ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Michigan Avenue Center for Health
Street Address: 2415 S Michigan Ave
City and Zip Code: Chicago, IL 60616
County: Cook. Health Service Area: Health Planning Area:

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

Exact Legal Name: Nicole E Williams
Street Address: 888 S Michigan Ave Unit 400
City and Zip Code: Chicago, IL 60605
Name of Registered Agent:
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer:
CEO Street Address:
CEO City and Zip Code:
CEO Telephone Number:

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Nicole E Williams
Title: President and Chief Executive

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

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:	Nicole E Williams
Title:	President and Chief Executive
Company Name:	The Gynecology Institute of Chicago
Address:	1147 S. Wabash #200 Chicago IL 60605
Telephone Number:	312 929 9191
E-mail Address:	nwill @ gynecologyinstitute.org
Fax Number:	

Site Ownership
[Provide this information for each applicable site] * Pending Sale *

Exact Legal Name of Site Owner:	
Address of Site Owner:	2415 S. Michigan Ave, Chicago IL 60616
Street Address or Legal Description of the Site: **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:	The Gynecology Consortium
Address:	1147 S. Wabash Ave Ste 200 Chicago IL 60605

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which 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

Company Name: The Gynecology Institute of Chicago, Ltd.
Address: 1147 S Wabash Ave Suite 200
Telephone Number: 312.929.9191
E-mail Address: nwill@gynecologyinstitute.org
Fax Number: 312.566.8986

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

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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.

Sole Proprietor / S-Corporation

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.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

[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

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.

In late 2019, it was decided that four hospitals on the South Side would close. Their coverage area encompasses a distance between 25th to 95th Streets. Mercy Hospital, located at 2525 S Michigan Avenue currently provides care for the population on the Near South Side of Chicago. With its closure, surgical services for women in this area would become nearly inaccessible.

We propose to open an already functioning surgery center repurposed to provide full service outpatient Gynecology care including outpatient gynecologic surgeries. The current Michigan Avenue Center for Health is operating as a pregnancy termination and counseling clinic with two working operating rooms, pre op, recovery, and 4 exam rooms. It is located at 2415 S Michigan Avenue, at the end of the South Loop well within reach of the Near South Side.

We plan on recruiting ObGyn surgeons affected by this change to continue to provide surgical care for their patient population at this center. We will accept Medicare, Medicaid, and private insurance.

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	2500	2500	5000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts		25000	25000
Modernization Contracts	25000		25000
Contingencies			
Architectural/Engineering Fees	15000		15000
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	42500	27500	70000
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**100000**	**50000**	**150000**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	**800000**		**800000**
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			

TOTAL SOURCES OF FUNDS	900000	50000	950000
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: $___1,000,000_____
Fair Market Value: $_____1,250,000_____ * Pending *

The project involves the establishment of a new facility or a new category of service
Yes No X

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 $ 187,500

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. X

Anticipated project completion date (refer to Part 1130.140):
_____8/1/2020_____

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.

Cost Space Requirements

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		3500			2000	1500	
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative		1500			1500		
Parking							
Gift Shop							
Total Non-clinical							
TOTAL		**5000**			**3500**	**1500**	

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

Facility Bed Capacity and Utilization

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: The Gynecology			**CITY:** Chicago, IL		
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	Ø	Ø			Ø
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:	Ø				Ø

* Outpatient Surgery ONLY

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 Self. * **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
Nicole E Williams	
PRINTED NAME	PRINTED NAME
President & Chief Executive	
PRINTED TITLE	PRINTED TITLE
* Notary NOT available due to Pandemic!	
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

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
Orthopedic Surgery
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 24, 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]:**

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;

APPEND DOCUMENTATION AS ATTACHMENT-32, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 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 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.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

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).

2.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Department						
(list below)A	B	C	D	E	F	G	H

Criterion 77 IAC 1110.275(b)(1) – "Location"

1. Document that the proposed birth center will be located in one of the geographic areas, as provided in the Alternative Healthcare Delivery Act.

2. Document that the proposed birth center is owned or operated by a hospital; or owned or operated by a federally qualified health center; or owned and operated by a private person or entity.

Criterion 77 IAC 1110.275(b)(2) – "Service Provision to a Health Professional Shortage Area"

Document whether the proposed site is located in or will predominantly serve the residents of a health professional shortage area. If it will not, demonstrate that it will be located in a health planning area with a demonstrated need for obstetrical service beds or that there will be a reduction in the existing number of obstetrical service beds in the planning area so that the birth center will not result in an increase in the total number of obstetrical service beds in the health planning area.

Criterion 77 IAC 1110.275(b)(3) – "Admission Policies"

Provide admission policies that will be in effect at the facility and a signed statement that no restrictions on admissions due to payor source will occur.

Criterion 77 IAC 1110.275(b)(4) – "Bed Capacity"

Document that the proposed birth center will have no more than 10 beds.

Criterion 77 IAC 1110.275(b)(5) – "Staffing Availability"

Document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

Criterion 77 IAC 1110.275(b)(6) – "Emergency Surgical Backup"

Document that either:

1. The birth center will operate under a hospital license and will be located within 30 minutes ground travel time from the hospital; **OR**

2. A contractual agreement has been signed with a licensed hospital within 30 minutes ground travel time from the licensed hospital for the referral and transfer of patients in need of an emergency caesarian delivery.

Criterion 77 IAC 1110.275(b)(7) – "Education"

A written narrative on the prenatal care and community education services offered by the birth center and how these services are being coordinated with other health services in the community.

Criterion 77 IAC 1110.275(b)(8) – "Inclusion in Perinatal System"

1. Letter of agreement with a hospital designated under the Perinatal System and a copy of the hospital's maternity service; **OR**

2. An applicant that is not a hospital shall identify the regional perinatal center that will provide neonatal intensive care services, as needed to the applicant birth center patients; and a letter of

O. BIRTH CENTER – REVIEW CRITERIA

These criteria are applicable only to those projects or components of projects involving a birth center.

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

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 37.

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 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

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

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

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

Attach #20-01924

Gynecology | Institute | of | Chicago

G: Non Hospital Based Ambulatory Surgery

We plan on expanding the existing service of the business at 2415 S Michigan Avenue with the addition of outpatient gynecologic surgical services to a primarily minority population on the South Side of Chicago. This minority and female owned business will also be able to pull from other zip codes in the greater Chicagoland area with our specific model of care.

With the closure of Mercy Hospital and Medical Center pending as well as the uncertainty of the 4 hospitals serving the South Side, surgical services will be sorely lacking, especially for our vulnerable population.

There are currently five physicians, all of whom have privileges at Mercy Hospital, who have agreed to bring their surgeries to our center with the closure. In addition, by expanding the ability of those physicians to perform surgeries outside of a hospital setting, access to care will be increased. With our opening, we expect to be able to serve an even larger number of patients and physicians.

Our new surgery center will also result in the creation of jobs. For each OR, we will employ a nurse, technician, and medical assistant. The facility will also require at least 2 administrative staff and a lead administrator, resulting in a net creation of 9 jobs.

Respectfully submitted,

Nicole E. Williams, MD, FACOG, FACS

#20-019

Gynecology | Institute | of | Chicago

ATTACHMENTS 32-34
Availability of Funds/Financial Viability/Economic Feasibility:

We are in the process of recruiting investors. Thus far, we have an initial investment of approximately $100,000 and are working with Lakeside Bank to secure further financing.

In addition, we plan on utilizing pending funds from the PPP to finalize the deal.

Attached please find The Gynecology Institute's Profit and Loss statements from 2019 and our most recent statements which will attest to our practice's financial viability.

Respectfully Submitted,

Nicole E. Williams, MD, FACOG, FACS

#20-019

The Gynecology Institute of Chicago, Ltd.

PROFIT AND LOSS

January - December 2019

	TOTAL
Income	
Commission	7,348.77
CoPay	6,393.09
Fees Billed	1,630,665.75
Insurance Adjustments	642.40
Refunds-Allowances	10,852.57
Services	84,473.45
Uncategorized Income	5,577.76
Total Income	**$1,745,953.79**
Cost of Goods Sold	
Cost of Goods Sold	151.91
Total Cost of Goods Sold	**$151.91**
GROSS PROFIT	**$1,745,801.88**
Expenses	
Advertising	64,382.74
Bank Charges	11,086.20
Commissions & fees	8,552.19
Consultant	123,338.66
Credit card payment	2,750.00
Donation	9,377.44
Dues & Subscriptions	8,425.24
Electronic Medical Record Fee	91,356.51
Employee Health Insurance	2,272.27
Equipment Rental	28,312.62
Insurance	1,774.84
Insurance - Liability	2,406.28
Insurance - Malpractice	37,921.04
Janitorial	3,819.66
Legal & Professional Fees	19,104.61
Loan Payment - Interest Expense	32,714.70
Meals and Entertainment	12,802.33
Medical Education	4,541.49
Medical Supplies	100,103.50
Office Expenses	21,795.34
Parking	3,436.26
Patient Refund	601.42
Payroll Expenses	
Company Contributions	
Health Insurance	45,354.65
Retirement	19,697.40
Total Company Contributions	**65,052.05**
Taxes	47,347.49

The Gynecology Institute of Chicago, Ltd.

PROFIT AND LOSS

January - December 2019

	TOTAL
Wages	610,111.11
Total Payroll Expenses	**722,510.65**
Promotional	5,408.43
Purchases	15,734.55
Rent or Lease	167,845.02
Repair & Maintenance	13,106.83
Richard Wolf	9,017.87
Sound Diagnostics	56,810.00
Stationery & Printing	645.51
Supplies	15,467.03
Taxes & Licenses	2,108.71
Telephone	12,158.17
Transfer to checking	2,500.00
Travel	32,387.58
Travel Expense	616.60
Travel Meals	254.34
Utilities	4,851.13
Total Expenses	**$1,652,297.76**
NET OPERATING INCOME	**$93,504.12**
Other Income	
Interest Earned	0.93
Total Other Income	**$0.93**
Other Expenses	
Miscellaneous	2,334.86
Total Other Expenses	**$2,334.86**
NET OTHER INCOME	**$ -2,333.93**
NET INCOME	**$91,170.19**

Gynecology | Institute | of | Chicago

ATTACHMENT 37 and 38

Safety Net Impact Statement/Charity Care Information:

1. The project will have a material impact on the safety net services in the community by increasing access to high quality surgical services to an underserved population.
2. This project will increase the ability to cross subsidize safety net services, especially given the uncertainty of the South Side Hospital merger by providing consistent surgical care throughout the transition.
3. If Mercy Hospital's surgical services no longer provide women's care and surgery, this will leave a major deficit in care on the South Side which The Gynecology Institute's Surgery Center can fill.

The physicians planning to operate at this center pull patients from Ingalls Hospital, Advocate Trinity, Little Company of Mary, and Mercy. At least 30% of these patients are Medicaid, and we plan to continue to provide this vital care for this patient population.

Medicaid # Patients	2017	2018	2019
Outpatient	330	377	432
Surgery	19	24	31
Revenue	0	0	0

Dr. Williams received no payment for the Medicaid patients she operated on at Mercy Hospital, and only received hourly wages for the clinics. These numbers are approximate.

Respectfully Submitted,

Nicole E. Williams, MD, FACOG, FACS

Gynecology | Institute | of | Chicago

Ms. Debra Savage
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 67261

Dear Ms. Savage,

My name is Dr. Nicole E. Williams, and I am a Gynecologic Surgeon. I am writing in support of the establishment of The Gynecology Institute Surgery Center. Outpatient gynecology cases already consist of a large portion of my work, and with the establishment of this center will increase our capacity to serve.

I have agreements in principle with five other gynecologic surgeons to perform surgery at this center. These physicians serve the near and far South Sides of Chicago.

Over the past 12 months, I have performed a total of 97 outpatient gynecologic surgeries at the following hospitals. These patients came from the zip codes listed in Exhibit 1. With the opening of The Gynecology Institute Surgery Center, I expect to refer my cases as noted below. Of the total cases, 85% will reside within the geographic service area. In addition, the five other gynecologic surgeons will add to the volume. The data for 1 additional physician is listed below for illustrative purposes under projected referrals.

Hospital/ASC	# of cases past 12 months	# of projected referrals
Mercy Hospital and Medical Center	56	124
Advocate Illinois Masonic Medical Center	15	27
Amita St. Joseph Hospital Chicago	21	30
Rush University Hospital and Medical Center	4	9

#20-019

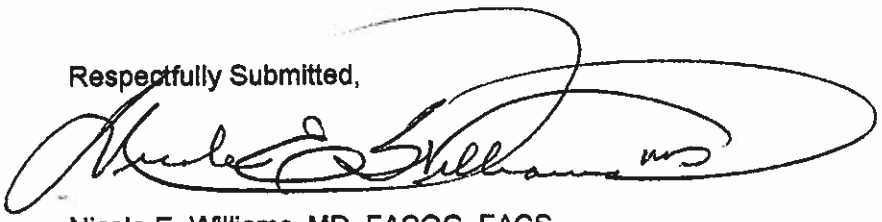
Patient Zip Code	Number of Cases
60605	17
60606	9
60615	8
60618	6
60619	5
60620	3
60621	3
60623	4
60630	4
60639	3
60642	3
60649	3
60651	2
60652	1
60657	2
60680	2
60827	1
60453	2
60443	2
60402	2
60438	1
60478	1

#20-019

These referrals have not been used to support the establishment of any other ambulatory surgery center application.

The information in this letter is true and correct to my knowledge.

Respectfully Submitted,



Nicole E. Williams, MD, FACOG, FACS
President and Chief Executive
The Gynecology Institute of Chicago, Ltd.
www.gynecologyinstitute.com
O: 312.929.9191
C: 312.493.0044

#20-019

File Number 6893-234-3

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

THE GYNECOLOGY INSTITUTE OF CHICAGO, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 22, 2013, 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.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

Authentication #: 1713902510 verifiable until 05/19/2018
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 19TH *day of* MAY *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

CERTIFICATE OF NEED PERMIT APPLICATION

OCTOBER 2019 EDITION

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2nd FLOOR
SPRINGFIELD, ILLINOIS 62761
(217) 782-3516

INSTRUCTIONS

GENERAL

- The application for permit (Application) must be completed for all proposed projects that are subject to the permit requirements of the Illinois Health Facilities Planning Act (Planning Act), including those involving the establishment, expansion, modernization and certain discontinuations of a service or facility.
- The persons preparing the application for permit are advised to refer to the Planning Act, as well as the rules promulgated there under (77 Ill. Adm. Codes 1100, 1110, 1120 and 1130) for more information.
- **The Application does not supersede any of the above-cited rules and requirements.**
- The Application is organized into several sections, involving information requirements that coincide with the Review Criteria in 77 Ill. Adm. Code 1110 (Processing, Classification Policies and Review Criteria) and 1120 (Financial and Economic Feasibility).
- Questions concerning completion of this form may be directed to Health Facilities and Services Review Board staff at (217) 782-3516.
- Copies of the Application form are available on the Health Facilities and Services Review Board Website www.hfsrb.illinois.gov.

SPECIFIC

- Use the Application as written and formatted.
- Complete and submit **ONLY** those Sections along with the required attachments that are applicable to the type of project proposed.
- **ALL APPLICABLE CRITERIA** for each applicable section must be addressed. **If a criterion is NOT APPLICABLE, label it as such and state the reason why.**
- For all applications for which time and distance documentation is required, submit copies of all MapQuest printouts that indicate the distance and time to or from the proposed facility.
- **ALL PAGES ARE TO BE NUMBERED CONSECUTIVELY BEGINNING WITH PAGE 1 OF THE APPLICATION. DO NOT INCLUDE INSTRUCTIONS AS PART OF THE APPLICATION OR IN NUMBERING THE PAGES IN THE APPLICATION.**
- Unless otherwise stated, attachments for each Section should be appended after the last page of the Application.
- Begin each attachment on a separate 8 1/2" x 11" sheet of paper and print or type the attachment identification in the lower right-hand corner of each attached page.
- Include documents such as MapQuest printouts, physician referral letters, impact letters, and documentation of receipt as appendices after the last attachment. Label as Appendices 1, 2, etc.
- For all applications that require physician referrals, the following must be provided: a summary of the total number of patients by zip code and a summary (number of patients by zip code) for each facility the physician referred patients to in the past 12 or 24 months, whichever is applicable.
- Information to be considered must be included with the applicable Section attachments. References to appended material not included within the appropriate Section will **NOT** be considered.
- The Application must be signed by the authorized representative(s) of each applicant entity.
- Provide an original Application and one copy, both **unbound. Label the copy that contains the original signatures original (put the label on the Application).**

Failure to follow these requirements WILL result in the Application being declared incomplete. In addition, failure to provide certain required information (e.g., not providing a site for the proposed project or having an invalid entity listed as the applicant) may result in the Application being declared null and void. Applicants are advised to read Part 1130 with respect to completeness (1130.620(c)).

ADDITIONAL REQUIREMENTS

FLOOD PLAIN REQUIREMENTS

Before an application for permit involving construction will be deemed **COMPLETE,** the applicant must **attest** that the project **is or is not in a flood plain** and that the location of the proposed project complies with the Flood Plain Rule under **Illinois Executive Order #2006-5**.

HISTORIC PRESERVATION REQUIREMENTS

In accordance with the requirements of the Illinois State Agency Historic Resources Preservation Act (Preservation Act), the Health Facilities Services and Review Board is required to advise the Historic Preservation Agency (HPA) of any projects that could affect historic resources. Specifically, the Preservation Act provides for a review by the Historic Preservation Agency to determine if certain projects may impact historic resources. These types of projects include:

1. Projects involving demolition of any structures;
2. Construction of new buildings; or
3. Modernization of existing buildings.

The applicant must submit the following information to the HPA so that known or potential cultural resources within the project area can be identified and the project's effects on significant properties can be evaluated:

1. General project description and address;
2. Topographic or metropolitan map showing the general location of the project;
3. Photographs of any standing buildings/structure within the project area; and
4. Addresses for buildings/structures, if present.

The HPA will provide a determination letter concerning the applicability of the Preservation Act. Include the determination letter or comments from HPA with the application for permit.

Information concerning the Preservation Act may be obtained by calling (217) 785-7930 or writing the Illinois Historic Preservation Agency, Preservation Services Division, 1 Old State Capitol Plaza, Springfield, Illinois 67201-1507.

SAFETY NET IMPACT STATEMENT

A SAFETY NET IMPACT STATEMENT must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**. **SEE SECTION X** OF THE APPLICATION FOR PERMIT.

CHARITY CARE INFORMATION

CHARITY CARE INFORMATION must be provided for **ALL** projects. **SEE SECTION XI** OF THE APPLICATION FOR PERMIT.