

CHARLES H. FOLEY & ASSOCIATES INC.

1638 South MacArthur Boulevard • Springfield, Illinois 62704
217/544-1551 • Fax: 217/544-3615 • E-mail: foley.associates@sbcglobal.net

HAND DELIVERED

March 18, 2010

RECEIVED

MAR 18 2010

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Mr. Michael Constantino, Plan Review Supervisor
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

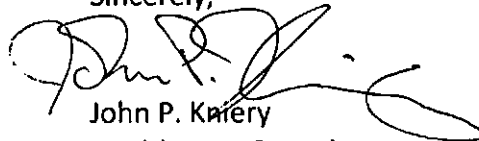
Re: Project Number **10-015**, Certificate of Need
for Change of Ownership of WT Surgicenter
d/b/a Water Tower Surgicenter to Gold
Coast Surgicenter.

Dear Mr. Constantino:

Per your request, enclosed is a revised first page application form changing the "Facility/Project Identification" to the existing entity's name. Throughout this application, as filed, the facility is referred to in future tense as Gold Coast Surgicenter. Please note that the Applicant is referred to the existing facility WT Surgicenter d/b/a Water Tower Surgicenter and that Gold Coast Surgicenter and the existing facility are one and the same. I apologize for any inconvenience that this may have caused. In further clarification of the facility issue, I am also enclosing a revised project narrative description. Finally, I am enclosing the original signature/signature page for the existing entity in accordance with the advice of State Staff.

I would like to thank you and Mr. Roate as well as all of your staff for their continued professionalism and guidance throughout the preparation of this particular application. Should you have any additional questions or concerns, please do not hesitate to contact me.

Sincerely,


John P. Kafery
Health Care Consultant

ENCLOSURES

C: Mark Silberman, Attorney at Law



Health Care Consulting

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: WT Surgicenter d/b/a/ Water Tower Surgicenter		
Street Address: 845 North Michigan Avenue, Suite 930 East		
City and Zip Code: Chicago 60611		
County: Cook	Health Service Area: VI	Health Planning Area: Cook

Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: WT Surgicenter, LLC
Address: 845N Michigan Avenue, Chicago, Illinois 60611
Name of Registered Agent: Paul C. Madison, MD
Name of Chief Executive Officer: Paul C. Madison, MD
CEO Address: 845N Michigan Avenue, Chicago, Illinois 60611
Telephone Number: (312) 202-0700

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

Type of Ownership

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input checked="" 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 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 during the review period]

Name: Charles H. Foley
Title: Health Care Consultant
Company Name: Charles H. Foley & Associates, Inc.
Address: 1638 South MacArthur Boulevard
Telephone Number: (217) 544-1551
E-mail Address: foley.associates@sbcglobal.net
Fax Number: (217) 544-3615

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Mark J. Silberman
Title: Attorney at Law
Company Name: Duane Morris LLP
Address: 190 South LaSalle Street, Suite 3700, Chicago, Illinois 60603-3433
Telephone Number: (312) 499-6713
E-mail Address: mjsilberman@DuaneMorris.com
Fax Number: (312) 499-6701

REVISED March, 18, 2010

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

3. Narrative Description

Provide in the space below, a brief narrative description of the project. 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. Include the rationale regarding the project's classification as substantive or non-substantive.

The Applicant, Gold Coast Surgicenter, LLC has entered into an agreement with W.T. Surgicenter, LLC to purchase the Ambulatory Surgical Treatment Center (ASTC), WT Surgicenter d/b/a/ Water Tower Surgicenter, subject to approval from the Illinois Health Facilities and Services Review Board. The proposed ASTC will be named Gold Coast Surgicenter and is referred to as such throughout the remainder of this application. The ASTC's administrative office was relocated within the existing ASTC to suite 985W which will be its corrected address from the address previously listed. This ASTC is only one tenant of many tenants with approximately 11,269 square feet of rented space on the ninth floor of this multi tenant, multi story commercial building. The Building owner, Water Tower, LLC, is not considered a co-Applicant but a landlord only as it has no input over the ASTC other than as dictated through the lease agreement. As WT Surgicenter, LLC holds the existing license, it is considered a co-Applicant. However, upon approval of this project, that entity ceases to have any further involvement in the Subject ASTC.

The ASTC has four operating rooms (2 ORs and 2 specialty procedure rooms) and twelve recovery stations (8-stage One and 4-stage Two) fully equipped to perform Gastroenterology, OB/Gynecology, Orthopedic, Pain Management, Plastic, and Podiatry procedures.

As this project is only for the change of ownership of the ASTC, this project is classified as non-substantive in accordance with the 77 Illinois Administrative Code, Section 1110.40.b). Furthermore, per this section, i.e., the 77 Illinois Administrative Code, Section 1110, 40.b), this application will address sections 1110.230), 1110.240, and Part 1120.

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of WT Surgicenter, 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

Paul Madonia
 SIGNATURE

 SIGNATURE

PAUL MADONIA
 PRINTED NAME

 PRINTED NAME

OWNER / Manager
 PRINTED TITLE

 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 17th day of March 2010

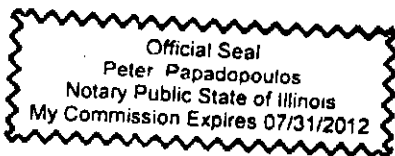
Notarization:
 Subscribed and sworn to before me
 this ____ day of _____

Peter Papadopoulos
 Signature of Notary

 Signature of Notary

Seal

Seal



*insert EXACT legal name of the applicant

GOLD COAST SURGERY CENTER LLC

ACCOUNT PAYABLE
845 MICHIGAN AVE STE 910W
CHICAGO, ILLINOIS 60611

1/29/2010

PAY TO THE ORDER OF Illinois Department of Public Health

\$ **2,500.00

Two Thousand Five Hundred and 00/100***** DOLLARS

Illinois Department of Public Health
536 W. Jefferson St.
Springfield, IL 62761

MEMO 10-015
Application for Exemption



AUTHORIZED SIGNATURE

⑈001041⑈ ⑆071001533⑆ ⑆12⑈23⑈002138⑈

GOLD COAST SURGERY CENTER LLC

Illinois Department of Public Health

1/29/2010

Date	Type	Reference	Original Amt.	Balance Due	Discount	Payment
2/4/2010	Bill		2,500.00	2,500.00		2,500.00
				Check Amount		2,500.00

RECEIVED
MAR 18 2010
HEALTH FACILITIES &
SERVICES REVIEW BOARD

Bank - NCB GCSC Ch Application for Exemption

2,500.00

Security features. Details on back.