#E-047-21

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:	Hoffman Estates Surgery Center		
Street Address:	1555 Barrington Road Doctors Building 3 Suite 400		
City and Zip Code:	Hoffman Estates, IL 60169		
County: Cook	Health Service Area: VII	Health Planning Area: 031	

Legislators

State Senator Name:	Cristina Castro
State Representative Name:	Fred Crespo

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

Exact Legal Name:	Hoffman Estates Surgery Center, LLC
Street Address:	1555 Barrington Road Doctors Building 3 Suite 400
City and Zip Code:	Hoffman Estates, IL 60169
Name of Registered Agent:	Illinois Corp Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Polly Davenport, Manager
CEO Street Address:	1555 Barrington Road
CEO City and Zip Code:	Hoffman Estates, IL 60169
CEO Telephone Number:	847/519-1600

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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:	Hoffman Estates Surgery Center	
Street Address:	1555 Barrington Road Doctors Building 3 Suite 400	
City and Zip Code:	Hoffman Estates, IL 60169	
County: Cook	Health Service Area: VII	Health Planning Area: 031

Legislators

State Senator Name:	Cristina Castro
State Representative Name:	Fred Crespo

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

Exact Legal Name:	St. Alexius Medical Center
Street Address:	1555 North Barrington Road
City and Zip Code:	Hoffman Estates, IL 60169
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:	Ms. Polly Davenport
CEO Street Address:	1555 North Barrington Road
CEO City and Zip Code:	Hoffman Estates, IL 60169
CEO Telephone Number:	847/843-2000

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- 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:	

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:	Hoffman Estates Surgery Center	
Street Address:	1555 Barrington Road Doctors Building 3 Suite 400	
City and Zip Code:	Hoffman Estates, IL 60169	
County: Cook	Health Service Area: VII	Health Planning Area: 031

Legislators

State Senator Name:	Cristina Castro
State Representative Name:	Fred Crespo

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

- 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.

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:	

Post Exemption Contact

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

Name:	Annamarie C. York
Title:	Executive Director
Company Name:	Hoffman Estates Surgery Center, LLC
Address:	1555 Barrington Road Doctors Building 3 Suite 400Hoffman Estates, IL 60169
Telephone Number:	847/519-1600
E-mail Address:	acyork@hesc1555.com
Fax Number:	

Site Ownership after the Project is Complete

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Healthcare Realty
Address of Site Owner:	3000 N. Halstead Street Suite 725 Chicago, IL

Street Address or Legal Description of the Site: 1555 Barrington Road Hoffman Estates, IL 60169

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:	Hoffman Estates Surgery Center, LLC
Address:	1555 Barrington Road Doctors Building 3 Suite 400Hoffman Estates, IL 60169

☐	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:	Hoffman Estates Surgery Center, LLC
Address:	1555 Barrington Road Hoffman Estates, IL 60169

☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
X	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.

Hoffman Estates Surgery Center ("HESC") is an IDPH-licensed ambulatory surgical treatment center ("ASTC") located in a medical office building on the campus of AMITA Health St. Alexius Medical Center in Hoffman Estates ("SAMC"). HESC has been in operation since 2005, has four operating rooms and two procedure rooms, and is approved for the provision of ten surgical specialties.

The ASTC's licensee is Hoffman Estates Surgery Center, LLC, 60% of which is owned by physicians ("Current Physician Owners"), and 40% of which is owned by SAMC. Through the proposed transaction and change of ownership and control, SAMC will acquire the Current Physician Owners' 60% interest, thereby securing "control" of the ASTC. The Current Physician Owners are not being required to liquidate their holdings; transfer of the Current Physician Owners' ownership interest is completely voluntary. Following the close of the proposed transaction to acquire the Current Physicians Owners' ownership interest, SAMC intends to make up to 49% of the ownership interest in the ASTC available for acquisition by new qualified physicians.

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): __December 31, 2021_____

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 _Hoffman Estates Surgery Center, 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.

Mark A. Rosanova

SIGNATURE

MARK A. Rosanova, MD

PRINTED NAME

President, Medical Director, Member, LLC

PRINTED TITLE

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

Signature of Notary

Seal

N Ansari

SIGNATURE

Naveed Ansari

PRINTED NAME

Board Member, Member, LLC

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

Matthew Jagger
SIGNATURE

Matthew Jagger
PRINTED NAME

Treasurer
PRINTED TITLE

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

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

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 _St. Alexius Medical Center_ in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Keith Parrott

PRINTED NAME

President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6 day of October, 2021

Signature of Notary

Seal

OFFICIAL SEAL
MELISSA KULIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/13/22

SIGNATURE

Earl J. Barnes II

PRINTED NAME

Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6 day of October, 2021

Signature of Notary

Seal

OFFICIAL SEAL
MELISSA KULIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/13/22

*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.
- X Stock transfer resulting in no change from current licensee.
- ☐ Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee.
- ☐ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee.
- ☐ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity.
- ☐ Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets.
- ☐ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility.
- ☐ Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee.
- ☐ Change of ownership among related persons resulting in a license being issued to an entity different from the current licensee
- ☐ Change of ownership among related persons that does not result in a license being issued to an entity different from the current licensee.
- ☐ Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets and explain in "Narrative Description."

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

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

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

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(3) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(4) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(5) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

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

SECTION IV.CHARITY CARE INFORMATION

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

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

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

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

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

CHARITY CARE			
	Year 2018	**Year 2019**	**Year 2020**
Net Patient Revenue	**9,360,768**	**7,339,648**	**12,023,126**
Amount of Charity Care (charges)	4,982	72,529	4,046
Cost of Charity Care	500	1,750	315

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

#E-047-21

File Number 0106065-1

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOFFMAN ESTATES SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 02, 2003, 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* 27TH *day of* JULY *A.D.* 2021 .

Authentication #: 2120802626 verifiable until 07/27/2022
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

#E-047-21

File Number 6009-640-6

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

ST. ALEXIUS MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 21, 1998, 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* 4TH *day of* AUGUST *A.D.* 2021 .

Authentication #: 2121603340 verifiable until 08/04/2022

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

#E-047-21

File Number 6783-860-2

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

ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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 26TH ***day of*** AUGUST ***A.D.*** 2020 .

ATTACHMENT 1

Authentication #: 2023602944 verifiable until 08/26/2021

Jesse White

SITE OWNERSHIP

With the signatures provided on the Certification pages of this Certificate of Exemption ("COE") application, the applicants attest that the site of Hoffman estates Surgery Center, is owned by Healthcare Realty.

#E-047-21

File Number 0106065-1

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOFFMAN ESTATES SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 02, 2003, 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.

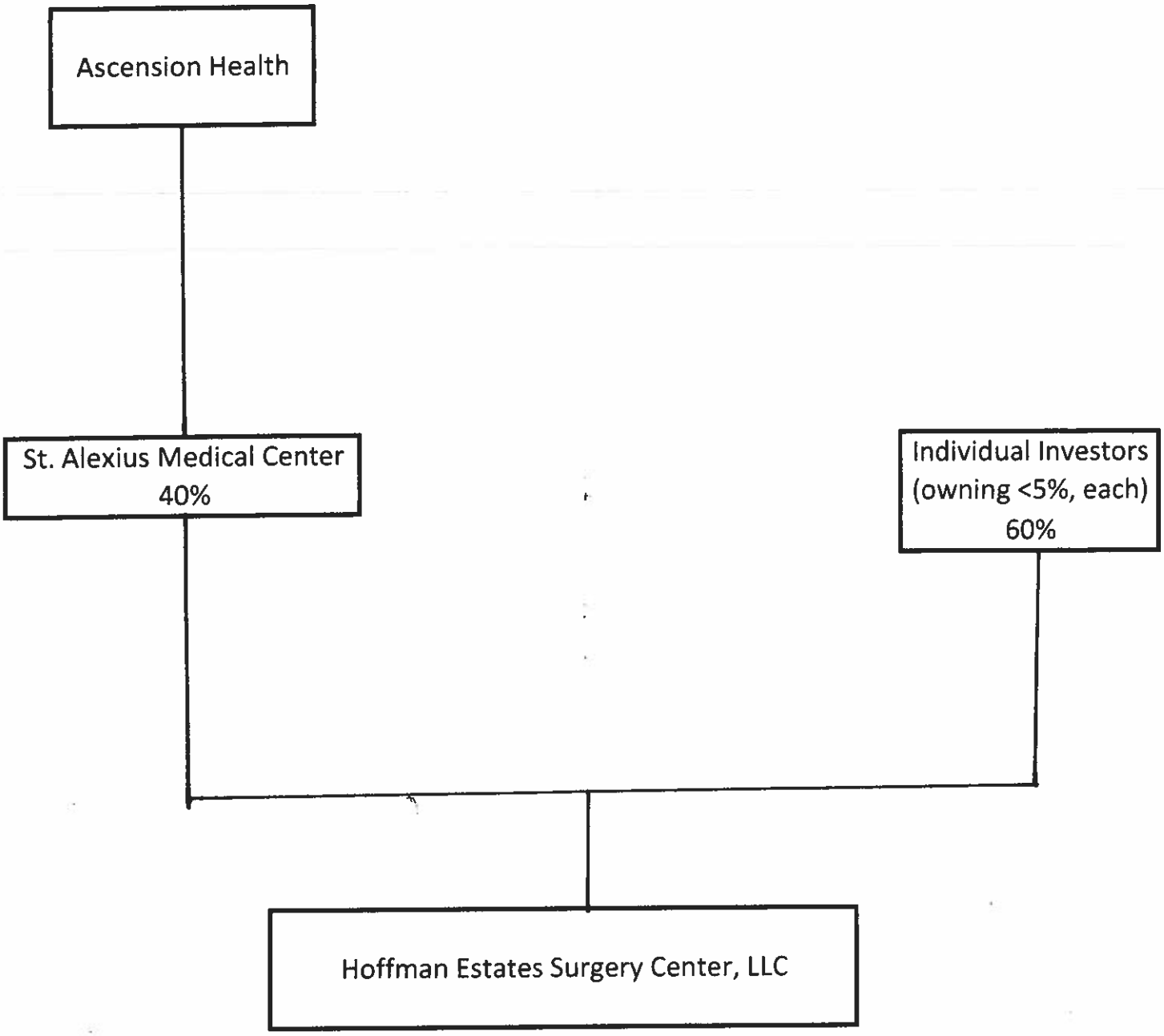
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 27TH *day of* JULY *A.D.* 2021 .

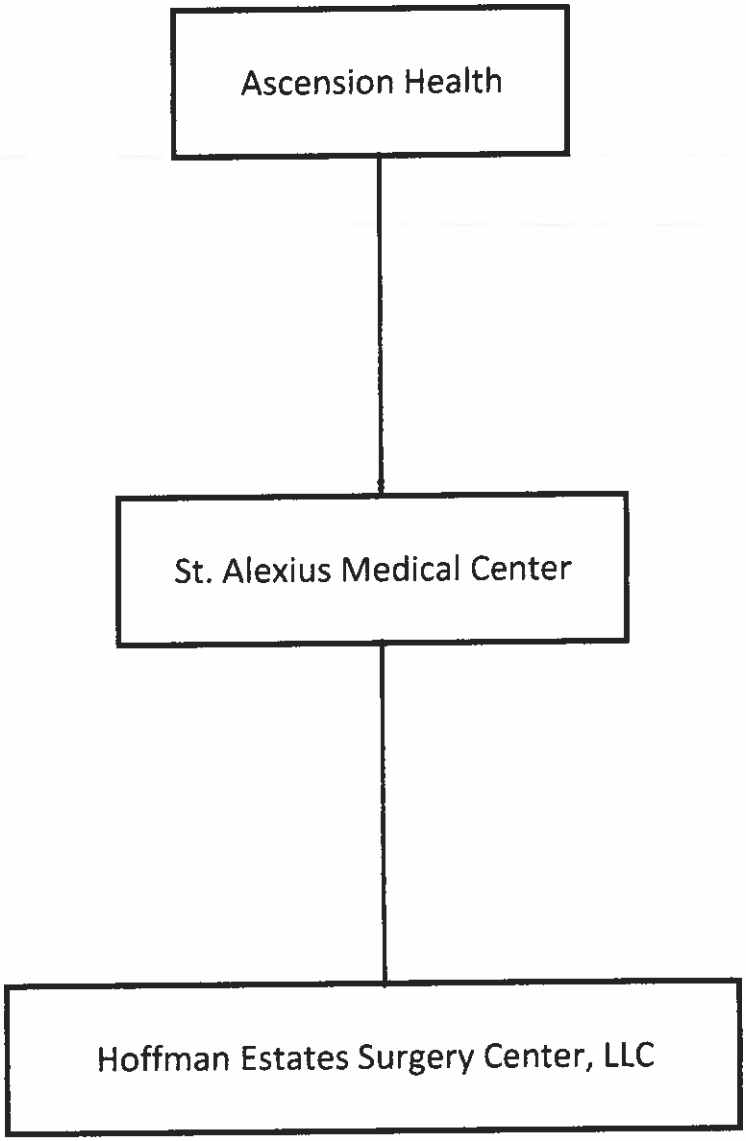
Authentication #: 2120802626 verifiable until 07/27/2022
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment 3


Ascension Health
St. Alexius Medical Center
40%
Individual Investors
(owning <5%, each)
60%
Hoffman Estates Surgery Center, LLC


Ascension Health
St. Alexius Medical Center
Hoffman Estates Surgery Center, LLC

BACKGROUND

Attached are a photocopy of Hoffman estates Surgery Center's IDPH license and confirmation of the ASTC's accreditation.

Applicant Ascension Health owns, operates and/or controls the following Illinois licensed acute health care facilities:

AMITA Health Adventist Medical Center Bolingbrook
Bolingbrook, IL IDPH #5496

AMITA Health Adventist Medical Center GlenOaks
Glendale Heights, IL IDPH #3814

AMITA Health Adventist Medical Center Hinsdale
Hinsdale, IL IDPH #0976

AMITA Health Adventist Medical Center La Grange
La Grange, IL IDPH #5967

AMITA Health Alexian Brothers Medical Center Elk Grove Village
Elk Grove Village, IL IDPH #2238

AMITA Health St. Alexius Medical Center Hoffman Estates
Hoffman Estates, IL IDPH #5009

AMITA Health Alexian Brothers Behavioral Health Hospital
Hoffman Estates, IL

AMITA Health Holy Family Medical Center Des Plaines
Des Plaines, IL

AMITA Health Resurrection Medical Center Chicago
Chicago, IL IDPH #6031

AMITA Health Saint Francis Hospital Evanston
Evanston, IL IDPH #5991

AMITA Health Saint Joseph Hospital Chicago
Chicago, IL IDPH #5983

AMITA Health Mercy Medical Center Aurora
Aurora, IL IDPH #4903

AMITA Health Saint Joseph Hospital Elgin
Elgin, IL IDPH #4887

AMITA Health Saint Joseph Medical Center Joliet
Joliet, IL IDPH #4838

AMITA Health St. Mary's Hospital Kankakee
Kankakee, IL IDPH #4879

AMITA Health Saint Elizabeth Hospital
Chicago, IL IDPH #6015

AMITA Health Saint Mary Hospital Chicago
Chicago, IL IDPH #6007

Lakeshore Gastroenterology
Des Plaines, IL

Belmont/Harlem Surgery Center
Chicago, IL IDPH #7003131

Lincoln Park Gastroenterology Center
Chicago, IL HFSRB Permit # 20-012

Additionally, Ascension Living, an affiliate of Ascension Health, operates and/or controls the following Illinois long term care facilities:

Presence Arthur Merkel and Clara Knipprath Nursing Home
Clifton, IL IDPH #21832

Presence Villa Scalabrini Nursing and Rehabilitation Center
Northlake, IL IDPH #44792

Presence Villa Franciscan
Joliet, IL IDPH# 42861

Presence Saint Joseph Center
Freeport, IL IDPH # 41871

Presence Saint Benedict Nursing and Rehabilitation Center
Niles, IL IDPH #44784

Presence Saint Anne Center
Rockford, IL IDPH #41731

Presence Resurrection Nursing and Rehabilitation Center
Park Ridge, IL IDPH #44362

Presence Resurrection Life Center
Chicago, IL IDPH #44354

Presence Our Lady of Victory Nursing Home
Bourbonnais, IL IDPH # 41723

Presence Nazarethville
Des Plaines, IL IDPH #54072

Presence McCauley Manor
Aurora, IL IDPH #42879

Presence Maryhaven Nursing Home and Rehabilitation Center
Glenview, IL IDPH #44768

Presence Heritage Village
Kankakee, IL IDPH #42457

Presence Cor Mariae Center
Rockford, IL IDPH #41046

With the signatures provided on the Certification pages of this Certificate of Exemption ("COE") 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 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.

#E-047-21

HF 122002

Illinois Department of PUBLIC HEALTH

DISPLAY THIS PART IN A CONSPICUOUS PLACE

ATTACHMENT 5

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/06/2022		7003122

Ambulatory Surgery Treatment Center

Effective: 02/07/2021

Hoffman Estates Surgery Center, LLC
1555 Barrington Road Suite 0400
Hoffman Estates, IL 60169

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

Exp. Date 02/06/2022

Lic Number 7003122

Date Printed 01/07/2021

Hoffman Estates Surgery Center, LLC

1555 Barrington Road Suite 400
Hoffman Estates, IL 60169-5040

FEE RECEIPT NO.

ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

ACCREDITATION NOTIFICATION

February 25, 2019

Organization #	75510		
Organization Name	Hoffman Estates Surgery Center, LLC		
Address	1555 Barrington Road DOB 3 Lower Level - Suite 0400		
City | State | Zip	Hoffman Estates	IL	60169
Decision Recipient	Dr. Ciro Cirrincione, MD		
Survey Date	2/7/2019-2/8/2019	**Type of Survey**	Re-Accreditation
Accreditation Type	Full Accreditation		
Accreditation Term Begins	3/17/2019	**Accreditation Term Expires**	3/16/2022
Accreditation Renewal Code		6A061F5175510	
Complimentary AAAHC Institute study participation code		75510FREEIQI	

As an ambulatory health care organization that has undergone the AAAHC Accreditation Survey, your organization has demonstrated its substantial compliance with AAAHC Standards. The AAAHC Accreditation Committee recommends your organization for accreditation.

Next Steps

1. Members of your organization should take time to thoroughly review your Survey Report.
   - Any standard rated less than "FC" (Fully Compliant) must be corrected promptly. Subsequent surveys by AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
   - The Summary Table provides an overview of compliance for each chapter applicable to your organization.
2. AAAHC Standards, policies and procedures are reviewed and revised annually. You are invited to participate in the review through the public comment process each fall. Your organization will be notified when the proposed changes are available for review. You may also check the AAAHC website in late summer for details.
3. Accredited organizations are required to maintain operations in compliance with the current AAAHC Standards and policies. Updates are published annually in the AAAHC *Handbooks*. Mid-year updates are announced and posted to the AAAHC website, www.aaahc.org.

ATTACHMENT 5

4. In order to ensure uninterrupted accreditation, your organization should submit the *Application for Survey* approximately five months prior to the expiration of your term of accreditation. In states for which accreditation is mandated by law, the *Application* should be submitted six months in advance to ensure adequate time for scoping and scheduling the survey.

   NOTE: You will need the Accreditation Renewal Code found in the table at the beginning of this document to submit your renewal application.

Additional Information

The complimentary AAAHC Institute study participation code on the first page of this document may be used to register for one six-month, AAAHC Institute for Quality Improvement benchmarking study. Please visit www.aaahc.org/institute for more information.

Throughout your term of accreditation, AAAHC will communicate announcements via e-mail to the primary contact for your organization. Please be sure to notify us (notifyeast@aaahc.org) should this individual or his/her contact information change.

If you have questions or comments about the accreditation process, please contact AAAHC Accreditation Services at 847.853.6060. We look forward to continuing to partner with you to deliver safe, high-quality health care.

REQUIREMENTS FOR EXEMPTIONS INVOLVING
THE CHANE 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:

Hoffman Estates Surgery Center, LLC, the current and proposed licensee
St. Alexius Medical Center which will control the licensee by virtue of its majority ownership interest in the licensee
Ascension Health, as the funding source and by virtue of its ultimate control over St. Alexius Medical Center.

Criterion 1130.520(b)(1)(B) Background of the parties
Provided in ATTACHMENT 1 are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 5 are:

1. A listing of each applicant's licensed health care facilities in Illinois, including an identification of each facility's licensee
2. The applicants' authorization permitting HFSRB, State Agency, and IDPH access to documents necessary to verify the information submitted
3. A statement addressing adverse actions.

Criterion 1130.520(b)(1)(C) Structure of transaction
Please see this application's Narrative Description.

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.

St. Alexius Medical Center ("SAMC") currently holds a 40% ownership interest in the licensee. The balance of the ownership interest in the licensee is currently held by 33 physicians ("Current Physician Owners"), with no individual physician holding in excess of a 3.0% ownership share. Through the proposed transaction and change of ownership and control, SAMC will acquire the Current Physician Owners' 60% interest, thereby securing "control" of the ASTC. The Current Physician Owners are not being required to liquidate their holdings; transfer of the Current Physician Owners' ownership interest is completely voluntary. Following the close of the proposed transaction to acquire the Current Physicians Owners' ownership interest, SAMC intends

to make up to 49% of the ownership interest in the ASTC available for acquisition by new qualified physicians.

Current and post-transactional organizational charts are provided in ATTACHMENT 4.

Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred
The purchase price was determined/validated by BDO USA, LLP, a valuation firm, engaged by the current members to identify the fair market value for the purposes of the proposed transaction.

Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets
The purchase price per 1% ownership unit was set by BDO USA, LLP at $114,037.

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.
By its respective signatures on the Certification Pages of this Certificate of Exemption application, the applicants affirm that the projects identified below will be completed in accordance with the provisions of Section 1130.

Permit 21-013	Major modernization project at AMITA Health Saint Alexius Center Medical Center, Hoffman Estates. Project was approved on June 16, 2021, and is on schedule,
Project 21-017	Major modernization project at AMITA Health Resurrection Medical Center, Chicago. Project was approved on September 1, 2021, and is on schedule.
Project 21-018	Major modernization project at AMITA Saint Mary Hospital, Chicago. Project was approved on September 13, 2021, and is on schedule.
Project 21-020	Major modernization project at AMITA Health Alexian Brothers Medical Center, Elk Grove Village. Project is currently under HFSRB review.
Project 21-023	Establishment of an infusion therapy center in Romeoville. Project is currently under HFSRB review.

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.

Not applicable.

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

The proposed change of ownership will not result in any changes apparent to the community. Therefore, and with no patient care-related changes anticipated as a result of the proposed transaction, no appreciable benefits or detriments to the community, are anticipated.

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

The ASTC operates with quality assurance and quality control programs and policies that are consistent with the recommendations and requirements of IDPH, and accreditation bodies. Copies of the quality control and quality assurance-related policies currently in place at the ASTC are provide in the APPENDIX to this application. Following the proposed transaction, the ASTC will continue to operate under the policies and procedures currently in place.

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

The governing Board members will be appointed by St. Alexius Medical Center and elected by the physician investors, with the number of members appointed by St. Alexius Medical Center exceeding the number elected by the physician investors by a minimum of one member.

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.

None are currently anticipated.

HESC QUALITY ASSURANCE PROGRAM

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

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

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

I. Goals

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

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

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

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

e. To assure complete and accurate medical record documentation.

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

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

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

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

APPENDIX

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

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

IV. Problem Identification: Identification of known or suspected problems in theCenter's delivery care is the foundation of the HESC Quality Assurance Program. Problems for study may be identified through, but not limited to, any of thefollowing means:

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

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

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

i. Quarterly Medication and controlled substance audits and chart reviews

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

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

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

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

Roles

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

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

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

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

a. Establish and enforce standards for professional work in the Center;
b. Review development and content of the written policies and procedures of the Center, the procedures for granting privileges, and the quality of the surgical procedures performed; evidence of such review is be recorded in writing;
c. Granting "provisional" status to new Members pending action by the Board of Managers.
d. Reporting activities of the Qualified Consulting Committee to the Board of Managers.
e. To represent and to act on behalf of the staff as a whole, subject to such limitations as may be imposed by these Bylaws.
f. To recommend actions on medical administrative matters, long range plans, clinical budgets, and licensure/accreditation issues.
g. To act as the Infection Control, Medical Records and Tissue Review Committee.
h. To provide the clinical expertise necessary to maintain the Center's compliance with Medicare, licensure and the standards and requirements of any organization that accredits the Center.
i. To provide surveillance of the Center's infection potentials, to review and analyze actual infections, and recommend corrective programs to minimize infection hazards.
j. To maintain standards for hazardous waste management.
k. To authorize the Executive Director to take corrective action as necessary and appropriate to prevent infection problems.
l. To review surgical cases for indications for surgery and variations in pre and post-operative diagnoses.
m. To review reports on all tissues removed and submitted to the Pathologist for examination to verify the correlation (or lack of) between the pathology report and pre/post-operative diagnosis and operative procedure on a quarterly basis.
n. To recommend further quality studies or reviews to be performed and corrective actions to be taken.
o. Ensure that surgical procedures are not being performed at the Center if a patient's medical, surgical or psychiatric condition warrants treatment in a hospital setting.
p. To evaluate and analyze medical/surgical and nursing care to assure the quality and appropriateness of these services.
q. To review the medical/surgical necessity and appropriateness of procedures performed at the Center
r. To identify variances or problems to be assessed and recommend action to be taken for correction or follow up.

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

APPENDIX

QUALITY ASSESSMENT & IMPROVEMENT PROGRAM

I. PURPOSE

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

II. Definitions:

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

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

III. GOALS AND OBJECTIVES:

A. The goals of the Quality Assessment & Improvement Program are to:
   1. Ensure optimal quality of care and appropriate utilization of resources through an effective mechanism for monitoring, evaluation and improving client care and service.
   2. Meet requirements of laws, regulations of government agencies, and accreditation organizations.
   3. Involve department staff in quality improvement process.
   4. Provide information as indicated for performance management.

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

IV. AUTHORITY

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

V. SCOPE OF PROGRAM

A. The Quality Assessment & Improvement Program will apply to all services and all clinical and business staff members who provide direct client care. This program will include, but not necessarily be limited to:
   1. Physicians
   2. Registered Nurses
   3. Licensed Practical Nurses
   4. CST
   5. Business Office Staff

APPENDIX

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

VI. COMMITTEE DEFINITION

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

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

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

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

VII. REVIEW PROCESS

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

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

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

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

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

APPENDIX

VIII. REPORTING MECHANISMS

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

IX. CONFIDENTIALITY POLICY

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

X. SCOPE OF THE QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM

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

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

HOFFMAN ESTATES SURGERY CENTER
UTILIZATION REVIEW WORKSHEET (Peer Review)

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

---

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

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

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

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

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

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

Additional Comments:

Signature of Reviewing Practitioner: _____

HOFFMAN ESTATES SURGERY CENTER
QUALITY ASSESSMENT AND IMPROVEMENT INDICATOR

DEPARTMENT: _____ DATE: _____

1. QA and I Indicator: _____

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

3. Evaluation of Care: _____

   a. Conclusion and Recommendation:

   b. Action Taken:

4. Assessment of Actions and Improvements: _____

   a. Follow-up:

   b. Further follow-up indicated:

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

Signature: _____

Date: _____

HOFFMAN ESTATES SURGERY CENTER
QUALITY INDICATORS

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

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

INFECTION PREVENTION PROGRAM

PROGRAM & RISK BACKGROUND

The Hoffman Estates Surgery Center (The Center) performs over 7,000 surgical procedures each year. The Infection Prevention Program (IPP) at the Center provides service to a patient population that includes the following patient populations:

- Adult surgical specialties, including ENT, orthopedic, ophthalmology, plastics, urology, general surgery, podiatry and gynecology
- Adult gastroenterology
- Pediatric patients between 6 months-18 years of age

The IPP is staffed by one 0.20 FTE Infection Preventionist. The Infection Preventionist is an Illinois licensed RN and who is certified in Infection Control (CIC. The designated Infection Preventionist will:

- Provide staff with consultation on infection prevention and control issues
- Act as the infection prevention liaison to, and resource for, the community and state health departments
- Meets with Zein Bertacchi, MS, MT (ASCP), CIC, the Center's outside Infection Control Professional Consultant at least once a year to review the Center's IC plan and program.

MISSION

The main objective and mission of the Infection Prevention Program (IPP) is to provide and maintain a systematic, coordinated infection control process to identify and reduce the risks for acquisition and transmission of infectious agents among patients, employees, visitors, physicians and licensed independent practitioners (LIPs). This is accomplished by:

- Education on methods for recognition and control of infections
- Surveillance of surgical site infections in patients undergoing surgical procedures at the Center
- Performance improvement efforts to develop initiatives to improve infection related clinical outcomes and/or infection prevention processes
- Design of infection prevention strategies to improve organizational compliance with regulatory standards

RISK ASSESSMENT

Annually, an assessment considering the geographic location and community environment of the Center's program/services provided and the characteristics of the population served is conducted. Based in its suburban Chicago Midwestern location, the Center provides care for patients at risk of infection. Patients who are nursing home residents, diabetics, obese, smoke or use IV drugs may also carry or acquire organisms such as C. difficile or drug resistant organisms such as VRE, MRSA, or ESBLs. These patients are also at risk of acquiring surgical site infections. The assessed risks, prioritized scoring, and strategies to minimize, reduce, or eliminate the infection risks are performed annually and maintained in the infection Control Manual.

SERVICES

To minimize risks associated with transmission of infectious agents, the identified scope of services the Infection Prevention Program (IPP) provides its customers includes:

- Conducting surveillance for healthcare acquired infections, antibiotic resistant pathogens and infectious disease outbreaks
- Developing and implementing protocols for suspected patients in need of isolation precautions appropriate for the Center's physical environment
- Initiating investigations of patient, medical staff members and employee illnesses or exposures to communicable diseases
- Reviewing aseptic practices including cleaning, disinfection, and sterilization procedures to ensure they follow national published guidelines based on the Center's risk assessment
- Developing and annually reviewing facility-wide infection control policies (the Infection Control Manual) adapted from the CDC, AORN, OSHA, and APIC guidelines and other professional evidence-based guidelines
- Serving as an infection control resource and consultant
- Orienting and educating all employees, medical staff, and health care practitioners with Center privileges on the cause, transmission, and prevention of infections to ensure a safe environment for patients, visitors, employees and staff
- Participation in QAPI projects as they relate to infection prevention opportunities
- Develop and maintaining systems to facilitate recognition of increases in infections as well as clusters and outbreaks
- Participating in planning for construction and renovation at the Center so that construction risks to patients will be minimized
- Reviewing hazardous waste management and disposal throughout the facility
- Developing policies and processes for employee, medical staff, volunteer and student immunizations, screening, and exposure follow-up
- Developing disease management policies for potential bioterrorist actions according to the county and state health department recommendations
- Collaborating with facilities management contacts in planning, monitoring and designing the operation of buildings and systems
- Ensuring an ongoing state of regulatory compliance

ANNUAL PLANNING

Based on the findings of the annual risk assessment and prioritization of those risks, the review of surveillance and key performance measurements and outcomes performed annually for purposes of monitoring and evaluating the effectiveness and impact of the Infection Prevention and Control Plan, and an assessment of available Infection Prevention Program Resources, the IPP proposes strategies to minimize, reduce, or eliminate the prioritized risks. These strategies may be in the form of policies, process improvement, quality control activity, or communication with the (Qualified Consulting Committee) QCC or staff. The program risk assessment, goals and priorities, and surveillance plans are developed in collaboration with Administrator, Clinical Nurse Manager and Center's professional IC consultant. They are then reviewed and approved for implementation by the QCC committee responsible for investigating, controlling and preventing infection in the facility.

DATA MANAGEMENT & ANALYSIS

Based on the annual approved surveillance plan, surveillance will be conducted to actively identify infections that may have been related to procedures performed at the Center. The Center conducts surveillance by contacting patients within 24 hours after discharge to ask if they developed any signs of a post-operative infection. The Center follows-up with the physician who performed the procedure and requires physicians to report post operative complications/infections to the Center. The Center maintains supporting documentation confirming this tracking activity and reports it quarterly to the QCC.

CDC definitions of healthcare-associated infections will be used in the IPP's surgical infection surveillance process, which follows the surveillance strategies outlined by the National Healthcare Safety Network (NHSN). When available, thresholds for surveillance data are established after review and analysis of current research literature, national norms, and region/community specific trends. The list of Reportable Quality Measure is as follows:

ASC-1 Patient Burn

ASC-2 Patient Fall

ASC-3 Wrong Site/Side/Patient/Procedure/Implant

ASC-4 Hospital Admission/Transfer

ASC-5 Prophylactic Intravenous (IV) Antibiotic timing.

ASC-6 Safe Surgery Checklist Used

ASC-7 Facility Volume Data on Selected ASC Surgical Procedures

ASC-8 Influenza Vaccination Coverage

ASC-9 Endoscopy/Poly Surveillance

ASC-13 Normal Thermia

ASC-14 Unplanned Vitrectomy

REPORTING STRUCTURE & RESPONSIBILITIES

Surveillance data analysis is initially performed by the Infection Preventionist and is then reviewed by the QCC for further interpretation and input. Data analysis results are then distributed to the governing body for further input. Infection prevention surveillance reports and opportunities for improvement are shared with the employees, medical staff and the Center's health professionals.

The multi-disciplinary group overseeing the Infection Prevention Program is responsible for:

- Risk assessment, program planning, regulatory compliance, and goal setting
- Activities and decisions related to the prevention of infections, including performance improvement initiatives
- Review and evaluation of the Employee Health Immunization and Screening Program compliance rates and bloodborne pathogen and communicable diseases exposures
- Evaluation of investigation findings and development of action plans as needed
- Development, approval, and implementation of effective infection control policies and procedures

The multi-disciplinary group overseeing the Infection Prevention Program (IPP) is the Qualified Consulting Committee (QCC) as defined by the Hoffman Estates Surgery Center Bylaws.

The QCC meetings are documented in the minutes that are approved at each meeting and stored in the administrator's office.

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Center personnel and medical staff members share responsibility in the reporting of isolation cases and reports of suspected infections or outbreaks of infections to the IPP. There is collaboration between all RN, LIPs, Medical staff and the Infection Preventionist to identify any nosocomial infection trends or patterns that may occur or opportunities for outcome improvement in the control and prevention of transmission of nosocomial infections. Post-operative infections will be reported to the IPP and to the QCC.

The Administrator is responsible to report state required reportable infections to the county of patient residence. If contacted, the IP program is available to assist with reporting infections to the county health department.

The Cook County Health Department is available to provide consultation and, if required, provide assistance to the Center should questions or concerns arise related to potential infection, disease management, or outbreaks.

The annual goal for hand hygiene compliance by the Clinical Staff is 65%.

Methods to achieve the goal include:

- Educating staff about the importance of hand hygiene to control the spread of germs
- Surveillance
- HESC staff may decline the vaccine for medical contraindications or as a matter of conscience, including religious beliefs. The declination must be in writing.

TB control: as mentioned in preceding sections, the control of tuberculosis depends upon the following measures. a. Prompt identification of possible tuberculosis. b. Prompt implementation of Airborne Precautions, including placement in an airborne isolation room (AIIR) with negative pressure. c. A respiratory protection program including fit testing for N95 respirators. d. TB skin tests (TST) upon hire to detect both latent and active disease and annually and post-exposure to screen for occupationally acquired infection. Blood tests (interferon-gamma release assay) may be used in certain circumstances. e. Management of staff with newly identified positive TST or IGRA to evaluate the need for treatment of latent TB or the presence and subsequent treatment for 2017 Infection Control Program Plan 11 of 13 active TB. f. Furlough of employees with active TB until rendered noninfectious by treatment.

Influenza prevention:

The goal for the 2018 influenza season (October, 2018--March 31, 2019) is to achieve an acceptance rate of 91% of staff defined by Clinical Staff.

1. The denominator includes all HESC staff employed during the 2018-2019 influenza season. The numerators are (a) all HESC staff who are vaccinated and (b) all HESC staff who decline vaccination).
2. Methods to achieve the goal include:

- Providing access to influenza vaccinations on site at no charge.
- Educating staff about influenza vaccination; non-vaccine infection control measures (such as the use of Droplet Precautions); and diagnosis, transmission, and potential impact of influenza.
- Evaluating declinations to identify opportunities to reduce the number.
- HESC staff may decline the vaccine for medical contraindications or as a matter of conscience, including religious beliefs. The declination must be in writing.

RISK MANAGEMENT PROGRAM

I. POLICY

It is the policy of the Center to establish an ongoing Risk Management Program under the direction of the Administrator.

II. Definitions:

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

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

III. PURPOSE

A. To ensure the professional, moral and ethical obligations of the Center are upheld.
B. To protect human life and intangible resources.
C. To prevent injury to patients, visitors, employees, vendors and contractors.
D. To safeguard the financial assets of the facility.
E. To decrease loss exposures in and around the physical facility.

IV. PROCEDURE

A. The Administrator is responsible for the following activities:
   1. Coordinating, planning and implementing educational programs to reduce patient and employee hazards.
   2. Reporting all risk management activities to the Quality Improvement Committee.
   3. Reporting to the Board of Managers when appropriate, but not less than annually, for the purpose of reviewing and evaluating the activities of the Risk Management Program.
   4. Report events in accordance with the general conditions regarding reporting of claims, occurrences and circumstances under the Center's professional liability policy .
   5. Report any employee injury in accordance with the IL Form 45 Employer's First Report of Injury under the Center's workman's compensation policy.

B. Components of the Risk Management Program will include but are not limited to the following:
   1. Variance Reports
   2. Infection Control Reports
   3. Legal Complaints and lawsuits
   4. Performance Improvement Program Statistics
   5. Hazardous Inspection Reports
   6. Third party reports, i.e., Fire Department, AAAHC, IDPH
   7. Preventive Maintenance Reports

C. At the quarterly meeting of the Qualified Consulting Committee and Board of Managers a review will include but not be limited to the following:
   1. Patient satisfaction surveys and actions taken
   2. All Variance Reports and their resolution
   3. Any ongoing litigation
   4. Formal adoption of any changes and recommendations made throughout the year involving the following:
      a. Mission statement, goals and objectives
      b. Organizational structure
      c. Long term plans of the organization
      d. Clinical staff privileges/new procedures proposed

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e. Personnel Policies and Procedures
f. Quality Improvement Program
g. Patient Rights and Responsibilities

5. Annually the Qualified Consulting Committee and Board of Managers will review all contracts and arrangements affecting the provision of health care to patients, including but not limited to:
   a. Employment of health care practitioners
   b. External medical, pathology and radiology laboratories
   c. Provisions for waste disposal/laundry
   d. Education programs involving students or residents
   e. Preventive maintenance agreements on equipment
   f. Review purchasing of supplies and equipment

D. For effective risk management at the Center risk exposure analysis will be conducted in the following manner:
   1. Centralization of identified risk information
   2. Integrations and sharing of information with appropriate personnel
   3. Formulation of appropriate educational activities necessary to effect change.

E. **IMMUNITY** No individual or institution reporting or providing information that is convened for the purpose of evaluating the quality of patient care shall be liable in a suit for damages based on such reporting providing that the report or information is given in good faith and with the reasonable belief that the said actions were motivated by the furtherance of providing high quality patient care within the facility.

F. **CONFIDENTIALITY** Any and all documents and records that are part of the Risk Management Program shall be confidential and not subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding.

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MEDICAL STAFF CREDENTIALING

I. POLICY

The Center will comply with The Health Care Professional Credentials Data Collection Act 410 ILCS 517. A credential file shall be maintained for all medical staff and updated every three (3) years.

II. PURPOSE

To assess and validate the qualifications of a licensed independent practitioner to provide patient care and services within the scope of their licenses and individually granted clinical privileges.

III. PROCEDURE

A. The Center shall only require the submission of the Illinois Uniform Credentialing Form obtained at www.idph.state.il.us and the following attachments
   - (i) Current state license
   - (ii) DEA registration
   - (iii) Proof of current medical liability coverage
   - (iv) Proof of staff privileges at a hospital in Illinois
   - (v) Referral letters from peers.

B. The Center will query American Medical Association Physician Profile Service as equivalent primary source verification. The criteria includes:
   1. Current licensure.
   2. Relevant education, training, or experience.
   3. Certification by National Board of Medical Examiners.
   4. Disclosure of any sanctions, license revocations, suspension, and adverse actions.
   5. Confirmation of ECFMG certification for graduates of foreign medical schools.
   6. Notification of Medicare/Medicaid Sanctions

C. The Center will query the National Practitioner Data Bank at initial appointment, every three years for reappointment and when a practitioner requests privileges not already granted.

D. Primary Source Verification is implemented for Podiatry applications for appointment.

E. The verification of Credentialing criteria may be obtained via mail, fax, and telephone or electronically, provided the means by which it is obtained are documented and measures are taken to demonstrate there was no interference in the communication by an outside party.

F. Once the Illinois Uniform Credentialing Form is completed and all necessary information verified the application is brought before The Qualified Consulting Committee.

G. The Qualified Consulting Committee shall review all pertinent information obtained and make a recommendation to the Board of Managers for conferring, deferring or rejection of appointment to medical staff.

H. The Board of Managers shall have final determination of conferring, deferring or rejection of appointment to medical staff. In arriving at its recommendation regarding the initial granting of privileges the continuation of privileges or the expansion or limitation of privileges, the Board of Directors will review and consider the following:
   1. Practitioner's education, training and experience
   2. Privileges granted by another institution (i.e., hospital privileges)
   3. Demonstrated competence as well as deficiencies
   4. Lawsuits, settlements and judgments involving the practitioner
   5. Ability to work professionally and constructively with other members of the Medical staff and Center personnel
   6. Like privileges at a hospital in the State of Illinois
   7. Other relevant information that is pertinent

I. Allied Health members, who are no longer employed by their sponsoring physicians, will have an administrative loss of all privileges.

IV. RECREDENTIALING:
Recredentialing of medical staff members shall be performed every three years.

Requirements:
On an ongoing basis and at the time of recredentialing, the Practitioner file shall be reverified and updated. A recredentialing evaluation shall include, but not be limited to:

- Valid, unrestricted State license or certification;
- Professional liability claims history;
- Health status relative to the performance of the privileges requested;
- Criminal history;
- Continued good standing at a hospital in the State of Illinois;
- Work history since initial appointment or previous reappointment; and
- Voluntary or involuntary investigations, sanctions, restrictions, reductions, terminations or disciplinary actions by any healthcare institution, employer, state or federal agency or program.

In addition to the above, recredentialing shall also include a review of data concerning:

- Member complaints; and
- Results of quality/peer reviews

V. Reporting to the National Practitioner Data Bank
The Center is required to report adverse actions to the NPDB. The Administrator would be responsible for any reporting requirements to the NPDB. The term "adversely actions" is defined to include any actions which reduce, restrict, suspend, revoke, deny, or fail to renew clinical privileges or membership in a health care entity. Adverse actions involving censures, reprimands, or admonishments are not to be reported.

The Guidebook published by the NPDB provides examples of reportable and non-reportable review actions including the following:

Reportable Actions:

- A physician's application for medical staff appointment is denied based on the professional competence or conduct. (However, a denial based upon failure to meet the initial credentialing criteria applied to all medical staff or clinical privilege applicants is not reportable.)
- A physician's request for clinical privileges is denied or restricted, based upon an assessment of his or her current clinical competence as defined by the health care entity.
- A physician voluntarily restricts or surrenders his clinical privileges while his professional competence or conduct is under investigation, or in return for an agreement not to conduct an investigation of his professional competence and/or conduct.
- Based on an assessment of his professional conduct, a proctor is assigned to a physician and the physician must be granted approval by the proctor before certain medical care is administered.

Non-Reportable Actions:

- Based on an assessment of his professional competence, a proctor is assigned to supervise a physician, but a proctor is not required to grant approval before medical care is provided by the physician.

- If a physician voluntarily restricts or surrenders his clinical privileges for personal reasons, when his professional competence and/or conduct is not under investigation.

- If a physician is denied medical staff appointment or clinical privileges because the health care entity already has too many specialists in the individual's discipline.

- If a physician's privileges are suspended because of failure to complete a patient's chart in accordance with the health care entity's policy.

Any revisions to previously reported adverse actions must also be reported. For each reportable professional review action, the name of the physician involved and a description of the acts or omissions or other reasons for the action or, if known, for the surrender of privileges, must be submitted within fifteen days after the reportable action is taken.

This information must be submitted in an NPDB Adverse Action Report Form. This may also need to be submitted to the Illinois Department of Professional Regulation.

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

INDEX OF ATTACHMENTS

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