of the program, accepting full responsibility and accountability for the following:
      - assists with monitoring of the program
      - recommends corrective actions
      - oversees actions taken
      - provides status reports to the Governing Body
      - assists in developing new policies and procedures
      - changes staffing and environment as needed
      - assists in developing educational programs for the employees and staff

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- ensures support of the Performance Improvement program

2. The clinical manager or designee has the following functions and responsibilities:
   a. Shares in the overall responsibility for developing and ensuring implementation of the Performance Improvement program in clinical areas;
   b. Participates with the Medical Director and other managers in the identification of clinical functions and ensures the following:
      - identification of indicators
      - establishment of thresholds for evaluation
      - identification of the yearly monitoring calendar which specifies clinical functions and frequencies for monitoring activities
      - identification of clinical staff for data collection and evaluation
      - implementation of appropriate action(s) and
      - evaluation of the impact of actions taken;
   c. Ensures clinical staff involvement by promoting team spirit and participation in the program;
   d. Communicates results of findings and actions with all staff members;
   e. Conducts regular meetings to allow for staff involvement and to elicit staff ideas and feedback regarding improvement of patient care and services;
   f. Determines corrective action in collaboration with the staff, interdisciplinary team members and the Medical Director and Performance Improvement/Medical Advisory Committee;
   g. Assists in the collection and analysis of data on important aspects of care and/or services; and
   h. Reports to the Medical Director on a quarterly basis, the monitoring activities, results, actions and recommendations for further action.

AREAS FOR REVIEW

Areas and activities for routine review include the following:

1. unanticipated event reports
2. medical record review
3. infection control reports
4. follow up patient phone calls
5. patient satisfaction surveys
6. communication from physicians/employees
7. patient morbidity/mortality
8. inconsistencies between pre and post procedure diagnosis
9. unanticipated hospital admissions

The medical staff shall conduct ongoing comprehensive self assessment of the quality of care provided, including the appropriateness of care. Physicians will perform peer review. All other reviews may be conducted by center staff with the medical staff reviewing summary information.

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Areas of review may address the following:

1. History and Physical done on each patient prior to admission
2. Appropriateness of treatment in accordance with history
3. Appropriate lab and radiology based on history, physical, and planned procedure
4. Drug usage reviews
5. Review of patient care services from contracted sources
6. Infection control reports
7. Review of services provided including the availability of services; e.g., under use, overuse, timeliness of scheduling, etc.
8. Timely procedure reports written or dictated immediately following the procedure and signed by the physician
9. Pathology summaries regarding pre and post diagnosis review

There shall be no limit as to the number of studies which can be conducted. However, it is preferred that studies be focused upon an opportunity to improve patient care, the cost of care, or the compliance with a standard or a recommendation.

ASPECTS OF CARE

Aspects of care to review may include:

1.	High volume aspects:	Procedures that occur frequently Nursing activities frequently performed Nursing care that affects large number of patients
2.	High risk aspects:	Areas that carry potential for liability and/or patient injury Care delivered inconsistent with standards Acts of omission/commission Failure to recognize cardiac arrhythmias Failure to perform aseptic techniques Failure to provide patient education
3.	Problem prone aspects:	Procedures that cause patient/staff anxiety Activities needing improved efficiency

INDICATORS

Indicators will focus on the patient, the staff, and the system and relate to the structure, process or outcome of care/service. All serious clinical events such as adverse effects and complications and unexpected changes in patient health status (infection, nerve damage, altered skin integrity) will be reviewed.

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THRESHOLDS

A threshold is established for each indicator. These are written as percentages not ranges. Consideration of the level of care must be given realistically and may be less than 100%. These thresholds are evaluated and revised at least annually.

Sources of Data may include the following, in addition to other sources:

- review of licensure/certification/accreditation findings
- variance reports
- patient satisfaction surveys
- medical records reviews
- personnel credentialing/inservice records
- post-procedure phone calls
- direct observation of staff
- review of physician orders
- patient complaints

Sample size of data is at least 5% of the monitored patient population or 10 patients/event.

Analysis and evaluation identifies trends or patterns of care. Action plans/solutions are then developed and enacted to solve the problems or improve care. The effectiveness of these actions are assessed through continuous monitoring. If the action/solution is ineffective, another plan is developed. A time limit shall be set for reevaluation.

COMMUNICATION

Relevant information from the Performance Improvement program will be disseminated as necessary to the affected individuals and groups in the following ways:

1. Written and/or oral reports
2. Performance Improvement review meetings at least quarterly
3. Quarterly reports to Governing Board

The Performance Improvement/Medical Advisory Committee will evaluate the objectives, scope of the organization and effectiveness of the center annually.

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