



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST, SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 FAX: (217) 785-4111

DOCKET NO: C-01	BOARD MEETING: July 27, 2023	PROJECT NO: E-026-23	PROJECT COST: \$38 million
FACILITY NAME: St. Margaret's Health-Peru		CITY: Peru	
TYPE OF PROJECT: Exemption – Change of Ownership			HSA: II

PROJECT DESCRIPTION: OSF Healthcare System is proposing to purchase St Margaret's Health-Peru (f/k/a Illinois Valley Community Hospital) a 49-bed acute care hospital located at 925 West Street, Peru, Illinois. The Applicants are OSF Healthcare System, Ottawa Regional Hospital and Healthcare Center dba OSF Saint Elizabeth Medical Center and St. Margaret's Health-Peru. This change of ownership is considered a **purchase** resulting in the issuance of a license to an entity different from the current licensee. The fair market value of the purchase is \$38 million and includes the hospital campus and personal property belonging to St. Margaret's Health-Peru as well as various off-campus real properties owned by St. Margaret's Health-Peru. The estimated completion date is August 31, 2023.

Information on this exemption applications can be found at

<https://hfsrb.illinois.gov/projects/project.e-026-26-st-margaret-health-peru.html>

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- OSF Healthcare System is proposing to purchase St. Margaret's Health-Peru (f/k/a Illinois Valley Community Hospital) a 49-bed acute care hospital located at 925 West Street, Peru, Illinois. The Applicants are OSF Healthcare System, Ottawa Regional Hospital and Healthcare Center dba OSF Saint Elizabeth Medical Center and St. Margaret's Health-Peru. This change of ownership is considered a purchase resulting in the issuance of a license to an entity different from the current licensee. The fair market value of the purchase is \$38 million and includes the hospital campus and personal property belonging to St. Margaret's Health-Peru as well as various off-campus real properties owned by St. Margaret Health-Peru. The estimated completion date is August 31, 2023.
- St. Margaret's Health-Peru closed January 28, 2023, **and remains a licensed Hospital.**

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The Applicants are before the State Board because the Application proposes a change of ownership of a IDPH licensed health care facility.

PUBLIC COMMENT:

- No public hearing was requested, and one letter of support was received and no letters of opposition.

SUMMARY:

- Upon approval of the purchase of St Margaret's Health-Peru by the State Board, Ottawa Regional Hospital and Healthcare Center will re-open the temporarily closed St. Margaret's Health-Peru hospital facility as soon as possible to provide service to residents served by St. Margaret's Health-Peru. OSF Healthcare System intends to operate this facility in Peru as a second campus under a multi-campus hospital license that requires approval from the Illinois Department of Public Health under the Illinois Hospital Licensing Act. The hospital will be operated by OSF Healthcare System and Ottawa Regional Hospital and Healthcare Center under the name of OSF Healthcare Saint Elizabeth Medical Center as a second campus located in Peru. The Applicants state as a second campus of OSF Saint Elizabeth Medical Center, the services will initially include Emergency Department services, and limited Inpatient Medical/Surgical beds and supportive diagnostic services. According to the Applicants over the next 24 months OSF Saint Elizabeth Medical Center will be developing a comprehensive plan to determine the inpatient and outpatient services that will be provided on each campus. **According to the Applicants any waivers of existing categories of service provided will be sought and consultation required from, IDPH and HFSRB.** The Applicants state future services may include inpatient ICU and Obstetric-Gynecological beds in addition to expanded Medical Surgical beds.
- **The Illinois Health Facilities Planning Act states** *"The State Board shall establish by regulation the procedures and requirements regarding issuance of exemptions. An exemption shall be approved when information required by the Board by rule is submitted. Projects eligible for an exemption, rather than a permit, include, but are not limited to, change of ownership of a health care facility and discontinuation of a category of service."* [20 ILCS 3960/6(b)]
- At the end of this report is OSF Financial Assistance Policy and Organizational Chart.
- All of the information required by the State Board has been submitted.



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STATE BOARD STAFF REPORT #E-026-23 – St Margaret's Health-Peru

I. Project Description

OSF Healthcare System is proposing to purchase St Margaret's Health-Peru (f/k/a Illinois Valley Community Hospital) located at 925 West Street, Peru, Illinois. The Applicants are OSF Healthcare System, Ottawa Regional Hospital and Healthcare Center dba OSF Saint Elizabeth Medical Center and St. Margaret's Health-Peru. This change of ownership is considered a purchase resulting in the issuance of a license to an entity different from the current licensee. The fair market value of the purchase is \$38 million and includes the hospital campus and personal property belonging to St. Margaret's Health-Peru as well as various off-campus real properties owned by St. Margaret's Health-Peru. The estimated completion date is August 31, 2023.

II. Transaction

According to the Applicants OSF Healthcare System intends for Ottawa Regional Hospital and Healthcare Center to purchase the St Margaret's Health-Peru campus in Peru, Illinois, along with select other real property assets owned by St. Margaret's Health-Peru. Upon approval of the transaction, Ottawa Regional Hospital and Healthcare Center will re-open the temporarily closed St. Margaret's Health-Peru hospital facility as soon as possible to provide service to residents served by St Margaret's Health-Peru. OSF Healthcare System intends to operate this facility in Peru as a second campus under a multi-campus hospital license that needs approval from the Illinois Department of Public Health under the Illinois Hospital Licensing Act. The hospital will be operated by OSF and Ottawa Regional Hospital and Healthcare Center under the name of OSF Healthcare Saint Elizabeth Medical Center as a second campus located in Peru.

Ottawa Regional Hospital & Healthcare Center will become the 100% owner of the Peru hospital campus. OSF Healthcare System is the sole corporate member of Ottawa Regional Hospital & Healthcare Center, and The Sisters of the Third Order of Saint Francis is the sole corporate member and operator of OSF Healthcare System.

The Applicants state St. Margaret's Health-Peru's existing charity care policies will be replaced by OSF's Charity Assistance Policy for Illinois Hospitals, which not only complies with, but exceeds the requirements of Illinois law. including the Illinois Hospital Uninsured Patient Discount Act. Those policies are included at the end of this report.

The Applicants state OSF Healthcare System will not adopt a more restrictive charity care policy than was in effect one year prior to the Closing Date of the proposed transaction. The OSF Charity Assistance Policy for Illinois Hospitals will remain in effect for at least a two (2) year period following the Closing Date. According to the Applicants the OSF Charity Assistance Policy for Illinois Hospitals is the same or more generous than the current St. Margaret's Health-Peru Charity Care Program.

The Applicants state as a second campus of OSF Saint Elizabeth Medical Center, the services will initially include Basic Emergency Department services, and limited Inpatient Medical/Surgical beds and supportive diagnostic services. According to the Applicants over the next 24 months OSF Saint Elizabeth Medical Center will be developing a comprehensive plan to determine the inpatient and outpatient services that will be provided on each campus. According to the Applicants, any waivers of existing categories of service provided will be sought and consultation required from, IDPH and HFSRB. The Applicants state future services may include inpatient ICU and Obstetric-Gynecological beds in addition to expanded Medical Surgical beds.

III. Applicants

OSF Healthcare System is an Illinois not-for-profit corporation incorporated in 1880 as The Sisters of the Third Order of St. Francis. The OSF Healthcare System maintains ownership of 14 hospitals and one freestanding emergency center in Illinois:

- OSF Healthcare Holy Family Medical Center, Monmouth
- OSF Healthcare Saint Francis Medical Center, Peoria
- OSF Healthcare Saint Anthony's Medical Center, Alton
- OSF Healthcare Saint James-John Albrecht Medical Center, Pontiac
- OSF Healthcare Saint Joseph Medical Center, Bloomington
- OSF Healthcare Saint Anthony Medical Center, Rockford
- OSF Healthcare Saint Luke Medical Center, Kewanee
- OSF Healthcare Saint Elizabeth Medical Center, Ottawa
- OSF Healthcare Saint Mary Medical Center, Galesburg
- OSF Healthcare Saint Paul Medical Center, Mendota
- OSF Healthcare Sacred Heart Medical Center, Danville
- OSF Healthcare Heart of Mary Medical Center, Urbana
- OSF Healthcare Little Company of Mary Medical Center, Evergreen Park
- OSF Saint Clare Medical Center, Princeton
- OSF Saint Elizabeth Medical Center Freestanding Emergency Ctr., Streator

Table One includes audited information for OSF Healthcare System for the FY 2022 and FY 2021.

TABLE ONE OSF Healthcare System FY 2021- FY 2022 Audited Information (In thousands)		
	2022	2021
Cash	\$261,428	\$516,712
Current Assets	\$958,453	\$1,223,193
Total Assets	\$5,615,062	\$6,471,382
Current Liabilities	\$754,981	\$1,128,328
Total Liabilities	\$3,265,677	\$3,674,609
Patient Revenue	\$3,586,931	\$3,439,728
Total Revenue	\$3,824,172	\$3,683,074
Operating Expenses	\$3,939,161	\$3,572,644
(Loss) Income from Operations	(\$114,989)	\$110,430
Nonoperating (losses) gains	(\$505,432)	\$386,795
Net (loss) income	(\$630,421)	\$497,225
Source: OSF Audited Financial Statements		

Ottawa Regional Hospital and Healthcare Center dba OSF Saint Elizabeth Medical Center is a 97-bed acute care hospital and is a wholly owned subsidiary of OSF Healthcare System. The Ottawa Hospital provides comprehensive emergency service and no cardiac catheterization services. The Hospital provides inpatient medical surgical, intensive care, OB/GYN and AMI services in Ottawa. In 2021 the Ottawa Hospital payor mix was 43% Medicare and 24% Medicaid and 98% of their patients were outpatients.

TABLE TWO OSF Saint Elizabeth Medical Center Average Daily Census by Bed Category 2017-2021								
	Beds	2017	2018	2019	2020	2021	Ave	Occ
Medical Surgical	54	22.9	23.6	22	21.6	23	22.62	41.89%
Intensive Care	5	2.7	3.3	2.7	3.3	3.5	3.10	62.00%
OB/GYN	12	3.2	2.9	3	2.9	3.1	3.02	25.17%
AMI	26	16.7	15.2	15.5	14.2	11.2	14.56	56.00%
Total	97						43.30	44.64%
Source: https://hfsrb.illinois.gov/inventoriesdata/facilityprofiles.html								
-Hospital Profiles								

TABLE THREE OSF Saint Elizabeth Medical Center Number of Patients by Payor Source 2021 Payor Mix							
Payor Source	Medicare	Medicaid	Other Public	Private Ins	Private Pay	Charity	Total
Inpatient	1,690	926	40	673	23	64	3,416
Outpatient	68,361	38,114	974	50,936	1,400	1,846	161,631
Total	70,051	39,040	1,014	51,609	1,423	1,910	165,047
% Of Total	42.44%	23.65%	0.61%	31.27%	0.86%	1.16%	100.00%
Source: https://hfsrb.illinois.gov/inventoriesdata/facilityprofiles.html -Hospital Profiles							

TABLE FOUR OSF Saint Elizabeth Medical Center Medicare Cost Report FY 2017-FY2021					
	2017	2018	2019	2020	2021
Total Patient Revenue	\$398,199,163	\$442,811,475	\$453,306,724	\$431,222,862	\$464,256,951
Less Cont. All	\$294,213,178	\$333,763,444	\$342,381,786	\$324,288,319	\$330,809,182
Net Patient Revenue	\$103,985,985	\$109,048,031	\$110,924,935	\$106,934,543	\$133,447,769
Operating Expense	\$98,921,502	\$104,746,834	\$105,012,749	\$107,830,898	\$110,915,924
Income from Patient Service	\$5,064,483	\$4,301,197	\$5,912,186	-\$896,355	\$22,531,845
Other Income	\$1,273,891	\$2,178,622	\$3,089,386	\$12,160,764	\$11,642,135
Income	\$6,338,374	\$6,479,819	\$9,001,572	\$11,264,409	\$34,173,980
Source: Medicare Cost Reports: https://hfs.illinois.gov/medicalproviders/costreports.html					

St. Margaret's Health – Peru is a 49-bed acute care hospital and is the current licensee and the owner of the site. The Hospital provides basic emergency service and no cardiac catheterization services. In 2021, the Hospital's payor mix was 36% Medicare and 8% Medicaid with 99% of their patient's outpatients. For the period 2017-2021 the Hospital inpatient utilization was 44.5%.

TABLE FIVE St Margaret's Health – Peru Average Daily Census by Bed Category 2017-2021								
	Beds	2017	2018	2019	2020	2021	Ave	Occ
Medical Surgical	38	19	18.3	17.4	14.4	15.5	16.92	44.53%
Intensive Care	4	2.2	2.3	2.5	2.7	2.9	2.52	63.00%
OB/GYN	7	2.7	2.5	2.6	2.2	1.9	2.38	34.00%
Total	49	23.9	23.1	22.5	19.3	20.3	21.8	44.5%
Source: https://hfsrb.illinois.gov/inventoriesdata/facilityprofiles.html -Hospital Profiles Hospital Annual Questionnaires								

TABLE SIX St Margaret's Health – Peru Number of Patients by Payor Mix 2021 Payor Mix							
Payor Source	Medicare	Medicaid	Other Public	Private Ins	Private Pay	Charity	Total
Inpatient	986	345	22	382	38	23	1,796
Outpatient	46,183	9,950	379	63,391	8,636	223	128,762
Total	47,169	10,295	401	63,773	8,674	246	130,558
% Of Total	36.13%	7.89%	0.31%	48.85%	6.64%	0.19%	100.00%
Source: https://hfsrb.illinois.gov/inventoriesdata/facilityprofiles.html -Hospital Profiles							

TABLE SEVEN St Margaret's Health-Peru Medicare Cost Report Profit/Loss					
Year	2017	2018	2019	2020	2021
Total Patient Revenue	\$264,234,592	\$258,586,191	\$257,568,264	\$230,282,447	\$60,553,232
Less Cont. All	\$183,391,750	\$175,728,782	\$177,322,397	\$161,147,673	\$42,338,364
Net Patient Revenue	\$80,842,742	\$82,857,409	\$80,245,867	\$69,134,774	\$18,214,868
Operating Expense	\$83,327,743	\$89,297,666	\$86,576,021	\$80,088,253	\$23,140,576
Patient Service Inc. (Loss)	-\$2,484,901	-\$6,440,257	-\$6,330,154	-\$11,953,479	-\$4,925,708
Other Income	\$948,699	\$4,152,823	\$1,436,814	\$11,103,217	\$2,818,804
Loss	-\$1,536,196	-\$2,287,434	-\$4,893,340	-\$766,172	-\$2,106,904
Source: Medicare Cost Reports: https://hfs.illinois.gov/medicalproviders/costreports.html					

IV. **Health Service Area**

St. Margaret's Health-Peru is located in the HSA II Health Service Area and the C-02 Hospital Planning Area. There are five hospitals in the C-02 Hospital Planning Area.

TABLE EIGHT Hospitals in the C-02 Hospital Planning Area		
Facility	City	Beds
OSF Saint Claire Medical Center	Princeton	25
OSF Saint Elizabeth Medical Center	Ottawa	97
OSF St. Paul Medical Center	Mendota	25
St Margaret's Health - Peru	Peru	49
St. Margaret's Health - Spring Valley ⁽¹⁾	Spring Valley	34
1. St. Margaret's Health-Spring Valley has submitted an Application for Permit to discontinue the Hospital in Spring Valley (Project #23-031).		

V. Applicable Rules

Section 1130.500 - General Requirements for Exemptions

Only those projects specified in Section 1130.410 are eligible for exemption from permit requirements. Persons that have initiated or completed such projects without obtaining an exemption are in violation of the provisions of the Act and are subject to the penalties and sanctions of the Act and Section 1130.790.

a) Application for Exemption

Any persons proposing a project for an exemption to permit requirements shall submit to HFSRB an application for exemption containing the information required by this Subpart, submit an application fee (if required), and receive approval from HFSRB.

b) General Information Requirements

The application for exemption shall include the following information and any additional information specified in this Subpart:

- 1) the name and address of the applicant or applicants (see Section 1130.220).
- 2) the name and address of the health care facility.
- 3) a description of the project, e.g., change of ownership, discontinuation, increase in dialysis stations.
- 4) documentation from the Illinois Secretary of State that the applicant is registered to conduct business in Illinois and is in good standing or, if the applicant is not required to be registered to conduct business in Illinois, evidence of authorization to conduct business in other states.
- 5) a description of the applicant's organization structure, including a listing of controlling or subsidiary persons.
- 6) the estimated project cost, including the fair market value of any component and the sources and uses of funds.
- 7) the anticipated project completion date.
- 8) verification that the applicant has fulfilled all compliance requirements with all existing permits that have been approved by HFSRB; and
- 9) the application-processing fee.

HFSRB NOTE: If a person or project cannot meet the requirements of an exemption, then an application for permit may be filed.

Section 1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

a) Submission of Application for Exemption

Prior to acquiring or entering a contract to acquire an existing health care facility, a person shall apply for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

b) Application for Exemption

The application for exemption is subject to approval under Section 1130.560 and shall include the information required by Section 1130.500 and the following information:

1) *Key terms of the transaction*, including the:

A) *names of the parties.*

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;

C) *structure of the transaction.*

D) *name of the person who will be the licensed or certified entity after the transaction.*

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.

F) *fair market value of assets to be transferred; and*

- G) *the purchase price or other forms of consideration to be provided for those assets.* [20 ILCS 3960/8.5(a)]

HFSRB NOTE: If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

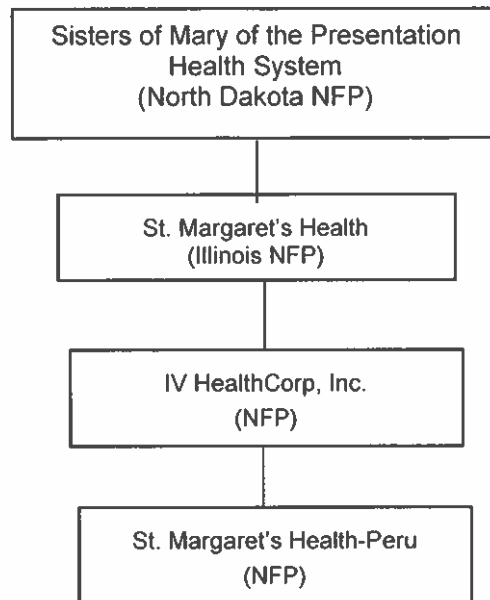
- 2) affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.
 - 3) if the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy 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.
 - 4) a statement as to the anticipated benefits of the proposed changes in ownership to the community.
 - 5) the anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership.
 - 6) a description of the facility's quality improvement program mechanism that will be utilized to assure quality control
 - 7) a description of the selection process that the acquiring entity will use to select the facility's governing body.
 - 8) a statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility; and
 - 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.
- c) Application for Exemption Among Related Persons

When a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall apply consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership. [20 ILCS 3960/8.5(a)]

- d) Opportunity for Public Hearing

Upon a finding by HFSRB staff that an application for a change of ownership is complete, the State Board staff shall publish a legal notice on one day in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published daily, the additional legal notice shall be published on one day. The applicant shall pay the cost incurred by the Board in publishing the change of ownership notice in the newspaper as required under this subsection. The legal notice shall also be posted on Health Facilities and Services Review Board web site and sent to the State Representative and State Senator of the district in which the health care facility is located. [20 ILCS 3960/8.5(a)] This legal notice shall provide the following:

- 1) Name of applicants and addresses.
 - 2) Name of facility and address.
 - 3) Description of the proposed project and estimated total cost.
 - 4) Notice of request for public hearing.
 - 5) Notice of tentative HFSRB meeting and location; and
 - 6) Notice of tentative release of the State Board Staff Report and the time to comment on the State Board Staff Report. See HFSRB website (www.hfsrb.illinois.gov).
- e) Completion of Projects with Outstanding Permits
- 1) A permit or exemption cannot be transferred.
 - 2) *In connection with a change of ownership, the State Board may approve the transfer of an existing permit without regard to whether the permit to be transferred has yet been obligated, except for permits establishing a new facility or a new category of service. (see 20 ILCS 3960/6(b))*
 - 3) If the requirements of this subsection (e) are not met, any outstanding permit will be considered a transfer of the permit and results in the permit being null and void.

Organizational Chart – Pre CHOW



Financial Assistance (AC-29)

DEFINITIONS:

1. **Amount Generally Billed (AGB)** - The amount generally billed is the expected payment for emergency or medically necessary services from Patients, and/or a Patient's Guarantor. For qualifying Patients, this amount does not exceed a rate that will be determined utilizing a Look Back Method described in §1.501(r)-5(b) (3) of the Internal Revenue Code. The Look Back Method is based on actual past claims paid to OSF by Medicare Fee-for-Service together with all Private Health Insurers paying claims. The claims included in the AGB calculation are claims allowed during the prior calendar year. The amounts for co-insurance, co-payments and deductibles are included in the numerator along with the Medicare Fee-for-Service together with all allowed claims from private health insurers. The Gross Charges for said claims are included in the denominator. The AGB is calculated annually by the 45th day following the close of the prior calendar year, and implemented by the 120th day following the close of the calendar year.
2. **Amount Generally Billed (AGB) Percentage** - The AGB percentage is calculated each calendar year by the 45th day of the year, and is described in Appendix 3 of this policy.
3. **Application Period** - The period during which applications are accepted and processed for Financial Assistance. The Application Period begins on the date the care is provided and ends on the 240th day after the date that the first post-service billing statement is provided.
4. **Cost-to-Charge Ratio** – The ratio of OSF's cost to its charges taken from its most recently filed Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios.)
5. **Eligible Services** - Services eligible under this Financial Assistance Policy are clinically appropriate and within generally accepted medical practice standards. They include the following services provided and/or billed by OSF:
 - a. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a Patient's condition.
 - b. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.
 - c. Medically Necessary services as defined by Medicare.
6. **Emergency Medical Condition** - As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - b. Serious impairment to bodily functions, or

c. Serious dysfunction of any bodily organ or part; or

d. With respect to a pregnant woman who is having contractions:

i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or

ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

7. **Family** - As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a Patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

8. **Family Income** - An applicant's Family Income is the sum of annual earnings and cash benefits from all sources before taxes, less payments made for child support, for all adult family members living in the household and included on the most recent federal tax return. Federal Poverty Level (FPL) - The FPL uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

9. **Guarantor** - An individual other than the Patient who is responsible for payment of the Patient's bill.

10. **Gross Charges** - OSF full established price for medical services that is consistently and uniformly charged to all Patients before applying any contractual allowances, discounts, or Financial Assistance.

11. **Homeless** - As defined by the Federal government, and published in the Federal Register on December 5, 2011 by HUD: An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

12. Ineligible Services

a. Elective procedures not Medically Necessary, as well as services typically not covered by Medicare or defined by Medicare or other health insurance coverage as not medically necessary including but not limited to: Lasik Surgery, Chiropractic Care, Fertility Services, Contacts/Glasses, Cosmetic Surgery/Plastic Services, Hearing Aides, Orthodontics, Dental Services, Optometry;

b. Services received from care providers not billed by OSF (e.g. private and/or non – OSF medical or physician professionals, ambulance transport, etc.) Patients are encouraged to contact these providers directly to inquire into any available assistance and to make payment arrangements. See Appendix 2 for full listing of providers not covered under this policy;

c. Services provided to insured Patients, including Underinsured Patients, who are out-of-network (meaning the provider or facility providing care is not an in-network provider or have a negotiated contract with the Patient's health insurance plan).

13. **Medically Necessary** - As defined by Medicare, services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

14. **Medicare Fee-For-Service (FFS)** - Health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 USC 1395c – 1395w-5).
15. **Patient Balance Due** – The amount a Patient or the Patient's Guarantor is personally responsible for paying, after all deductions, insurance reimbursements, and Uninsured Discount (as defined below) have been applied.
16. **Payment Plan** - A Payment Plan that is agreed to by both OSF and a Patient, or Patient's Guarantor, for out-of-pocket expenses. The Payment Plan shall take into account the Patient's financial circumstances, the amount owed, and any prior payments.
17. **Presumptive** - Under certain circumstances, Uninsured Patients may be presumed or deemed eligible for Financial Assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the Patient, to make an individual assessment of financial need.
18. **Private Health Insurer** - Any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.
19. **Qualification Period** - Applicants determined eligible for Financial Assistance will be granted assistance for a period of twelve months. Assistance will also be applied retroactively to all eligible accounts incurred for services received during the application period.
20. **Uninsured Patient** - A Patient who is not covered in whole or in part under a policy of health insurance, including high deductible policies, and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program (including, without limitation, private health insurance, an ERISA plan, Medicare, Medicaid, or CHIP, or CHAMPUS), and whose injury, illness or treatment is not compensable for purposes of workers' compensation, automobile insurance, liability or other third party insurance, as determined by OSF based on documents and information provided by the Patient or obtained from other sources, for the payment of health care services provided by OSF.
21. **Underinsured Patient** - An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by OSF.

PURPOSE:

1. In the spirit of Christ and the example of Francis of Assisi, the Mission of OSF HealthCare (hereinafter collectively referred to as "OSF") is to serve persons with the greatest care and love in a community that celebrates the gift of life.
2. In service to this Mission, OSF is committed to providing emergency and medically necessary health care services to Patients regardless of their insurance status or ability to pay. This Financial Assistance Policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for care received from qualifying OSF providers.
3. Financial Assistance provided under this policy is done so with the expectation that Patients will cooperate with the policy's application procedures and those of public benefit or coverage programs that may be available to cover the cost of care. OSF will not discriminate on the basis of age, sex, race, religion, color, disability, sexual orientation, national origin, or immigration status when making Financial Assistance determinations.

POLICY:

OSF shall provide Financial Assistance and community services in the tradition of The Sisters of the Third Order of Saint Francis. All patients, regardless of ability to pay are eligible to apply for Financial Assistance for services provided at the OSF entities listed in Appendix 6.

PROCESS:

1. Financial Assistance will be extended to Uninsured and Underinsured Patients, or such Patient's Guarantor, who receive Eligible Services and meet specified criteria, as defined below. These criteria will assure that this Financial Assistance Policy is consistently applied across OSF and complies with any federal and state requirements. OSF reserves the right to revise, modify or change this policy as necessary or appropriate.
2. Financial Assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or Patient's Guarantors, choosing not to cooperate in applying for programs identified by OSF as possible sources of payment for care, may be denied Financial Assistance. Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.
3. Patients, or Patient's Guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial that was received within the previous six (6) months of applying for OSF Financial Assistance. Patients, or Patient's Guarantors, must cooperate with the application process outlined in this policy to obtain Financial Assistance.
4. OSF utilizes a third party to determine whether Uninsured Patients receiving care in its hospitals are eligible for Medicaid, and assist in the application for Medicaid. If the vendor review finds that the Patient or Patient's Guarantors are not eligible for Medicaid and documents same in the medical record, neither the Patient nor the Patient's Guarantor will be required to apply for Medicaid coverage.
5. The criteria to be considered by OSF when evaluating a Patient for Financial Assistance include Family Income, Family size, and medical cost obligations. OSF's Financial Assistance program is available to all Patients meeting the requirements set forth in this policy, regardless of geographic location or residency status. Financial Assistance will be extended to Patients, or a Patient's Guarantor, based on financial need and in compliance with federal and state laws.
6. Financial Assistance will be offered to eligible Underinsured Patients, providing such assistance is in accordance with OSF's contractual agreement with insurer. Financial Assistance is typically not available for Patient co-payment or balances after insurance in the event that a Patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Generally, out of network balances are reviewed on a case by case basis. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account, are expected to utilize account funds prior to being granted Financial Assistance. OSF reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of OSF.

FINANCIAL ASSISTANCE

Based on an assessment of an applicant's Family Income, family size, and medical obligations, eligible applicants may receive the following assistance.

Uninsured Discount: Uninsured Patients will be provided an Uninsured Discount, as described in Appendix 5, at the time that the undiscounted charges are rendered, and prior to when a Patient or Patient Guarantor is billed. In the event that insurance or other coverage, identified in the definition of Uninsured Patient, is subsequently discovered, the Uninsured Discount will be removed and full charges billed to that coverage as appropriate. Patients, or Patient Guarantors, granted the Uninsured Discount, are not precluded from applying and qualifying for additional Financial Assistance provided herein.

Free and Discounted Care: The full amount of OSF charges are determined covered under this Financial Assistance Policy for any Uninsured or Underinsured Patient, or such Patient's Guarantor, who's gross Family Income is at or below 250% of the current Federal Poverty Level. A sliding scale discount will be provided for OSF charges for services covered under this Financial Assistance Policy for any Uninsured or Underinsured Patient, or Patient Guarantor, who's gross Family Income is greater than 250% but less than or equal to 400% of the current Federal Poverty Level. Free or Discounted Care will be provided based on the Family Income of the Patient, or the Patient's Guarantor in accordance with the following schedule:

1. Family Income up to 250% FPL are eligible to receive a 100% discount on the Patient Balance Due;
2. Family Income of above 250% FPL but equal to or less than 300% FPL are eligible to receive a 75% discount on the Patient Balance Due;
3. Family Income of above 300% FPL but equal to or less than 350% FPL are eligible to receive a 50% discount on the Patient Balance Due;
4. Family Income of above 350% FPL but equal to or less than 400% FPL are eligible to receive a 25% discount on the Patient Balance Due

For Uninsured Patients with Family Income equal to or less than 600% of the Federal Poverty Level, OSF has compared the discounts scheduled above, together with the Uninsured Discount, to 135% of OSF's Cost-to-Charge Ratio and have applied the more generous discounts for Patients.

Catastrophic Care Assistance: Patients, or their Guarantors, may be eligible for Catastrophic Care Assistance if they have incurred out-of-pocket obligations – after all deductions, insurance reimbursements, and discounts (including discounts available under this Financial Assistance Policy) have been applied – resulting from Eligible Services provided by OSF that exceed 25% of Family Income

Patients, or Patient Guarantors, determined by OSF to be eligible for Catastrophic Care Assistance will have their OSF charges discounted to an amount not to exceed 25% of Family Income.

Payment Plans: Payment in full is expected for balances due upon receipt of initial Patient statement. If a Patient, or Guarantor cannot pay in full, a Payment Plan may be extended for any balance remaining after discounts have been granted to applicants eligible for Financial Assistance. A reasonable Payment Plan will be established between OSF and the Patient. The term of the Payment Plan will be based on the applicant's outstanding medical bills, Family Income, and any extenuating circumstances. If approved, the plan will be interest-free.

Patients are responsible for communicating with OSF anytime an agreed upon Payment Plan cannot be fulfilled. Lack of communication from the Patient may result in the account being assigned to a collection agency.

OSF reserves the right to reverse the Financial Assistance described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of OSF.

PRESUMPTIVE ELIGIBILITY

1. OSF understands that not all Patients are able to complete a Financial Assistance application or comply with requests for documentation. There may be instances under which a Patient's qualification for Financial Assistance is established without completing the formal Financial Assistance application. Other information may be utilized by OSF to determine whether a Patient's account is uncollectible and this information is used to determine Presumptive eligibility.
2. Presumptive eligibility may be granted to Patients based on their eligibility for other programs or life circumstances such as:
 - a. Patients or Guarantors who have declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off;
 - b. Patients or Guarantors who are deceased with no estate in probate;
 - c. Patients or Guarantors determined to be Homeless;
 - d. Patients or Guarantors who qualify for State Medicaid programs (including but not limited to WIC, SNAP) are eligible for assistance for any cost-sharing obligations associated with the program;
 - e. Patients who qualify for SisterCare or BrotherCare program
 - f. Accounts returned by the collection agency as uncollectible due to any of the above reasons;
 - g. Incarceration, when Eligible Services are provided but payment is not the responsibility of the jail or prison in which Patient is incarcerated;
 - h. Mental incapacitation with no one to act on the Patient's behalf
3. OSF understands that certain Patients may be non-responsive to OSF's application process. Under these circumstances, OSF may utilize other sources of information to make an individual assessment of financial need. This information will enable OSF to make an informed decision on the financial need of non-responsive Patients utilizing the best estimates available in the absence of information provided directly by the Patient.
4. OSF may utilize a third-party to conduct an electronic review of Patient information to assess financial need. This review will utilize a health care industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets, and liquidity. The electronic technology is designed to assess each Patient to the same standards and is calibrated against historical approvals for OSF Financial Assistance under the traditional application process.
5. The electronic technology, when utilized, will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows OSF to screen all Patients for Financial Assistance prior to pursuing any extraordinary collection actions (ECA) as described in OSF's Self-Pay Billing & Collection Policy. The data returned from this electronic review will constitute adequate documentation of financial need under this policy.
6. When electronic enrollment is used as the basis for Presumptive eligibility, the highest discount level will be granted for Eligible Services for retrospective dates of service only. If a Patient does not qualify under the electronic enrollment process, the Patient may still be considered under the traditional Financial Assistance application process. OSF will provide Patients not qualifying for Financial Assistance through this process with a written notice informing them that Financial Assistance is available. This notice will include a plain language summary of the Financial Assistance Policy and actions to be taken if an application is not submitted or the outstanding balance paid.

7. Patient accounts granted Presumptive eligibility will be reclassified under the Financial Assistance Policy. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their electronic qualification, and will not be included in the hospital's bad debt expense.

EMERGENCY MEDICAL SERVICES

In accordance with the FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, OSF shall provide, without discrimination, care for Emergency Medical Conditions to individuals regardless of whether they can pay for the care or are eligible for Financial Assistance. OSF shall not engage in actions that discourage individuals from seeking care for Emergency Medical Conditions, including, but not limited to, demanding payment or screening for Financial Assistance eligibility or payment information prior to receiving care for Emergency Medical Conditions. OSF may request that Patient cost-sharing payments (i.e. co-payments) be made at the time of service, provided such requests do not cause a delay or otherwise interfere with the provision, without discrimination, of care for Emergency Medical Conditions.

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

1. The amount generally billed (AGB) is the expected payment from Patients, or a Patient's Guarantor, eligible for Financial Assistance. For qualifying Underinsured and Uninsured Patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method. Financial Assistance eligible Patients may not be charged more than AGB for emergency or other Eligible Services.
2. The Look Back Method will be based on amounts allowed under Medicare Fee-For-Services together with all private health insurers paying claims to OSF. The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts for co-insurance, co-payments, and deductibles will be included in the numerator along with the Medicare Fee-For-Service together with all private health insurers paying claims. The Gross Charges for said claims are included in the denominator. The AGB will be calculated annually. The percentages will be applied by the 120th day after the end of the calendar year used by OSF to calculate the AGB percentage(s).
3. Patients determined eligible for Financial Assistance will not be expected to pay Gross Charges for Eligible Services while covered under OSF Financial Assistance Policy.

APPLYING FOR FINANCIAL ASSISTANCE

1. Eligibility for Financial Assistance will be based on financial need at the time of application. In general, documentation is required to support an application for Financial Assistance. If adequate documentation is not provided, OSF may seek additional information.
2. Reliable evidence to support the need for Financial Assistance is required.
3. One of the following is required from Patients, or their Guarantors, to determine eligibility based on Family Income:
 - a. Copy of the Federal tax return, and all attached Schedules, from the most recent tax year;
 - b. Most recent W2 or 1099;

- c. Current Proof of Income (copy of two most recent pay stubs) or written income verification from an employer if paid in cash;
 - d. Proof of other income, including unemployment, workers' compensation, alimony, trust income, veteran's benefits;
 - e. Current Bank Statements
4. If a Patient is not able to provide any of the documents listed above, OSF will work with the Patient to determine if there is another acceptable means of documenting Family Income.
5. Applications for Financial Assistance may be submitted up to 240 days after the date of the first post discharge statement. If an application is incomplete, or there has been a request for additional information, the application remains active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30 day time frame, the application will be denied unless the applicant satisfies one of the non-responsive categories identified above.
6. During the period in which the fully completed Financial Assistance Application (FAA) is being reviewed, there will be a stay of all collection proceedings. The FAA will be documented in the Patient record or scanned and the account will be noted. The normal billing process is to continue while the FAA is reviewed and considered. If a complete, conforming FAA is approved by the appropriate OSF Mission Partner, this will be noted in the Patient's file and the account balance is adjusted off to the appropriate code. Financial Assistance applications are submitted in the following ways:
- a. By Mail to: OSF HealthCare
Patient Financial Services
PO Box 1701
Peoria, IL 61656-1701
 - b. On line at: OSFHealthCare.org/billing/financial-assistance/
 - c. By Fax: (309) 308-3963
7. If denied Financial Assistance, the Patient or Patient's Guarantor, may re-apply at any time there has been a change in income or status.
8. Patients applying for Financial Assistance under this FAP are required to certify that all information provided by the Patient to OSF is true. If any of the information provided by the Patient is found to be untrue, any Financial Assistance granted to the Patient may be forfeited and the Patient may be responsible for payment of OSF's Gross Charges.
9. In addition, Patients shall communicate to OSF any material change in the Patient's financial situation that occurs during the Qualification Period that may affect Financial Assistance determination within thirty (30) days of the change. Patient's failure to disclose a material improvement in Family Income may void any provision of Financial Assistance by OSF after the material improvement occurs.

DETERMINATIONS, APPEALS, AND DISPUTE RESOLUTION

1. Patients must be notified of the decision in writing regarding their FAP within thirty (30) days of submitting a completed application. An applicant determined eligible for Financial Assistance will be refunded payments in excess of the amount determined owed by the Patient or Guarantor on the accounts for which they are granted assistance under this Financial Assistance Policy. Refunds apply to excess payments of \$5 or more. In accordance with this policy, Financial Assistance is generally not

extended for co-payments or balances after insurance when a Patient fails to obtain proper referrals or authorizations, or if such assistance is not in accordance with insurer's contractual agreement, therefore such payments received will not be refunded.

2. Patients may appeal this decision in writing within 30 days of receiving notification to:
OSF HealthCare
Patient Financial Services
PO Box 1701
Peoria, IL 61656-1701
3. Appeals must be filed within 30 days of the date of the original decision. The Senior Vice President or designee of Revenue Cycle will review the appeal for further consideration. Decisions of the Senior Vice President or designee will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, OSF will grant Financial Assistance for a period of 12 months from application date. Financial Assistance will also be applied retroactively to all unpaid bills for eligible accounts incurred for services received during the application period. No Patient shall be denied assistance based on failure to provide information or documentation not required in the application.

NOTIFICATION OF FINANCIAL ASSISTANCE

1. Information on the OSF Financial Assistance Policy and instructions on how to contact OSF for assistance and further information, as well as information on payment options, will be posted in hospital and clinic registration and admitting locations, and in the hospital emergency department. This information may also be obtained from financial navigators throughout the organization.
2. The OSF Financial Assistance Policy, application, and a plain language summary of the policy will be available on the system's website at <https://www.osfhealthcare.org/billing/financial-assistance/>. This information is also available, free of charge, by calling (800) 421-5700. If you need help in completing the Financial Assistance application, you may call (800) 421-5700 to speak with a financial navigator.
3. Information on the OSF Financial Assistance Policy will be communicated to Patients in culturally appropriate language. Information on Financial Assistance, and the notice posted in hospital and clinic locations, will be translated and in any language that is the primary language spoken by the lessor of 1,000 or 5% of the residents in the service area.
4. In addition, OSF includes reference to payment policies and Financial Assistance on all printed OSF monthly Patient statements and collection letters. Information on the OSF Financial Assistance Policy is available, at any time, upon Patient request.

NONPAYMENT OF SELF PAY BALANCES

The OSF Self-Pay Billing & Collection Policy describes the actions OSF may take in the event of nonpayment of self-pay balances. Patients or their Guarantors may obtain a copy of the OSF Self-Pay Billing & Collection Policy on its website at: <https://www.osfhealthcare.org/billing/>

REGULATORY REQUIREMENTS

OSF will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that OSF track Financial

Assistance provided to ensure accurate reporting. Information on Financial Assistance provided under this policy will be reported as required annually on the IRS Form 990 Schedule H, the Hospital Financial Assistance Report with the Office of the Illinois Attorney General at the same time as each hospital files its Community Benefits Report, and the Community Benefit Report with the Michigan Attorney General.

RECORD KEEPING

OSF will document all Financial Assistance in order to maintain proper controls and meet all internal and external compliance requirements.