

**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, LLC		
Street Address:	1555 N. Barrington Road Doctors Building 3 Suite 400		
City and Zip Code:	Hoffman Estates 60169		
County:	Cook	Health Service Area:	VII Health Planning Area: 031

**Legislators**

State Senator Name:	Christina 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 N. Barrington Road Doctors Bldg. 3 Suite 400
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:	Roxann Barber
CEO Street Address:	1555 N. Barrington Road
CEO City and Zip Code:	Hoffman Estates, IL 60169
CEO Telephone Number:	847/755-8465

**Type of Ownership of Applicants**

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

- ☐ Partnership  
☐ Governmental  
☐ Sole Proprietorship

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

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

**Primary Contact [Person to receive ALL correspondence or inquiries]**

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

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
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City and Zip Code:	Hoffman Estates 60169		
County:	Cook	Health Service Area:	VII Health Planning Area: 031

**Legislators**

State Senator Name:	Christina 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. Impicicche
CEO Street Address:	4600 Edmunson Road
CEO City and Zip Code:	St. Louis, MO 63134
CEO Telephone Number:	314/733-8000

**Type of Ownership of Applicants**

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

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☐ Governmental  
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Fax Number:	

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION**

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County:	Cook	Health Service Area:	VII Health Planning Area: 031

**Legislators**

State Senator Name:	Christina 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 N. 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:	Roxann Barber
CEO Street Address:	1555 N. Barrington Road
CEO City and Zip Code:	Hoffman Estates, IL 60169
CEO Telephone Number:	847/755-8465

**Type of Ownership of Applicants**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership                                  |
| <input type="checkbox"/> For-profit Corporation            | <input type="checkbox"/> Governmental                                 |
| <input type="checkbox"/> Limited Liability Company         | <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> |
| Other  |   |
- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
  - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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Company Name:	
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Fax Number:	

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
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**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**  
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**Facility/Project Identification**

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City and Zip Code:	Hoffman Estates 60169		
County:	Cook	Health Service Area:	VII Health Planning Area: 031

**Legislators**

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

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

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

**Type of Ownership of Applicants**

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/>
Other	

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

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

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

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

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

**Post Exemption Contact**

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

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

**Site Ownership after the Project is Complete**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	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
<b>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.</b>	

**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 400 Hoffman Estates, IL 60169		
<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
X	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
	Other		

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

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

Exact Legal Name: same as above

Address:

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

☐ Partnership  
☐ Governmental  
☐ Sole Proprietorship

☐

- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- o 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.
- o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

**APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Organizational Relationships**

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

**APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Narrative Description**

In the space below, provide a brief narrative description of the change of ownership. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site.

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

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

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

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

This Certificate of Exemption application addresses the change of ownership of Hoffman Estates Surgery Center, LLC.

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



**Related Project Costs**

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$ _____		
Fair Market Value: \$ _____		

**Project Status and Completion Schedules**

**Outstanding Permits:** Does the facility have any projects for which the State Board issued a permit that is not complete? Yes \_\_\_ No X. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

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

**State Agency Submittals**

Are the following submittals up to date as applicable:

X Cancer Registry

X APORS

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

X All reports regarding outstanding permits

**Failure to be up to date with these requirements will result in the Application being deemed incomplete.**

**CERTIFICATION**

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of 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.



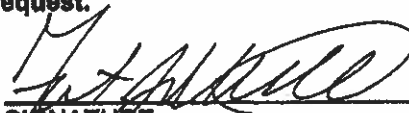
SIGNATURE

POLLY DAVENPORT

PRINTED NAME

Regional officer - Board Member

PRINTED TITLE



SIGNATURE

Ernest Whuchard

PRINTED NAME

Chief Finance Officer

PRINTED TITLE

Notarization:

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

Notarization:

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

Signature of Notary

Seal

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;
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- ☐ 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:

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

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

  
SIGNATURE

Keith Parrott  
PRINTED NAME

President  
PRINTED TITLE

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

Signature of Notary

Seal

\_\_\_\_\_  
SIGNATURE

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

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

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

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

Seal

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\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE

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

G. Thor Thordarson

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

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

Treasurer

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

Notarization:

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

Notarization:

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

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

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

Seal

Seal

\*Insert the EXACT legal name of the applicant

**SECTION II. BACKGROUND.****BACKGROUND OF APPLICANT**

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application. Please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one Application, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

**APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 5.**

**SECTION III. CHANGE OF OWNERSHIP (CHOW)****Transaction Type. Check the Following that Applies to the Transaction:**

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

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

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.
2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.
3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

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



APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(5) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X
APPEND DOCUMENTATION AS <u>ATTACHMENT 6</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

**SECTION IV.CHARITY CARE INFORMATION**

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE			
	2018	2019	2020
<b>Net Patient Revenue</b>	<b>\$9,360,748</b>	<b>\$30,256,585</b>	<b>\$2,181,126</b>
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.**

File Number

0106065-1



***To all to whom these Presents Shall Come, Greeting:***

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

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 13TH  
day of JANUARY A.D. 2022 .***

*Jesse White*

SECRETARY OF STATE ATTACHMENT1

# STATE OF MISSOURI



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

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

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

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

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

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

  
Secretary of State

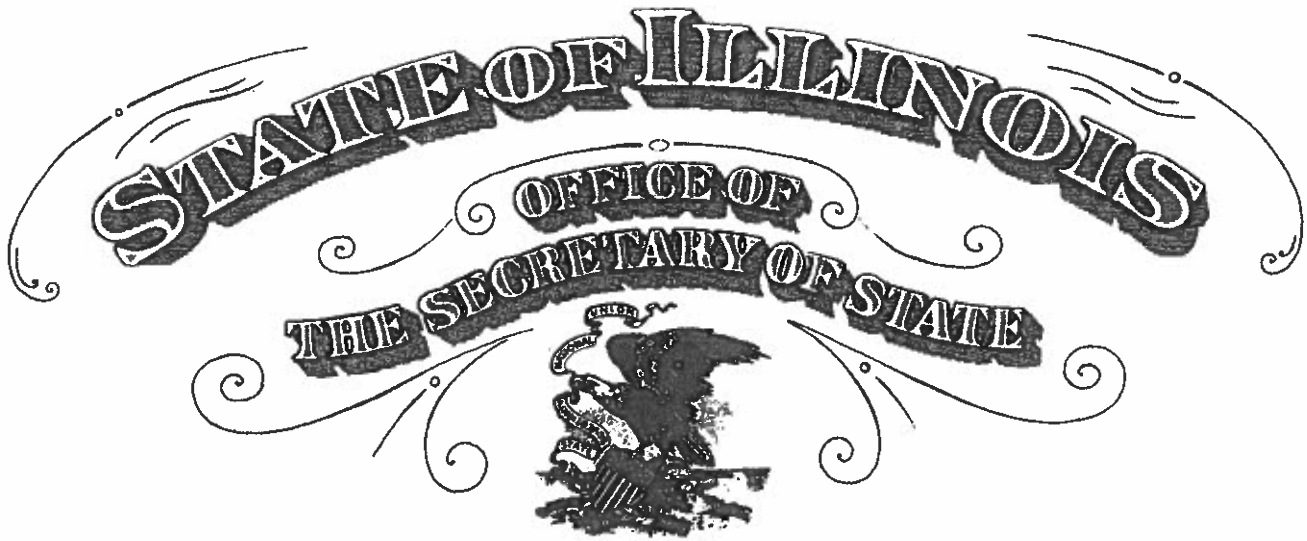


Certification Number: CERT-01202022-0113

ATTACHMENT I

File Number

6009-640-6



***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 13TH  
day of JANUARY A.D. 2022 .***

*Jesse White*

Authentication #: 2201302776 verifiable until 01/13/2023  
Authenticate at: <http://www.ilsos.gov>

SECRETARY OF STATE

ATTACHMENT 1

File Number

6964-462-7



**To all to whom these Presents Shall Come, Greeting:**

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

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 20TH  
day of JANUARY A.D. 2022 .***

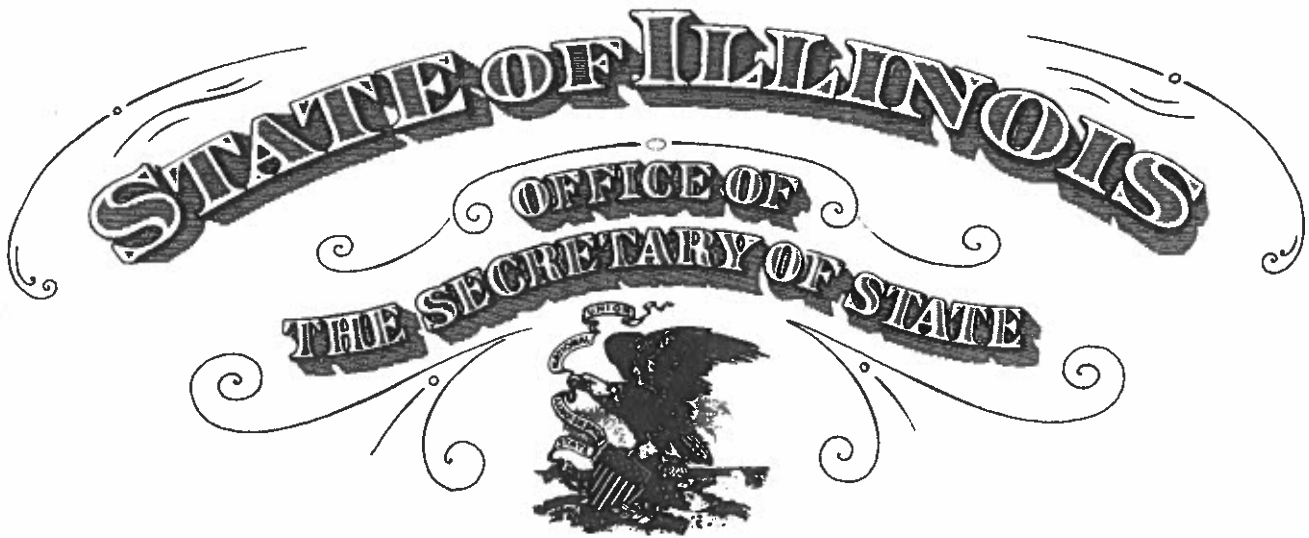
*Jesse White*

SITE OWNERSHIP

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

File Number

0106065-1



***To all to whom these Presents Shall Come, Greeting:***

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

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 13TH  
day of JANUARY A.D. 2022 .***

*Jesse White*

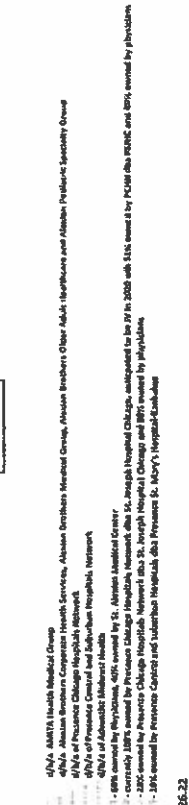
Authentication #: 2201303276 verifiable until 01/13/2023

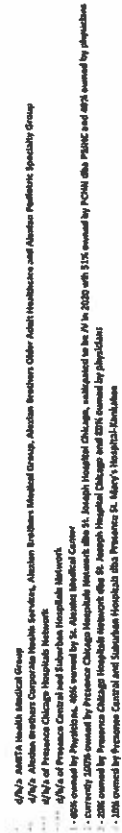
Authenticate at: <http://www.ilsos.gov>

SECRETARY OF STATE

ATTACHMENT 3







## BACKGROUND OF APPLICANT

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

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

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

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.

		<b>Illinois Department of PUBLIC HEALTH</b>		HF 122002	
<b>LICENSE, PERMIT, CERTIFICATION, REGISTRATION</b>					
A 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	ID 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			ATTACHMENT 5		
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					

## ASCENSION HEALTH HOSPITAL LISTING (Wholly Own

by location

### ALABAMA

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

### BALTIMORE, MD

Ascension Saint Agnes Hospital

### BINGHAMTON, NY

Lourdes Hospital

### CHICAGO, IL

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

### FLORIDA AND GULF COAST

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

### INDIANA

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

ATTACHMENT 5

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

#### KANSAS

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

#### MICHIGAN

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

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

OKLAHOMA

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

TENNESSEE

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

TEXAS

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

WISCONSIN

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

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



**Ascension Health ASCs (Wholly Owned)**

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

**Ascension Health SNFs (Wholly Owned)**

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

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

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

The parties named as an applicant are:

- Hoffman Estates Surgery Center, LLC, the current and proposed licensee
- Ascension Health, which currently has and will continue to have “ultimate control” over the licensee
- St. Alexius Medical Center, which holds a 100% interest in the ASTC
- Alexian Brothers-AHS Midwest Region Health Co. (operating as AMITA Health), which currently has certain designated “control” over the licensee through the Affiliation Agreement between Adventist Health System Sunbelt Healthcare Corporation and Ascension Health, with an original effective date of October 30, 2014.

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

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

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

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

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

Key points of the disaffiliation are:

1. There will be no impact on the ownership and control of the facility’s assets, which continue to remain with its original sponsor (Ascension Health).

2. There will be no impact on licensure. The facility's license will not change and it will continue to hold the license.
3. The facility will continue to operate under the umbrella of Presence Alexian Brothers Health System and be clinically and operationally integrated with Ascension Health.

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

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

**Criterion 1130.520(b)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.**

Current and proposed organizational charts are provided in ATTACHMENT 4.

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

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

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

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

**Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.**

Applicant Ascension Health holds seven Certificate of Need Permits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No change will be made to the selection process for the facility's governing body. The governing board consists of three representatives appointed by the Class H Member (St. Alexius Medical Center) and two representatives appointed by the Class P Members holding an aggregate company percentage that is in excess of seventy-five percent of the aggregate company percentage held by all Class P Members. Class P Managers are Physician Interest Holders. Currently, there are no Physician Interest Holders and thus no physician member representatives on the board.

**Criterion 1130.520(b)(9) A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.**

While there may be a need for some changes in the future because of financial conditions in the health care industry, at this time, no changes to the scope of services provided at the facility are anticipated to occur within 24 months of the proposed transaction. However, the ASTC is exploring potential changes in the facility's ownership structure to allow for new physician ownership; and if changes to the ownership structure that require the filing and approval of a Certificate of Exemption application are anticipated, that application will be prepared and filed consistent with Part 1130.



## 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

- 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.
- 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.
- 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](http://www.aaahc.org).

Organization # 75510  
Organization: Hoffman Estates Surgery Center, LLC  
February 25, 2019  
Page 2

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](http://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](mailto: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.



## CHARITY/ INDIGENT CARE POLICY

### PURPOSE:

Hoffman Estates Surgery Center-provides care based on the following principles:

- We provide care to all those in need regardless of their ability to pay.
- Our Financial Assistance policies maintain a careful balance between the need for fiscal responsibility and our desire to serve our patients to the best of our ability.
- All patients are treated fairly, with dignity, compassion and respect.

### POLICY:

It is the policy of HESC to promote the health and well being of the people in the communities that we serve.

It is the responsibility of the HESC staff to respond to all patients requests for charity eligibility during any patient business interactions; namely pre-registration, registration, and discharge; or at any other time the HESC representative encounters information detailing the patient's financial need.

It is the responsibility of the patient to actively participate in the financial assistance screening process and in providing requested information on a timely basis, including without limitations providing the surgery center with information concerning actual or potentially available health benefits coverage (including available COBRA coverage), financial status (i.e. income, assets) and any other information that is necessary for the surgery center to make a determination regarding the patient's financial and insured status.

Charity approval will affect all accounts for which the approved guarantor is responsible for. The approved charity percentage will be applied to all existing accounts with debit balances. Any patient credit balance created by applying the charity percentage will be refunded to the guarantor within thirty (30) days of receiving the charity care designation. Accounts may also be returned from Bad Debt status, if financial circumstances warrant and charity may be applied. Patients requesting charity may be required to apply for Medicaid benefits. If Medicaid eligibility was established for dates of service covered under charity, those charity adjustments will be reversed and the services will be billed to Medicaid for processing.

HESC surgery center has a set of Charity Care assessment guidelines to supplement this policy. These guidelines are consistent with all applicable state and federal laws and are meant to reduce our patients' financial worries as much as possible:

- Pre-Screen payment questions for admitting and pre-registration staff.
- Discussions on payment policies regarding Non-Covered Services (Elective Cosmetic services, etc.)

- Full Charity care sponsorship for those at or below 100% of the federal poverty standard pending approval by the Administrator and/or Medical Director.
- Other self-pay options for patients denied charity based on income. (Payment plan; Uninsured Discount, Prompt Payment Discount)

**Eligibility Requirements**

- Eligibility shall be based on financial need at the time of application.
- All resources of the family/both spouses are considered together.
- All guarantors, with family income equal to or below one hundred percent (100%) of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of surgery center charges related to appropriate surgery center based medical services that are not covered by private or public third-party sponsorship. Eligibility shall be based solely on the total gross family income adjusted for family size. Assets shall not be considered.
- All guarantors, with family income between one hundred and one and four hundred percent (101-400%) of the federal poverty standard, adjusted for family size and assets, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate surgery center-based medical services.
- Documentation may be requested and, in most cases, will be required to establish eligibility for charity care; however the absence of documentation in certain circumstances deemed reasonable and understandable by the Center's billing staff (e.g., homeless person) will not necessarily require a charity denial.
- The Medical Director and/or the Administrator may approve charity care in circumstance.

**Charity/Indigence Care Evaluation Process**

The process for determining which patients qualify for charity care is based on the evaluation of the following:

- Exhausted or not eligible for any third-party payment sources
- All possible insurance payors have been billed.
- Patients requesting charity on accounts may be required to apply for Medicaid benefits. Charity may supplement Medicare/Medicaid benefits in the case of non-covered services.
- Patient is not eligible for Medicare/Medicaid benefits.
- Making an initial determination whether the patient is eligible for charity care, prior to initiating any surgical services or collection efforts, assuming the patient cooperates with the Center's attempt to make the determination;
- Making reasonable attempts to determine if a third-party payor or sponsor may pay some or all of the charges;
- Any of the following documents shall be considered sufficient evidence upon which to base a determination of eligibility for charity care; last 3 months of pay stubs, current bank statements and/or income tax return from the previous year, W-2 statements from the previous year,

unemployment compensation forms, forms approving or denying Medicaid or written statements from employers or welfare agencies; or federal or state award letters; directive from the Medical Director or Administrator.

- If financial information is not provided to support an application for charity assistance, it can be denied.
- The Center will notify the patient of its final determination of Charity Care within fourteen (14) business days of receiving the necessary documentation.

**Billing and Collection Practices:**

- The Center has a written policy about when and under whose authority patient debt is advanced for collection and it uses its best efforts to ensure that patient accounts are processed fairly and consistently.
- At time of billing, the Center provides to all low-income uninsured patients the same information concerning services, payment plans and charges provided to all other patients who receive care at the surgery center.
- Any patient seeking financial assistance from surgery center prior to the surgical event is provided information concerning health benefits coverage, financial status (i.e. income, assets) and any other information that is necessary for the surgery center to make a determination regarding the patient's status relative to the surgery center's financial assistance policy, discounted payment policy, eligibility for government-sponsored programs.
- Eligibility for financial assistance is determined prior to the date of service.

**Communication to the Public:**

- The Center ensures that appropriate staff members are knowledgeable about the existence of the surgery center's financial assistance policies. Training is provided to staff members (i.e., billing office, physician offices, etc.) who directly interact with patients regarding their surgery center bills.
- When communicating to patients regarding their financial assistance policies, the Center attempts to do so in a manner consistent with all applicable federal and state laws and regulations.

**Hoffman Estates Surgery Center Assistance Application****REQUEST FOR DETERMINATION OF ELIGILITY FOR HESC ASSISTANCE**

PATIENT NAME: \_\_\_\_\_

ACCOUNT NUMBER(S) \_\_\_\_\_

RESPONSIBLE PARTY/GUARANTOR NAME: \_\_\_\_\_

I understand that the information, which I will submit concerning my annual income and family size, is subject to verification.

Last Name	First Name	M.I.	Telephone No.
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Street Address	City/State	Zip Code
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Guarantor Social Security Number \_\_\_\_\_

Name and Address of Guarantor's Employer \_\_\_\_\_

Name and Address of Spouse's Employer \_\_\_\_\_

If unemployed, what was the last date worked? \_\_\_\_\_

Did you have insurance coverage with former employer? \_\_\_\_\_

If unemployed, please describe on reverse side how you meet your daily living expenses.

Please list all family member(s) who live with you

Name	Age	Relationship
------	-----	--------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Hoffman Estates Surgery Center Application****FINANCIAL DISCLOSURE FORM**

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Responsible Person/Guarantor Name: \_\_\_\_\_

**List All Sources Of Your Monthly Gross Income:**

Responsible Party's Salary Before Deductions \$ \_\_\_\_\_

Pension \$ \_\_\_\_\_

Spouse's Salary Before Deductions \$ \_\_\_\_\_

Pension \$ \_\_\_\_\_

Social Security \$ \_\_\_\_\_

Unemployment \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Investment Income \$ \_\_\_\_\_

Checking \$ \_\_\_\_\_ Savings \$ \_\_\_\_\_

Property Value \$ \_\_\_\_\_

Liquid Assets (stocks/Bonds/Ira's/CD) \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Please Describe \_\_\_\_\_

**MONTHLY EXPENSES:**

Rent/Mortgage/Room &amp; Board \$ \_\_\_\_\_

Medical Insurance\$ \_\_\_\_\_ Monthly Medical Expenses \$ \_\_\_\_\_

Loans \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Total Monthly Expenses \$ \_\_\_\_\_

**I hereby state that the information provided in this document is true and accurate to the best of my knowledge.**\_\_\_\_\_  
Print Name:\_\_\_\_\_  
Signature\_\_\_\_\_  
Date

APPENDIX A

**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 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. 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

APPENDIX B

- 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.

## **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.

APPENDIX B

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.

**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](http://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.