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: Lindenhurst Surgery Center
Street Address: 1050 Red Oak Lane
City and Zip Code: Lindenhurst 60046
County: Lake County Health Service Area: VIII Health Planning Area: 97

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

Exact Legal Name: Lindenhurst Surgery Center, LLC
Street Address: 1050 Red Oak Lane
City and Zip Code: Lindenhurst, IL 60046
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 S. LaSalle St., Ste 814
Registered Agent City and Zip Code: Chicago, 60604
Name of Chief Executive Officer: Tomas E. Nemickas
CEO Street Address: 350 S. Greenleaf, #405
CEO City and Zip Code: Gurnee, IL 60031
CEO Telephone Number: 847-336-3335

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	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: Juan Morado Jr. and Mark J. Silberman
Title: CON Counsel
Company: Benesch Friedlander Coplan and Aronoff LLP
Address: 71 South Wacker Drive, Suite 1600, Chicago, Illinois 60606
Telephone Number: 312-212-4967 and 312-212-4952
E-mail Address: jmorado@beneschlaw.com and msilberman@beneschlaw.com
Fax Number: 312-767-9192

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:

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Lindenhurst Surgery Center
Street Address: 1050 Red Oak Lane
City and Zip Code: Lindenhurst 60046
County: Lake County Health Service Area: VIII Health Planning Area: 097

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

Exact Legal Name: Ortho-Pod, LLC
Street Address: 350 S. Greenleaf St., #405
City and Zip Code: Gurnee, IL 60031
Name of Registered Agent: Tomas E. Nemickas
Registered Agent Street Address: 350 S. Greenleaf St., #405
Registered Agent City and Zip Code: Gurnee, IL 60031
Name of Chief Executive Officer: Tomas E. Nemickas
CEO Street Address: 350 S. Greenleaf, #405
CEO City and Zip Code: Gurnee, IL 60031
CEO Telephone Number: 847-336-3335

Type of Ownership of Applicants

☐ Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
☒ 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: Juan Morado Jr. and Mark J. Silberman
Title: CON Counsel
Company: Benesch Friedlander Coplan and Aronoff LLP
Address: 71 South Wacker Drive, Suite 1600, Chicago, Illinois 60606
Telephone Number: 312-212-4967 and 312-212-4952
E-mail Address: jmorado@beneschlaw.com and msilberman@beneschlaw.com
Fax Number: 312-767-9192

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:

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: Rachel Wadkins
Title: Administrator
Company Name: Lindenhurst Surgery Center, LLC
Address: 240 Center Drive, Vernon Hills, Illinois 60061
Telephone Number: (847)-367-8100 ext. 7231
E-mail Address: Rachel.wadkins@scasurgery.com
Fax Number: (866)-998-0186

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: Waukegan Illinois Hospital Company, LLC
Address of Site Owner: 1573 Mallory Lane, Suite 100, Brentwood, TN 37027
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: Lindenhurst Surgery Center					
Address: 1050 Red Oak Lane, Lindenhurst, IL 60064					
☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	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 [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)**. **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.
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.

Lindenhurst Surgery Center, LLC seeks authority from the Illinois Health Facilities and Services Review Board to modernize the Lindenhurst Surgery Center, LLC, located at 1050 Red Oak Lane, Lindenhurst, Illinois 60046.

This project is classified as non-substantive in that it does not involve the establishment of any category of services nor does involve a replacement facility on a new site. The purpose of this modernization project is to renovate the existing facility's commons areas and expand the size of three existing operating rooms while eliminating an existing fourth operating room.

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	$57,200	$46,800	$104,000
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	-	-	-
Modernization Contracts	$1,967,421	$1,311,614	$3,279,035
Contingencies	$120,000	$80,000	$200,000
Architectural/Engineering Fees	$105,600	$70,400	$176,000
Consulting and Other Fees	$96,957	$64,638	$161,594
Movable or Other Equipment (not in construction contracts)	$1,183,687	$695,181	$1,878,868
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	$420,236	$280,157	$700,393
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	**$3,951,100**	**$2,548,790**	**$6,499,890**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	$2,247,177	$1,752,823	$4,000,000
Leases (fair market value)	$1,703,923	$795,967	$2,499,890
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$3,951,100**	**$2,548,790**	**$6,499,890**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

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

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is **N/A.**

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): __October 31, 2022_____

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.**

Not Reviewable Space [i.e. non-clinical]: *means an area for the benefit of the patients, visitors, staff or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

		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	-	-	-	-	-	-	-
Operating Rooms (3)	-	1653	-	-	1653	-	-
Storage	-	310	-	-	310	-	-
Sterile Supply	-	1688	-	-	1688	-	-
Nursing Station	-	780	-	-	780	-	-
Recovery Rooms	-	2563	-	-	2563	-	-
Total Clinical	$3,951,100	6994	-	-	6994	-	-
NON-REVIEWABLE							
Reception		1423	-	-	1423	-	-
Administrative		2633	-	-	2633	-	-
Total Non-clinical	$2,548,790	4057	-	-	4057	-	-
TOTAL	**$6,499,890**	**11051**	-	-	**11051**	-	-

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

SIGNATURE	SIGNATURE
Tomas E. Nemickas PRINTED NAME	PRINTED NAME
Managing Member PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 13 day of April 2022	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal RACHEL WADKINS Official Seal Notary Public - State of Illinois My Commission Expires May 13, 2025	Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- 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 Ortho-Pod, 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
Tomas E. Nemickas PRINTED NAME	PRINTED NAME
Managing Member PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 13 day of April 2022	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal RACHEL WADKINS Official Seal Notary Public - State of Illinois My Commission Expires May 13, 2025	Seal

Insert the EXACT legal name of the applicant

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

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

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one application 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 can 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** 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:

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?**
ASTC (3 Operating Rooms)	**6994 GSF**	**8250 GSF**	**-1256 GSF**	**YES**

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

PROJECT SERVICES UTILIZATION: NOT APPLICABLE

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:

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:

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.

The following Sections <u>DO NOT</u> 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)**

VII. 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;
_____	b)	Pledges − for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable 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 timetable of receipts;
<u>$6,499,890</u>	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.
$6,499,890	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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 the project's 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.

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 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).

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		Gross Sq. Ft.		Gross Sq. Ft.		Const. $ (A x C)	Mod. $ (B x E)	
	New	Mod.	New	Circ.*	Mod.	Circ.*			
Clinical Components	-	$281.30	-	-	6994	-	-	$1,967,421	$1,967,421
Contingency	-	$17.16	-	-	0	-	-	$120,000	$120,000
TOTALS		$298.46	-	-	6994	-	-	$2,087,421	$2,087,421

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 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, ***including the impact on racial and health care disparities 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 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			
	Year	**Year**	**Year**
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: **Lindenhurst Surgery Center, LLC 1050 Red Oak Lane, Lake Villa, IL 60046 847-356-4710**

2. Project Location: **1050 Red Oak Lane, Lake Villa, IL 60046, Lake County, Lake Villa Township**
   (Address) (City) (State)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go To NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.
   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No _X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title:_____

Business/Agency:_____ Address:_____

_____

(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date:_____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

INDEX OF ATTACHMENTS

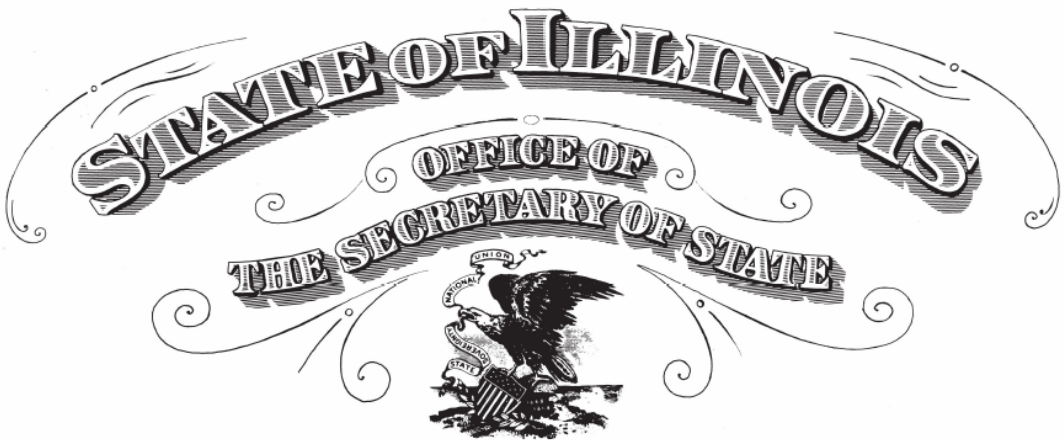
Attachment 1
Type of Ownership of Applicants

Included with this attachment are:

1. The Certificate of Good Standing for the applicant facility.
2. The Certificate of Good Standing for Ortho-Pod, LLC.

Attachment 1
Certificate of Good Standing
Lindenhurst Surgery Center, LLC

File Number 0366383-3



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

LINDENHURST SURGERY CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON OCTOBER 20, 2011, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS 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* 4TH *day of* APRIL *A.D.* 2022 .

Jesse White

Authentication #: 2209404038 verifiable until 04/04/2023

Attachment 1
Certificate of Good Standing
Ortho-Pod, LLC

File Number 0082969-2

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

ORTHO-POD, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 19, 2002, 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.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 4TH *day of* APRIL *A.D.* 2022 .

Jesse White

Authentication #: 2209404046 verifiable until 04/04/2023

Attachment 2
Site Ownership

Attached is a copy of the facility's property tax statements for 2021. The tax documents reflect that Waukegan Illinois Hospital Company, LLC is the site owner. Additionally, included as evidence is a copy of the Second Amendment to the Lease Agreement reflecting that the property is leased to Lindenhurst Surgery Center, LLC.

Attachment 2

Page datalets/datalet.aspx?mode=legal_desc not registered

PARID: 0603100049
NBHD: 9505020
WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC
Tax Year: 2021 (Taxes Payable in 2022),
Parcel

ASSESSOR #: 049
ROLL: RP
1050 RED OAK LN
Select **Tax Year** on the right:

Assessment Year:	2021
Pay Year:	2022
Property Location:	1050 RED OAK LN
Building/Unit #:	
City/State/Zip:	LINDENHURST IL 60046
Mailing Address:	14400 METCALF AVE
	OVERLAND PARK KS 66223-2989
Split/Combine Occurred:	Yes - see Split/Combine History tab for more info
Living Units:	
Neighborhood:	9505020 - Offices
Class:	COM - Commercial
Property Use Code:	60 - Commercial Improvements
Acres:	3.3128
Square Feet:	144,306
GIS Acres:	3.2994
Subdivision #:	
Subdivision Name:	
Lot:	
Block:	
Legal 1:	PT E1/2 GOVT LOT 2 NW1/4; BEG 40' S & 531.24' W OF NE COR N
Legal 2:	W1/4, S00D03'55"W 216.78', S 69D33'42"W 149.28', SWLY ALG CU
Legal 3:	RVE 129.65' TO POB, CONT SLY ALG CURVE 259.69', SLY ALG CURV
Tax Code Area:	05126 - LAKE VILLA TWP 126
Mortgage Company:	-
ACH:	No

Alternate Address

Address Type	Address
P – Postal	1050 RED OAK LN , LINDENHURST, IL 60046-1998

Parcel Status

Tax Year:	2021
Active/Deactive:	Active

Tax Status

Tax Year:	2021
In Forfeiture:	No
In Bankruptcy	No
Taxes Due:	Yes - see Taxes Due tab for more information
Tax Lien on Property:	No
Tax Adjustment:	No

Tax District Information

Township:	TOWNSHIP OF LAKE VILLA
Road & Bridge:	ROAD AND BRIDGE-LAKE VILLA
Municipality:	VIL OF LINDENHURST
Community College:	COLLEGE OF LAKE COUNTY #532
Elementary School:	LAKE VILLA SCHOOL DISTRICT #41
High School:	ANTIOCH COMM HIGH SCHOOL DISTRICT #117
Unit K-12 School District	
Park:	LINDENHURST PARK DISTRICT
Fire Protection:	LAKE VILLA TOWNSHIP FIRE PROT DIST

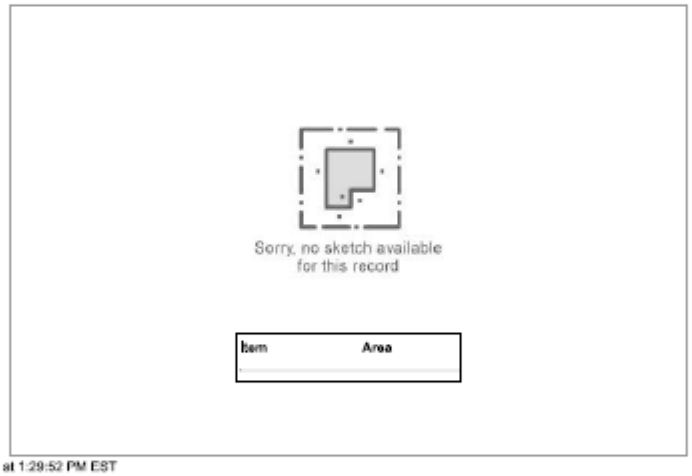
Attachment 2

4/30/22, 1:29 PM Lake County, IL Property Tax Information

Library:	LAKE VILLA PUBLIC LIBRARY DIST
Sanitary:	LINDENHURST SAN DIST
Mosquito Abatement:	
Central Lake Cty Joint AC:	CEN LK COUNTY JAWA - BONDS SER 2002
	CEN LK COUNTY JOINT ACTION WATER AGENCY
Special Service Area:	LAKE COUNTY SPECIAL SERVICE AREA 16
Tax Increment Finance Area:	

Exemption Credits

Tax Year	
Prorated Exemption:	
Fully Exempt:	
Senior Freeze:	
Home Improvement:	
General Homestead:	
Senior Homestead:	
Disbled Persons:	
Disabled Veterans:	
Disabled Veterans Standard:	
Returning Veterans:	
Natural Disaster:	
Mobile Home Exemption:	



Printed on Saturday, April 30, 2022, at 1:29:52 PM EST

Attachment 2

SECOND AMENDMENT TO LEASE AGREEMENT

This Second Amendment to Lease Agreement ("Amendment") is made effective as of ___ _____, 2022 (the "Effective Date"), by and between WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC, an Illinois limited liability company ("Landlord") and LINDENHURST SURGERY CENTER, LLC, a Delaware limited liability company ("Tenant") with reference to the following facts and circumstances.

A. Landlord is the owner of that certain building located at 1050 Red Oak Lane, Lindenhurst, Illinois 60046 (the "Office Building").

B. Landlord and Tenant entered into that certain Lease Agreement dated May 1, 2012 as amended by that certain First Amendment to Lease Agreement dated August 31, 2021 (collectively, the "Lease") for certain premises consisting of approximately 13,548 rentable square feet in the Office Building (the "Premises").

C. Landlord and Tenant desire to amend the Lease upon terms and conditions hereinafter set forth.

NOW, THEREFORE, in consideration of the foregoing facts and circumstances, the mutual covenants and promises contained herein and after good and valuable consideration, the receipt and sufficiency of which is acknowledged by each of the parties, the parties do hereby agree to the following:

1. Definitions. Each capitalized term used in this Amendment shall have the same meaning as is ascribed to such capitalized term in the Lease, unless otherwise provided for herein.

2. Premises. Section 1.01(xvi) of the Lease is hereby deleted in its entirety and replaced with the following:

(xvi) "Premises" means the "Ambulatory surgery Center suite", consisting of 11,046 rentable square feet located on the first floor of the Office building, as more particularly depicted on Exhibit B attached hereto.

3. Tenant's Proportionate Share. Section 1.01(xxi) of the Lease is hereby deleted in its entirety and replaced with the following:

(xxi) "Tenant's Proportionate Share" shall mean the percentage equivalent of a fraction whose numerator is the Rentable Area of the Premises and whose denominator is the Rentable Area of the Office Building, which the parties agree to be Twenty Four and 67/100 percent (24.67%) for purposes of this Lease, which is the fraction resulting from 11,046 divided by 44,781.

Attachment 2

4. Exhibit B. Exhibit B of the Lease is hereby deleted in its entirety and replaced with Exhibit B attached hereto and made a part hereof.

5. Miscellaneous.

a. *Time of Essence*. Time is of the essence of this Amendment and each and every term and provision hereof.

b. *Modification*. A modification of any provision herein contained, or any other amendment to this Amendment, shall be effective only if the modification or amendment is in writing and signed by both Landlord and Tenant.

c. *Successors and Assigns*. This Amendment shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

d. *Number and Gender*. As used in this Amendment, the neuter includes masculine and feminine, and the singular includes the plural.

e. *Construction*. Headings at the beginning of each Section and subsection are solely for the convenience of the parties and are not a part of this Amendment. Except as otherwise provided in this Amendment, all exhibits referred to herein are attached hereto and are incorporated herein by this reference. Unless otherwise indicated, all references herein to Articles, Section, subsections, paragraphs, subparagraphs or provisions are to those in this Amendment. Any reference to a paragraph or Section herein includes all subparagraphs or subsections thereof. This Amendment shall not be construed as if it had been prepared by only Landlord or Tenant, but rather as if both Landlord and Tenant had prepared the same. In the event any portion of this Amendment shall be declared by any court of competent jurisdiction to be invalid, illegal or unenforceable, such portion shall be deemed severed from this Amendment, and the remaining parts hereof shall remain in full force and effect, as fully as though such invalid, illegal or unenforceable portion had never been part of this Amendment.

f. *Integration of Other Agreements*. This Amendment, the Lease and prior amendments set forth the entire agreement and understanding of the parties with respect to the matters set forth herein and supersedes all previous written or oral understandings, agreements, contracts, correspondence and documentation with respect thereto. Any oral representation or modifications concerning this Amendment shall be of no force or effect.

g. *Duplicate Originals; Counterparts*. This Amendment may be executed in any number of duplicate originals, all of which shall be of equal legal force and effect. Additionally, this Amendment may be executed in counterparts, but shall become effective only after a counterpart hereof has been executed by each party; all said counterparts shall, when taken together, constitute the entire single agreement between parties.

Attachment 2

h. *No Waiver*. No failure or delay of either party in the exercise of any right given to such party hereunder shall constitute a waiver thereof unless the time specified herein for exercise of such right has expired, nor shall any single or partial exercise of any right preclude other or further exercise thereof or of any other right. No waiver by any party hereto of any breach or default shall be considered to be a waiver of any other breach or default. The waiver of any condition shall not constitute a waiver of any breach or default with respect to any covenant, representation or warranty.

i. *Further Assurances*. Landlord and Tenant each agree to execute any and all other documents and to take any further actions reasonably necessary to consummate the transactions contemplated hereby.

j. *No Third Party Beneficiaries*. Except as otherwise provided herein, no person or entity shall be deemed to be a third party beneficiary hereof, and nothing in this Amendment, (either expressed or implied) is intended to confer upon any person or entity, other than Landlord and/or Tenant (and their respective nominees, successors and assigns), any rights, remedies, obligations or liabilities under or by reason of this Amendment.

k. *Full Force and Effect*. The Lease, as amended hereby, shall continue in full force and effect, subject to the terms and provisions thereof and hereof. In the event of any conflict between the terms of the Lease and the terms of this Amendment, the terms of this Amendment shall control.

[Signatures Page Follows]

Attachment 2

IN WITNESS WHEREOF, this Amendment is executed as of the day and year aforesaid.

LANDLORD:

WAUKEGAN ILLINOIS HOSPITAL COMPANY, LLC

By: _____

Printed Name: JON ROZENFELD

Title: CEO

Date: 4/29/2022

TENANT:

LINDENHURST SURGERY CENTER, LLC

By: _____

Printed Name: _____

Title: _____

Date: _____

ATTACHMENT 3
OPERATING ENTITY/LICENSEE

The Lindenhurst Surgery Center is licensed by the Illinois Department of Public Health and will remain the licensee following this project. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

ATTACHMENT 3
OPERATING ENTITY/LICENSEE
CERTIFICATE OF GOOD STANDING FOR
LINDENHURST SURGERY CENTER, LLC

File Number 0366383-3

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

LINDENHURST SURGERY CENTER, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON OCTOBER 20, 2011, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS 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* 4TH *day of* APRIL *A.D.* 2022 .

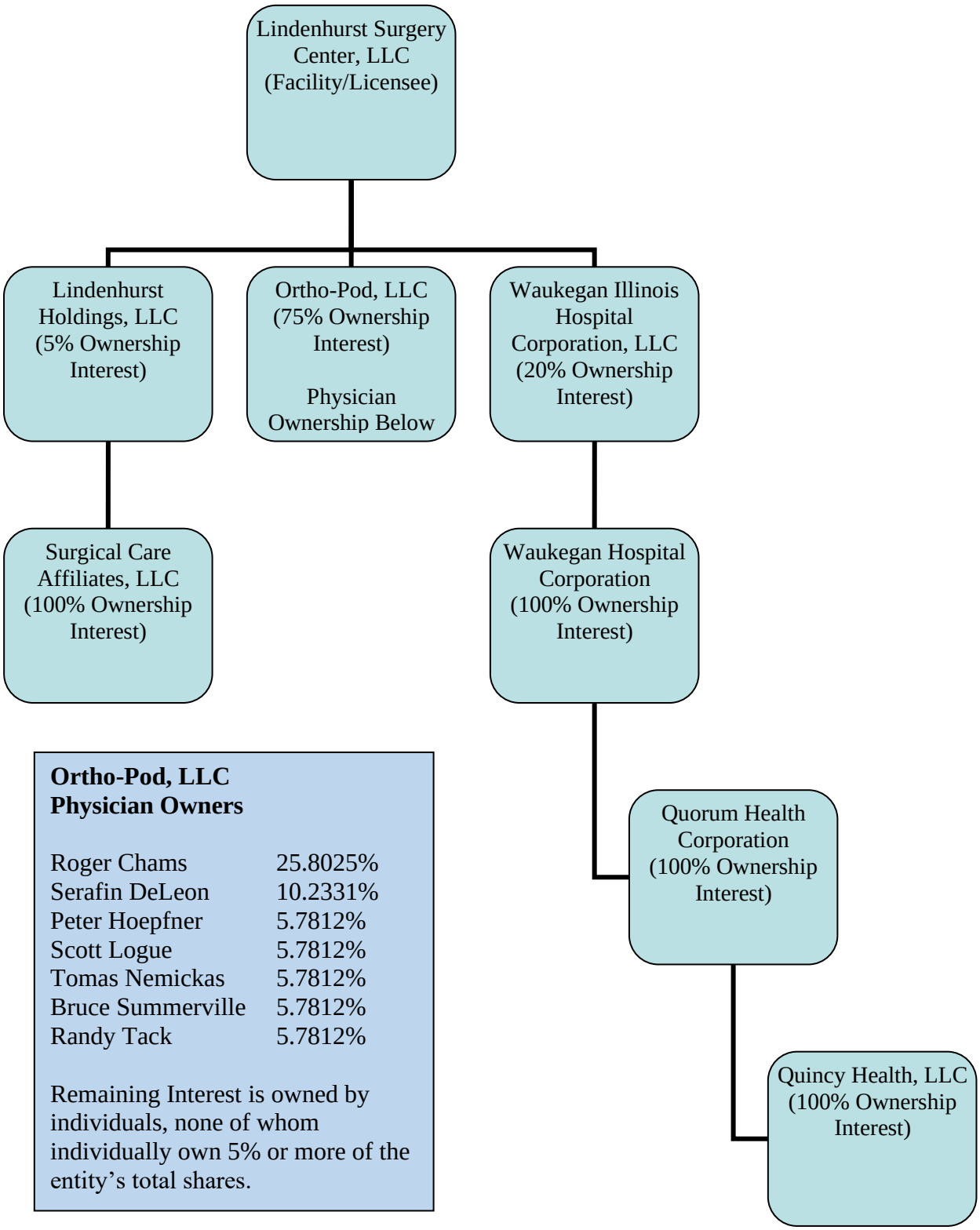
Jesse White

Authentication #: 2209404038 verifiable until 04/04/2023

ATTACHMENT 4
ORGANIZATIONAL RELATIONSHIPS

The majority of the facility is owned by the Applicant, Ortho-Pod, LLC. All direct owners of a 5% or more interest in the applicant facility are identified in the organizational charts.

ATTACHMENT 4
ORGANIZATIONAL RELATIONSHIPS



ATTACHMENT 5
FLOOD PLAIN REQUIREMENTS

April 4, 2022

Debra Savage
Board Chair
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Lindenhurst Surgery Center- Flood Plain Requirements

Dear Chair Savage:

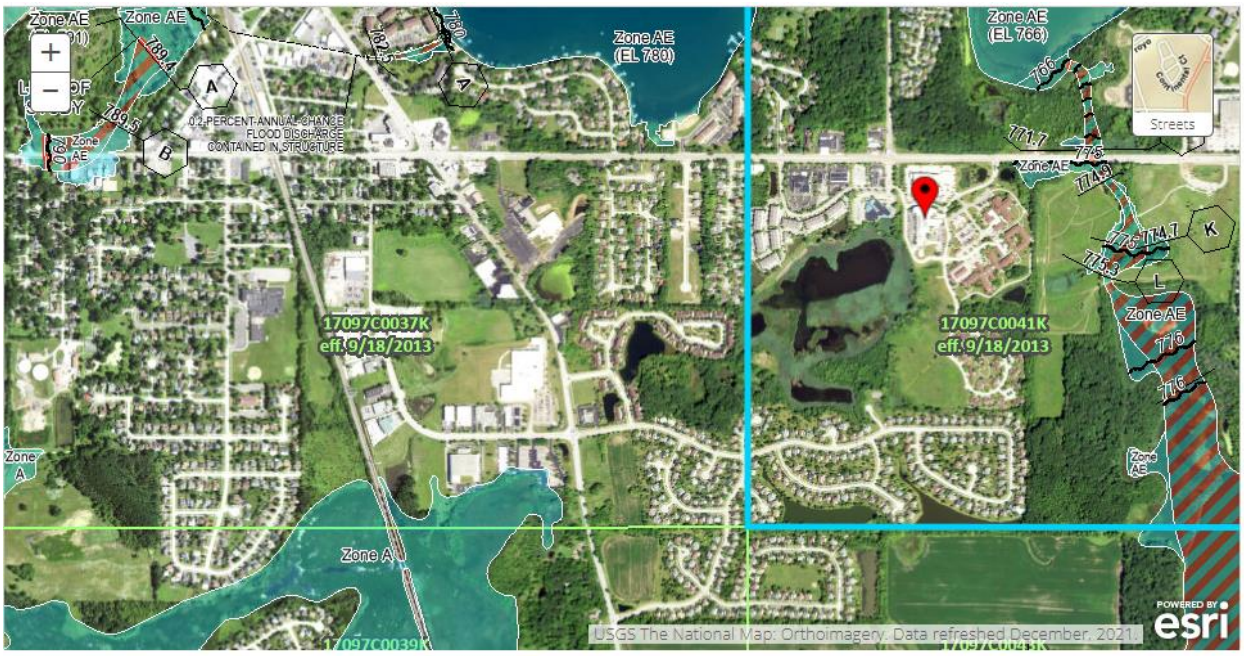
As representative of Lindenhurst Surgery Center, I, Rachel Wadkins affirm that the proposed location for the modernization of Lindenhurst Surgery Center, LLC complies with Illinois Executive Order #2005-5. The facility location at 1050 Red Oak Lane, Lindenhurst, IL 60046 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

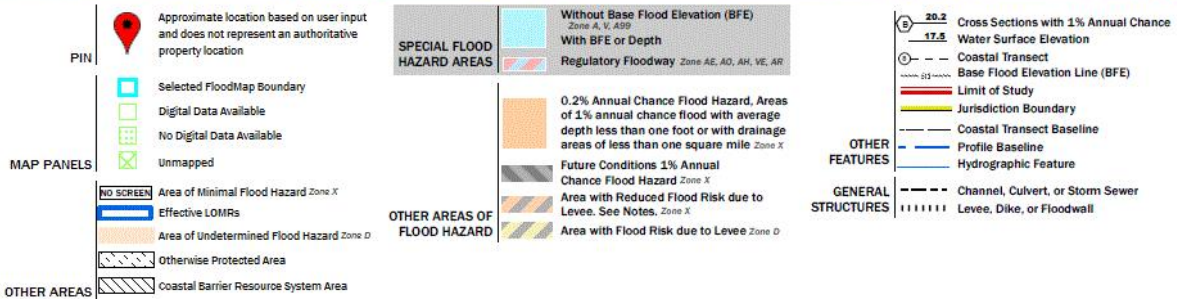
I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Rachel Wadkins
Administrator
Lindenhurst Surgery Center

ATTACHMENT 5
FLOOD PLAIN REQUIREMENTS





ATTACHMENT 6
HISTORIC PRESERVATION ACT REQUIREMENTS

The applicant submitted a request for determination to the Illinois Department of Natural Resources- Preservation Services Division on April 5, 2022. A final determination from the Department was made on April 25, 2022 that no historic, architectural or archeological sites exist within the project area (attached).

ATTACHMENT 6
HISTORIC PRESERVATION ACT REQUIREMENTS

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of
Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

JB Pritzker, Governor
Colleen Callahan, Director

Lake County
Lindenhurst
CON - Modernization of Ambulatory Surgical Treatment Center, Lindenhurst Surgery Center
1050 Red Oak Lane
SHPO Log #016040522

April 25, 2022

Juan Morado
Benesch, Friedlander, Coplan and Aronoff LLP
71 S. Wacker Dr., Suite 1600
Chicago, IL 60606

Dear Mr. Morado:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact Rita Baker, Cultural Resources Manager, at 217/785-4998 or at Rita.E.Baker@illinois.gov.

Sincerely,

Carey L. Mayer

Carey L. Mayer , AIA
Deputy State Historic
Preservation Officer

ATTACHMENT 6

Juan Morado Jr.
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

April 5, 2022

VIA E-MAIL

Jeffrey Krutchen
Chief Archaeologist
Preservation Services Division
Illinois Historic Preservation Office Illinois Department of Natural Resources
1 Natural Resources Way
Springfield, Illinois 62702
Jeffrey.kruchten@illinois.gov
SHPO.Review@illinois.gov

Re: Certificate of Need Application for Lindenhurst Surgery Center

Dear Jeffrey:

I am writing on behalf of my client, Lindenhurst Surgery Center ("Lindenhurst"), to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). Lindenhurst is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. Lindenhurst is proposing to modernize an existing ambulatory surgical treatment center located at 1050 Red Oak Lane, Lindenhurst, Illinois 60046.

The purpose of this modernization project is to renovate the existing facility commons areas and expand the size of three existing operating rooms while eliminating the existing fourth operating room.For your reference, we have included pictures of the land where the facility will be constructed and topographic maps (Attachments 1-2) showing the general location of the project.

We respectfully request review of the project area and a determination letter at your earliest convenience. Thank you in advance for all the time and effort that will be going into this review.

Very truly yours,
BENESCH, FRIEDLANDER,
COPLAN & ARONOFF, LLP

Juan Morado, Jr.

15565592 v1

ATTACHMENT 6

Lindenhurst Surgery Center Topographic Map
(1050 Red Oak Lane, Lindenhurst, Illinois 60046)

15565592 v1

ATTACHMENT 6

Lindenhurst Surgery Center Aerial Map View

15565592 v1

ATTACHMENT 6

Lindenhurst Surgery Center Street View

15565592 v1

ATTACHMENT 7
PROJECT COSTS AND SOURCES OF FUNDS

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$57,200	$46,800	$104,000
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	-	-	-
Modernization Contracts	$1,967,421	$1,311,614	$3,279,035
Contingencies	$120,000	$80,000	$200,000
Architectural/Engineering Fees	$105,600	$70,400	$176,000
Consulting and Other Fees	$96,957	$64,638	$161,594
Movable or Other Equipment (not in construction contracts)	$1,183,687	$695,181	$1,878,868
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	$420,236	$280,157	$700,393
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	**$3,951,100**	**$2,548,790**	**$6,499,890**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	$2,247,177	$1,752,823	$4,000,000
Leases (fair market value)	$1,703,923	$795,967	$2,499,890
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$3,951,100**	**$2,548,790**	**$6,499,890**

ATTACHMENT 7
PROJECT COSTS AND SOURCES OF FUNDS (cont'd)

Pre-Planning Costs	• Miscellaneous- $24,000 • Development/Feasibility Studies-$25,000 • Architect and Consultant Selection -$25,000 • Evaluation of alternatives- $30,000	$104,000
Modernization Construction Costs	• General Contractor cost, material, and labor cost	$3,279,035
Contingencies	• Unexpected costs associated with matter not covered under construction contract	$200,000
Architectural/Engineering Fees	• A/E Site Plans Preparation, Review Process	$176,000
Consulting and Other Fees	• CON and Permit Related Fees- $80,000 • Testing Services- $25,329 • Physical Reports- $3,325 • IDPH Consultant- $9,350 • Beltman Logistics- $43,590	$161,594
Moveable or Other Equipment (not in construction contracts)	• Ortho Instrument Allowance-$637,266 • Updated Facility Equipment-$1,112,821 • Nurse Calling System-$54,855 • Furniture- $73,926	$1,878,868
Other Costs to be Capitalized	• Surge Device Protection- $607,920 • IT Related Upgrades to Data Room-$92,473	$700,393
Total Uses of Funds	**$6,499,890**	**$6,499,890**

Preplanning Costs- The clinical preplanning costs are estimated to be $57,200, which is 1.75% of the clinical construction, contingency, and equipment costs for the project.

Modernization Construction Contracts- The proposed project will modernize an existing surgery center and reduce the number of operating spaces from four to three total. The project building costs are based on national architectural and construction standards and adjusted to compensate for several factors. This application also reflects recently received bids which were significantly higher due to unexpected increases in labor and raw material costs due to the COVID-19 pandemic. The clinical construction costs are estimated to be $1,967,421 or $281.30 per clinical square foot.

Contingencies- The contingency costs listed are for unforeseeable events relating to construction or modernization costs that are not included in the construction contracts. The clinical costs are estimated to be $120,000 or 6.10% of the modernization contract costs.

Architectural/Engineering Fees- The clinical project cost for architectural/engineering fees are projected to be $105,600 or 5.06% of the new construction and contingencies costs.

Consulting and Other Fees- The Project's consulting fees are primarily comprised of various project-related fees, additional state/local fees, and other CON related costs.

Moveable Equipment Costs- The moveable equipment costs are necessary component for the operation of the updated operating rooms at the facility. The clinical costs divided among the remaining operating rooms equals $394,562.30 per operating room.

Other Costs that are to be Capitalized- The Project has clinical costs to be capitalized in the amount of $420,236. These costs include expenses that are not included in construction contracts and working capital expenses related to the project.

ATTACHMENT 8
PROJECT STATUS AND COMPLETION SCHEDULES

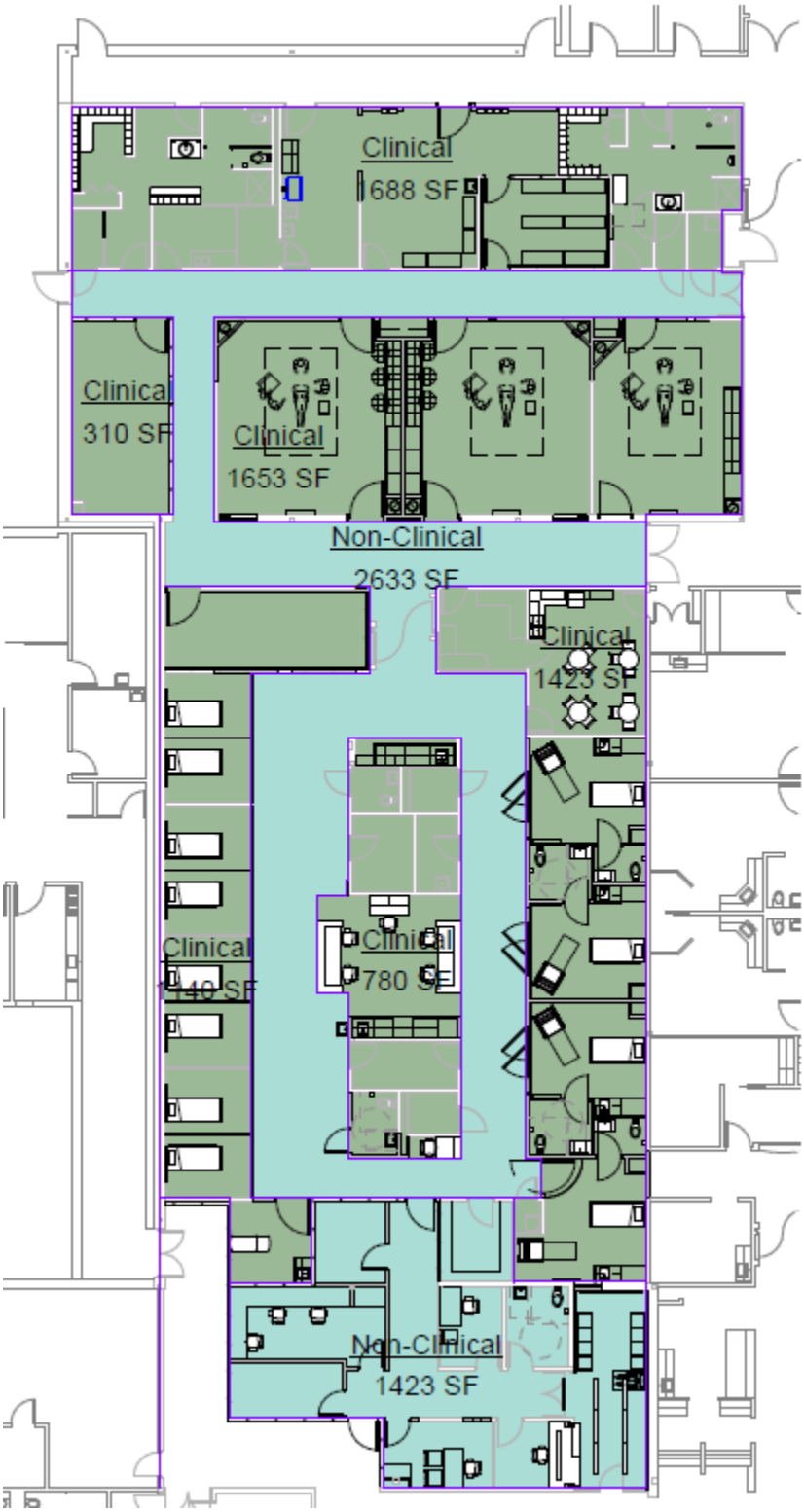
The proposed project plans are still at a schematic stage. The proposed project completion date is December 31, 2022. Financial commitment for the project will occur following permit issuance, but in accordance with HFSRB regulations.

ATTACHMENT 9
COST SPACE REQUIREMENT

The proposed modernization project involves the removal of one of four existing operating rooms and the expansion of the three remaining operating rooms.

		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	-	-	-	-	-	-	-
Operating Rooms (3)	-	1653	-	-	1653	-	-
Storage	-	310	-	-	310	-	-
Sterile Supply	-	1688	-	-	1688	-	-
Nursing Station	-	780	-	-	780	-	-
Recovery Rooms	-	2563	-	-	2563	-	-
Total Clinical	$3,951,100	6994	-	-	6994	-	-
NON-REVIEWABLE							
Reception		1423	-	-	1423	-	-
Administrative		2633	-	-	2633	-	-
Total Non-clinical	$2,548,790	4057	-	-	4057	-	-
TOTAL	**$6,499,890**	**11051**	-	-	**11051**	-	-

ATTACHMENT 9



Attachment 11
Background of the Applicant

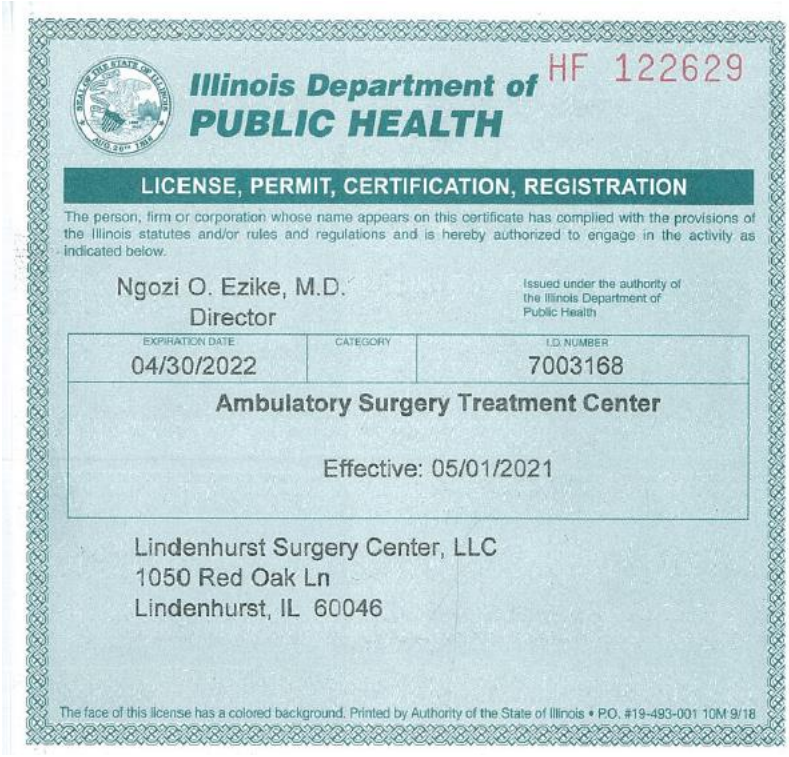
The following information is provided to illustrate the qualifications, background and character of the Applicants, and to assure the Health Facilities and Services Review Board that the proposed hospital will provide a proper standard of health care services for the community.

Lindenhurst Surgery Center, LLC

1. The proposed project is brought forth by Ortho-Pod, LLC the majority owner of Lindenhurst Surgery Center, LLC. The ownership of facility is reflected in Attachment 4.

2. Lindenhurst Surgery Center does not have a direct ownership interest in any other health care facility in Illinois. However, Ortho-Pod, LLC does maintain an ownership interest in excess of 5% in one other healthcare facility. The facility is described in the enclosed certification letter. The applicants certify that there have been no adverse actions taken during the three (3) years prior to filing of this application. A letter certifying to the above information is included at Attachment 11.

3.We have included a letter authorizing access to the HFSRB and IDPH to verify information contained in the application at Attachment 11.



Illinois Department of PUBLIC HEALTH

HF 122629

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
04/30/2022		7003168

Ambulatory Surgery Treatment Center

Effective: 05/01/2021

Lindenhurst Surgery Center, LLC
1050 Red Oak Ln
Lindenhurst, IL 60046

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

Attachment 11
Background of the Applicant

The Joint Commission

February 7, 2022

Michelle Hess
Director of Operations at SCA
Lindenhurst Surgery Center, LLC
1050 Red Oak Lane
Lindenhurst, IL 60046

Re: # 525962
CCN: # 14C0001152
Deemed Program: Ambulatory Surgical Center
Accreditation Expiration Date: October 29, 2024

Dear Mrs. Hess:

This letter confirms that your October 26, 2021 - October 28, 2021 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for ambulatory surgical centers through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on February 4, 2022. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of October 29, 2021.

The Joint Commission is also recommending your organization for continued Medicare certification effective October 29, 2021. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location:

Lindenhurst Surgery Center, LLC
d/b/a Lindenhurst Surgery Center, LLC
1050 Red Oak Lane, Lindenhurst, IL, 60046

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Attachment 11
Background of the Applicant

Background of Ortho-Pod, LLC

1. Ortho-Pod, LLC is a joint venture entity created by several orthopedic surgeons associated with Illinois Bone and Joint (biographies below) and other independent physicians. The joint venture group only obtained its ownership interest in the facility in recent months. Illinois Bone and Joint has no direct or indirect interest in this entity and the physicians who hold an ownership interest in Ortho-Pod, LLC hold that interest in their individual capacities.

2. Ortho-Pod, LLC is the majority owner of Lindenhurst Surgery Center, LLC (75% ownership). The ownership of facility is reflected in Attachment 4. Ortho-Pod, LLC is also a limited partner in Hawthorn Place Outpatient Surgery and holds a 62% interest in that facility. Both facilities are described in the enclosed certification letter. The applicants certify that there have been no adverse actions taken during the three (3) years prior to filing of this application. A letter certifying to the above information is included at Attachment 11.

3. We have included a letter authorizing access to the HFSRB and IDPH to verify information contained in the application at Attachment 11.

Roger Chams, M.D.

Dr. Roger Chams is a board-certified orthopedic surgeon specializing in Sports Medicine, knee and shoulder disorders. He was fellowship trained at the prestigious Southern California Orthopedic Institute where he received specialized training in minimally invasive arthroscopic surgery of complex knee and shoulder disorders and sports injuries. After his fellowship, he introduced many of these innovative procedures that had not previously been performed to the area, including cartilage restoration.

His extensive Sports Medicine experience includes treating thousands of professional, NCAA, amateur athletes, as well as work-related injuries. He is the team physician for the Chicago Red Stars professional women's soccer team of the NWSL. He is a longstanding team physician for Lake Forest College, as well as multiple high schools and club sports teams. Dr. Chams has been chosen as a team physician for the US Soccer Federation Men and Women National Teams.

He has presented at national meetings, published multiple journal articles, instructional videos, and has authored a textbook chapter on Advanced Shoulder Arthroscopy. He continues to be active as a member and instructor for the Arthroscopy Association of North America (AANA), American Association of Orthopedic Surgeons (AAOS), and the American Orthopedic Society for Sports Medicine (AOSSM), teaching advanced knee and shoulder arthroscopic surgical technique courses for other orthopedic surgeons. He is an instructor for the Residents / Fellows Advanced Surgical Arthroscopic Shoulder/ Knee Course at the Academy Learning Center and continues to routinely teach medical education courses for physicians, physical therapists, and athletic trainers.

Dr. Chams has been honored with numerous awards and titles, including "Top Tier MD", "Chicago's Top Doctor", American Registry "Patient's Choice" and Becker's Orthopedic Review "Outstanding Knee Surgeons". He has been selected to "America's Top Orthopedists "by the Consumer Research Counsel of America for the last 15 years. Today he brings advanced experience in Platelet Rich Plasma Therapy, also known as PRP, and is on the cutting edge of stem cell therapy.

Attachment 11
Background of the Applicant

Roger Chams, M.D. (cont'd)

Additional Areas of Expertise

- Shoulder
- Labral Tear
- Rotator Cuff Tear
- Ac Sprain
- Biceps Tendinopathy
- Frozen Shoulder
- Shoulder Arthritis
- Shoulder Bursitis
- Shoulder Calcific Tendonitis
- Shoulder Impingement
- Shoulder Instability
- Shoulder Complex
- Shoulder Osteoarthritis
- Thrower's Shoulder / Little League Shoulder
- Rheumatoid Arthritis
- Fractures
- Distal Bicep ruptures
- Bankart and Reverse Bankart Tear
- SLAP Tear
- Knee

Collateral And Cruciate Ligament Injuries:

- MCL and LCL Injuries
- Meniscus Tear and Repair
- Patellofemoral Ligament Injuries: Lateral Release and Ligament Reconstruction
- ACL Injuries
- Arthrofibrosis of the Knee
- Chondromalacia Patella
- Osteochondritis Dissecans
- Osgood Schlatter Disease
- Patellar / Quadriceps Tendonitis
- Patellofemoral Pain
- Runners and Jumpers Knee
- Knee Complex
- Knee Arthritis

Attachment 11
Background of the Applicant

Serafin DeLeon, M.D.

Dr. Serafin DeLeon is a board-certified orthopedic surgeon with a subspecialty certification in hand surgery. He specializes in treating conditions of the hand, wrist, and elbow such as arthritis, fractures and other traumatic injuries, nerve compression, and carpal tunnel syndrome. Dr. DeLeon also has advanced training and experience in the care of sports injuries and treats athletes of all ages, including college and professional athletes. Dr. DeLeon is a Chicago Wolves Team Physician, specializing in Hand and Upper Extremity care.

In most cases, Dr. DeLeon is able to offer arthroscopy or other minimally invasive procedures, which decrease patient discomfort and speed recovery times. He also offers patients injections with platelet- rich plasma to stimulate tissue healing.

In providing care, Dr. DeLeon looks at the patient as a whole, treating the person, not merely the orthopedic condition. He takes the time to explain each patient's condition and treatment options thoroughly, so that patients can participate in decisions about their care. Dr. DeLeon customizes care to each patient individually to address any unique concerns or issues the patient may have. His goal is to eliminate pain and restore function.

Additional Areas of Expertise

- Hand/ Wrist/ Elbow Injuries
- Joint Replacement of the Hand/ Wrist/ Elbow
- Minimally Invasive Carpal Tunnel Surgery
- Nerve Repair & Treatment of Nerve Compression Tendonitis & Cumulative Trauma Disorders in the Workplace
- Platelet Rich Plasma Treatment of Recalcitrant Lateral Epicondylitis (Tennis Elbow)
- Sports Medicine
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

Tomas Nemickas, M.D.

Dr. Tomas Nemickas provides care for conditions such as rotator cuff tears, shoulder instability and tears of the labrum, meniscus, anterior cruciate ligament and posterior cruciate ligament. In most cases, he is able to offer arthroscopy or other minimally invasive procedures, which increase patient comfort and speed recovery times. These procedures also include total hip arthroplasty and anterior total hip replacement.

Dr. Nemickas also has expertise in computer-assisted minimally invasive knee replacement surgery. In addition, he offers Carticel implants, autologous cultured chondrocyte and DeNovo cartilage implants and injections with platelet-rich plasma. Dr. Nemickas grew up in a medical family – his father and uncle were cardiologists, and his mother and aunt were nurses. Watching them help patients get well and seeing the patients' gratitude inspired him to become a physician himself.

In providing care, Dr. Nemickas combines his knowledge of the latest proven technology and treatments with empathy gained from his own experience being treated for a severe ankle fracture in college. His patients are always treated individually, customizing their treatment plan to address their personal as well as medical needs.

Additional Areas of Expertise

- Computer Assisted Knee Replacement Surgery
- ACL Reconstruction
- Rotator Cuff Repair
- Meniscal Repair
- Shoulder Arthroscopy for SLAP, Bankart & Labral Repair & Stabilization Procedures
- Articular Cartilage Repair & Regeneration
- Total Hip Arthroplasty
- Platelet Rich Plasma Therapy
- Trauma
- Embryonic derived stem cell injections
- Adipose derived stem cell injections
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

Edward J. Logue, M.D.

Dr. Edward ("Scott") Logue is an orthopedic surgeon who specializes in treating shoulder and knee conditions and general trauma care. He has particular expertise in treating endurance athletes. In most cases he is able to offer arthroscopy or other minimally invasive procedures, which decrease patient discomfort and speed recovery times. He also performs unicondylar knee surgery and the OATS procedure (also known as mosaicplasty). In addition, he offers Carticel knee cartilage implantation; injections with platelet-rich plasma to stimulate tissue healing; and viscosupplement injections to lubricate knee joints.

A middle-distance runner in high school and college, Dr. Logue suffered stress fractures repeatedly. The care he received for these injuries, which enabled him to keep running, prompted his interest in pursuing medicine as a career. In providing care, Dr. Logue respects the individuality and wishes of each patient. He enjoys getting to know his patients and understanding their goals in seeking treatment. He pursues conservative treatments such as injections and physical therapy as well as surgery. His goal is to return patients to their desired level of activity, whether it's athletes returning to competition or older adults retaining functional abilities.

Dr. Logue is the team physician for the Chicago Wolves hockey team.

Additional Areas of Expertise

- ACL Reconstruction
- Arthroscopic Shoulder SLAP, Labral & Rotator Cuff Repair
- Knee Articular Cartilage Repair
- Meniscal Surgery
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

Bruce Summerville, M.D.

Dr. Bruce Summerville is a board-certified orthopaedic surgeon who specializes in treating conditions of the hip, knee, and shoulder. He provides care for conditions such as arthritis, trauma and fractures, tears of the shoulder ligaments, cartilage and tendons (rotator cuff, bicep, and labrum). Knee surgeries include arthroscopy for meniscal cartilage and ACL tears. He performs primary and revision hip, knee, and shoulder joint replacement including partial knee replacement and ASI (anterior) hip replacement.

Partial knee replacement allows for a faster recovery with fewer risks or complications. Anterior hip replacement may result in faster rehabilitation and reduces the risk of dislocation after surgery. Dr. Summerville still performs traditional total knee and hip replacement in appropriate cases. Ever since his Fellowship in Joint Replacement Surgery he continues to stay up to date on the latest techniques and technologies in that subspecialty as well as other conditions and treatments in Sports Medicine and Trauma.

His treatment of complex conditions requires significant attention and knowledge for those patients but he provides the same care and compassion for less serious conditions as well. His goal is to treat individuals without surgery if possible but in cases where surgery is needed he provides his expertise and technical skills for that purpose. He takes the time to explain each patient's condition and treatment options thoroughly so that patients can participate in decisions about their care. He has a passion for the field of Orthopedics and compassion for his patients.

Additional Areas of Expertise

- Partial Knee Replacement (Unicompartmental)
- ACL & Meniscus Surgery
- Rotator Cuff Surgery
- Bicep and Labral Cartilage Surgery
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

Stanford Tack, M.D.

Dr. Stanford Tack is a board-certified orthopaedic surgeon who specializes in treating disorders of the cervical and lumbar spine in adults. He provides care for stenosis, herniated disks and spondylolisthesis. Dr. Tack has extensive experience in performing cervical disk replacement in patients who previously have been treated with cervical fusion.

He performs most of his procedures using minimally invasive techniques that reduce patients' pain and speed their recovery times. Dr. Tack usually is able to perform surgery as an outpatient procedure, and patients typically do not require physical therapy or other post-operative care.

The son of a nurse, Dr. Tack inherited his mother's aptitude for caring for others, which combined with his interest in science led him to become a physician. Other members of his family are engineers, and he chose to specialize in orthopedics because it combines his familial background in medicine and mechanics.

In providing care, Dr. Tack begins with a conservative approach and spends a great deal of time working with patients to provide them with non-surgical management of their condition. He is very selective about when he recommends surgery for patients in order to make certain they need and will benefit from the procedure.

Additional Areas of Expertise

- Surgical Disorders of the Cervical & Lumber Spine
- Cervical Spine
- Peripheral Nerve Surgery
- Total Joints – Hip and Knee
- Carpal Tunnel
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

Peter Hoepfner, M.D.

Dr. Peter Hoepfner is dual board-certified in orthopaedic surgery and in hand and upper extremity surgery. He has published numerous articles in leading medical journals and serves as an instructor of hand injuries for the national hand surgery organization where he teaches the most current techniques in treating complex wrist, elbow and shoulder injuries. Dr. Hoepfner was on the Northwestern University Medical School faculty and holds a patent for an implant in thumb arthritis.

Whether using a surgical or nonsurgical approach, the appropriate treatment is tailored to each patient. As an expert in open and arthroscopic surgery, Dr. Hoepfner also specializes in carpal tunnel release, cubital tunnel release, sports injuries, fractures, dislocations, arthritis, tennis elbow, and complex elbow and wrist reconstruction. He also has specialized experience with complicated surgical reconstructions for patients with rheumatoid arthritis. In many difficult cases, he has enhanced his patient's quality of life and independence.

With a focus on restoring function and eliminating pain with the newest, least invasive methods possible, Dr. Hoepfner is often referred complicated upper extremity cases from other orthopedic surgeons. He performs all of his own surgeries and is one of the few surgeons in the Chicago area who performs total wrist replacements. Dr. Hoepfner also offers injections with platelet-rich plasma to stimulate tissue healing.

Board-certified in the evaluation of disability and impairment, Dr. Hoepfner is known to provide highly respected opinions when performing independent medical evaluations at the request of the medico-legal community.

Additional Areas of Expertise

- Complex Disorders of the Upper Extremity
- Arthroscopy of the Wrist & Elbow
- Total Wrist Replacement
- Orthopaedic Trauma: Hand, Wrist, Elbow, Humerus or Shoulder
- Fracture Care
- Carpal Tunnel Syndrome & Cubital Tunnel Syndrome
- Workplace Injuries
- Workers' Compensation
- Independent Medical Evaluations (IME)

Attachment 11
Background of the Applicant

April 11, 2022

Debra Savage
Board Chair
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification and Authorization

Dear Chair Savage,

As representative of Lindenhurst Surgery Center, LLC, I, Rachel Wadkins, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that, Lindenhurst Surgery Center, LLC, has no ownership interest in any Illinois healthcare facilities, and as such we no adverse actions to report for the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Rachel Wadkins
Administrator
Lindenhurst Surgery Center

Attachment 11
Background of the Applicant

April 5, 2022

Debra Savage
Board Chair
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification and Authorization

Dear Chair Savage,

As representative of Ortho-Pod, LLC, I, Tomas E. Nemickas, M.D., give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that, Ortho-Pod, LLC, also has an ownership interest in the Hawthorne Place Outpatient Surgery. Neither facility has had an adverse actions to report for the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Tomas E. Nemickas, M.D.
Managing Member
Ortho-Pod, LLC

Attachment 12
Purpose of the Project

Lindenhurst Surgery Center is designed to provide services for patients requiring routine, elective surgery in an outpatient setting. The center occupies space in a two-story, multi-tenant building. It is estimated that between 80 and 100 cases will be performed per month. The owners of the surgery center will use the facility, but the facility will maintain an open staff policy. It is also expected that colleagues and associates of the owners will also utilize the center upon obtaining credentials at the facility.

Lindenhurst Surgery Center will provide orthopedic, ophthalmologic, pain, general, neurologic and spine surgery, otolaryngology, podiatric and urologic services. The genesis for this project began last year when Ortho-Pod, LLC, a joint venture entity created by independent physicians and several physicians affiliated with Illinois Bone and Joint acquired the majority interest in the facility. Currently the facility is designed and operating with four operating rooms. Prior to the new owners acquiring their interest in the facility, the four operating rooms did not meet the target state utilization standards.

Ortho-Pod, LLC underwent a significant analysis of potential patient volume that could utilize the facility as well as the types of procedures that could be performed and it became clear that larger operating rooms than are currently available would be necessary. Larger operating rooms would allow for the accommodation of new equipment and would provide surgeons with ample space to perform a variety of procedures such as total joint replacements.

The Centers for Medicare & Medicaid Services (“CMS”) last year published an 81 page rule to both extend and change the Comprehensive Care for Joint Replacement (“CJR”) model. The CJR model is consistent with the goals of the Board in that it is designed to target and minimize cost inefficiencies and support more robust care for Medicare beneficiaries who undergo hip and knee replacements—also known as lower extremity joint replacements.

Modernizing this ASTC will provide patients with increased options for care and it also allows surgeons greater control over time spent in the operating room. These factors alone increase efficiency of an ASTC while maintaining quality, increasing access to care for patients, and providing services at a greatly reduced cost. Moreover, during the ongoing pandemic studies have shown that there are low incidences of infection among patients obtaining outpatient orthopedic surgeries. As previously discussed there is an ongoing push by CMS to limit or reduce reimbursement of certain procedures unless they are performed in an ASTC. This reduces the available options for patients and puts them in the position of needing to see a different doctor or take their chances with obtaining an appointment in a hospital surgical suite.

The facility is already approved as a multi-specialty facility and will continue to offer a wide variety of surgeries to its patients. In the area of Orthopedics, those procedures include fractures, arthroscopies, arthroplasties, tendon repairs, ligament repairs, total joint replacements, as well as carpel tunnel releases, trigger finger releases, and cyst and other mass removals. Spine and neurologic procedures include laminectomies/discectomies, anterior cervical fusions, and kyphoplasties.

Ophthalmologic cases will include cataract repair and lens implant as well as phacoemulsification, eyelid procedures and strabismus repairs. Pain cases will include injections to the epidural, transforminal epidural, medial branch spaces as well as to joints, as well as radiofrequency ablations, nerve blocks and insertion of spinal cord stimulators.

General surgeries will include cholecystectomies, hernia repairs, incision and drainage and mass removals. Otolaryngology procedures will include all operations of the ear including lesion excisions and myringotomies, operations of the accessory sinuses, rhinoplasty and septoplasty, tonsil and adenoid surgery and other excisions of lesions in the throat and nose.

Podiatric procedures will include bunionectomy, arthoplasties, osteotomies, amputations, lesion and mass excisions, tendon and ligament repairs. Urologic procedures will include cystoscopies and lithotripsy procedures and will also include penile implantation and prostatic urethral lift, circumcision and vasectomies and insertion of stents.

Attachment 12
Purpose of the Project (cont'd)

In an emergency, the patient will be transferred to the closest hospital via a transfer agreement between Lindenhurst Surgery Center and the acute care facility.

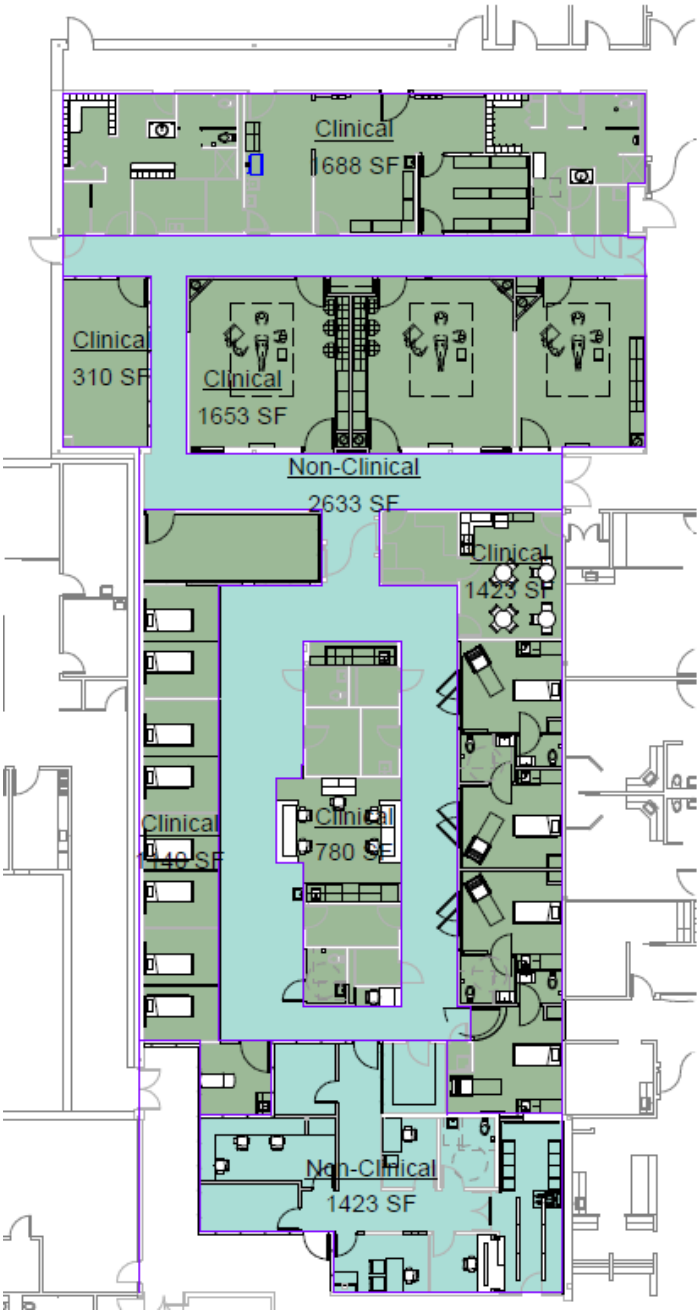
Existing Lindenhurst Surgery Center Floor Plan (4 Operating Rooms)

GastingerWalker& | Existing Building
22 June 2021

Lindenhurst Surgery Center
Surgical Care Affiliates

Attachment 12
Purpose of the Project

Proposed Lindenhurst Surgery Center Floor Plan (3 Operating rooms)



Attachment 12
Purpose of the Project

Curr Rev Musculoskelet Med (2017) 10:567–574
https://doi.org/10.1007/s12178-017-9451-2

QUALITY AND COST CONTROL IN TJA (B WADDELL, SECTION EDITOR)

Outpatient Total Joint Arthroplasty

Jack M. Bert[1,2] · Jessica Hooper[3] · Sam Moen[1]

Published online: 24 October 2017

Abstract

Purpose of Review Outpatient total joint arthroplasty (OTJA) allows for a safe, cost effective pathway for appropriately selected patients. With current pressures on arthroplasty surgeons and their associated institutions to reduce costs per episode of care, it is important to define the steps and challenges associated with establishing an outpatient arthroplasty program.

Recent Findings Several studies have outlined techniques of selecting patients suitable for this type of postoperative pathway. With emerging concerns about patients who undergo outpatient arthroplasty being at increased risk of medical complications, which may lessen projected cost savings, it is important to identify value-based strategies to optimize patient recovery after OTJA.

Summary This article reviews digital techniques for patient selection and data collection, operating room efficiency systems, and provides a summary of methods to build and maintain value in outpatient total joint replacement within the framework of bundled payment reimbursement.

Keywords Outpatient total joint arthroplasty · Patient stratification · Episode of care management

This article is part of the Topical Collection on *Quality and Cost Control in TJA*

✉ Jack M. Bert
bertx001@gmail.com

✉ Sam Moen
SamuelMoen@netclinic.com

[1] 730 N 4th Street Unit 113, Minneapolis, MN 55401, USA

[2] Minnesota Bone and Joint Specialists, Ltd, 2025 Woodlane Drive, Woodbury, MN 55125, USA

[3] NYU Langone Orthopedic Hospital, 301 E 17th St #1402, New York, NY 10003, USA

Introduction

Outpatient total joint arthroplasty (OTJA) is a means of providing safe, cost effective care for select patients indicated for unicompartmental knee arthroplasty (UKA), total knee arthroplasty (TKA), or total hip arthroplasty (THA). Establishing a successful OTJA program involves meticulous attention to detail and anticipation of potential complications. In addition to preparing the surgery center, surgeons must also establish procedure to optimize anesthetic technique, pain management, blood management, rehab and physiotherapy, and patient safety [1]. Despite the immense amount of planning required, the rate of arthroplasty procedures done in the outpatient setting is increasing. Between 2012 to 2015, there was a 47% increase in elective OTJA, and it is expected that there will be a 77% growth in OTJA over the next 10 years, with inpatient TJA growing only 3% during the same period (Fig. 1) [2].

In 2014, Medicare paid $50,000 per TJA hospitalization, totaling approximately $7 billion paid out that year [3]. In 2011, the Center for Medicare and Medicaid Services (CMS) introduced the Bundled Payment for Care Improvement (BPCI) with the goal of establishing a payment model that would lead to "higher quality, more coordinated care at a lower cost to Medicare" [4]. This model incentivizes improving quality while cutting costs in order to improve the value generated per unit arthroplasty procedure. In practice, this payment model promotes two primary goals: first, to reduce nonessential operating room (OR) and hospital services and minimize adverse events requiring increased length of stay, readmission, and/or discharge to inpatient rehab units, and second, to better coordinate care for arthroplasty patients between the inpatient and outpatient settings. By streamlining the surgical procedure and eliminating the postoperative stay, OTJA accomplishes both goals.

Bundling orthopedic knee and hip procedures requires a different approach from traditional fee-for-service practice.

Attachment 12
Purpose of the Project

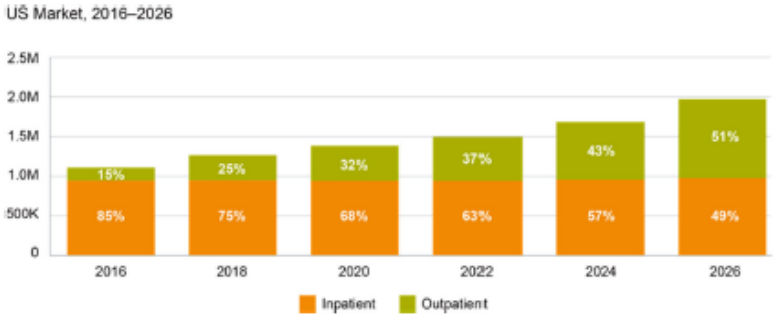


Fig. 1 Primary hip and knee replacement growth across settings [2]

Bundles include all areas of the surgical process beginning with the surgical consult and in most cases ending 90 days after the surgical procedure. Paramount to episodic bundling best practice is the preoperative clinical and social risk screening to identify risks for high cost and low quality and managing these risk factors prior to surgery. Understanding the patient's risks is a proactive way to effectively manage and eliminate all risk factors reducing cost and increasing quality of the patient's surgical outcome.

A successful bundled program for total joint procedures requires a cultural shift in the way a case is managed including predictive risk assessments/scoring and shared decision-making. Figure 2 outlines the components of a bundled payment program.

Organizations that participate in bundled payments risk significant financial loss. This is because the bundle assumes that care for all patients will be covered by the single bundle payment. However, a small subset of patients, termed "avalanche events" or "bundle busters," can have increased cost of care due to multiple-comorbidities or complications resulting in hospital re-admissions and this can cost between $100,000 to $150,000 per admission [5]. These patients, when mismanaged, fall outside the organization's process and capabilities. Organizations looking to become "best in class" have the opportunity to reduce the risk factors for every patient prior to surgery, which will result in the most optimized and low-risk patients. These results in a reduced expense to the bundled payment with high-quality outcomes and increased patient satisfaction. In our experience, identification of the patients' clinical and social risk factors has been critically important in determining the most important risk mitigation interventions prior to OTJA.

Although the future of the CMS BPCI initiative for TJA is uncertain, there is bipartisan support in congress for the cost savings promoted by the Comprehensive Care for Joint Replacement (CJR) program [6]. As further evidence that the ways in which we provide care to arthroplasty patients are changing, the Advisory Panel on Outpatient Payment unanimously recommended that CMS move the CPD code for TKA (27447) from inpatient-only status to hospital outpatient department (HOPD) status in August 2016 [7]. No matter the location of the surgery, it is the responsibility of the surgeon to take all measures necessary to keep costs down without compromising patient outcomes or experiences.

Insurance Contracting

Patient and ambulatory surgery center (ASC) insurance contracting is critical to make certain that the insurance pre-approval process identifies any facility-fee reimbursement issues as well as non-covered patient costs. It is not uncommon for some insurers to consider TJA performed at an ASC an "out of network" procedure, as opposed to the "in-network" TJA performed the local hospital. It is critical for the ASC to obtain credentialing for OTJA and do a thorough pro-forma based upon payer mix, meet with the payers, and negotiate a bundled payment rate for each TJA procedure.

For Medicare patients, insurance contracting can discourage OTJA. Currently, CMS will reimburse UKA for same day discharge and allows overnight stays or admissions under "observation" class, for less than 24 h without penalty. Conversely, many hospitals are charged an early discharge penalty for outpatient TKA. Identifying these situations ahead of time can help minimize undue financial burden on the patient and is an essential component of a comprehensive screening program for OTJA.

Patient Selection and Screening

Establishing patient selection criteria is the most critical aspect of OTJA, with several articles written in the past year outlining the necessary criteria to avoid complications. Sibia et al. reviewed a series of 381 TKAs and found that older age, female gender, ASA scores of III/IV, history of atrial fibrillation, and prior TKA were associated with increased hospital costs and increased length of stays [8]. Berger et al. reported on 5373 TJAs between 2004 and 2013 and confirmed that patients who received medical clearance and the coordinated

Attachment 12
Purpose of the Project

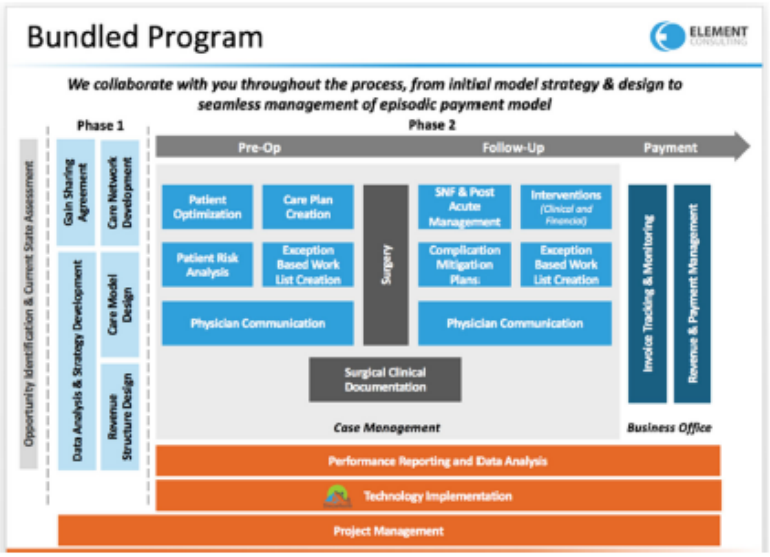


Fig. 2 Organizing the episode of care

efforts of a dedicated postoperative caregiver and a discharge planner have better outcomes after TJA [9].

The only way to ensure a consistent and manageable episode of care is to mandate that each patient has a detailed risk assessment prior to their surgical event. Risk assessments give the surgical team accurate, updated information on the patient's risks of perioperative complications. This information also helps the surgeon determine whether a patient can safely proceed with OTJA; they are better candidates for inpatient TJA, or further medical evaluation and optimization are necessary prior to surgery.

Unlike traditional medical risk stratification for TJA, it is important to evaluate anxiety levels and social support for patients being considered for OTJA. Even patients without diagnosed anxiety disorder are often concerned about postoperative pain, being able to care for themselves, and mobility, especially if they live alone. A study of the effect of psychological support on patients indicated for primary TJA published by Tristano et al. demonstrated that patients who received psychological support had a lower incidence of anxiety and depression than those who did not [10]. Additionally, THA patients who received psychological support reached their physical therapy goals 1.2 days sooner than those who did not receive any psychological support [10]. Patients being considered for OTJA, who are required to manage their own pain control, physical therapy, and self-care, are even more likely to benefit from a strong psychological support. Identifying patients who already have strong social support vs. those who do not is thus extremely beneficial.

A detailed clinical and social assessment such as the General Anxiety Disorder-7 (GAD-7), which is a self-reported questionnaire for screening and measuring general anxiety disorder, is a useful tool and can be used in concert with other tools for screening overall health, such as the revised cardiac risk index (RCRI). For example, a patient may have three identified risk factors:

- High body mass index (BMI)
- Symptomatic chronic heart failure
- Anxiety

These risk factors need to be properly managed and tracked until they are clinically capable of proceeding with surgery. Possible interventions for this patient may be setting up an appointment with a dietician, working with their primary care physician and cardiologist to manage congestive heart failure (CHF), and setting them up with psychotherapy prior to their visit. Risk calculations and historical data tell us the obese patients have higher risk for readmissions and complications [11]. If these issues are not managed, this patient could become one of the "bundle busters," and experience complications and/or costly readmissions that may have been avoidable with more thorough preoperative optimization.

Making sure the patient is healthy, properly managed, and ready for surgery is the difference between a successful and unsuccessful bundled program. Organizations may be able to manage a low volume of bundled patients without detailed protocols, process, and technologies. However, once the volume increases, it quickly becomes more difficult for providers to keep up with all patients and understand how each of them is responding to their medical management. Reactive

Attachment 12
Purpose of the Project

management, responding after a complication or readmission has occurred, is not advisable when caring for large groups of patients; anticipatory management enables adherence to the OTJA strict protocols.

Data collection and outcome measures are very important and can be accomplished with a software program (Fig. 3). Tracking volume, surgical outcomes, and patient progress help surgeons identify successful practices and areas for improvement. A "total joint coordinator," "nurse manager," or "case manager" must be assigned to every patient to make certain that the surgeons' and patients' needs are being met. Additionally, this individual ensures that the necessary staff and service line resources have been coordinated successfully. This individual must do a patient home assessment, which is part of the software program (Fig. 3) to make certain that the home caregiver is competent to tend to the needs of the patient in the first 48 to 72 h postoperatively. This person also helps coordinate preoperative multidisciplinary patient education and preoperative physical therapy, to ensure patients in the best possible condition before surgery [12]. Home physical therapy can be instituted by video learning tools or utilizing a mobile physical therapist making home visits.

Cautions—Identifying Patients Who Are Not Candidates for OTJA

Published literature is mixed on medical comorbidities associated with perioperative complications and readmissions following OTJA. In their retrospective study of 110 patients who underwent OTJA at a center accustomed to rapid rehab protocols and minimally invasive techniques, Berger et al. found that inadequate pain control and completing surgery late in the day were most strongly associated with preventing same-day discharge [10]. They found no differences in BMI, average age, body weight, or medical comorbidities between patients who underwent OTJA and those who required inpatient stay [13]. They also found that for patients undergoing TKA, compared to UKA, history of myocardial infarction within 1 year, BMI > 40, and greater than three medical comorbidities were most strongly associated with increased risk of readmission [14].

In their review of 1012 patients undergoing elective TJA, Courtney et al. found that chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), and cirrhosis were identified as independent risk factors for late (> 24 h) postoperative complications [15]. As such, the authors do not recommend OTJA for patients with any of these comorbidities. They proposed a 6-point risk assessment model (AUC = 0.738) to help determine a patient's candidacy for short stay TJA; patients without any of the aforementioned risk factors have a 3.1% probability of developing late complications, while the presence of one risk factor elevates the patient's risk to 10% [15].

These studies, rather than providing steadfast indication and contraindication criteria for patients undergoing outpatient TJA, serve to underscore the importance of thorough preoperative medical evaluation. Also, established protocols for therapy and pain control are essential to help patients be successfully discharged from ASCs; disorganized postoperative treatment can derail OTJA for even the most medically and psychologically optimized patient.

ASC Facility and Staff Preparation

While careful patient selection is essential to minimize risks and ensure optimal candidates for OTJA surgery, ambulatory

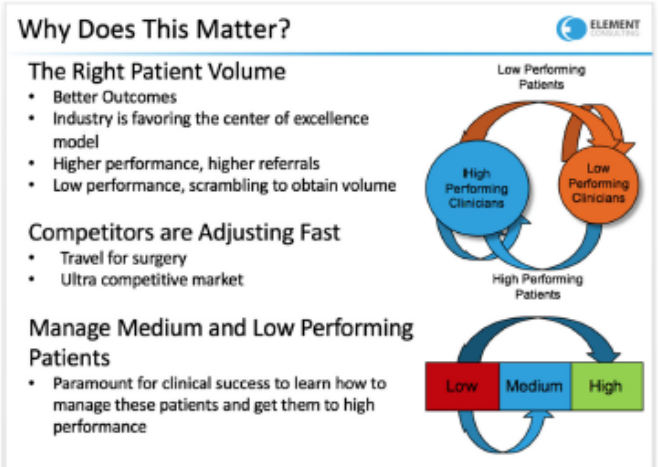


Fig. 3 Data collection and outcome measures

Attachment 12
Purpose of the Project

care facilities also pose new challenges and considerations for surgeons. These include the following:

- Training staff to be proficient on multiple procedures as well as each surgeon's exact procedure preferences and instrument sequencing
- Minimizing instruments to be sterilized for time and cost savings
- Timely turnover of operating rooms to maximize OR utilization and patient throughput

In an ambulatory care facility, outpatient total joint replacement requires an efficient and streamlined OR and central processing. Two areas, staff training and instrumentation, significantly impact the success of outpatient total joint replacement procedures and the ability to reduce costs. At the same time, the use of clinically proven hip and knee implants can help reduce the risk of complications.

While not unique to an ambulatory care setting, staff training in a high-volume, time-sensitive environment is vital to achieving the benefits offered by OTJA. The ability to train staff on a surgeon's specific procedure and instrument sequencing can affect procedure duration, and staff trained on a surgeon's preferred patient setup and room layout can facilitate faster OR turnover. Enabling easy and fast access to instructions for robotic or other complex equipment also supports procedure efficiency and speed.

Not only is staff competence improved with easy access to training and self-testing prior to procedures, ensuring proficiency in the OR also saves time in an ambulatory environment. When systems and programs are put in place to support the needs of each surgeon, the procedures performed and instrument sequencing, surgeon's confidence in outpatient OR staff increases.

The ability to reduce costs is a significant driver for the increase in OTJA. Streamlining the OR via the standardization of instrument trays can decrease setup time and reduce the costs associated with sterilizing instruments that go unused. With the ability to only pull the instruments, a surgeon uses, with back-up instruments sterilized and ready but unopened, outpatient total joint replacement procedures can save the costs of sterilizing unused instruments while also reducing procedure time.

Technology-Enabled Improvements Facilitate Outpatient Total Joint Replacement

Advancements in technology-enabled solutions can help ensure outpatient OR staff proficiency and facilitate efficiency in OTJA procedures. These digital solutions leverage the convenience of self-guided, personalized training for staff prior to procedures and can also be deployed to help training in other areas of the outpatient facility, such as central processing. Digital solutions can also support the streamlining and standardization of instrument trays to help decrease instrumentation setup time and reduce costs associated with sterilizing unused instrumentation.

Interactive Training

With the ability to deliver interactive training modules that rapidly onboard staff and reinforce protocols and procedures, while also enabling customized training for surgeon-specific preferences and instrument sequencing, digital solutions build OR staff competency. By digitizing surgeon preference cards and procedure instrument sequencing, these assets can be placed online for staff to review and facilitate an interactive experience that leverages gaming technology. This allows training and reinforcement, to take place anywhere, anytime, at staff convenience. Flexible solutions that support on-site training as well as remote access to training modules and can support a breadth of content for procedure types and protocols in one place can empower staff and increase confidence in an outpatient environment. The benefits of interactive training platforms for outpatient total joint replacement include the following:

- Decreased OR time
- Decreased time to onboard staff
- Reinforce protocols and procedure preferences prior to a case
- Improve staff competence
- Increase surgeon confidence in staff

Streamlined Instrumentation

Instrument utilization identification is used to streamline and standardize instrument trays, which can help decrease setup time and reduce the costs associated with sterilizing unused instruments. By "right-sizing" trays based upon surgeon and procedure requirements, streamlining trays for outpatient total joint replacement also helps ensure that shelf space is optimized for the reduced footprint in ambulatory facilities. Technology platforms designed to streamline and standardize instrument trays can as follows:

- Help decrease setup time
- Reduce costs associated with sterilizing unused instruments
- Maximize shelf space
- Provide a visual platform for tray assembly and special instructions
- Document and validate proper tray inspection

Attachment 12
Purpose of the Project

One example of a cloud-based technology to improve outpatient OR efficiency and enhance patient care is a surgeon specific suite called Virtual BackTable (S2 Interactive, Smith and Nephew, Andover, MA) that combines digital interactive training and instrument utilization identification to help improve staff competency and streamline trays to reduce instrumentation and sterilization costs.

In one pilot study, using S2 technology resulted in a 60% reduction in instrument tray processing costs, with an estimated savings of $83,000 per year for just one tray [15]. At the same time, the technology also facilitates improved workflow and support for compliance and quality protocols.

In OTJA procedures, the costs of instrument processing and implant waste can quickly add up and impact the very cost-saving benefits both surgeons and patients seek to realize through OTJA. In addition, the inefficiencies associated with insufficiently trained staff and large instrument inventories can also impact the potential cost benefits that can be achieved in an ambulatory environment. Regardless of the solution, technology can play an important role in supporting the realization of the time and cost saving benefits that outpatient total joint replacement can offer.

Intraoperative Considerations: Minimizing Adverse Events

Multimodal pain management pathways have become the standard of care for TJA in the inpatient and outpatient settings [16, 17]. It is of particular importance for patients undergoing outpatient TJA that an effective anesthesia program be in place to control pain, minimize adverse reactions to anesthesia, such as nausea, and allow rapid mobilization after surgery. Ideally, pain and anesthesia pathways should be established by a team consisting of anesthesiologists, surgeons, and pain management physicians and should combine oral medications and local anesthetics. These protocols would reduce the need for oral medications and prevent peripheral sensitization by neurogenic blockade [11].

Adductor canal blocks are the procedure of choice for patients undergoing either TKA or UKA, and short-acting spinal blocks are effective for THA. Short-acting spinal anesthetic agents often consist only of local anesthetics, such as lidocaine or ropivacaine, which helps minimize the potential nausea, sedation, and pruritus, that occur with longer-acting anesthetics containing opioids [18]. Injection of the capsular and soft tissue structures by the surgeon may include one of various reported "cocktails," often consisting of a combination of narcotics, local anesthetics, and non-steroidal anti-inflammatory drugs (NSAIDs) and/or the utilization of a liposomal bupivicaine injection. Another important aspect of perioperative care is preventing dehydration, which can exacerbate postural hypotension and therefore delay postoperative mobilization necessary for discharge. Utilizing these techniques allows the patient to be ambulatory within a few hours after surgery without significant pain. Cold therapy has been shown to be beneficial in the early postoperative period as well.

It is important to avoid significant blood loss and bleeding at the time of surgical intervention, both in the interest of preventing symptomatic anemia, and also because blood is a noxious stimulus and massive hemarthrosis can cause significant pain delaying progress with physical therapy [19]. Some OTJA surgeons avoid using a tourniquet completely during TKA and keep a tourniquet in place to inflate only if any untoward bleeding ensues during the procedure [20]. If using a tourniquet for a TKA, it is important to release the tourniquet prior to closure and coagulate all major bleeders prior to soft tissue injection of using one of the anesthetic "cocktails" or a bupivacaine liposomal injection. Regional anesthesia, by precipitating a hypotensive state, also helps decrease blood loss, especially from cut bone surfaces in UKA and TKA [21, 22]. The use of perioperative tranexamic acid (TXA), which has been used successful in primary and revision TJA without a corresponding increase in the incidence of thromboembolic events [23, 24], is critically important to minimize blood loss. Any unexpected blood loss will slow patients' recovery after surgery and can lead to the conversion of an OTJA case to an inpatient stay.

Outcomes

In the last 10 years, many arthroplasty surgeons have made the move toward performing OTJA for patients without serious medical or psychiatric comorbidities. Published literature has shown that OTJA can be safely performed without negatively affecting patient outcomes or patient perceptions of the quality of their care.

With the development of fast-track arthroplasty programs, expedited recovery programs, such as OTJA, have been shown to improve efficiency while maintaining low-revision rates, improved quality of life and functionality, and high-patient satisfaction scores [25]. OTJA programs have demonstrated the ability to maintain the positive outcomes of the fast-track programs without undue increase in risk to patients.

In their study comparing rates of perioperative complications between patients who underwent inpatient and outpatient UKA, Bovonratwet et al. reported no significant differences in complication rate or 30-day readmission rate between the matched patient groups [26]. Dorr et al. reported on a series of patients offered outpatient THA and found that, though outpatient surgery offered no objective physical benefits, such as accelerated functional recovery, it did not result in any medical complications or readmissions [27]. Their results demonstrated that THA could safely be performed for a select

Attachment 12
Purpose of the Project

group of patients and that these patients were also willing to accept the responsibilities associated with outpatient surgery, underscoring the importance of patient engagement in care to a successful outcome. Six weeks after surgery, 87% of patients reported that going home the day of surgery increased their confidence in their hip replacement [27].

Aynardi et al. compared outcomes and costs between patients who underwent inpatient THA and those who had outpatient THA. All surgeries were performed by the same surgeon through the same approach, and there were no significant differences between the two groups with respect to complications or blood loss. Importantly, the authors reported that the non-itemized bill charged to the patient or third-party payer was nearly $7000 less for the outpatient cases [28]. Similarly, a case control study conducted by Huang et al. comparing costs for inpatient and outpatient TKA demonstrated that outpatient TKA, on average, resulted in 30% cost savings for the hospital per episode of care without a significant increase in complications or readmissions [29]. These results demonstrate that, so long as the infrastructure is in place for outpatient arthroplasty and patients are appropriately selected, OTJA can be considered a means of cost savings for hospitals and can thus increase value of care within a bundled-payment reimbursement model.

Conclusions

OTJA is economically and practically feasible and yields excellent outcomes in carefully selected patients. A well-designed OTJA program provides safe surgical care with equivalent patient-reported outcomes, such as anxiety, depression, satisfaction, and pain, compared to standard "fast track patients" that require a 1-day hospitalization [30, 31]. Furthermore, OTJA programs generate cost savings by improving OR efficiency via surgeon-specific instrumentation and online training tools and improving post-anesthesia care and pain control. Postoperative home physical therapy training, either by a therapist or with modules accessible by the patient's cell phone, facilitate safe, timely pre-habilitation and rehabilitation, and obviate the need for patient transfer to a skilled nursing or extended care facility. It is critical to understand that patient stratification and case management are of paramount importance in the success of the procedure, as well as controlling the total cost of the episode of care. Choosing the wrong patient can cause an "avalanche" case or "bundle buster," which reaffirms that, without appropriate patient selection and monitoring, the remainder of the care pathway will be doomed to failure.

Rigorous medical screening and optimization, along with multi-specialty care programs to control pain, limit blood loss, minimize adverse reactions to anesthesia, and mobilize more quickly, help patients recover from surgery more quickly and avoid unnecessary medical interventions. Though not all patients will be candidates for OTJA, the future of total joint arthroplasty will involve a movement to the outpatient setting for the average patient. By shifting the setting of postoperative care from hospitals to patients' homes, costs to patients are less [32] and help patients become more engaged in their care. Building a successful OTJA endeavor requires the input of a multidisciplinary team and allows surgeons to affect the way comprehensive care is delivered to arthroplasty patients.

Compliance with Ethical Standards

Conflict of Interest All authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

1. Kehlet H, Søballe K. Fast-track hip and knee replacement — what are the issues? Acta Orthop. 2010;81(3):271–2.
2. Impact of Change® v16.0; HCUP National Inpatient Sample (NIS). Healthcare cost and utilization project (HCUP). 2013. Agency for Healthcare Research and Quality, Rockville, MD; OptumInsight, 2014; The following 2014 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; The Nielsen Company, LLC, 2016; Sg2 Analysis, 2016.
3. Courtney P, Boniello A, Berger R. Complications following outpatient total joint arthroplasty: an analysis of a national database. J Arthroplast. 2017;32:1426–30.
4. Iorio R. Strategies and tactics for successful implementation of bundled payments: bundled payment for care improvement at a large, urban, Academic Medical Center. J Arthroplast. 2015;30(3):349–50.
5. Ellimoottil C, Ryan A, Hou H, Dupree J, Hallstrom B, Miller D. The new bundled payment program for joint replacement may unfairly penalize hospitals that treat patients with medical comorbidities. Health Aff (Millwood). 2016;35(9):1651–7.
6. Caffrey M. The future of the comprehensive care for joint replacement program. Am J Manag Care. 2017.
7. Gollogly S Safety and efficacy of outpatient arthroplasty. Advisory panel on outpatient payments. Center for Medicare and Medicaid services report. Woodlawn, Maryland, August 22, 2016.
8. Sibia US, King PJ, MacDonald JH. Who is not a candidate for a 1-day hospital-based total knee arthroplasty. J Arthroplast. 2017;32(1):16–9.
9. Berger RA, Cross MB, Sanders S. Outpatient hip and knee replacement: the experience from the first 15 years. Instr Course Lect. 2016;65:547–51.
10. Tristaino V, Lantieri F, Tornago S, Gramazio M, Carriere E, Camera A. Effectiveness of psychological support in patients undergoing primary total hip or knee arthroplasty: a controlled cohort study. J Orthop Traumatol. 2016;17(2):137–47.
11. Argenson J-NA, Husted H, Lombardi A, Booth RE, Thienpont E. Global forum: an international perspective on outpatient surgical procedures for adult hip and knee reconstruction. J Bone Joint Surg. 2016;98(13):e55.

Attachment 12
Purpose of the Project

12. Reinke C, Kelz R, Zubizarreta J, Lanyu M, Saynisch P, Kyle F, et al. Obesity and readmission in elderly surgical patients. Surgery. 2012;152(3):355–62.
13. Berger RA, Kusuma SK, Sanders SA, Thill ES, Sporer SM. The feasibility and perioperative complications of outpatient knee Arthroplasty. Clin Orthop Relat Res. 2009;467(6):1443–9.
14. Courtney PM, Rozell JC, Melnic CM, Lee G-C. Who should not undergo short stay hip and knee arthroplasty? Risk factors associated with major medical complications following primary total joint arthroplasty. J Arthroplast. 2015;30(9):1–4.
15. Hensell MG, Pins J. Virtual BackTable. Reducing cost of onboarding. AORN Annual Meeting. Denver, Colorado, March 7–11, 2015.
16. Berend ME, Berend KR, Lombardi AV. Advances in pain management. Bone Joint J. 2014;96(11):7–9.
17. Parvizi J, Miller AG, Gandhi K. Multimodal pain management after total joint arthroplasty. J Bone Joint Journal. 2011;93(11):1075–84.
18. Lombardi A, Barrington JW, Berend KR, Berend ME, Dorr LD, Hamilton W, et al. Outpatient arthroplasty is here now. Instr Course Lect. 2016;65:531–46.
19. Liu D, Dan M, Martinez Martos S, Beller E. Blood management strategies in total knee arthroplasty. Knee Surg Rel Res. 2016;26(3):179–87.
20. Aglietti P, Baldini A, Vena LM, et al. Effect of tourniquet use on activation of coagulation in total knee replacement. Clin Orthop Rel Res. 2000;371:169–77.
21. Sculco TP, Baldini A, Keating EM. Blood management in total joint arthroplasty. Instr Course Lec. 2005;54:51–66.
22. Hooper J, Schwarzkopf R. Additional tools to prevent blood loss in total joint arthroplasty. Tech Orthop. 2017;32(1):34–40.
23. Wind TC, Barfield WR, Moskal JT. The effect of tranexamic acid on transfusion rate in primary total hip arthroplasty. J Arthroplast. 2014;29(2):387–9.
24. Yang ZG, Chen WP, Wu LD. Effectiveness and safety of tranexamic acid in reducing blood loss in total knee arthroplasty. J Bone Joint Surg. 2012;94(13):1153–9.
25. Winther SB, Foss OA, Wik TS, Davis SP, Engdal M, Jessen V, et al. 1-year follow-up of 920 hip and knee arthroplasty patients after implementing fast-track: good outcomes in a Norwegian university hospital. Acta Orthop. 2015;86(1):78–85.
26. Bovonratwet P, Ondeck NT, Tyagi V, Nelson SJ, Rubin LE, Grauer JN. Outpatient and inpatient unicompartmental knee arthroplasty procedures have similar short-term complication profiles. J Arthroplast. 2017;S0883-5403(17):30443–6.
27. Dorr LD, Thomas DJ, Zhu J, Dastane M, Chao L, Long WT. Outpatient total hip arthroplasty. J Arthroplast. 2010;25(4):501–6.
28. Aynardi M, Post Z, Ong A, Orozco F, Sukin DC. Outpatient surgery as a means of cost reduction in Total hip Arthroplasty: a case-control study. HSS J. 2014;10(3):252–5.
29. Huang A, Ryu J-J, Dervin G. Cost savings of outpatient versus standard inpatient total knee arthroplasty. Can J Surg. 2017;60(1):57.
30. Hoorntje A, Koenraadt KLM, Boevé MG, van Geenen RCI. Outpatient unicompartmental knee arthroplasty: who is afraid of outpatient surgery. Knee Surg Sports Tramatol Arthrosc. 2017;25(3):759–66.
31. Lovecchio, et al. Is outpatient arthroplasty as safe as fast-track inpatient arthroplasty? A propensity score matched analysis. J Arthroplast. 2016;31:197–201.
32. Kaplan RS, Porter ME. How to solve the cost crisis in health care. Harv Bus Rev. 2011;89(9):46–52.

Attachment 13
Alternatives

1. Not Move Forward With Project (Cost: There would be no cost associated with not moving forward with the project.

This option would not allow for expansion of procedures at the facility and would keep an operating room in the state inventory that is not fully utilized. Better utilization of right sized facilities is consistent with the tenets of the Board, and that goal has been deemed worth of pursuing. It is for these reasons this alternative is not being pursued.

2. Propose a project of greater or lesser scope than proposed (Cost: Depending on the size reduction, the applicant would expect a reduction or increase commensurate with the facility's altered size)

A further reduction of operating rooms was contemplated by the applicant but that would limit capacity and did not allow for the full spectrum of services that are able to be offered by the facility as proposed. The facility is in an existing structure and thus there were limitations which would not allow for a larger facility footprint. For these reasons, this alternative was rejected.

3. Pursue a Joint Venture with Another Provider (Cost: The cost of the project as proposed would remain the same.

The facility ownership is already a joint venture between Ortho-Pod, LLC and Vista Health System. The proposed project is driven by the Ortho-Pod, LLC group of physicians that recently acquired an interest in the facility in 2021. The proposed projects reflect their commitment to the full utilization of an existing healthcare facility with an aim to reduced costs for patients and increased access to outpatient surgical care. Additional partners were not sought because the ownership of the facility is already a joint venture and additional partners would not reduce the overall costs of the project. For those reasons, this alternative was rejected.

4. Project as proposed

The purpose of this modernization project is twofold. The expansion of existing operating rooms will allow for the performance of additional procedures that cannot currently be completed due to the existing size of the rooms. Further, the reduction of one operating room is consistent with proper health planning for the area and will allow for better utilization of the existing facility. For all the reasons outlined above and within the Purpose of the Project, this was the alternative selected.

Attachment 14
Size of the Project

The square footage identified in this application for the proposed projects, includes three operating rooms, 12 recovery stations is necessary, not excessive, and consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ASTC (3 Operating Rooms)	**6994 GSF**	**8250 GSF**	**-1256 GSF**	**YES**

Attachment 16
Unfinished or Shell Space

NOT APPLICABLE- The proposed project does not include plans for shell space.

Attachment 17
Assurances

NOT APPLICABLE- The proposed project does not include plans for shell space.

Attachment 33
Availability of Funds

The total estimated project cost is $6,499,890. The Applicant/Licensee will fund the project costs through debt taken on in the form of a loan from Wintrust Bank and equipment leases through K2 Capital Group. Enclosed as evidence are copies of loan commitments from both organizations confirming their commitment to provide loans to fund the proposed projects. Additionally, due to the size of Lindenhurst Surgery Center, LLC it does not have yearly financial audits performed. However, included with this attachment is a financial statement for the practice since Ortho-Pod, LLC acquired an interest in the practice.

Attachment 33
Availability of Funds

5050 Lincoln Dr., #400
Edina, MN 55436

April 15, 2022

Kevin Elliot
Surgical Care Affiliates, LLC
569 Brookwood Village, #901
Birmingham, AL 35209

Dear Kevin,

On behalf of Popular Equipment Finance, LLC d/b/a K2 Capital Group, I am pleased to confirm that we are approving Lindenhurst Surgery Center for $2,500,000 in equipment financing. Popular Equipment Finance, LLC d/b/a K2 Capital Group, has provided equipment financing for the majority of Surgical Care Affiliate's Surgery Centers and we appreciate the opportunity to work with Lindenhurst Surgery Center on this project. Please do not hesitate to call me if you have any questions.

Sincerely,

Patrick Daly

Patrick Daly
POPULAR EQUIPMENT FINANCE,
LLC D/B/A K2 CAPITAL GROUP
(952) 224-2474

Attachment 33
Availability of Funds

WINTRUST
COMMERCIAL BANKING

April 14, 2022

Ms. Debra Savage
Board Chair
Illinois Health Facilities and Service Board Review
Springfield, IL 62761

RE: Lindenhurst Surgery Center, LLC

Dear Ms. Savage:

Wintrust Financial Corp. has more than $50 billion in assets with more than 175 locations throughout the Chicago, southeast Wisconsin and northwest Indiana metropolitan areas providing comprehensive banking, brokerage, mortgage and wealth management services to the communities it serves.

We have had conversations with Lindenhurst Surgery Center, LLC related to their planned Surgery Center at 1050 Red Oak Lane, Lake Villa ("The Project"). We have received and reviewed the preliminary information related to the financial metrics of The Project (budget, pro-forma financial projections, lease, etc.) and we remain interested in providing Lindenhurst Surgery Center with up to $4,000,000 in term financing and a $500,000 working capital line of credit. We are aware this letter is being submitted in connection with the Lindenhurst Surgery Center, LLC application for Permit related to the proposed renovation project.

Wintrust engages in profitable yet safe lending. The process the Bank undertakes to extend credit to the Company is rigorous and ongoing. This is not a commitment to lend, and our underwriting remains subject to further due-diligence. Should you have any additional questions, please feel free to reach me at jdraths@lakeforestbank.com or directly at 847-295-4264.

Sincerely,

James Draths
Executive Vice President

Lake Forest Bank & Trust Company, N.A. | 727 North Bank Lane, Lake Forest, Illinois 60045
847-234-2882 | www.lakeforestbank.com

Attachment 33
Availability of Funds

		Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022
Current Assets							
1010	Facility Cash- Nonrestricted	(7,289)	4,894	(16,139)	8,902	9,373	8,585
1980	I/C Due To/Due From	207,851	46,651	106,395	(14,108)	16,759	(77,006)
	Cash & Temp Investments	200,563	51,545	90,256	(5,207)	26,132	(68,421)
1200	A/R- Trade	67,471	140,601	77,353	183,875	75,224	65,937
1201	AR - Star	87,038	58,890	(11,849)	(15,512)	(17,753)	(20,180)
1202	A/R Accrued - Automated	106,662	43,621	75,545	11,683	16,818	4,750
1220	A/R- Credit Balance	167,549	426,549	196,565	171,944	163,919	160,383
1222	BCBSIL - Credit Balance	-	-	398,772	563,079	7,830	8,366
1230	Unapplied Cash	-	-	(812)	(1,420)	666	943
1240	Patient Refund Clearing	(9,966)	(9,966)	(43,403)	(22,421)	(22,421)	(22,421)
	Accounts receivable	418,754	659,694	692,170	891,229	224,283	197,778
1279	Allow C/A - Other Misc	52,457	43,613	7,099	6,181	6,181	4,939
	Less: Allowance for C/A	52,457	43,613	7,099	6,181	6,181	4,939
1280	Bad Debt Allowance	3,366	5,723	8,248	11,518	11,789	11,813
1281	Bad Debt Allowance - Star	46,331	46,331	46,331	46,331	46,331	46,331
	Less: Allowance for B/D	49,697	52,054	54,578	57,849	58,119	58,144
	Inventories	-	-	-	-	-	-
1504	Prepaid Other Expenses	2,536	-	-	8,044	7,800	7,556
1552	Building Lease Clearing	-	-	-	-	(29,354)	-
	Prepaids & other current assets	2,536	-	-	8,044	(21,554)	7,556
	Total Current Assets	519,699	615,573	720,749	830,036	164,560	73,830
Other Assets							
	Notes receivable	-	-	-	-	-	-
1652	Building Oper Lease ROU Asset	1,908,553	1,885,959	1,863,284	1,840,529	1,817,694	1,794,778
1653	Deferred Rent/Prepaid - Operat	(1,507)	(3,015)	(4,522)	(6,030)	(7,537)	(9,045)
	Trusteed funds & other assets	1,907,046	1,882,944	1,858,762	1,834,500	1,810,157	1,785,733
	Total Other Assets	1,907,046	1,882,944	1,858,762	1,834,500	1,810,157	1,785,733
Property, Plant & Equipment							
	Land	-	-	-	-	-	-
	Buildings	-	-	-	-	-	-
	Leasehold improvements	-	-	-	-	-	-
1755	Medical Equipment	84,978	84,978	84,978	327,000	327,000	327,000
	Furniture, fixtures & equipment	84,978	84,978	84,978	327,000	327,000	327,000
1690	Construction in Progress	-	7,891	17,506	27,787	35,352	87,053
	Construction-in-progress	-	7,891	17,506	27,787	35,352	87,053
		84,978	92,869	102,484	354,787	362,352	414,053
1837	Acc Depr- Medical Equipment	2,774	5,548	8,322	47,556	59,444	71,333
	Less: Accumulated Depreciation	2,774	5,548	8,322	47,556	59,444	71,333
	Total Property, Plant & Equipment	82,204	87,321	94,162	307,231	302,907	342,720
Intangible Assets							
1880	Certificate of Need	35,000	35,000	35,000	35,000	35,000	35,000
1882	Licenses	31,900	31,900	31,900	31,900	31,900	31,900
	Organ, P'ship formation & Start-up Costs	66,900	66,900	66,900	66,900	66,900	66,900
	Bond issue costs	-	-	-	-	-	-
1871	Noncompete Agreement	82,200	82,200	82,200	82,200	82,200	82,200
	Non-compete Agreements	82,200	82,200	82,200	82,200	82,200	82,200
1698	Goodwill & Intangible Clearing	-	-	-	(250,344)	-	-
1860	Goodwill	613,494	613,494	613,494	613,494	363,150	363,150
	Goodwill	613,494	613,494	613,494	363,150	363,150	363,150
		762,594	762,594	762,594	512,250	512,250	512,250
1890	Acc Amort- NonCompetes	3,425	6,850	10,275	13,700	17,125	20,550
	Less: Accumulated Amortization	3,425	6,850	10,275	13,700	17,125	20,550
		759,169	755,744	752,319	498,550	495,125	491,700
Intercompany Accounts							
	Notes Receivable	-	-	-	-	-	-
	Investments in Subsidiaries	-	-	-	-	-	-
		-	-	-	-	-	-
	TOTAL ASSETS	3,268,118	3,341,582	3,425,992	3,470,317	2,772,749	2,693,983

Attachment 33
Availability of Funds

	2021-9	2021-10	2021-11	2021-12	2022-1	2022-2	TTM
							Actual
Gross Patient Revenue							
OP Revenue							
Medicare	1,207,378.73	963,004.53	956,244.32	743,487.99	(10,710.06)	(12,350.27)	3,847,055.24
Medicaid	69,596.69	64,341.62	30,791.52	78,446.62	-	-	243,176.45
BCBS	264,677.30	376,320.10	469,429.76	203,047.85	(1,072.74)	20,182.44	1,332,584.71
Managed Care and Oth Disc Plan	138,088.36	203,723.86	149,908.45	114,671.78	10,484.33	-	616,876.78
Workers' Compensation	-	-	14,721.22	13,560.48	-	-	28,281.70
Other	-	12,511.86	8,456.80	12,621.24	(192.24)	(1,944.67)	31,452.99
OP Revenue	1,679,741.08	1,619,901.97	1,629,552.07	1,165,835.96	(1,490.71)	5,887.50	6,099,427.87
Gross Patient Revenue	1,679,741.08	1,619,901.97	1,629,552.07	1,165,835.96	(1,490.71)	5,887.50	6,099,427.87
Contractual Allowance							
OP Contractual Allowance							
Medicare	1,076,057.22	894,866.53	870,634.60	646,780.62	(15,337.03)	(13,455.43)	3,459,546.51
Medicaid	63,249.58	62,604.18	30,916.21	74,172.59	232.16	629.58	231,804.30
BCBS	210,468.29	325,916.58	413,173.15	169,853.42	(4,117.80)	18,283.18	1,133,576.82
Managed Care and Oth Disc Plan	105,562.07	170,145.10	129,276.19	98,323.68	7,163.05	2,100.00	512,570.09
Workers' Compensation	-	-	9,518.74	10,256.56	-	-	19,775.30
Other Payors	-	-	-	-	(4,192.58)	(2,466.20)	(6,658.78)
Other	-	9,236.26	7,711.06	(51,581.99)	(3,260.17)	(830.69)	(38,725.53)
OP Contractual Allowance	1,455,337.16	1,462,768.65	1,461,229.95	947,804.88	(19,512.37)	4,260.44	5,311,888.71
Contractual Allowance	1,455,337.16	1,462,768.65	1,461,229.95	947,804.88	(19,512.37)	4,260.44	5,311,888.71
IP Net Patient Revenue	-	-	-	-	-	-	-
OP Net Patient Revenue	224,403.92	157,133.32	168,322.12	218,031.08	18,021.66	1,627.06	787,539.16
Net Patient Revenue	224,403.92	157,133.32	168,322.12	218,031.08	18,021.66	1,627.06	787,539.16
Other Income							
Rental income	-	-	-	-	-	-	-
Other operating income	3,588.98	28,362.27	(19,596.65)	42.00	56.00	73,975.19	86,427.79
Other Income	3,588.98	28,362.27	(19,596.65)	42.00	56.00	73,975.19	86,427.79
Net Revenue	227,992.90	185,495.59	148,725.47	218,073.08	18,077.66	75,602.25	873,966.95
Salaries and benefits							
Salaries	46,280.39	45,208.59	47,512.83	55,819.54	11,601.98	22,978.91	229,402.24
FICA	3,243.80	2,997.53	3,288.20	3,852.61	1,258.36	1,672.65	16,313.15
FUTA	238.73	140.02	7.36	20.00	160.87	68.01	634.99
SUI	1,304.16	1,236.66	935.21	300.71	707.08	625.23	5,109.05
401K	31.77	660.09	1,274.20	2,110.66	835.50	783.56	5,695.78
Group Med Ins	2,158.51	3,092.04	2,126.56	1,497.73	685.26	1,767.62	11,327.72
Voluntary-Supplemental Insurnc	37.22	101.29	171.42	335.93	37.45	14.85	698.16
Work Comp Ins	561.08	561.08	561.08	561.08	561.08	561.08	3,366.48
Contract Labor	2,927.50	2,849.03	5,213.27	1,906.23	997.76	-	13,893.79
Salaries and benefits	56,783.16	56,846.33	61,090.13	66,404.49	16,845.34	28,471.91	286,441.36
Medical Supplies							
Med Supplies - Chargeable	161,540.52	190,163.15	17,312.35	5,666.47	342.23	(2,318.97)	372,705.75
Med Supplies - Non Chargeable	176.74	1,462.70	18,102.74	13,355.09	10,892.54	3,101.32	47,091.13
Drugs and Medicine	-	-	89,554.84	14,264.62	1,981.59	3,879.74	109,680.79
O&P devices and implants	-	436.00	75,672.49	41,261.43	5.25	2,472.29	119,847.46
Medical Supplies	161,717.26	192,061.85	200,642.42	74,547.61	13,221.61	7,134.38	649,325.13
Variable Expenses							
Food and Catering	26.98	-	-	52.40	-	-	79.38
Office Supplies	-	72.98	571.96	538.21	753.79	76.52	2,013.46
Housekeeping and Janitorial	387.34	-	81.72	184.79	(7.07)	57.00	703.78
Linens	4,439.47	3,063.06	317.68	427.80	-	-	8,248.01
Minor Equipment	849.41	387.36	660.18	3,600.74	216.66	214.30	5,928.65
Repairs	-	412.50	-	-	-	-	412.50
Bank Service Charges	-	67.31	68.53	30.88	97.90	54.23	318.85
Dues and Subscriptions	180.00	-	-	-	-	-	180.00
Printing	-	60.00	-	-	-	-	60.00
Postage and Delivery	(7.83)	-	-	11.82	-	-	3.99
Telephone	719.18	765.10	(673.64)	46.36	44.86	341.94	1,243.80
Recruitment and Relocation	(105.92)	929.62	128.90	1,375.00	-	350.25	2,677.85
Contract Services	10,403.24	10,508.73	13,879.63	12,402.62	6,763.54	13,054.22	67,011.98
Collection Fees	1,036.38	1,161.69	1,214.06	829.71	211.04	86.58	4,539.46
Legal Fees	6,285.55	-	(6,285.55)	4,762.33	-	26,012.72	30,775.05
Professional fees	-	2,536.00	6.00	731.25	8,648.52	11,023.52	22,945.29
Travel and Entertainment	-	881.19	-	-	-	-	881.19
Management Fee Expense	13,477.61	10,988.32	8,772.04	12,888.16	1,068.44	96.63	47,291.20
Other Variable Expenses	6,472.86	120.59	2,362.65	1,564.10	148.00	343.79	11,011.99
Variable Expenses	44,164.27	31,954.45	21,104.16	39,446.17	17,945.68	51,711.70	206,326.43
Fixed Expenses							
Rent	30,861.43	30,861.43	30,861.43	30,861.43	30,861.43	30,861.43	185,168.58
Insurance	2,093.28	36,634.28	2,093.28	2,093.28	2,093.28	2,093.28	47,100.68
Fixed Expenses	32,954.71	67,495.71	32,954.71	32,954.71	32,954.71	32,954.71	232,269.26
Provision for doubtful accts	3,366.06	2,357.00	2,524.83	3,270.47	270.33	24.41	11,813.10
EBITDA	(70,992.56)	(165,219.75)	(169,590.78)	1,449.63	(63,160.01)	(44,694.86)	(512,208.33)
Interest, Depreciation, Amort							
Depreciation Expense	2,774.00	2,774.00	2,774.00	47,555.56	11,888.90	11,888.90	79,655.36
Amortization Expense	3,425.00	3,425.00	3,425.00	3,425.00	3,425.00	3,425.00	20,550.00
Interest Income	-	-	(313.00)	(119.70)	-	-	(432.70)
	6,199.00	6,199.00	5,886.00	50,860.86	15,313.90	15,313.90	99,772.66
Total Exp Before Mgmt Fee and I/C	305,184.46	356,914.34	324,202.25	267,484.31	96,551.57	135,611.01	1,485,947.94
Income (loss) before Mgmt Fee, I/C, Taxes, & Sale	(77,191.56)	(171,418.75)	(175,476.78)	(49,411.23)	(78,473.91)	(60,008.76)	(611,980.99)
							-
Net Income (Loss) Before Minority Interest, Sale of Investment	(77,191.56)	(171,418.75)	(175,476.78)	(49,411.23)	(78,473.91)	(60,008.76)	(611,980.99)

Attachment 35
Financial Viability

April 11, 2022

Debra Savage
Board Chair
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Letter

Dear Chair Savage,

As representative of Ortho-Pod, LLC, I, Tomas E. Nemickas, M.D., hereby attest that the terms and conditions of the proposed debt financing associated with modernization of the Lindenhurst Surgery Center are reasonable. Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash and used to retire debt within a 60-day period. The project will be financed by the facility licensee taking out a construction loan through Lake Forest Bank for the work to be completed, and some of the new equipment associated with the project will be leased. The leasing of equipment and the expenses incurred are less costly than purchasing new equipment.

Furthermore, I certify that as this project will require debt financing, the selected form of debt financing will be at the lowest net cost available.

Sincerely,

Tomas E. Nemickas, M.D.
Managing Member
Ortho-Pod, LLC

Notary Signature

Subscribed and sworn to before me this 13 day of April 2022.

Notary Stamp

RACHEL WADKINS
Official Seal
Notary Public - State of Illinois
My Commission Expires May 13, 2025

Attachment 36
Economic Feasibility

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)	
Clinical Components	-	$281.30	-	-	6994	-	-	$1,967,421	$1,967,421
Contingency	-	$17.16	-	-	0	-	-	$120,000	$120,000
TOTALS		$298.46	-	-	6994	-	-	$2,087,421	$2,087,421

Attachment 37
Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2018**	**2019**	**2020**
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**
Charity (cost in dollars)			
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**
MEDICAID			
Medicaid (# of patients)	**2018**	**2019**	**2020**
Inpatient	0	0	0
Outpatient	114	88	85
Total	114	88	85
Medicaid (revenue)			
Inpatient	0	0	0
Outpatient	$1,748,352	0	$21,153
Total	$1,748,352	0	$21,153

Attachment 38
Charity Care

CHARITY CARE			
Charity (# of patients)	**2018**	**2019**	**2020**
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**
Charity (cost in dollars)			
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**

Attachment 39
Flood Zone Letter

April 4, 2022

Debra Savage
Board Chair
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Lindenhurst Surgery Center- Flood Plain Requirements

Dear Chair Savage:

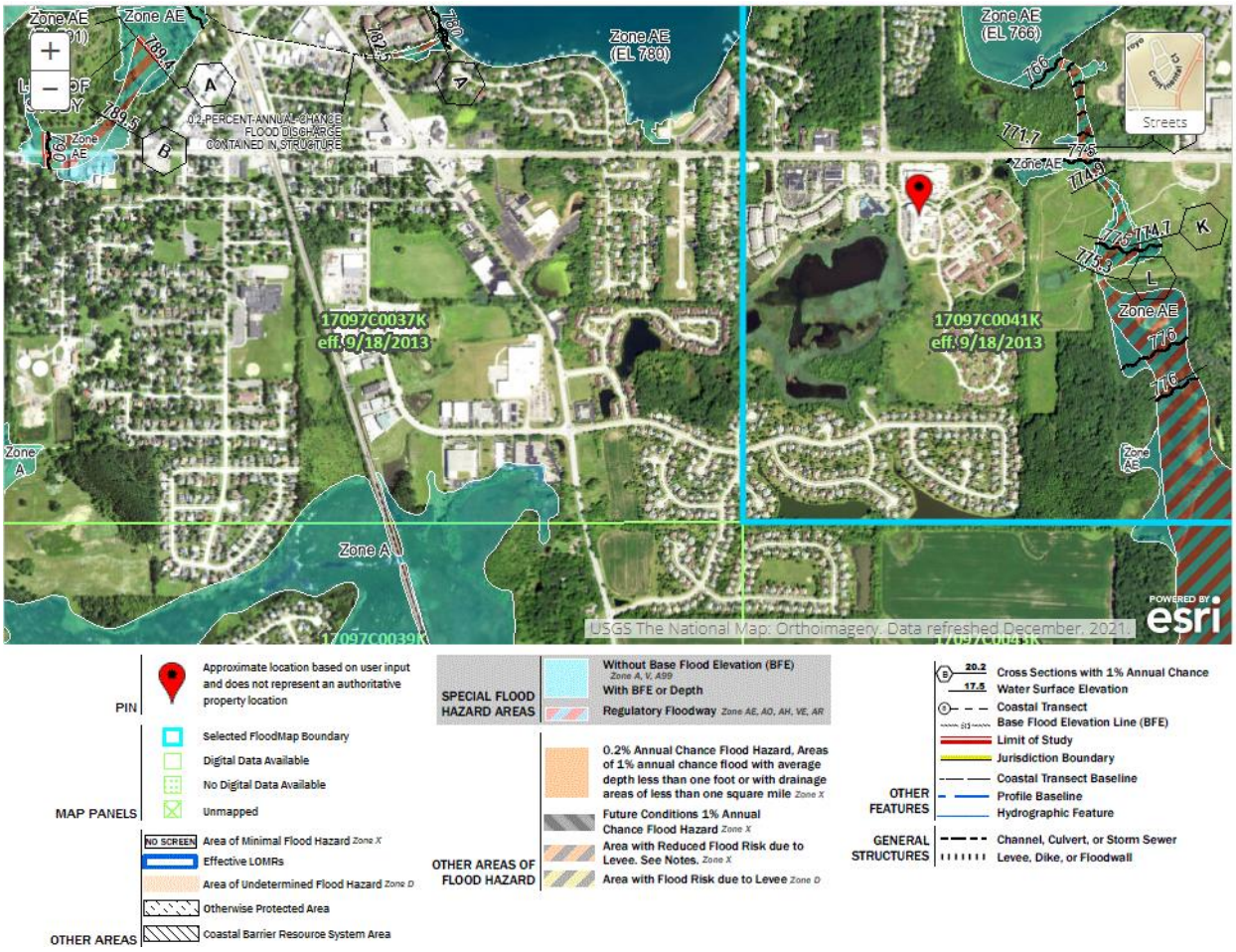
As representative of Lindenhurst Surgery Center, I, Rachel Wadkins affirm that the proposed location for the modernization of Lindenhurst Surgery Center, LLC complies with Illinois Executive Order #2005-5. The facility location at 1050 Red Oak Lane, Lindenhurst, IL 60046 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Rachel Wadkins
Administrator
Lindenhurst Surgery Center

Attachment 39
Flood Zone Letter



INDEX OF ATTACHMENTS