ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

19-054

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

ORIGINAL

RECEIVED
OCT 29 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Associated Surgical Center f/k/a Chicago Surgical Clinic, Ltd.		
Street Address:	129 West Rand Road		
City and Zip Code:	Arlington Heights, IL 60004		
County: Cook	Health Service Area: VII	Health Planning Area: 031	

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

Exact Legal Name:	Associated Surgical Center, LLC
Street Address:	129 West Rand Road
City and Zip Code:	Arlington Heights, IL 60004
Name of Registered Agent:	James M. Sulzer
Registered Agent Street Address:	20 N. Wacker Drive Suite 2250
Registered Agent City and Zip Code:	Chicago, IL 60606
Name of Chief Executive Officer:	Yelena Levitin, MD
CEO Street Address:	129 West Rand Road Suite 1
CEO City and Zip Code:	Arlington Heights, IL 60004
CEO Telephone Number:	847/215-0530

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Post 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:	Yelena Levitin, MD
Title:	Principal
Company Name:	Associated Surgical Center, LLC
Address:	129 West Rand Road Arlington Heights, IL 60004
Telephone Number:	847/215-0530
E-mail Address:	ylevitinmd@yahoo.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Rand Road Center, LLC
Address of Site Owner:	129 West Rand Road Arlington Heights, IL 60004

Street Address or Legal Description of the Site: 129 West Rand Road Arlington Heights, IL 60004

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:	Associated Surgical Center, LLC
Address:	129 West Rand Road Arlington Heights, IL 60004

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

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

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

Flood Plain Requirements — Not Applicable

[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.hfsrb.illinois.gov).

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

Historic Resources Preservation Act Requirements — Not Applicable

[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 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☐ Substantive

X Non-substantive

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.

Associated Surgical Center f/n/a Chicago Surgical Clinic, Ltd. was granted a Certificate of Need Permit on December 10, 2012 to operate as a multi-specialty ambulatory surgery treatment center ("ASTC"), and became operational in late 2016.

The proposed project is limited to the addition of orthopedic surgery as an "approved service", and does not involve any construction, renovation, or major equipment. Therefore, the project is classified as non-substantive.

Project Costs and Sources of Funds

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	$40,000		$40,000
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	**$120,800**	**$0**	**$120,800**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**$120,800**	**$0**	**$120,800**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$120,800**	**$0**	**$120,800**
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 X No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes X 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 $ _____.

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:

X None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): __within 60 days of CON Permit_

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
X 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 Not Applicable
☐ APORS Not Applicable
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 for permit being deemed incomplete.

Cost Space Requirements — Not Applicable

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization **Not Applicable**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

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 _Associated Surgical 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	SIGNATURE
PRINTED NAME	PRINTED NAME: YELENA LEVITIN
PRINTED TITLE	PRINTED TITLE: president
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 28 day of SEPTEMBER, 2019
Signature of Notary	Signature of Notary
Seal	Seal

OFFICIAL SEAL
IGOR KROIN
Notary Public - State of Illinois
My Commission Expires 5/09/2021

*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.

1110.110(a) – Background of the Applicant

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 1110.110(b) & (d)

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 Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) 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 IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

Not Applicable

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE: **Not Applicable**

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES: **Not Applicable**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ **Cardiovascular**
☐ **Colon and Rectal Surgery**
☐ **Dermatology**
☐ **General Dentistry**
☐ **General Surgery**
☐ **Gastroenterology**
☐ **Neurological Surgery**
☐ **Nuclear Medicine**
☐ **Obstetrics/Gynecology**
☐ **Ophthalmology**
☐ **Oral/Maxillofacial Surgery**
X **Orthopedic Surgery---proposed to be added**
☐ **Otolaryngology**
☐ **Pain Management**
☐ **Physical Medicine and Rehabilitation**
☐ **Plastic Surgery**
☐ **Podiatric Surgery**
☐ **Radiology**
☐ **Thoracic Surgery**
☐ **Urology**
☐ **Other**_____

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X

1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VI. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

_$120,800__	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a

_____ _____	resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$120,800	**TOTAL FUNDS AVAILABLE**

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

not applicable, project funded through internal sources

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

not applicable, no debt to be used

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

not applicable, project does not involve modernization

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

not applicable, non-substantive project

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

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 39.

CHARITY CARE			
	2016	2017	2018
Net Patient Revenue	**$34,518**	**$557,074**	**$989,883**
Amount of Charity Care (charges)	$0	$28,570	$37,345
Cost of Charity Care	$0	$11,428	$14,938

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 0591967-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

ASSOCIATED SURGICAL CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 09, 2016, 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* 5TH *day of* JULY *A.D.* 2018 .

Authentication #: 1818601770 verifiable until 07/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site occupied by Associated Surgical Center, and located at 129 West Rand Road in Arlington Heights, Illinois, is owned by Rand Road Center, LLC.

Sincerely,

Yelena Levitin, MD

09 - 28 — 2019

OFFICIAL SEAL
IGOR KROIN
Notary Public - State of Illinois
My Commission Expires 5/09/2021

Notarized:

OPERATING IDENTITY/LICENSEE

The ASTC's operating entity and licensee is and will continue to be Associated Surgical Center, LLC ("the LLC"). The sole current investor in the LLC is Yelena Levitin, MD. Dr. Levitin will maintain, at minimum, a 50% ownership interest in the LLC for a minimum of two years. As a result of Dr. Levitin's sole ownership, an organizational chart is not provided.

ATTACHMENT 3

File Number 0591967-3

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* JULY *A.D.* 2018 .

Jesse White

SECRETARY OF STATE

Authentication #: 1818601770 verifiable until 07/05/2019
Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 3

PROJECT COSTS AND SOURCES OF FUNDS

Project Costs	
Movable and Other Equipment (list attached)	
Misc. orthopedic surgery equipment	$80,800
Consulting and Other Fees	
CON-Related	$25,000
Legal	$5,000
Misc.	$10,000
Sources of Funds	
Cash and Liquid Assets	$120,800

ATTACHMENT 7

ASSOCIATED SURGICAL CENTER
ORTHOPEDIC EQUIPMENT LIST

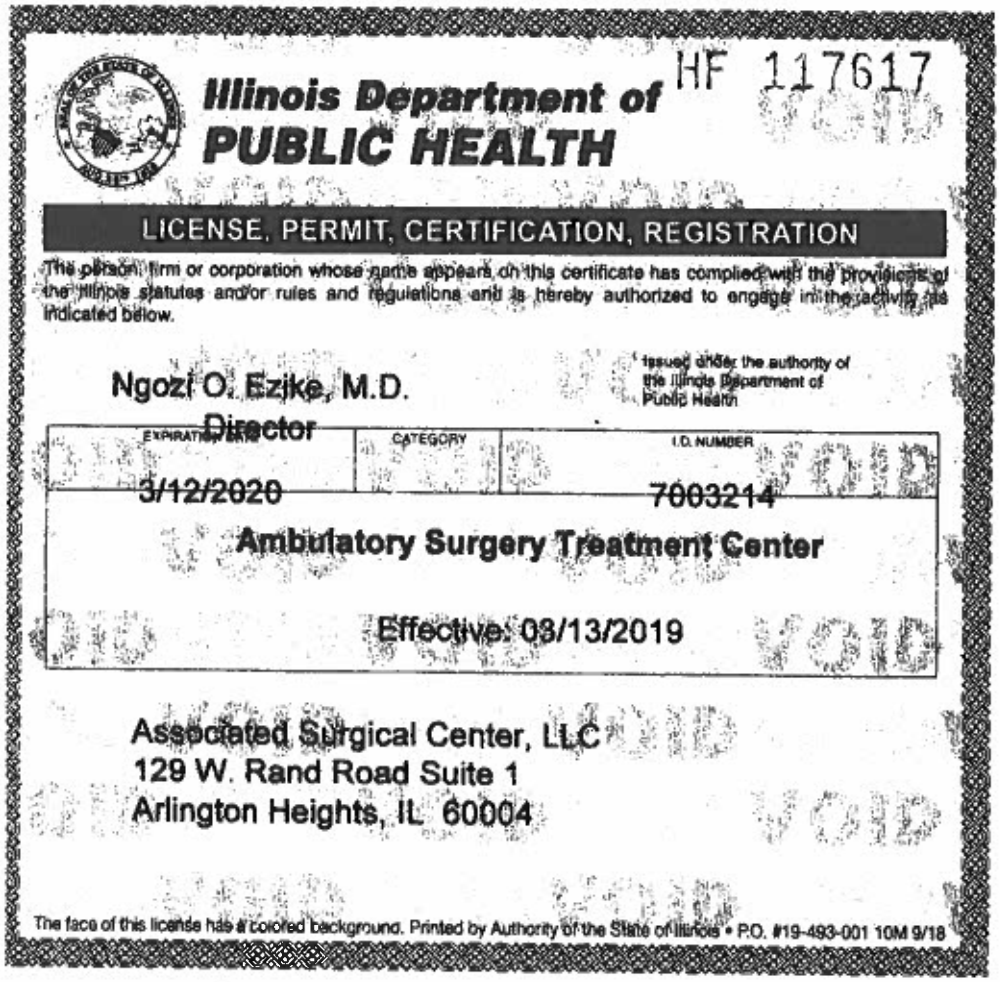
ORTHOPEDIC EQUIPMENT TO PURCHASE		COST
Arthroscopy Instrument Tray Sets		$ 5,600
ACL Instrument Tray Sets		$ 2,650
Meniscus Instrument Tray Sets		$ 3,425
Small Joint Instrument Tray Sets		$ 2,875
Carpal Tunnel Intrument Tray Sets & System		$ 3,425
Hand Instrument Tray Sets		$ 3,270
Cervical Instrument Tray Sets		$ 2,375
Lumbar Instrument Tray Sets		$ 4,750
Large Fragment Set		$ 1,930
Cannulated Screw Sets (Various Sizes)		$ 3,000
Carpal Tunnel System		$ 2,760
Bone Intrument Set		$ 2,395
Power Driver/Drill/Saw Set (Zimmer or Other)		$ 5,550
Equipment Cart		$ 2,450
Side Table		$ 1,475
Bipolar Electrocautery Unit		$ 2,000
Fluoroscanner		$ 9,650
Shaver		$ 2,850
Leg Holder		$ 1,930
Shoulder Holder		$ 1,950
Finger Traps		$ 125
Beach Chair		$ 1,825
Cast Saw		$ 2,550
Surgical Headlights		$ 4,850
Image Printer		$ 1,890
Surgical Irrigation System/Arthroscopy Pump		$ 3,250
Total Equipment		$ 80,800

ATTACHMENT 7

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of Proposed Total Square Feet			
					That is:		
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ASTC	$ 120,800	7,700	7,700			7,700	
Non-Reviewable							
None							
TOTAL	$ 120,800	7,700	7,700			7,700	

ATTACHMENT 9



Illinois Department of PUBLIC HEALTH

HF 117617

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
3/12/2020		7003214

Ambulatory Surgery Treatment Center

Effective: 03/13/2019

Associated Surgical Center, LLC
129 W. Rand Road Suite 1
Arlington Heights, IL 60004

VOID

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 3/12/2020

Lic Number 7003214

Date Printed 2/21/2019

Associated Surgical Center, LLC

129 W Rand Road Suite 1
Arlington Heights, IL 60004-3142

FEE RECEIPT NO.

ATTACHMENT 11

7500 Grand Ave, Suite 200
Gurnee, Illinois 60031

Toll Free: 1-888-545-5222
Phone: 847-775-1970
Fax: 847-775-1985
reception@aaaasf.org
www.aaaasf.org

Re-Accreditation Decision Letter

Date of Notice: Tuesday, August 13, 2019

Director: Yelena Levitin, M.D.

Thank you for participating in this important quality assurance and patient safety process administered by the American Association for Accreditation of Ambulatory Surgery Facilities. The following report contains information relevant to the conclusion of your recent accreditation survey process including your facility accreditation demographic information, accreditation decision, and recent survey history. AAAASF requires that all standards be met in order to achieve accreditation and that 100% compliance must be maintained at all times. AAAASF reserves the right to conduct additional surveys to validate the findings of previous surveys and to ensure continued compliance with standards.

Attached you will find a report containing all of the deficiencies cited during the accreditation survey along with the corrective action plans submitted to AAAASF. The Final Accreditation Decision based on the findings and corrective action taken in response to your recent survey process is Full.

Survey Details Below

Accrediting Organization: AAAASF

Survey Identification Number: 25580

AAAASF Facility Identification Number: 6500

Program Type: ASC

CCN Number: 14C0001169

Provider/Supplier Name and Address:
Associated Surgical Center LLC
129 W Rand Rd Suite 1
Arlington Heights, IL 60004
United States

Survey Request Type: Self-Evaluation

Survey Type: Full Accreditation Survey

ATTACHMENT 11

Survey Began: Tuesday, July 30, 2019 Survey Ended: Tuesday, July 30, 2019

Date Acceptable Plan of Correction Received: N/A

Method of Follow Up: N/A

Accreditation Decision: Full

Effective Date of Accreditation: Friday, August 23, 2019

Expiration Date of Accreditation: Sunday, August 23, 2020

Recommended for Continued Deemed Status: Yes

CMS Condition for Coverage Cited: N/A

Recent Survey History:

Survey	Survey Description	Survey Type	Begin	End	Deficiencies	Corrected	Decision
25580	Full Accreditation Survey	Re-Survey	7/30/2019	7/30/2019	0	0	Full

Sincerely,

Jeanne Henry
Director of Accreditation

ATTACHMENT 11

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Associated Surgical Center LLC

33

for having met the standards of a CLASS C MEDICARE ambulatory surgery facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital organs.

Global Accreditation Program

ATTACHMENT 11

CEO of Accreditation
Gary M Brownstein, MD

Secretary/Treasurer
Lawrence S. Reed, MD

Certified: 8/23/2019 to 8/23/2020

Certification Number: 6500

ASC in Arlington Heights earns recognition from AAAASFI as one of the first international healthcare facilities that promotes superior quality and safety standards

AAAASFI issues "Global Accreditation Program" Accreditation Certificate to ASC

Associated Surgical Center (ASC), located in Arlington Heights, IL, is one of the first ambulatory surgical facilities to be accredited by The American Association for Accreditation for Ambulatory Surgery Facilities International (AAAASFI). The global accreditation program has surveyed ASC and found it to exceed superior standards.

"We are very proud to have earned this global accreditation in recognition of the outstanding care given to our patients by the dedicated team of doctors, nurses and support staff who work every day at ASC to provide great care," said Dr. Yelena Levitin, M.D., medical director at Associated Surgical Center.

Patients undergoing surgery in an accredited operating room such as at ASC are assured the same level of care and safety preparedness as those receiving care in a hospital, according to AAAASFI.

AAAASF works with health professionals and organizations that are dedicated to delivering high-quality and innovative care to the communities we serve. Together ASC and AAAASFI work to help increase awareness and promote the efforts of health care organizations to address health care concerns and the delivery of quality care.

Globally, there is a growing need and demand for uniform standards and practices to ensure quality health care and patient safety. AAAASFI and ASC work together to address and meet these high standards of care.

ATTACHMENT 11

PURPOSE

The purposes of the proposed project are to provide an accessible site for the area residents in need of outpatient orthopedic surgery and having language and/or financial barriers; and to provide an avenue for orthopedic surgeons to perform cases at the Associated Surgical Center. Following approval, orthopedic surgeons seeking and gaining surgical privileges at the ASTC will provide their patients with greater access to ASTC services, and therein the health care and well-being of their patients, the majority of which reside in the geographic service area ("GSA") described below, will be improved.

It is not anticipated that the addition of orthopedic surgery to the services approved for the ASTC will change the GSA in any appreciable way. As discussed elsewhere in this application, the GSA, per IDPH rule, consists of those communities and ZIP Code areas located within ten miles of the proposed site. This area generally covers the communities from Vernon Hills on the north, to Waukegan Road on the east, to O'Hare airport on the south and Schaumburg on the west.

The singular goal of the project is to allow the performance of orthopedic surgery cases in the ASTC within two months of receipt of a Certificate of Need Permit to do so.

Associated Surgical Center's 2018 patient origin is provided in ATTACHMENT 27c2. It is not anticipated that the addition of orthopedic surgery will change the facility's patient origin to any appreciable degree. Also attached is a listing of ZIP Codes located within ten miles of Associated Surgical Center. The population of this area is approximately 901,000.

ZIP Codes in a Radius

ZIP: 60004
Radius: 10 Search Clear

About this Tool

- Get the list of ZIP codes within a given radius from entered ZIP Code
- The list will display city, state, county, population, number of businesses and the distance

ZIP	City	State	County	Population	Businesses	Distance
60004	ARLINGTON HEIGHTS	IL	COOK	52,602.00	1565	0
60006	ARLINGTON HEIGHTS	IL	COOK	0.00	17	1.681
60038	PALATINE	IL	COOK	0.00	1	2.722
60055	PALATINE	IL	COOK	0.00	0	2.722
60078	PALATINE	IL	COOK	0.00	18	2.722
60094	PALATINE	IL	COOK	0.00	1	2.722
60090	WHEELING	IL	COOK	39,989.00	1290	3.025
60070	PROSPECT HEIGHTS	IL	COOK	16,925.00	412	3.028
60095	PALATINE	IL	COOK	0.00	2	3.082
60008	ROLLING MEADOWS	IL	COOK	23,647.00	962	3.494
60074	PALATINE	IL	COOK	40,610.00	757	3.691
60005	ARLINGTON HEIGHTS	IL	COOK	31,144.00	1469	3.767
60089	BUFFALO GROVE	IL	LAKE	42,934.00	1487	4.062
60056	MOUNT PROSPECT	IL	COOK	58,812.00	1444	4.493
60067	PALATINE	IL	COOK	41,030.00	1333	4.509
60173	SCHAUMBURG	IL	COOK	13,773.00	2149	5.317
60069	LINCOLNSHIRE	IL	LAKE	7,721.00	547	5.955
60016	DES PLAINES	IL	COOK	62,757.00	1356	6.243
60015	DEERFIELD	IL	LAKE	27,013.00	1450	6.764
60195	SCHAUMBURG	IL	COOK	5,142.00	362	6.819
60179	HOFFMAN ESTATES	IL	COOK	0.00	42	7.004
60007	ELK GROVE VILLAGE	IL	COOK	34,727.00	2550	7.018
60062	NORTHBROOK	IL	COOK	42,278.00	2850	7.205
60026	GLENVIEW	IL	COOK	14,685.00	515	7.378
60017	DES PLAINES	IL	COOK	0.00	16	7.439
60047	LAKE ZURICH	IL	LAKE	44,183.00	1530	7.448
60009	ELK GROVE VILLAGE	IL	COOK	0.00	9	7.553
60159	SCHAUMBURG	IL	COOK	0.00	8	7.591
60168	SCHAUMBURG	IL	COOK	0.00	10	7.591
60065	NORTHBROOK	IL	COOK	0.00	17	7.876
60019	DES PLAINES	IL	COOK	0.00	1	8.117
60011	BARRINGTON	IL	LAKE	0.00	19	8.335
60194	SCHAUMBURG	IL	COOK	20,792.00	558	8.337

ATTACHMENT 12

60025	GLENVIEW	IL	COOK	41,603.00	1550	8.407
60169	HOFFMAN ESTATES	IL	COOK	35,620.00	638	8.448
60061	VERNON HILLS	IL	LAKE	28,633.00	1019	8.543
60018	DES PLAINES	IL	COOK	30,813.00	1700	8.963
60193	SCHAUMBURG	IL	COOK	40,238.00	1045	9.164
60010	BARRINGTON	IL	LAKE	47,037.00	1987	9.545
60082	TECHNY	IL	COOK	0.00	5	9.548
60192	HOFFMAN ESTATES	IL	COOK	16,791.00	429	9.748
60068	PARK RIDGE	IL	COOK	39,189.00	1462	9.767
				900,688.00	34,582.00	

ATTACHMENT 12

ALTERNATIVES

The scope of this application is limited to the addition of orthopedic surgery as a service to be provided by an existing ASTC, and as such, with the exception of not seeking approval to add the service, there are no alternatives available to the applicant.

ATTACHMENT 13

SIZE

The existing ASTC consists of 7,700 DGSF, and has two Class C surgical suites, one Class B procedure room and nine Phase I recovery stations. The proposed project does not involve any changes to the size or configuration of the ASTC.

DEPARTMENT/SERVICE	EXISTING DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	7,700	9,330	-1,630	YES

UTILIZATION

Associated Surgical Center opened in 2016, and has three operating rooms.

Utilization of the ASTC increased dramatically in 2018, with 927 cases, compared to 448 in the previous year, an increase of 107%. Utilization has continued to increase during 2019, with the number of cases performed during the first nine months of the year exceeding that of the prior year by another 59%. These dramatic increases have resulted from the addition of surgeons to the Medical Staff, as well as the ASTC securing full Medicaid certification. Upon the approval to provide orthopedic surgery, it is the ASTC's plan to recruit additional orthopedic surgeons desirous of performing cases in the ASTC. Utilization is also anticipated to increase through the active recruitment of surgeons practicing the specialties already approved to be provided at the ASTC, a process that has been initiated during the past year. The center's continued growth can undoubtedly progress to meet the utilization standard over the coming years, with an expected annual increase of 30% during the first full year following this project's completion, and at least 20% in the second year.

Year	Historical & Projected Utilization (Hours)	State Standard	Met/Meet Standard?
2017	204	3,000+	NO
2018	1,158	3,000+	NO
2020	2,238	3,000+	NO
2021	2,685	3,000+	NO

ATTACHMENT 15

SERVICE TO GEOGRAPHIC SERVICE AREA RESIDENTS

A majority of the patients treated at the ASTC during 2018 were residents of the geographic service area ("GSA"), as defined in Section 1110.235, that being the ZIP Code areas located within ten miles of the ASTC. A listing of those ZIP Code areas is provided in ATTACHMENT 12, with the area having a population of approximately 901,000 residents.

During 2018, 55.8% of the patients treated at the ASTC were residents of the GSA (patient origin analysis attached). As discussed in ATTACHMENT 27c6, over 80% of the ASTC's patients are Russian/Eastern European or Spanish-speaking, many of whom travel greater distances than typical to access ASTC services because of the applicant ASTC's commitment to providing a broad spectrum of multi-lingual staff. An example of this experienced during 2018 are the patients residing in Elgin and adjacent Carpentersville (ZIP Code areas 60110, 60120, and 60123), located outside of the 10-mile radius, but accounting for 5.5% of the 2018 surgical cases performed in the ASTC. A very high percentage of these patients are Spanish-speaking.

ASSOCIATED SURGICAL CENTER
PATIENTS BY ZIP CODE 2018

ZIP CODE	CITY	TOTAL
60002	Antioch	1
60004	Arlington Heights	31
60005	Arlington Heights	24
60007	Elk Grove Village	5
60008	Rolling Meadows	12
60010	Deer Park	1
60010	Barrington	3
60013	Cary	3
60014	Crystal Lake	2
60015	Deerfield	10
60015	Riverwoods	1
60016	Des Plaines	42
60018	Rosemont	1
60018	Des Plaines	23
60020	Fox Lake	2
60021	Fox River Grove	1
60022	Glencoe	1
60025	Glenview	23
60026	Glenview	6
60030	Grayslake	2
60031	Gurnee	9
60035	Higland Park	7
60042	Island Lake	2
60044	Lake Bluff	1
60045	Lake Forest	1
60046	Lake Villa	1
60046	Lindenhurst	2
60047	Kildeer	2
60047	Lake Zurich	10
60047	Long Grove	5
60048	Libertyville	8
60051	Lakemoore	1
60053	Morton Grove	3
60056	Mt Prospect	34
60060	Long Grove	1
60060	Mundelein	16
60061	Vernon Hills	25
60062	Northbrook	17
60064	North Chicago	4
60067	Palatine	6
60068	Park Ridge	2
60069	Lincolnshire	1
60070	Prospect Heights	16
60071	Prospect Heights	1
60073	Round Lake	14

ATTACHMENT 25c2

ASSOCIATED SURGICAL CENTER
PATIENTS BY ZIP CODE 2018

ZIP CODE	CITY	TOTAL
60073	Round Lake Beach	7
60074	Deer Park	1
60074	Kildeer	1
60074	Palatine	59
60076	Skokie	6
60077	Skokie	6
60078	Palatine	1
60084	Wauconda	3
60085	Waukegan	5
60087	Beach Park	2
60089	Buffalo Grove	51
60090	Wheeling	115
60091	Wilmette	1
60099	Zion	1
60101	Addison	5
60102	Algonquin	1
60103	Bartlett	5
60104	Bellwood	2
60106	Bensenville	3
60107	Sreamwood	10
60108	Bloomingdale	1
60110	Barrington	
60110	Carpentersville	11
60120	Elgin	24
60123	Elgin	13
60131	Schiller Park	1
60133	Hanover Park	3
60136	Gilberts	1
60137	GlenEllyn	3
60139	Glendale Heights	1
60140	Hampshire	4
60143	Itasca	2
60152	Marengo	2
60154	Westchester	1
60156	Lake In The Hills	2
60157	Medinah	3
60160	Melrose Park	1
60169	Hoffman Estates	10
60171	River Grove	1
60172	Roselle	2
60173	Schaumburg	2
60174	St Charles	1
60176	Schiller Park	2
60177	South Elgin	1

ATTACHMENT 25c2

ASSOCIATED SURGICAL CENTER
PATIENTS BY ZIP CODE 2018

ZIP CODE	CITY	TOTAL
60188	Carol Stream	1
60189	Wheaton	1
60192	Hoffman Estates	5
60193	Schaumburg	14
60194	Schaumburg	8
60195	Hoffman Estates	2
60435	Joliet	1
60439	Lemont	2
60440	Boilingbrook	1
60453	Oak Lawn	3
60458	Justice	1
60462	Orland Park	1
60463	Palos Heights	1
60467	Orland Park	2
60477	Tinley Park	1
60487	Tinley Park	1
60491	Homer Glen	1
60513	Brookfield	2
60515	Downers Grove	1
60516	Downers Grove	2
60527	Burr Ridge	1
60527	Willowbrook	1
60555	Warrenville	2
60556	Waterman	1
60559	Westmont	5
60561	Darien	3
60563	Naperville	1
60564	Naperville	2
60565	Naperville	2
60606	Chicago	1
60613	Chicago	3
60614	Chicago	1
60617	Chicago	2
60618	Chicago	3
60622	Chicago	1
60626	Chicago	1
60628	Chicago	1
60630	Chicago	9
60631	Chicago	3
60632	Chicago	5
60634	Chicago	8
60639	Chicago	2

ATTACHMENT 25c2

ASSOCIATED SURGICAL CENTER
PATIENTS BY ZIP CODE 2018

ZIP CODE	CITY	TOTAL
60640	Chicago	2
60641	Chicago	8
60642	Chicago	1
60645	Chicago	5
60646	Chicago	3
60647	Chicago	2
60651	Chicago	2
60653	Chicago	2
60656	Chicago	2
60657	Chicago	1
60659	Chicago	1
60660	Chicago	4
60706	Norridge	3
60706	Chicago	1
60707	Chicago	1
60707	Elmwood Park	1
60712	Lincolnwood	1
60714	Niles	10
60804	Cicero	1
62901	Carbondale	1
	OUT OF STATE	
32730	Fern Park, FL	1
33160	Sunny Isles Beach, FL	1
33843	Frostproof, FL	1
34952	Port St Lucie, FL	1
53142	Kenosha, WI	1
	TOTAL	927

ATTACHMENT 25c2

SERVICE DEMAND

The proposed project is limited to the addition of orthopedic surgery to an existing IDPH-licensed ASTC. No additional operating rooms will be provided to accommodate the additional specialty.

Attached are letters from three orthopedic surgeons, Dr. Brian Donahue, who performed 391 cases in qualified facilities during 2018, and who proposes to refer 50 cases annually to the applicant ASTC, Dr. John O'Keefe, who performed 285 cases in qualified facilities during 2018, and who proposes to refer 20-40 cases annually to the applicant ASTC, and Dr. Thomas Poepping, who performed 64 cases in qualified facilities during 2018, and proposes to refer 30 patients annually to the applicant ASTC.

ATTACHMENT 27C3

NAME (please print): Dr Brian Donahue

SPECIALTY: ORTHOPEDIC SURGERY

DATE: 9 / 4 / 2019

TO: Illinois Health Facilities Planning Board
Springfield, IL 62761

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to add Orthopedic Surgery as an approved surgical specialty at the already-existing Associated Surgery Center in Arlington Heights.

I am able to provide historical information and state that during 2019 and 2018 I performed surgical procedures on approximately the following numbers of patients in the hospitals and licensed ASTCs identified below:

NAME OF HOSPITAL or ASTC	2019	2018
NW Community Hospital See sheet	276 pts	391 pts
	____ pts	____ pts
	____ pts	____ pts

I estimate that I will refer 50 patients to Associated Surgery Center during the second year (2021) following the receipt of their requested Certificate of Need Permit to add Orthopedic Surgery.

Attached is a Zip Code-specific patient origin analysis for my 2018 patients.

The information contained in this letter and the attached Zip Code analysis is true and correct, to the best of my available information and belief, and has not been used in the support of any other CON project.

Sincerely,

(Signature)

Notarized: Marilyn K Maierhofer
9/4/19

"OFFICIAL SEAL"
Marilyn K. Maierhofer
Notary Public, State of Illinois
My Commission Expires 3/25/2

ATTACHMENT 2/C3

Total Number of Patients
by Zip Code for 2018

	A	B	C
1	**Name of Dr: Brian Donahue**		**Number of Patients from**
2	**Specialty: Orthopedic Surgeon**	**Zip Code**	**01/01/2018 - 12/31/2018**
3		60005	31
4		60107	3
5		60008	24
6		60156	1
7		60634	4
8		60074	26
9		60093	6
10		60056	51
11		60004	64
12		60010	15
13		60062	2
14		60173	3
15		60067	29
16		60084	2
17		60089	13
18		60016	16
19		60047	15
20		60641	1
21		60070	4
22		60050	4
23		60090	8
24		60622	1
25		60654	1
26		60022	2
27		60195	2
28		60020	2
29		60193	11
30		60631	1
31		60610	2
32		60504	2
33		60071	1
34		60120	1
35		60098	1
36		60525	1
37		60018	1
38		60191	1
39		60143	1
40		60007	4
41		60133	1
42		60192	1
43		60102	2
44		60194	3
45		60026	2
46		60142	3

ATTACHMENT 27C3

Total Number of Patients
by Zip Code for 2018

	A	B	C
47		60081	2
48		60031	1
49		60042	1
50		60603	2
51		60174	1
52		60030	1
53		60406	1
54		60078	1
55		60073	3
56		60136	1
57		60169	1
58		60118	1
59		60643	1
60		60110	3
61		60048	1
62		60139	1
63	**Total Count**		**391**

ATTACHMENT 27C3

Total Number of Patients
by Zip Code for 2019

	A	B	C
1	**Name of Dr: Brian Donahue**		**Number of Patients from**
2	**Specialty: Orthopedic Surgeon**	**Zip Code**	**2019**
3		60192	1
4		60016	5
5		60074	21
6		60004	44
7		60056	33
8		60005	25
9		60010	14
10		60101	2
11		60067	22
12		60018	1
13		60172	1
14		60007	5
15		60089	11
16		60124	1
17		60047	7
18		60142	1
19		85284	1
20		60008	24
21		60020	2
22		60193	3
23		60102	2
24		60070	10
25		60013	1
26		60090	7
27		60041	2
28		60013	2
29		33626	1
30		60126	1
31		34481	1
32		60629	1
33		60029	1
34		60133	3
35		60173	2
36		60093	2
37		60107	3
38		60477	1
39		60618	1
40		60194	2
41		60169	3
42		60431	1
43		32162	1
44		60630	3
45		60068	1
46	**Total Count**		**276**

NAME (please print): Dr John O'Keefe

SPECIALTY: ORTHOPEDIC SURGERY

DATE: 09 / 12 / 2019

TO: Illinois Health Facilities Planning Board
Springfield, IL 62761

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to add Orthopedic Surgery as an approved surgical specialty at the already-existing Associated Surgery Center in Arlington Heights.

I am able to provide historical information and state that during 2017 and 2018 I performed surgical procedures on approximately the following numbers of patients in the hospitals and licensed ASTCs identified below:

NAME OF HOSPITAL or ASTC	2017	2018
Alexian Brothers Medical Center	130 pts	140 pts
Fullerton Surgical Center	130 pts	145 pts
	____ pts	____ pts

I estimate that I will refer 20-40 patients to Associated Surgery Center during the second year (2021) following the receipt of their requested Certificate of Need Permit to add Orthopedic Surgery.

Attached is a Zip Code-specific patient origin analysis for my 2018 patients.

The information contained in this letter and the attached Zip Code analysis is true and correct, to the best of my available information and belief, and has not been used in the support of any other CON project.

Sincerely,

(Signature)

OFFICIAL SEAL
IGOR KROIN
Notary Public - State of Illinois
My Commission Expires 5/09/2021

Notarized:

ATTACHMENT 27C3

09-12-2019

Total Number of Patients
by Zip Code for 2018

	A	B	C
1	Name of Dr: John O'Keefe		Number of Patients from
2	Specialty: Orthopedic Surgeon	Zip Code	01/01/2018 - 12/31/2018
3		53142	1
4		60004	1
5		60007	3
6		60056	5
7		60090	1
8		60101	1
9		60106	2
10		60107	1
11		60120	4
12		60133	2
13		60140	7
14		60143	2
15		60164	2
16		60169	3
17		60172	6
18		60177	8
19		60185	4
20		60191	1
21		60192	1
22		60193	29
23		60194	2
24		60305	4
25		60402	10
26		60411	2
27		60415	1
28		60431	1
29		60432	1
30		60435	3
31		60436	1
32		60438	2
33		60440	1
34		60446	1
35		60458	1
36		60484	3
37		60505	2
38		60532	1
39		60552	1
40		60609	5
41		60615	3
42		60617	8
43		60618	16
44		60620	10
45		60623	2
46	Total Count	60624	4

ATTACHMENT 27C3

Name of Dr: John O'Keefe Specialty: Orthopedic Surgeon	Zip Code	Number of Patients from 01/01/2018 - 12/31/2018	
	60625	10	
	60614	4	
	60629	7	
	60630	14	
	60634	3	
	60633	11	
	60639	24	
	60640	7	
	60641	29	
	60643	5	
	60646	8	
	60653	3	
	60660	2	

ATTACHMENT 27C3

NAME (please print): Dr Thomas Poepping

SPECIALTY: ORTHOPEDIC SURGERY

DATE: 9 / 5 / 2019

TO: Illinois Health Facilities Planning Board
Springfield, IL 62761

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to add Orthopedic Surgery as an approved surgical specialty at the already-existing Associated Surgery Center in Arlington Heights.

I am able to provide historical information and state that during 2017 and 2018 I performed surgical procedures on approximately the following numbers of patients in the hospitals and licensed ASTCs identified below:

NAME OF HOSPITAL or ASTC	2017	2018
Illinois Orthopedic Network	65 pts	117 pts
Elmhurst Memorial Hosp.	56 pts	32 pts
Lakeshore Surgery Ctr.	31 pts	32 pts

I estimate that I will refer 30 patients to Associated Surgery Center during the second year (2021) following the receipt of their requested Certificate of Need Permit to add Orthopedic Surgery.

Attached is a Zip Code-specific patient origin analysis for my 2018 patients.

The information contained in this letter and the attached Zip Code analysis is true and correct, to the best of my available information and belief, and has not been used in the support of any other CON project.

Sincerely,

(Signature)

OFFICIAL SEAL
IGOR KROIN
Notary Public - State of Illinois
My Commission Expires 5/08/2021

Notarized:

09-05-2019

ATTACHMENT 27C3

Total Number of Patients
by Zip Code for 2018

	A	B	C
1	Name of Dr: Thomas Poepping		Number of Patients from
2	Specialty: Orthopedic Surgeon	Zip Code	01/01/2018 - 12/31/2018
3		60120	1
4		60653	1
5		60609	1
6		60559	1
7		60171	1
8		60618	1
9		60193	2
10		60172	2
11		60061	1
12		60139	3
13		60649	3
14		60005	1
15		60068	3
16		60804	6
17		60617	2
18		60505	2
19		60101	8
20		44030	1
21		60620	2
22		60654	24
23		60402	3
24		60639	2
25		60007	4
26		60532	1
27		60534	1
28		60008	2
29		60645	10
30		60560	1
31		60459	3
32		60644	3
33		60954	1
34		60429	1
35		60620	2
36		60169	1
37		60056	1
38		60418	1
39		60074	1
40		60453	1
41		60047	1
42		60827	1
43		60073	1
44		60652	3
45		46410	2
46	Total Count	55	113

ATTACHMENT 27C3

Total Number of Patients
by Zip Code for 2018

	A	B	C
1	Name of Dr: Thomas Poepping		Number of Patients from
2	Specialty: Orthopedic Surgeon	Zip Code	01/01/2018 - 12/31/2018
3		60629	7
4		60160	4
5		60803	2
6		60621	1
7		60642	1
8		60181	4
9		60126	3
10		60431	1
11		60089	1
12		60194	1
13		60632	6
14		60634	1
15		60174	1
16		60142	1
17		60162	2
18		60638	4
19		60641	1
20		61802	1
21		60143	1
22		60625	1
23		60157	1
24		60133	2
25		60443	2
26		60612	1
27		60176	1
28		60202	1
29		60656	2
30		60563	1
31		60104	1
32		60423	1
33		60455	1
34		60615	1
35		60623	4
36		60060	1
37		60445	1
38		60586	1
39		60016	1
40		60636	1
41		60827	1
42		60406	1
43		60457	1
44		60548	1
45		61108	1
46	Total Count	56	73

ATTACHMENT 27C3

Total Number of Patients
by Zip Code for 2018

	A	B	C
1	Name of Dr: Thomas Poepping		Number of Patients from
2	Specialty: Orthopedic Surgeon	Zip Code	01/01/2018 - 12/31/2018
3		60647	2
4		60628	4
5		60480	1
6		46394	1
7		60458	1
8		46311	1
9		60651	2
10		60630	1
11		60402	1
12		60156	1
13		60714	1
14		60153	1
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46	Total Count	51	17

ATTACHMENT 27C3

TREATMENT ROOM NEED ASSESSMENT

The proposed project is limited to the addition of a surgical specialty to an existing ASTC, and does not include the addition of any operating rooms or procedure rooms. Therefore, this review criterion is not applicable to the proposed project.

ATTACHMENT 25c5

SERVICE ACCESSIBILITY

Since its inception, Associated Surgical Center ("ASC") has provided services to patients that have historically had great difficulty in accessing outpatient surgical services in a low-cost ASTC setting. Accessibility is compromised both as a result of patients' financial limitations as well as language barriers. As discussed below, ASC 1) treats a higher percentage of Medicaid recipients than other area ASTCs, 2) treats a higher percentage of "charity care" patients than other area ASTCs, 3) provides a significant level of discounted care for uninsured individuals, 4) is a primary provider of services to the large Russian and Eastern European populations living in the northwest suburbs and beyond, and 4) routinely provides late-in-the-day and weekend services to patients unable to miss work. These practices will all continue following the proposed addition of orthopedic surgery services.

Accessibility Related to Financial Limitations

There are three other ASTC's in the HFSRB-defined geographic service area ("GSA"), those being Northwest Community Day Surgery Center, Northwest Surgicare and LGH-Golf Surgical Center. The table below compares ASC's commitment to the provision of services to Medicaid recipients to that of the other area ASTCs, in terms of the percentage of each ASTC's total patient volume, using data provided to IDPH by the ASTCs through the IDPH annual *Ambulatory Surgical Treatment Center Questionnaires*. ASC participates in five Medicaid programs. It is unknown which, if any such programs the other ASTCs participate in.

ASTC	% Medicaid Recipients
Associated Surgical Center*	5.8%
Northwest Comm. Day Surgery Ctr.**	4.2%
Northwest Surgicare**	.02%
LGH Golf Surgical Center**	0.8%

* 2018
** 2017

The majority of "private pay" patients treated at an ASTC are without private insurance, and not qualifying for coverage under either Medicare or Medicaid. Many of these patients are referred to in some circles as the "working poor". Typically, the ASTC agrees to a reduced facility fee with the patient on a case-by-case basis, often involving a payment schedule. The table below compares ASC's provision of services to "private pay" patients to that of the other area ASTCs, in terms of the percentage of each ASTC's total patient volume, using data provided to IDPH by the ASTCs through the IDPH annual *Ambulatory Surgical Treatment Center Questionnaires*.

ASTC	% Private Pay Patients
Associated Surgical Center*	10.6%
Northwest Comm. Day Surgery Ctr.**	2.0%
Northwest Surgicare**	2.1%
LGH Golf Surgical Center**	0.4%

* 2018
** 2017

"Charity Care" patients are those patients to whom services are provided without any expectation of payment. The table below compares ASC's commitment to the provision of "charity care" services to that of the other area ASTCs, in terms of the percentage of each ASTC's total patient volume, using data provided to IDPH by the ASTCs through the IDPH annual *Ambulatory Surgical Treatment Center Questionnaires*.

ASTC	% "Charity Care Patients
Associated Surgical Center*	1.2%
Northwest Comm. Day Surgery Ctr.**	0.3%
Northwest Surgicare**	0.0%
LGH Golf Surgical Center**	0.0%

* 2018
** 2017

The data provided in the three tables above confirms Associated Surgical Center's commitments to addressing compromised accessibility to ASTC services for patients having financial limitations, and that it leads the other area providers in that commitment.

Accessibility Related to Language Issues

Associated Surgical Center attracts a large number of patients having limited command of English, with the vast majority of those patients speaking Russian, Ukrainian, Polish, Lithuanian, Serbian/Croatian, and Spanish. *ZIP Atlas* identifies over 19,500 Russian residents alone, living in the HFSRB-defined GSA, and ASC has traditionally attracted many Eastern European-speaking patients from outside of the GSA, particularly from Chicago. Russian Media Group estimates that there are 464,000 individuals of Russian heritage living in Illinois, the vast majority residing in Chicago and its northern suburbs.

ASC staff estimates that approximately 89% of the patients treated at the ASTC are of different ethnicities or have different countries of origin, with approximately 48% being immigrants from Russia/Eastern European countries, 35% being from Spanish speaking countries, and 6% being from other countries. To accommodate these patients and to ensure that the patients fully understand pre- and post-procedure instructions, ASC employs staff speaking fifteen languages, including each of the languages noted in the paragraph above. Calls to the other area ASTCs confirm that, with the exception of Spanish-speaking staff, communication with patients in the other languages noted above is limited, or cannot take place at all.

UNNECESSARY DUPLICATION/MALDISTRIBUTION

The proposed project will not result in unnecessary duplication or a mal-distribution of services, as the project does not involve the establishment of a new facility, or the addition of operating rooms or procedure rooms. As such, and consistent with direction provided by HFSRB staff, review criteria 1110.235 (c)(7) (A) through (C) are not applicable to this project.

STAFFING

Associated Surgical Center is an existing, licensed and accredited, and Medicare and Medicaid-certified ASTC, fully staffed, and in compliance with relevant clinical and professional staffing requirements, including those required by for IDPH licensure. The ASTC has not experienced difficulty in recruiting staff in the past. In evaluating the potential of adding orthopedic surgery as an additional service to be provided at the ASTC, the applicant determined that additional staffing would not be required.

Dr. Yelena Levitin will continue to serve in her role as Medical Director of the ASTC.

ATTACHMENT 27c8

CHARGE COMMITMENT

With the signature placed on the Certification page of this *Application for Permit*, the applicant attests that the charges associated with orthopedic surgery services, and as identified in this ATTACHMENT will not increase for, at minimum, two years following the receipt of the Certificate of Need Permit associated with this Application for Permit.

Ambulatory Surgery Center, LLC
Facility Fee Schedule - Ortho

CPT CODE	ORHTOPEDIC PROCEDURES	ASC OR FEE
20610	Arthrocenteis, Aspiration and/or Injection	$ 250
20816	Replantation Digit	$ 4,000
23020	Surgical I & D Shoulder	$ 5,180
23333	Surgical Removal Foreign Body, Shoulder, Deep	$ 2,250
23405	Tenotomy, Shoulder	$ 8,250
23410	Repair Ruptured Rotator Cuff	$ 8,250
23420	Reconstruction of Rotator Cuff Inc. Acromioplasty	$ 8,250
23460	Revision of Shoulder Arthoplasty	$ 8,250
23480	Osteotomy, Clavicle W W/O Interal Fixation	$ 8,250
23515	Open Treatment of Clavicular Fracture	$ 8,250
23550	Open Treatment of Acromioclavicular Dislocation	$ 8,250
23585	Open treatment of Scapular Fracture	$ 8,250
23700	Manipulation of Shoulder Under General Anesthesia	$ 2,980
23930	I & D Deep Abscess Upper Arm or Elbow	$ 2,250
24006	Arthrotomy of Elbow W Capsular Release	$ 4,300
24100	Arthrotomy Elbow W Synovical Biopsy	$ 5,180
24102	Athrotomy Elbow W Synovectomy	$ 5,180
24155	Arthrectomy Elbow Joint	$ 5,180
24201	Excision Foreign Body Upper Arm or Elbow, Deep	$ 3,225
24300	Manipulation Elbow Under Anesthesia	$ 2,625
24310	Tentomy, Elbow, Open	$ 3,885
24341	Repair Tendon or Muscle, Upper Arm or Elbow	$ 8,250
24343	Repair Lateral Collateral Ligament	$ 8,250
24360	Arthroplasty, Elbow	$ 8,250
24515	Open Treatment of Shaft Fracture W Plates & Screws	$ 18,900
24615	Opent Treatment of Acute or Chronic Elbow Disclocation	$ 8,250
25000	Incision Extensor Tendon Sheath, Wrist	$ 2,980
25040	Arthrotomy of Radiocarpal or Midcarpal Jopint, Wrist	$ 5,180
25085	Capsulotomy Wrist	$ 5,180
25115	Radical Excision of Bursa, Wrist	$ 2,980
25259	Manipulation of Wrist Under Anetshesia	$ 2,625
25320	Arthroplasty Wrist	$ 8,250
23130	Acromioplasty	$ 11,250
25447	Arthroplasty Intercarpal or Carpometatarsal Wrist	$ 5,180
25645	Open Treatment of Carpal Bone Fracture	$ 3,885
26040	Fasciotomy Palmar Fascia	$ 2,980
24371	Revision of Total Elbow Arthroplasty	$ 22,300
26135	Synovectomy, Metacarpophalangeal Joint	$ 3,885
20690	Application of External Fixation System	$ 8,250
26230	Partial Excision Metacarpal Bone	$ 3,885
20973	Osteocutaneous Graft Great Tow W Web Space	$ 8,250
26471	Tenotomy of Proximal Interphalangeal Joint	$ 3,885
26520	Capsulectomy Metacarpophalangeal Joint	$ 3,885
26535	Arthroplasty, Interphalangeal Joint	$ 3,885
26615	Open Treatment of Metacarpal Fracture W W/O Internal Fixation	$ 3,885
26951	Amputation Finger or Thumb	$ 4,475

Ambulatory Surgery Center, LLC
Facility Fee Schedule - Ortho

26991	I & D Deep Abscess / Bursa Pelvis or Hip	$ 2,980
20924	Tendon Graft	$ 7,000
27041	Biopsy Hip / Pelvis Deep Submuscular	$ 2,200
27052	Arthrotomy W Synovectomy, Hip Joint	$ 2,980
22551	Arthrodesis, Anterior Interbody	$ 14,158
27097	Release or Recession Hamstring	$ 3,885
27301	I & D Deep Abscess / Bursa Thigh or Knee	$ 3,225
27306	Tenotomy of Tendon Femur or Knee	$ 2,980
27327	Excision Tumor Soft Tissue Thigh or Knee	$ 2,200
27330	Arthrotomy Knee W Synovical Biopsy	$ 3,885
27345	Excision of Synovial Cyst, Knee	$ 3,885
27390	Tenotomy, Open, Knee or Hip	$ 3,885
27403	Arthrotomy W Meniscus Repair, Knee	$ 3,885
27409	Repair Collateral & Cruciate Ligaments	$ 8,250
27416	Osteochrondal Autograph, Knee, Open	$ 8,250
27435	Capsulotomy, Posterior Capsular Release, Knee	$ 3,885
27510	Open Treatment of Femoral Shaft Fracture W Plates & Screws	$ 8,250
27537	Open Treatment of Tibial Fracture W W/O Internal Fixation	$ 3,885
27566	Opent Treatment of Kneecap Dislocation W W/O Internal Fixation	$ 8,250
27570	Manipulation of Knee Under General Anesthesia	$ 2,250
27580	Arthodesis of Knee	$ 5,180
27625	Arthrotomy W Synovectomy, Ankle	$ 3,885
27650	Repair Ruptured Achilles Tendon	$ 5,385
27664	Repair Extensor Tendon Leg	$ 8,250
27758	Open Treatment Tibial Shaft Fracture W Plates & Screws	$ 15,375
27784	Opent Treatment of Proximal Fibula or Fracture W Plates & Screws	$ 8,250
27860	Manipulation of Ankle Under General Anesthesia	$ 2,850
27870	Arthrodesis, Ankle, Open	$ 18,500
27892	Decompression Fasciotomy Leg	$ 2,850
28200	Repair of Tendon, Flexor, Foot	$ 3,885
28297	Hallux Valgus Correction	$ 8,250
C1781	Implants & Prosthetics	Cost + 5%
28322	Metatarsals Repair	$ 8,250
28485	Metatarsal Fracture Repair	$ 8,250
28820	Amputation Toe	$ 5,650
29125	Application of Arm Splint	$ 1,900
29405	Application of Short Leg Cast	$ 1,900
29806	Arhtroscopy Shoulder	$ 8,250
29820	Arthoscopy Shoulder	$ 8,250
29827	Athroscopy Shoulder W Rotator Cuff Repair	$ 8,250
29840	Athroscopy of Wrist	$ 3,885
29862	Athroscopy of Hip W Debridement	$ 8,250
29870	Dx Knee Arthroscopy	$ 3,885
29881	Arthroscopy Knee w Meniscectomy	$ 3,885
29888	ACL Reconstruction	$ 10,400
29895	Arthroscopy Ankle Synovectomy	$ 3,885
29892	Ankle Arthroscopy	$ 8,250

PEER REVIEW

With the signature placed on the Certification page of this *Application for Permit*, the applicant attests that a peer review program exists at Associated Surgical Center, and that the peer review program evaluates whether patient outcomes are consistent with quality standards established by professional organizations for ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan is initiated. Further, with the signature placed on the Certification page of this *Application for Permit*, the applicant attests that it anticipates that within two years of the issuance of the requested Certificate of Need Permit, the annual utilization of the ASTC will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

ATTACHMENT 27c10

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

ASSOCIATED SURGICAL CENTER

YEAR 2 OPERATING COST per SURGICAL CASE

Projected Cases: 274

Salaries & Benefits		$184,701
Medical Supplies		$82,945
		$267,646
per Surgical Case:	$	976.81

YEAR 2 CAPITAL COST per SURGICAL CASE

Projected Cases: 274

Interest Expense	$	1,635
Depreciation & Amort.	$	15,307
	$	16,942
per Surgical Case:	$	61.83

ATTACHMENTS 37D and 37E

PNC BANK

09/30/2019

Associated Surgical Center LLC
129 W Rand Rd
Arlington Heights IL 60004

Dear To whom it may concern

In response to your request that PNC Bank, National Association provide written verification concerning your (checking/savings/certificate of deposit) account(s), we are providing the following information:

Account No.	Routing No.	Date Opened	Balance as of date of this letter
4660326688	071921891	09/07/2016	$201,085.00

This information is subject to any outstanding items or charges.

Sincerely,

PNC Bank, National Association

Thelma Lugo Gonzalez
Universal Banker

CUSTOMER AUTHORIZATION/ ACKNOWLEDGEMENT

I/we hereby acknowledge that I/we have requested and authorized PNC Bank, National Association to provide this written verification concerning my/our (checking/savings/certificate of deposit) account(s).

Dated this 30TH day of August, 2019.

Customer Signature: _____

Customer Signature: _____

BDMS0007-1018

ATTACHMENT 39B

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

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FEE

An application-processing fee (refer to Part 1130.230 to determine the fee) must be submitted with most applications. If a fee is applicable, an initial fee of $2,500 MUST be submitted with the application. HFSRB staff will inform applicants of the amount of the fee balance, if any, that must be submitted. **The application will not be deemed complete and review will not be initiated until the entire processing fee is submitted. Payment may be made by check or money order and must be made payable to the Illinois Department of Public Health**.

APPLICATION SUBMISSION

Submit an original and one copy of all Sections of the application, including all necessary attachments. **The original must contain original signatures in the certification portions of this form.** Submit all copies to:

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761