

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Golf Surgical Center			
Street Address: 8901 Golf Road, #100			
City and Zip Code: Des Plaines, IL 60016			
County: Cook	Health Service Area	007	Health Planning Area: 031

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

Exact Legal Name: LGH-A/Golf ASTC, L.L.C.	
Street Address: 8901 Golf Road, #100	
City and Zip Code: Des Plaines, IL 60016	
Name of Registered Agent: Corporate Creations Network IN	
Registered Agent Street Address: 350 S. Northwest Highway, #300	
Registered Agent City and Zip Code: Park Ridge, IL 60068	
Name of Chief Executive Officer: John Kinzer, M.D.	
CEO Street Address: 8901 Golf Road, #100	
CEO City and Zip Code: Des Plaines, IL 60016	
CEO Telephone Number: 847-299-2273	

Type of Ownership of Applicants

☐ Non-profit Corporation ☐ For-profit Corporation ☒ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
☐ Other	
- 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 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: Anne Cooper
Title: Attorney
Company Name: Polsinelli
Address: 150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606
Telephone Number: 312-873-3606
E-mail Address: acooper@polsinelli.com
Fax Number: 312-276-4317

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

Name:
Title:
Company Name:

Address:
Telephone Number:
E-mail Address:
Fax Number:

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County: Cook	Health Service Area	007	Health Planning Area: 031

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

Exact Legal Name: ASTC Management, Inc.	
Street Address: 8901 Golf Road, #100	
City and Zip Code: Des Plaines, IL 60016	
Name of Registered Agent: Corporate Creations Network IN	
Registered Agent Street Address: 350 S. Northwest Highway, #300	
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City and Zip Code: Des Plaines, IL 60016			
County: Cook	Health Service Area	007	Health Planning Area: 031

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

Exact Legal Name: ASTC Management – II, LLC	
Street Address: 8901 Golf Road, #100	
City and Zip Code: Des Plaines, IL 60016	
Name of Registered Agent: Corporate Creations Network IN	
Registered Agent Street Address: 350 S. Northwest Highway, #300	
Registered Agent City and Zip Code: Park Ridge, IL 60068	
Name of Chief Executive Officer: John Kinzer, M.D.	
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☐ Non-profit Corporation ☐ For-profit Corporation ☒ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship	☐ Other
- 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
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Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name:
Title:
Company Name:

Address:
Telephone Number:
E-mail Address:
Fax Number:

Post Exemption Permit 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: Anne Cooper
Title: Attorney
Company Name: Polsinelli
Address: 150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606
Telephone Number: 312-873-3606
E-mail Address: acooper@polsinelli.com
Fax Number: 312-276-4317

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: GA HC REIT II Des Plaines Surgical Center, LLC
Address of Site Owner: 18191 Von Karman Ave, Suite 300, Irvine, CA 92612
Street Address or Legal Description of the Site: 8901 Golf Road, #100, DesPlaines, IL 60016
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: LGH-A/Golf ASTC, L.L.C.			
Address: 8901 Golf Road, Des Plaines, IL 60016			
☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☒	Limited Liability Company	☐	Sole Proprietorship
		☐	Other
- 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.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

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

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☒ Change of Ownership
- ☐ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide 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 applicants seek authority from the Illinois Health Facilities and Review Board ("HFSRB") for a Change of Ownership of the entity who has operational control over Golf Surgical Center. Post-closing the name of the surgical center will remain the same, Golf Surgical Center.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: \$ <u>0</u> Fair Market Value: \$ <u>0</u>
The project involves the establishment of a new facility or a new category of service ☐ Yes ☒ No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ <u>N/A</u> .

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

- ☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): July 31, 2019

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

- ☐ Cancer Registry
☐ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

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

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

This Application is filed on the behalf of ASTC Management, Inc * 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.

John Kinzer, M.D.
SIGNATURE

SIGNATURE

John Kinzer, M.D.
PRINTED NAME

PRINTED NAME

President
PRINTED TITLE

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5 day of July

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

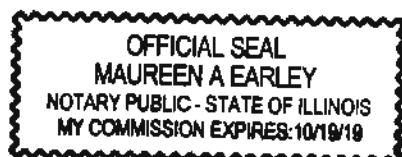
Maureen A Earley
Signature of Notary

Signature of Notary

Seal

Seal

*Insert the EXACT legal name of the applicant



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John Kinzer, M.D.
SIGNATURE

SIGNATURE

John Kinzer, M.D.
PRINTED NAME

PRINTED NAME

Manager
PRINTED TITLE

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5 day of July

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

Maureen A Earley
Signature of Notary

Signature of Notary

Seal

Seal

*Insert the EXACT legal name of the applicant



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John Kinzer, M.D.
SIGNATURE

SIGNATURE

John Kinzer, M.D.
PRINTED NAME

PRINTED NAME

PRINTED TITLE

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 5 day of July

Notarization:
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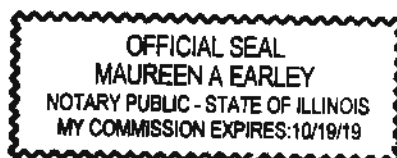
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SIGNATURE

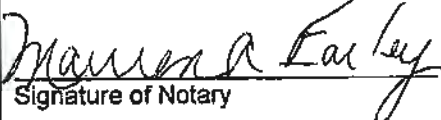
Damon N. Havill

PRINTED NAME

Member, Board of Managers

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 5 day of July


Signature of Notary

Seal

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this ____ day of ____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant



SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES **- INFORMATION REQUIREMENTS**

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

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 certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. 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.**
4. If, during a given calendar year, an applicant submits more than one application for permit, 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 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to

achieving the stated goals as appropriate.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-8) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHANGE OF OWNERSHIP (CHOW)**1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility**

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - 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)(2) - A statement as to the anticipated benefits of	X

the proposed changes in ownership to the community	
1130.520(b)(2) - 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)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- 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

Application for Change of Ownership Among Related Persons

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

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

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 41.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

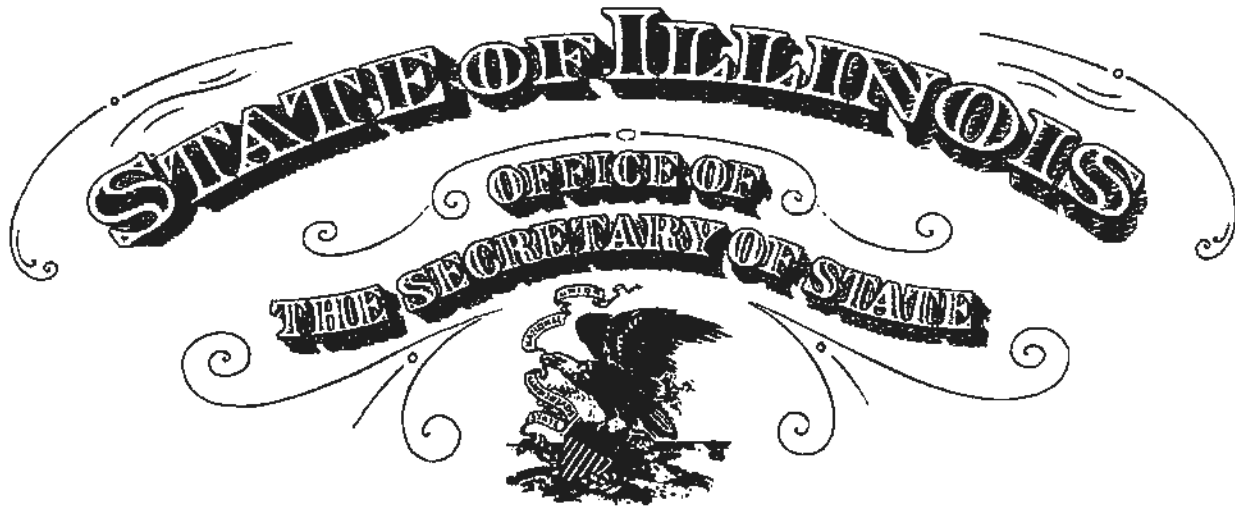
APPEND DOCUMENTATION AS **ATTACHMENT 21**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for LGH-A/Golf ASTC, LLC, ASTC Management, Inc. and ASTC Management- II, LLC (collectively, the "Applicants") are attached at Attachment – 1. LGH-A/Golf ASTC, LLC is the operator of Golf Surgical Center.

File Number

0663134-7



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

ASTC MANAGEMENT- II, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 22, 2017, 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 29TH
day of MAY A.D. 2018 .***

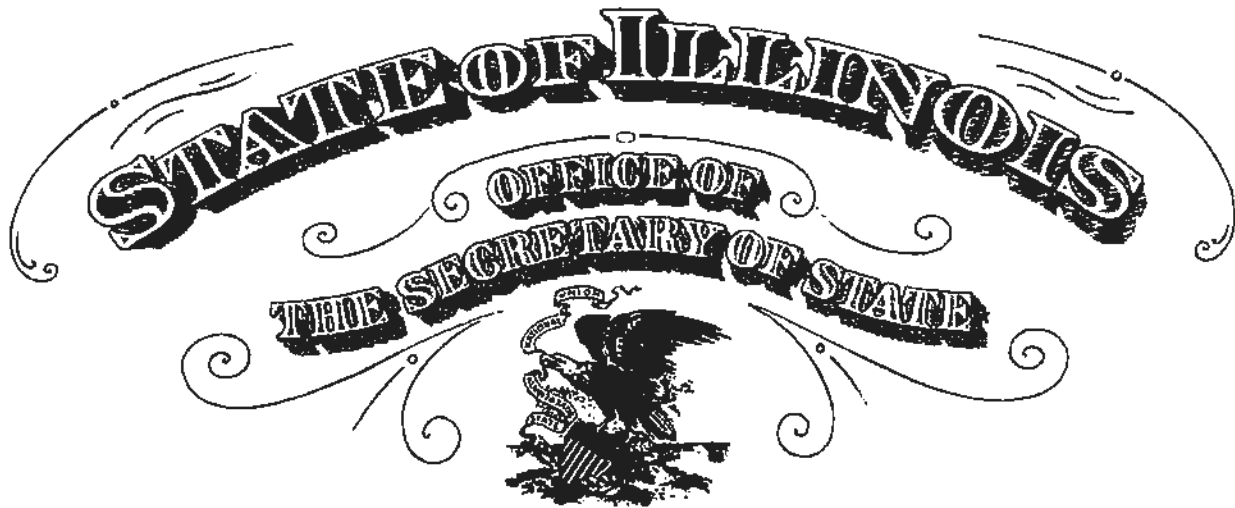
Jesse White

SECRETARY OF STATE

Authentication #: 1814902528 verifiable until 05/29/2019
Authenticate at: <http://www.cyberdriveillinois.com>

File Number

5430-665-2



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

ASTC MANAGEMENT, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 03, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, 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 29TH
day of MAY A.D. 2018 .***

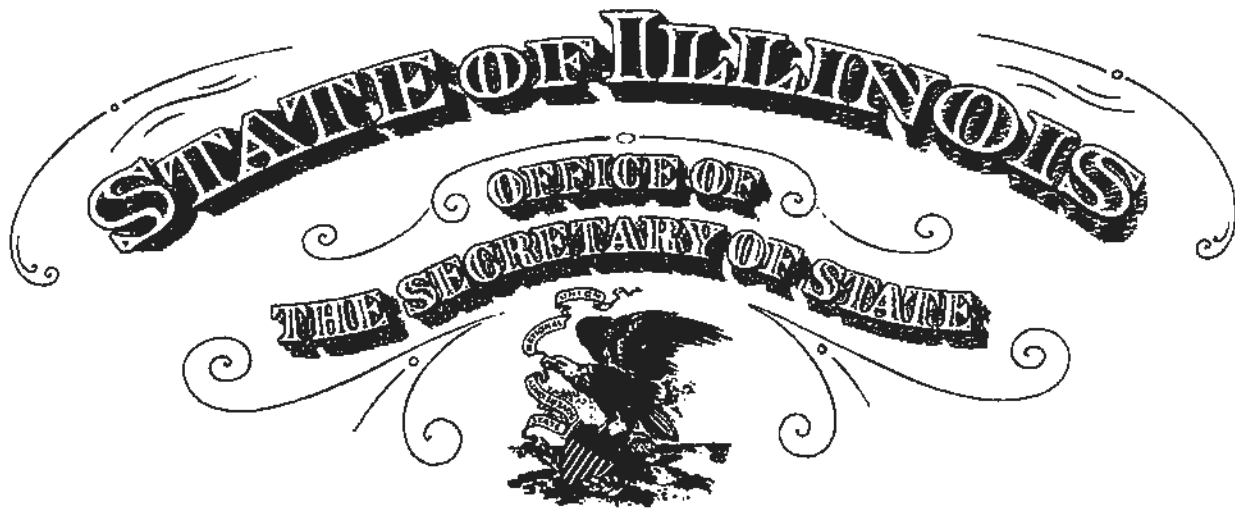
Jesse White

SECRETARY OF STATE

Authentication #: 1814902518 verifiable until 05/29/2019
Authenticate at: <http://www.cyberdriveillinois.com>

File Number

0013505-4



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

LGH-A/GOLF ASTC, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 03, 1997, 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 29TH
day of MAY A.D. 2018 .

Jesse White

SECRETARY OF STATE

Authentication #: 1814902502 verifiable until 05/29/2019
 Authenticate at: <http://www.cyberdriveillinois.com>

Section I, Identification, General Information, and Certification
Site Ownership

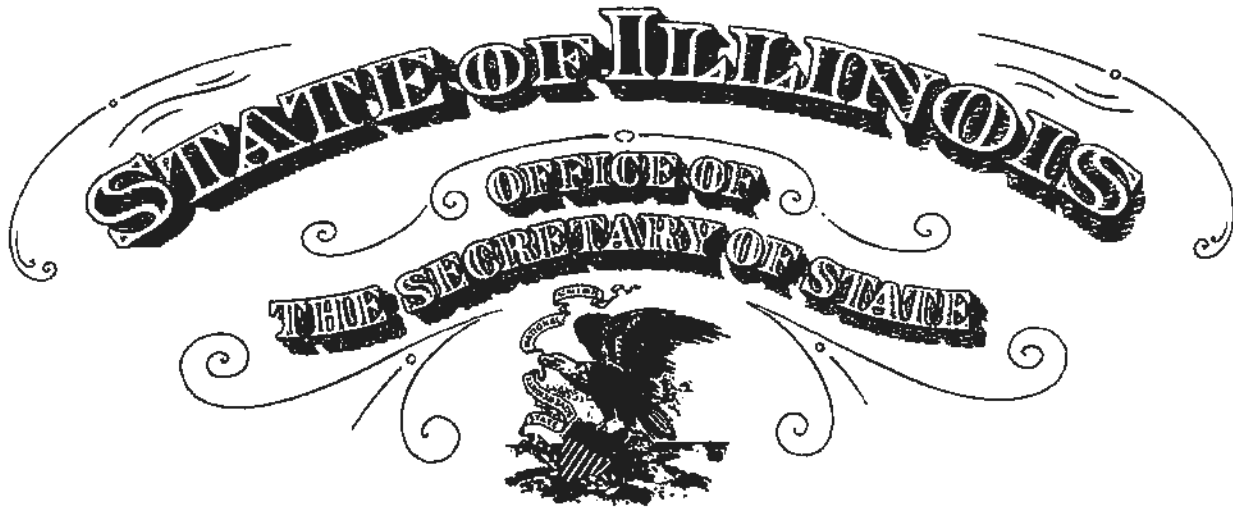
There is no change in site ownership.

Section I, Identification, General Information, and Certification
Operating Identity/Licensee

LGH-A/Golf ASTC, LLC is currently the approved operating entity for Golf Surgical Center. Following the transaction LGH-A/Golf ASTC, LLC will remain the operating entity for the facility. The Illinois Certificate of Good Standing for LGH-A/Golf ASTC, LLC is attached at Attachment – 3.

File Number

0013505-4



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

LGH-A/GOLF ASTC, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 03, 1997, 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 29TH
day of MAY A.D. 2018 .***

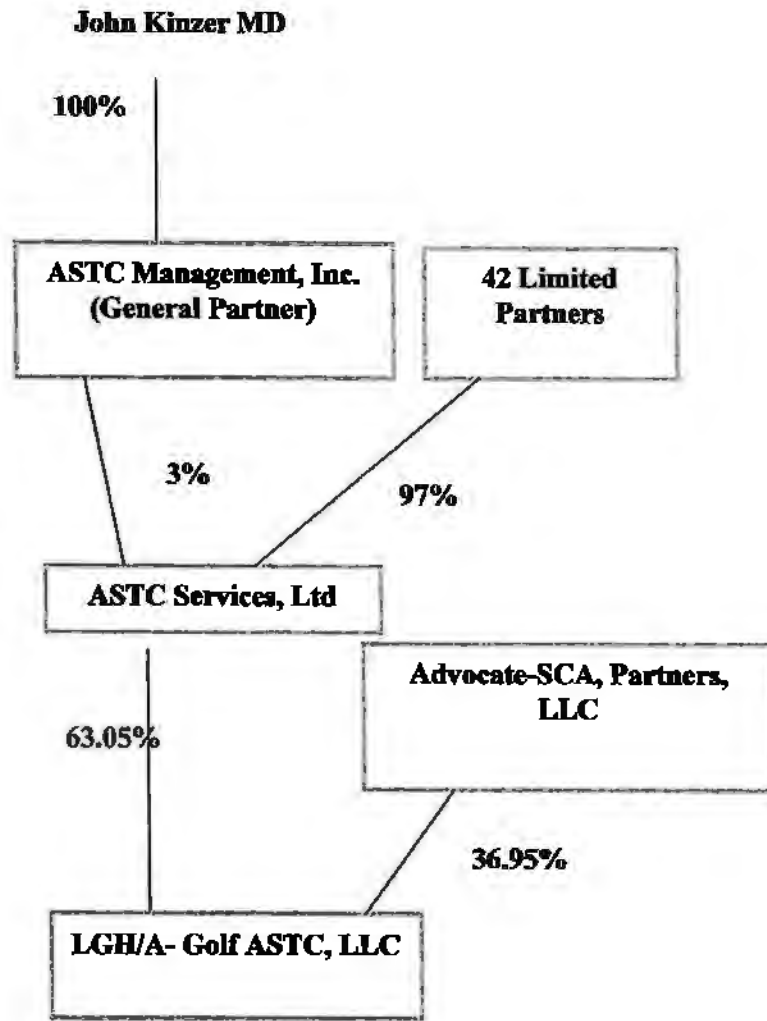
Jesse White

SECRETARY OF STATE

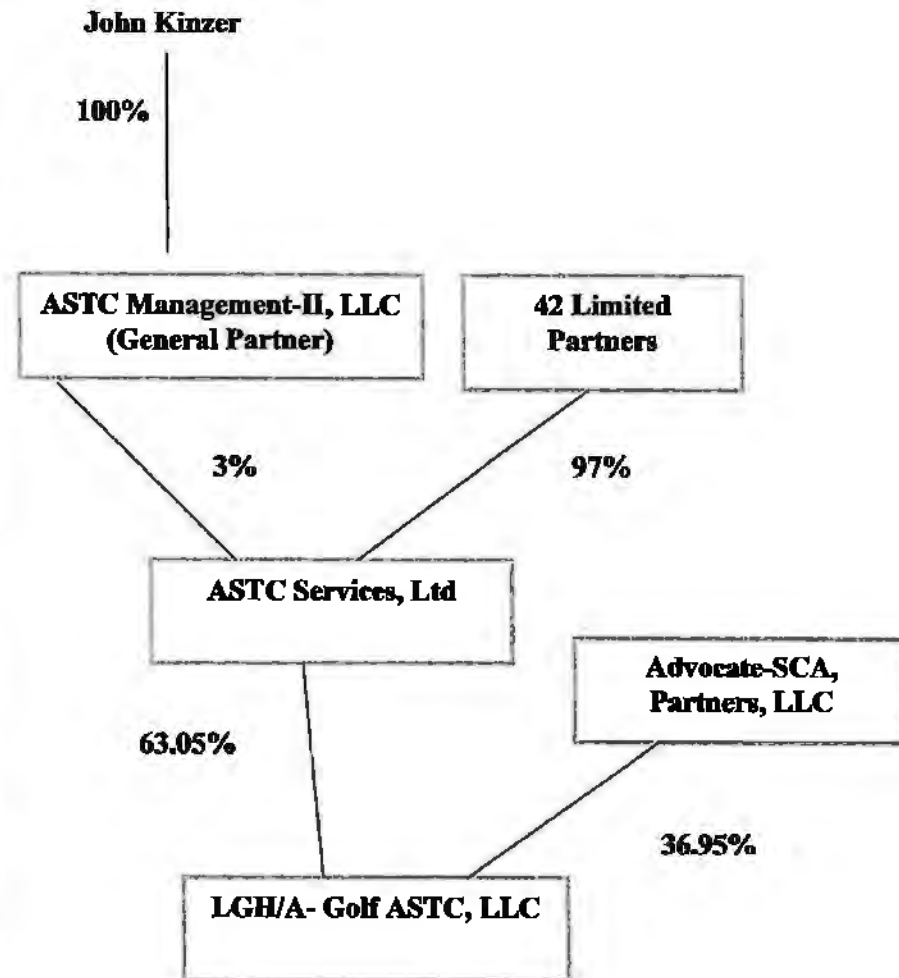
Authentication #: 1814902502 verifiable until 05/28/2019
Authenticate at: <http://www.cyberdriveillinois.com>

Section I, Identification, General Information, and Certification
Organizational Relationships

The organizational chart showing the current ownership structure of Golf Surgical Center, along with the post-closing ownership structure is enclosed at Attachment – 4.

OLD:

62819174.3

PROPOSED:

Section I, Identification, General Information, and Certification
Flood Plain Requirements

The proposed change of ownership of Golf Surgical Center involves no construction or modernization. Accordingly, this criterion is not applicable.

Section I, Identification, General Information, and Certification
Historic Resources Preservation Act Requirements

The proposed project will not involve construction or modernization of Golf Surgical Center. Accordingly, this criterion is not applicable.

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(b), Project Purpose, Background and Alternatives

Background of Applicant

- 1. A listing of all health care facilities owned or operated by the Applicant, including licensing, and certificates, if applicable.**

Applicant owns and operates only one health care facility: Golf Surgical Center, located at 8901 Golf Road, Des Plaines, IL 60018

- 2. A certified listing of any adverse action taken against any facility owned and/or operated by the Applicant during the three years prior to the filing of the application.**

By their signature on the Certification pages to this application, each of the Applicants attest that no adverse action has been taken by IDPH, CMS, or any other State or Federal Agency against any facility owned and/or operated by them during the three years prior to the filing of this application.

- 3. 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 national recognized accreditation organizations.**

By their signature on the Certification pages to this application, each of the Applicants authorize the HFSRB and IDPH to access any documents necessary to verify the information submitted, including but limited to: (i) official records of DPH or other State Agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of national recognized accreditation organizations.

Section V, Change of Ownership
Criterion 1110.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

Applicable Review Criteria – CHOW

1. 1130.520 (b)(1)(A)- Names of the parties

1. The Applicants are LGH/A – Golf ASTC, L.L.C., ASTC Management, Inc. and ASTC Management-II, LLC (collectively, "Golf ASTC").

2. 1130.520(b)(1)(B) – Background of the parties

Each of the applicants, by their signatures to the Certification pages of this application, attest 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.

Each of the applicants, by their signatures to the Certification pages of this application, attest 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 facilities owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.

3. 1130.520(b)(1)(C) – Structure of the transaction

LGH-A/Golf ASTC, LLC is currently the approved operating entity of Golf Surgical Center. Following the transaction, ASCTC Management-II, LLC will have a majority ownership interest in Golf Surgical Center. LGH-A/Golf ASTC, LLC will remain the operating entity for the surgical center.

4. 1130.520(b)(1)(D) – Name of Licensed Entity after Transaction

LGH-A/Golf ASTC, LLC. will be the certified operating entity for the facility following the transaction.

5. 1130.520(b)(1)(E) – List of ownership or membership interests in such licensed or certified entity both prior to and after transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons

An organizational structure of the current owner, as well as the post-closing organizational structure of the proposed applicants are attached at Attachment - 4.

6. 1130.520(b)(1)(F) – Fair market value of assets to be transferred

The fair market value of the transferred assets is \$0.00.

7. 1130.520(b)(1)(G) – Purchase price or other forms of consideration to be provided

Purchase price is \$0.00.

8. 1130.520(b)(2) – Affirmations

In accordance with 77 Ill. Adm. Code §1130.520, Applicants affirm that any project for which permits have been issued have been completed, or will be completed, or altered in accordance with the provision of this section.

9. **1130.520(b)(2) – If ownership change is for hospital, affirmation that the facility will not adopt a more restrictive charity care policy that 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.**

Not applicable.

10. **1130.520(b)(2), A statement as to the anticipated benefits of the proposed changes in ownership to the community.**

This COE application is due to a corporate re-structuring. There will be no change in the legal entity that holds the license for the ambulatory surgery center in this COE application. Accordingly, this criterion is not applicable.

11. **1130.520(b)(2) The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change of ownership**

The Applicants have not identified empirically quantifiable cost savings at the outset of the change of ownership.

12. **1130.520(b)(2) – A description of the facilities quality improvement program mechanism that will be utilized to assure quality control**

The Applicants intend to utilize Golf Surgical Center's established quality control mechanisms.

13. **1130.520(b)(2) – A description of the selection process that the acquiring entity will use to select the facilities governing body**

There will be no change in the legal entity that holds the license for the ambulatory surgery center in this CEO application. Rather, as described above in the Summary of Transaction section, the corporate change will be in the creation of the new corporate entity ASTC Management – II, LLC, which will serve as the ultimate parent of the surgery center.

14. **1130.520(b)(2) – Statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility**

The Applicants have or will prepare a written statement response to address the review criteria contained in 77 Ill. Adm. Code 1110.240 that will be available for public review at the facility.

15. **1130.520(b)(2) – A description or summary of any proposed changes to the scope of service or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition**

There are no proposed changes to the scope of services or levels of care that were planned to be provided at the facility that are anticipated to occur within twenty-four months after the acquisition.

Section X, Charity Care Information

The table below provides charity care information for all dialysis facilities located in the State of Illinois that are owned or operated by the Applicants.

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	\$9,654,126	\$10,282,728	\$7,658,740
Amount of Charity Care (charges)	\$11,712	\$7,808	\$590
Cost of Charity Care	\$11,712	\$7,808	\$590

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

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		21-24
2	Site Ownership		25
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		26-27
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		28-29
5	Flood Plain Requirements		30
6	Historic Preservation Act Requirements		31
7	Project and Sources of Funds Itemization		
8	Financial Commitment Document if required		
9	Cost Space Requirements		
10	Discontinuation		
11	Background of the Applicant		32
12	Purpose of the Project		
13	Alternatives to the Project		
	Service Specific:		
14	Neonatal Intensive Care Services		
15	Change of Ownership		33-34
	Financial and Economic Feasibility:		
16	Availability of Funds		
17	Financial Waiver		
18	Financial Viability		
19	Economic Feasibility		
20	Safety Net Impact Statement		
21	Charity Care Information		35



150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312.819.1900

July 5, 2018

Anne M. Cooper
(312) 873-3606
(312) 819-1910 fax
acooper@polsinelli.com

FEDERAL EXPRESS

Michael Constantino
Supervisor, Project Review Section
Illinois Department of Public Health
Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Application for Exemption Permit - Golf Surgical Center

Dear Mr. Constantino:

I am writing on behalf of ASTC Management, Inc, ASTC Management-II, LLC and LGH-A/Golf ASTC, L.L.C. (collectively, "Golf Surgical Center") to submit the attached Application for Exception Permit for Change of Ownership of the entity who has operational control over Golf Surgical Center, an ambulatory surgery center located in Des Plaines. For your review, I have attached the following documents:

1. Check for \$2,500 for the application processing fee;
2. Completed Application for Exemption Permit;
3. Copies of Certificate of Good Standing for the Applicants;
4. Charity care data.

Thank you for your time and consideration of Golf Surgical Center's application for exemption permit. If you have any questions or need any additional information to complete your review of the Golf Surgical Center's application for exemption permit, please feel free to contact me.

Sincerely

A handwritten signature in blue ink that reads "Anne M. Cooper".

Anne M. Cooper

Attachments