

**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:	Summit Center for Surgery		
Street Address:	1S210 Summit Avenue		
City and Zip Code:	Oakbrook Terrace, IL 60181		
County: DuPage	Health Service Area: VII	Health Planning Area: 043	

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

Exact Legal Name:	Summit Center for Surgery, LLC
Street Address:	64 Sheffield Court
City and Zip Code:	Oakbrook, IL 60523
Name of Registered Agent:	GW Accounting, Ltd.
Registered Agent Street Address:	15 Spinning Wheel Drive, Suite 314
Registered Agent City and Zip Code:	Hinsdale, IL 60521
Name of Chief Executive Officer:	Ibrahim Majzoub
CEO Street Address:	1S210 Summit Avenue
CEO City and Zip Code:	Oakbrook Terrace, IL 60181
CEO Telephone Number:	630/282-6000

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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	348 Chicory Lane Buffalo Grove, IL 60089
Telephone Number:	312/969-4759
E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

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

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E-mail Address:	jacobmaxel@msn.com
Fax Number:	

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

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

Post Permit Contact

[Person to receive all correspondence after permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name:	Ibrahim Majzoub, MD
Title:	Sole Member
Company Name:	Summit Center for Health, LLC
Address:	1S210 Summit Avenue Oakbrook Terrace, IL 60181
Telephone Number:	630/282-6000
E-mail Address:	imajzoub123@gmail.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Summit Center for Health Building, LLC
Address of Site Owner:	64 Sheffield Lane Oakbrook, IL 60523
Street Address or Legal Description of the Site:	1S210 Summit Avenue Oakbrook Terrace, IL 60181
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:	Summit Center for Surgery, LLC		
Address:	1S210 Summit Avenue Oakbrook Terrace, IL 60181		
☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
X	Limited Liability Company	☐	Sole Proprietorship
		☐	Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

Flood Plain Requirements

[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.

Summit Center for Health ("SCFH") was established in 2016 in Oakbrook Terrace, and provides a variety of services, including primary care, an urgent care center, selected specialty services, and an ASTC. The ASTC is accredited by The Joint Commission, and, upon the approval of the requested Certificate of Need Permit, the applicant will apply for IDPH licensure. That licensure will allow Medicaid recipients to be referred to the ASTC.

The cost of the proposed project is minimal, compared to other proposals to establish an ASTC because, and as noted above, the ASTC is currently in place, and the facility modifications required to meet IDPH licensure requirements are believed by the applicant to be minimal. The major portion of the project's costs is anticipated to be for the acquisition and installation of equipment.

This Certificate of Need application is classified as "substantive" in that it addresses the establishment of a licensed health care facility.

PROJECT COST AND SOURCES OF FUNDS

	Clinical	Non-Clinical	Total
Project Cost:			
Preplanning Costs	\$ 1,500		\$ 1,500
Site Survey and Soil Investigation			
Site Preparation	\$ 1,500		\$ 1,500
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$ 53,075		\$ 53,075
Contingencies	\$ 4,775		\$ 4,775
Architectural/Engineering Fees	\$ 7,000		\$ 7,000
Consulting and Other Fees	\$ 60,000		\$ 60,000
Movable and Other Equipment (not in construction contracts)	\$ 350,000		\$ 40,000
Net Interest Expense During Construction Period			
Fair Market Value of Leased Space			
Fair Market Value of Leased Equipment			
Other Costs to be Capitalized			
Acquisition of Building or Other Property			
TOTAL USES OF FUNDS	\$ 477,850		\$ 167,850
Sources of Funds:			
Cash and Securities	\$ 477,850		\$ 477,850
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 477,850		\$ 477,850

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 X Yes ☐ No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ <u>0</u>

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): 6 mo. following receipt of CON_

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? not 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 departments 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]

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

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

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 Summit Center for Surgery, 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.

Ibrahim Majzoub
SIGNATURE

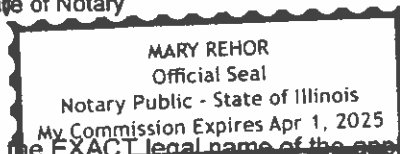
Ibrahim Majzoub, MD
PRINTED NAME

Sole Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of February 2023

Mary Rehor
Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

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SIGNATURE

Ibrahim Majzoub, MD
PRINTED NAME

Sole Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of February 2023


Signature of Notary

Seal

MARY REHOR
Official Seal
Notary Public - State of Illinois
My Commission Expires Apr 1, 2025

*Insert the EXACT legal name of the applicant

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

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?

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

not applicable, no shell space included in project

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

not applicable, no shell space included in project

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

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

G. Non-Hospital Based Ambulatory Surgery

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

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☒ Dermatology
☐ General Dentistry
☐ General Surgery
☒ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☐ Oral/Maxillofacial Surgery
☐ Orthopedic Surgery
☒ Otolaryngology
☒ Pain Management
☐ Physical Medicine and Rehabilitation
☒ Plastic Surgery
☒ Podiatric Surgery
☒ Radiology (Interventional)
☐ Thoracic Surgery
☒ Urology
☒ Other Pulmonary

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

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

#23-013

1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

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

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:

\$477,850	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. d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, 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.
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_____ _____ _____	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.
\$477,850	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, 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.

not applicable, funded through internal sources

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing**not applicable, no debt to be incurred**

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 New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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.

not applicable

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.

not applicable

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.

Projected Year 2 Payor Mix*

Medicare	4%
Medicaid	9%
Commercial Insurance	80%
Self-Pay	5%
Charity Care	2%

*similar to that of DuPage Immediate Care Center

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 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: PLEASE SEE PAGE 1 OF APPLICATION
2. Project Location: PLEASE SEE PAGE 1 OF APPLICATION
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)

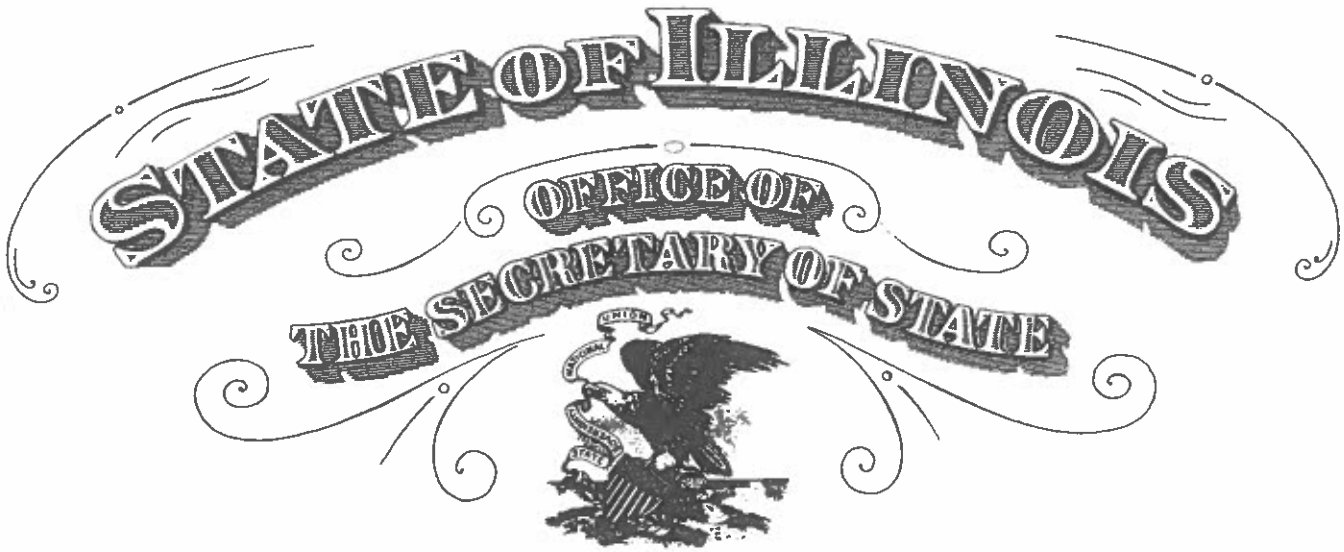
Signature: _____ Date: _____

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

File Number

1272038-6



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

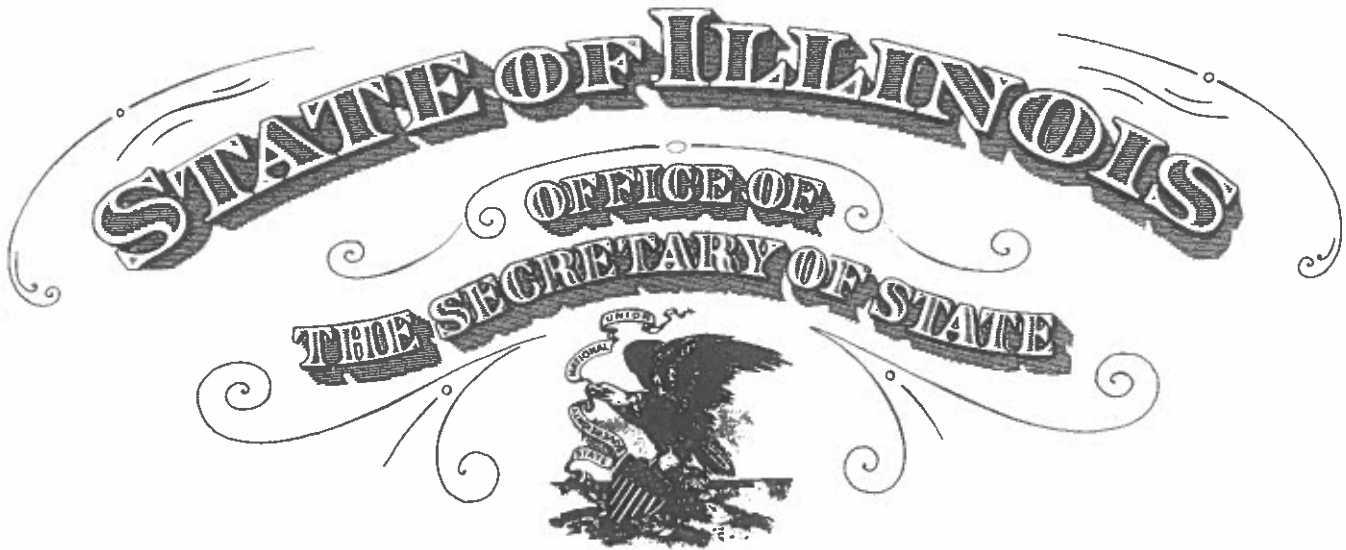
SUMMIT CENTER FOR SURGERY LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 19, 2023, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of JANUARY A.D. 2023 .

File Number

0333000-1



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

SUMMIT CENTER FOR HEALTH LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 13, 2010, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 16TH day of JANUARY A.D. 2023 .

Authentication #: 2301601004 verifiable until 01/16/2024

Authenticate at: <https://www.ilsos.gov>

Alexi Giannoulas

SECRETARY OF STATE ATTACHMENT 1

SITE OWNERSHIP

Please see ATTACHMENT 11.

File Number

1272038-6



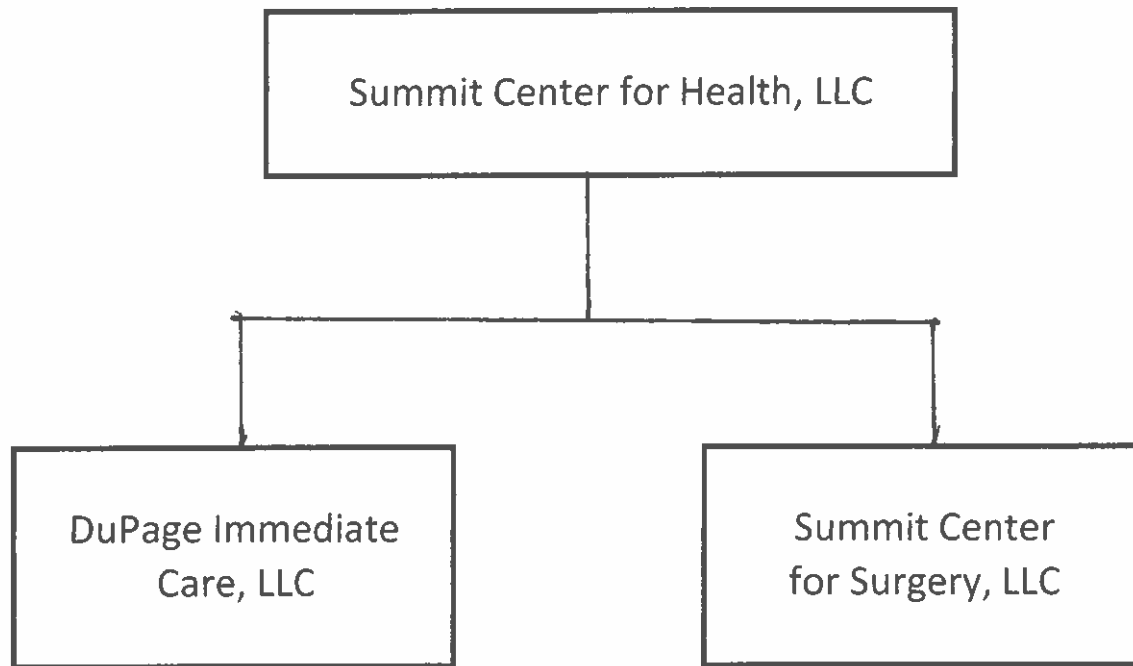
To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

SUMMIT CENTER FOR SURGERY LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 19, 2023, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 23RD day of JANUARY A.D. 2023 .



FLOOD PLAIN REQUIREMENTS

With the signatures provided on the Certification page of this Certificate of Need application, the applicant confirms that the project addressed thorough this Certificate of Need application, that being the establishment of an ASTC within an existing building located at 1S210 Summit Avenue in Oakbrook Terrace, Illinois,, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA is attached.



FEMA Flood Map Service Center: Search By Address

Navigation

Search

MSC Home (/portal/)

MSC Search by Address
(/portal/search)

MSC Search All Products
(/portal/advanceSearch)

MSC Products and Tools
(/portal/resources/productsandtools)

Hazus
(/portal/resources/hazus)

LOMC Batch Files
(/portal/resources/lomc)

Product Availability
(/portal/productAvailability)

MSC Frequently Asked
Questions (FAQs)
(/portal/resources/faq)

MSC Email Subscriptions
(/portal/subscriptionHome)

Contact MSC Help
(/portal/resources/contact)

Enter an address, place, or coordinates: ?

1S210 Summit Avenue Oakbrook Terrace, IL 60181

Search

Whether you are in a high risk zone or not, you may need [flood insurance](https://www.fema.gov/national-flood-insurance-program) because most homeowners insurance doesn't cover flood damage. If you live in an area with low or moderate flood risk, you are 5 times more likely to experience flood than a fire in your home over the next 30 years. For many, a National Flood Insurance Program's flood insurance policy could cost less than \$400 per year. Call your insurance agent today and protect what you've built.

Learn more about [steps you can take](https://www.fema.gov/what-mitigation) to reduce flood risk damage.

Search Results—Products for OAKBROOK TERRACE, CITY OF

Show ALL Products » (<https://msc.fema.gov/portal/availabilitySearch?addcommunity=170215&communityName=OAKE>)

The flood map for the selected area is number 17043C0176J, effective on 08/01/2019 ?

DYNAMIC MAP



MAP IMAGE



DOWNLOAD
FIRM PANEL

(<https://msc.fema.gov/portal/downloadProduct?>

[productTypeID=FINAL_PRODUCT&productSubTypeID=FIRM_PANEL&productID=17043C0176J](https://msc.fema.gov/portal/downloadProduct?productTypeID=FINAL_PRODUCT&productSubTypeID=FIRM_PANEL&productID=17043C0176J))

Changes to this FIRM ?

Revisions (0)

Amendments (7)

Revalidations (4)

You can choose a new flood map or move the location pin by selecting a different location on the locator map below or by entering a new location in the search field above. It may take a minute or more during peak hours to generate a dynamic FIRMette.

Go To NFHL Viewer » (<https://hazards-fema.maps.arcgis.com/apps/webappviewer/index.html?id=8b0adb51996444d>)



Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

August 29, 2022

Mr. Jeffrey Kruchten
Chief Archaeologist
Illinois Historic Preservation Office
Illinois Dept. of Natural Resources
1 Natural Resources Way
Springfield, IL 62702-1271

RE: Proposed Ambulatory Surgical Treatment
Center
Oakbrook Terrace, IL

Dear Mr. Kruchten:

I am in the process of developing a Certificate of Need application, to be filed with the Illinois Health Facilities Services and Review Board, and I am in need of a determination of applicability from your agency.

The project proposes the development of an ambulatory surgical treatment center ("ASTC"). The center will be located in an existing building at 1S210 Summit Avenue in Oakbrook Terrace. There will be no new construction, and there are no structures that appear to be of historical significance approximate to the site.

I have enclosed a map of the site and pictures of the the building to be renovated, as well as surrounding structures for your review.

A letter from your office, confirming that the Preservation Act is not applicable to this project would be greatly appreciated.

Should you have any questions, I may be reached at the phone number below.

Sincerely,


Jacob M. Axel
President

enclosures

ATTACHMENT 6

PROJECT COSTS and
SOURCES OF FUNDS

PROJECT COSTS

Preplanning Costs		
Legal	\$ 1,500	
		\$ 1,500
Site Survey and Preparation		
Exterior Signage	\$ 1,500	
		\$ 1,500
Modernization		\$ 53,075
Contingencies		\$ 4,775
Architectural and Engineering		
Design	\$ 5,000	
Agency Interaction	\$ 2,000	
		\$ 7,000
Consulting and Other Fees		
CON-Related	\$ 40,000	
Local Fees	\$ 10,000	
Misc./Other	\$ 10,000	
		\$ 60,000
Movable and Other Equip		
Surgery & Endoscopy	\$ 340,000	
Misc./Other	\$ 10,000	
		<u>\$ 350,000</u>
TOTAL		\$ 477,850

SOURCES OF FUNDS

Cash & Other Liquid Sources	\$ 477,850
TOTAL	\$ 477,850

Cost Space Requirements

Dept./Area	Gross Square Feet			Amount of Proposed Total Square Feet That Is:				Vacated Space
	Cost	Existing		Proposed	New Const.	Modernized	As Is	
Surgery & Endoscopy	\$ 453,958	0	2,920	0	2,920	0	0	0
Recovery	\$ 23,893	0	1,855	0	1,855	0	0	0
	\$ 477,850	0	4,775	0	4,775	0	0	0

Summit Center for Health, LLC

Oakbrook Terrace, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Ambulatory Health Care Accreditation Program

April 26, 2021

Accreditation is customarily valid for up to 36 months.

James E. Pugh
James E. Pugh, MD, FACP, MBA
Chief, Office of Compliance

1124515640
First Surveys Date: 11/27/2019

Mark R. Chason, MD, FACP, MBA, AHA
Mark R. Chason, MD, FACP, MBA, AHA
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-688-7411. Information regarding accreditation and the accreditation performance of individual organizations can be reviewed through The Joint Commission's website at www.jointcommission.org.



SUMMIT CENTER FOR HEALTH, LLC
15210 SUMMIT AVE
OAKBROOK TERRACE, IL 60181
630-426-3969
Fax: 630-477-0465

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

I hereby certify that no adverse action has been taken against either applicant named in the Certificate of Need application addressing the establishment of an ASTC to be located at 15210 Summit Avenue in Oakbrook Terrace, Illinois, directly or indirectly, over the past three years; and authorize HFSRB and IDPH to access any documentation which it finds necessary to verify any information submitted, including, but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

The applicants are not affiliated in any way with any existing licensed health care facility.

Further, and with the signature below, I hereby certify that 1) Summit Center for Health Building, LLC owns the building in which the proposed ASTC will be located; 2) a peer review program will be implemented, consistent with Section 1110.235(c)10(A); and 3) it is anticipated by the applicants that, by the second year of operation following the project's completion date, the annual utilization of the operating rooms and treatment room will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.



Ibrahim Majzoub, MD
Sole Member

Date: 2/9/23, 2023

Notarized:

VERIFICATION ON OATH OR AFFIRMATION WITH AFFIANT STATEMENT

State of ILLINOIS } ss.
 County of DUPage }

- ☒ See Attached Document (Notary to cross out lines 1-7 below)
☐ See Statement Below (Lines 1-7 to be completed only by document signer[s], not Notary)

1 _____
 2 _____
 3 _____
 4 _____
 5 _____
 6 _____

7 *[Signature]*
 Signature of Document Signer No. 1

 Signature of Document Signer No. 2 (if any)

Subscribed and sworn to (or affirmed) before me

this 9th day of FEBRUARY, 2023, by
 Day Month Year

Ibrahim M. Al-Zoub

Name of Signer No. 1

 Name of Signer No. 2 (if any)

[Signature]

Signature of Notary Public

Exp. 04/01/2025

Any Other Required Information
 (Residence, Expiration Date, etc.)



Place Notary Seal/Stamp Above

OPTIONAL

Completing this information can deter alteration of the document or
 fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Letter to Illinois Health Facilities

Document Date: 2/9/2023 Number of Pages: 1

Signer(s) Other Than Named Above: _____

PURPOSE OF PROJECT

The ASTC's service population, as documented in ATTACHMENT 25, will consist primarily of residents of the HFSRB-defined geographic service area, which consists of those ZIP Code areas located within ten miles of the hospital. The proposed project, which addresses the establishment of an ambulatory surgical treatment center ("ASTC") for the provision of selective procedures/specialties, will improve the health and well-being of the market area population to be served. In addition, upon receipt of the requested CON Permit and subsequent IDPH licensure, Medicaid recipients will have access to the ASTC.

This project will, generally, and consistent with current delivery trends, move the procedures to be performed in the ASTC into a lower-cost setting, as well as moving some procedures currently performed in unlicensed settings to an IDPH-licensed ASTC.

The goal of this project is to have the ASTC licensed and operational within six months of the awarding of the Certificate of Need Permit sought through the filing of this application.

SIZE

The square footage identified for the project addressed in this CON application, which includes two Class C operating rooms, one Class B procedure room, three Phase I recovery stations and four Phase II recovery stations (which will also be used for pre-procedure patient prep), is necessary, not excessive, and consistent with the standards identified in Appendix B to Section 1110. The only functional area included in the project having a HFSRB-adopted space standard is the ASTC, which includes all functional area with the exception of the recovery stations noted above.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (1) (2)	2,920	7,700	(4,780)	YES
(1) two operating rooms and one procedure room				
(2) includes 25% apportionment of staff and waiting areas shared with other functions				

PROJECT SERVICES UTILIZATION

Letters, documenting historical caseloads and projected referrals to the ASTC are provided in ATTACHMENT 25. Nine letters have been provided, addressing the following specialties: urology, plastic surgery, reconstructive plastic surgery, interventional radiology, pain management, pulmonary, gastroenterology, podiatry and dermatology. Due to the types of surgery to be performed in the ASTC, with many of the cases being minimally invasive, approximately half of the documented historical cases have been performed either in the office setting or in unlicensed facilities.

To determine projected utilization in terms of hours, a physician's projected number of cases to be referred to the ASTC was multiplied by the hours per case experienced in IDPH-licensed ASTCs in HSA VII during 2020. (Note: Because of the nature of the complex reconstructive cases performed by Dr. Toriumi, his hours per case were projected to be 4.5, and pulmonary cases are estimated to require .75 hour per case).

The table below identifies the specialty-specific hours per case used to project the ASTC's utilization.

Specialty	Hours per Case
Urology	1.21
Plastic Surgery	2.40
Interventional Radiology	2.50
Plastic Surgery-Revisions	4.50
Pain Management	0.87
Gastroenterology	0.68
Pulmonary	0.75
Podiatry	1.97
Dermatology	0.99

As noted above, and due primarily to the types of surgery performed by the physicians providing referral letters, 49.3% of the cases anticipated to be referred to the ASTC have historically been performed outside of the hospital/licensed ASTC setting.

Cumulatively, and as documented in the table below, the nine physicians account for a projected 2,025 hours of OR/procedure room time to be consumed at the proposed ASTC, with the gastroenterology procedures to be performed in a non-sterile procedure room, as is commonplace.

Name	Specialty	Hrs/Case	Qualified* Cases	Qualified Hours	Non-Qualified Cases	Non-Qualified Hours	Total Hours
Sadah	Urology	1.21	0	0	10	12	12
Rochel	Plastic	2.4	10	24	40	96	120
Chopa	Intervent. Rad.	2.5	0	0	148	370	370
Toriumi	Plastic/Revisions	4.5	50	225	0	0	225
Candido	Pain Mgt.	0.87	500	435	0	0	435
Verma	Gastro	0.68	95	65	0	0	65
Nagori	Pulmonary	0.75	13	10	0	0	10
Maghrabi	Podiatry	1.97	0	0	325	640	640
Agha	Dermatology	0.99	<u>0</u>	<u>0</u>	<u>150</u>	<u>148</u>	<u>148</u>
			668	759	673	1,267	2,025

*performed in a hospital or IDPH-licensed surgery center

The 2,015.45 projected hours of OR/procedure room utilization documented above, “support” the two operating rooms and the one procedure room to be provided, based on the HFSRB’s standard of 1,500 hours per room, rounded up.

	PROJECTED UTILIZATION (hrs)		STATE STANDARD	MET STANDARD?
	YEAR 1	YEAR 2		
Operating Rms. (2)	1,470	1,960	1,501	YES
Procedure Rms (1)	576	640	N/A	N/A

SERVICE TO GEOGRAPHIC SERVICE AREA RESIDENTS

The primary purpose of the proposed ASTC is to provide outpatient surgery services to residents of the HFSRB-defined geographic service area ("GSA"), which consists of the 72 ZIP Code areas (54 of which are residential) located within ten miles of the ASTC site. The ZIP Code areas in the GSA are identified below.

60101	ADDISON	60009	ELK GR. VILLAGE	60160	MELROSE PARK
60104	BELLWOOD	60007	ELK GR. VILLAGE	60161	MELROSE PARK
60105	BENSENVILLE	60126	ELMHURST	60523	OAK BROOK
60106	BENSENVILLE	60707	ELMWOOD PARK	60301	OAK PARK
60163	BERKELEY	60130	FOREST PARK	60304	OAK PARK
60117	BLOOMINGDALE	60599	FOX VALLEY	60302	OAK PARK
60108	BLOOMINGDALE	60131	FRANKLIN PARK	60303	OAK PARK
60155	BROADVIEW	60137	GLEN ELLYN	60305	RIVER FOREST
60513	BROOKFIELD	60138	GLEN ELLYN	60171	RIVER GROVE
60199	CAROL STREAM	60139	GLENDALE HTS	60546	RIVERSIDE
60188	CAROL STREAM	60706	HARWOOD HTS	60172	ROSELLE
60197	CAROL STREAM	60162	HILLSIDE	60196	SCHAUMBURG
60116	CAROL STREAM	60141	HINES	60176	SCHILLER PARK
60128	CAROL STREAM	60522	HINSDALE	60165	STONE PARK
60132	CAROL STREAM	60521	HINSDALE	60181	VILLA PARK
60666	CHICAGO	60143	ITASCA	60154	WESTCHESTER
60682	CHICAGO	60525	LA GRANGE	60558	WEST. SPRINGS
60634	CHICAGO	60526	LA GRANGE PARK	60559	WESTMONT
60656	CHICAGO	60532	LISLE	60189	WHEATON
60514	CL'DON HILLS	60148	LOMBARD	60187	WHEATON
60561	DARIEN	60534	LYONS	60527	WILLOWBROOK
60018	DES PLAINES	60153	MAYWOOD	60190	WINFIELD
60515	DOWNERS GR.	60157	MEDINAH	60399	WOOD DALE
60516	DOWNERS GR.	60164	MELROSE PARK	60191	WOOD DALE

The project addressed in this CON application addresses the establishment of an ASTC, and therefore, "...patient origin information by ZIP Code for all admissions for the last 12-month period..." as requested in Section 1110.235.c02.(B)(ii) cannot be provided.

A majority of the physicians providing letters in the attachment addressing "Service Demand" did not have the ability to efficiently develop a patient origin analyses of their past cases. Therefore, those physicians without that ability were given a list of all of the ZIP Code areas/communities located within the project's GSA, and asked to estimate the percentage of their patients that resided in the GSA. Those estimates ranged from 0% to 80%. However, the applicants are confident that, by the second year of the ASTC's operation, well in excess of 50% of the patients treated in the ASTC will be residents of the GSA. This belief is based on the absolute anticipation that a high percentage of the patients referred to the surgeons who will ultimately perform the cases in the proposed ASTC will be referred by Summit Center for Health ("SCFH"), primarily through its subsidiary DuPage Immediate Care, Ltd. ("DIC"). DIC is an active urgent care center, treating approximately 32,000 patients a year, that is in the same building that will house the ASTC. During 2022, nearly 80% of the patients seen/treated at DIC resided in the GSA.

The table on the following page provides a 2022 ZIP Code-specific patient origin analysis of patient encounters at DIC, documenting that nearly 78% of the primary patient base for the ASTC...patients originally treated at DIC... reside within ten miles of the ASTC. As a result, and as noted above, the applicants are confident that the vast majority of patients to be treated in the proposed ASTC will reside in the area.

DuPage Immediate Care. Ltd.
2022 Patient Origin

GSA:	ZIP Code	Community	Patients
	60181	Villa Park	5,790
	60126	Elmhurst	3,451
	60148	Lombard	3,354
	60523	Oak Brook	1,122
	60154	Westchester	1,009
	60559	Westmont	694
	60162	Hillside	693
	60515	Downers Grove	625
	60137	Glen Ellyn	566
	60101	Addison	485
	60521	Hinsdale	472
	60104	Bellwood	467
	60139	Glendale Heights	368
	60525	La Grange	367
	60163	Berkley	339
	60106	Bensenville	326
	60526	La Grange Park	284
	60527	Willowbrook	275
	60155	Broadview	270
	60153	Maywood	258
	60516	Downers Grove	254
	60189	Wheaton	254
	60514	Clarendon Hills	247
	60558	Western Springs	229
	60513	Brookfield	205
	60164	Melrose Park	203
	60526	Riverside	193
	60532	Lisle	174
	60188	Carol Stream	162
	60191	Wood Dale	154
	60187	Wheaton	152
	60561	Darien	138
	60304	Oak Park	117
	60160	Melrose Park	115
	60108	Bloomingtondale	100
	60130	Forest Park	84
	60707	Elmwood Park	73
	60131	Franklin Park	66
	60302	Oak Park	59

60143	Itasca	57		
60007	Elk Grove Village	53		
60634	Chicago	50		
60172	Roselle	46		
60171	River Grove	41		
60190	Winfield	40		
60534	Lyons	39		
60706	Harwood Heights	34		
60176	Schiller Park	25		
60165	Stone Park	23		
60305	River Forest	21		
60656	Chicago	18		
60301	Oak Park	11		
60018	Des Plaines	7		
60157	Medinah	<u>1</u>		
			24,660	77.7%
Non-GSA			<u>7,096</u>	<u>22.3%</u>
	Total		31,756	100.0%

Form B

Name (print): Rania Agha, MD

Specialty (print): Dermatology

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
(print site): Summit Dermatology Oakbrook Terrace	<u>309</u>	<u>554</u>
(print site): _____	_____	_____
(print site): _____	_____	_____
(print site): _____	_____	_____
<u>TOTAL</u>	<u>309</u>	<u>554</u>

*represents approximate 20-30 % reduction from prior years due to COVID-19 pandemic

I estimate that I will refer 150 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.

I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 80% of my patients reside in that area.

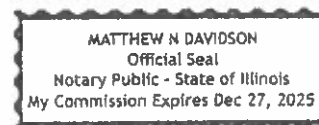
The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,



Notarized: _____

12/06/22



ATTACHMENT 25

Form B

Name (print): Kenneth D. Candido, MDSpecialty (print): Pain ManagementTO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
(print site): <u>Advocate IL. MASONIC</u>	<u>1,750</u>	<u>2,000</u>
(print site): <u>Thorek Mem. Hospital</u>	<u>X</u>	<u>50</u>
(print site): <u>Advocate Good SAMARITAN</u>	<u>X</u>	<u>50</u>
(print site): _____	_____	_____
<u>TOTAL</u>	<u>1,750</u>	<u>2,100</u>

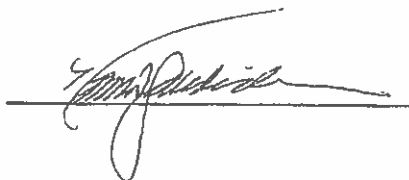
*represents approximate 25 % reduction from prior years due to COVID-19 pandemic

I estimate that I will refer 500 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.

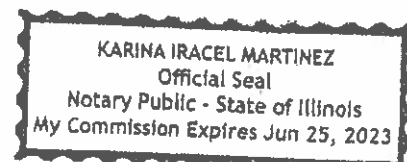
I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 35 % of my patients reside in that area.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,



Notarized:




ATTACHMENT 25

Form B

Michael M Maghrabi, DPM
Podiatrist-Foot Surgeon
Diplomate, American Board of Podiatric Surgery
2623 South Lawndale Ste C
Chicago, IL 60623
Phone: 773-522-9700
Fax: 773-522-9700

Name (print): Michael Maghrabi, DPM

Specialty (print): Podiatry

TO: Illinois Health Facilities Planning Board
 Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
(print site): <u>2222 west division street</u> <u>275</u>	<u>325</u>	
Chicago, IL 60622		
(print site): _____	_____	_____
(print site): _____	_____	_____
(print site): _____	_____	_____
<u>TOTAL</u> _____	<u>275</u>	<u>325</u>

*represents approximate 30 % reduction from prior years due to COVID-19 pandemic

I estimate that I will refer 400 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.

I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 35 % of my patients reside in that area.

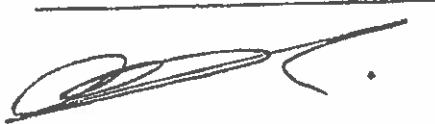
ATTACHMENT 25

Form B

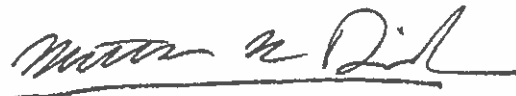
The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Michael M Maghrabi, DPM



Notarized:



11/2/2022

MATTHEW N DAVIDSON
Official Seal
Notary Public - State of Illinois
My Commission Expires Dec 27, 2022

ZIP Codes/Communities located within 10 miles of Oak Brook Terrace:

60101	ADDISON	60526	LA GRANGE PARK
60104	BELLWOOD	60532	LISLE
60106	BENSENVILLE	60148	LOMBARD
60163	BERKELEY	60534	LYONS
60108	BLOOMINGDALE	60153	MAYWOOD
60155	BROADVIEW	60157	MEDINAH
60513	BROOKFIELD	60164	MELROSE PARK
60188	CAROL STREAM	60160	MELROSE PARK
60634	CHICAGO	60523	OAK BROOK
60656	CHICAGO	60301	OAK PARK
60514	CLARENDON HILLS	60304	OAK PARK
60561	DARIEN	60302	OAK PARK
60018	DES PLAINES	60305	RIVER FOREST
60515	DOWNERS GROVE	60171	RIVER GROVE
60516	DOWNERS GROVE	60546	RIVERSIDE
60007	ELK GROVE VILLAGE	60172	ROSELLE
60126	ELMHURST	60176	SCHILLER PARK
60707	ELMWOOD PARK	60165	STONE PARK
60130	FOREST PARK	60181	VILLA PARK
60131	FRANKLIN PARK	60154	WESTCHESTER
60137	GLEN ELLYN	60558	WESTERN SPRINGS

ATTACHMENT 25

Form B

Name (print): Mohammedum R. NagariSpecialty (print): Pulmonary & Critical CareTO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
(print site): <u>West Suburban Medical Center</u>	_____	<u>37</u>
(print site): _____	_____	_____
(print site): _____	_____	_____
(print site): _____	_____	_____
<u>TOTAL</u>	_____	<u>37</u>

*represents approximate 25 % reduction from prior years due to COVID-19 pandemicI estimate that I will refer 35% patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 25 % of my patients reside in that area.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

M.R. NagariNotarized: Mary Rehor
Mary Rehor

ATTACHMENT 25

Name (print): John Rachel, MD
 Specialty (print): ENT/Facial Plastics

TO: Illinois Health Facilities Planning Board
 Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
(print site): <u>St Alexius - Hoffman Estates</u>	<u>10</u>	<u>15</u>
(print site): <u>Aspirus - Oakbrook</u>	<u>25</u>	<u>45</u>
(print site): <u>St. Mary's - Oakbrook Park</u>	<u>25</u>	<u>45</u>
(print site): <u>Metropolitan MD - Glenview</u>	<u>150</u>	<u>200</u>
<u>TOTAL</u>	<u>210</u>	<u>305</u>

*represents approximate 15 % reduction from prior years due to COVID-19 pandemic

I estimate that I will refer 50 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.

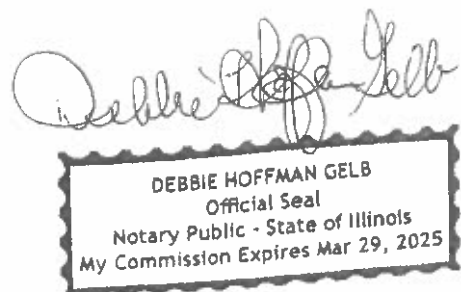
I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 50 % of my patients reside in that area.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

John Rachel, MD
10-13-22

Notarized:



Form B

Name (print): Alan Y. Sadah, MD
 Specialty (print): Urology

TO: Illinois Health Facilities Planning Board
 Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	<u>2020*</u>	<u>2021*</u>
<u>HCSO @ Hoffman Estates</u> (print site): _____	<u>540</u>	<u>540</u>
(print site): _____	_____	_____
(print site): _____	_____	_____
(print site): _____	_____	_____
<u>TOTAL</u> _____	_____	_____

*represents approximate 5-10 % reduction from prior years due to COVID-19 pandemic

I estimate that I will refer 10-15 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.

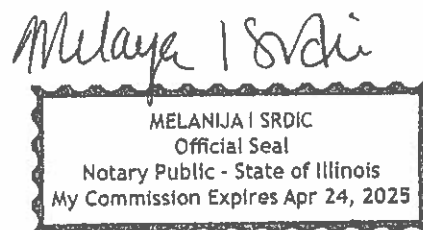
I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 50 % of my patients reside in that area.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

[Signature]

Notarized:



ATTACHMENT 25

Form B

Name (print): Dean M. Toriumi MD.Specialty (print): ENT / Facial Plastic SurgeTO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	2020*	2021*
(print site): <u>Proton Michigan Surgery Ctr</u>	<u>140</u>	<u>188</u>
(print site): <u>St. Josephs Hospital</u>	<u>5</u>	<u>8</u>
(print site): <u>Rush University Hosp.</u>	<u>—</u>	<u>10</u>
(print site): <u>Summit Center for Health</u>	<u>—</u>	<u>10</u>
<u>TOTAL</u>	<u>190</u>	<u>216</u>

*represents approximate ____% reduction from prior years due to COVID-19 pandemic

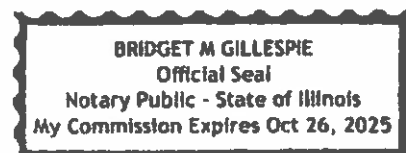
I estimate that I will refer 50 patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 0% of my patients reside in that area.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Dean M. Toriumi

Notarized:



Bridget M. Gillespie
 Bridget M. Gillespie
 ATTACHMENT 25

10-11-2022

55

Form B

Name (print): ARUN VERMA MDSpecialty (print): GASTROENTEROLOGYTO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the plans to develop an ambulatory surgical treatment center ("ASTC") in Oak Brook Terrace.

During 2020 and 2021 I performed procedures on approximately the following numbers of patients in the facilities identified below.

	2020*	2021*
(print site): <u>HUMBOLDT PARK HEALTH HOSPITAL</u>	<u>700</u>	<u>900</u>
(print site): _____	_____	_____
(print site): <u>ST. MARY HOSPITAL CHICAGO</u>	<u>100</u>	<u>50</u>
(print site): _____	_____	_____
<u>TOTAL</u>	<u>800</u>	<u>950</u>

*represents approximate 15% reduction from prior years due to COVID-19 pandemicI estimate that I will refer 10% patients to the proposed ASTC during its second year following the receipt of the requested Certificate of Need Permit.I have reviewed a listing of all ZIP Codes/communities located within 10 miles of the proposed ASTC's site (attached), and I estimate that 10% of my patients reside in that area.

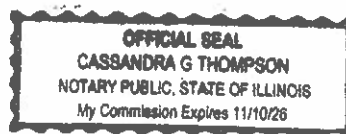
The information contained in this letter is true, and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Arun Verma
12/19/22

Notarized:

CPM 12/19/2022
County of Cook, State of Illinois



TREATMENT ROOM NEED ASSESSMENT

The proposed ASTC will provide two Class C operating rooms and one Class B procedure room, to be used for gastroenterology procedures, exclusively. The proposed three rooms are necessary to service the projected service volume, as documented in the *Service Demand* ATTACHMENT, preceding this ATTACHMENT. Per the HFSRB's standard, 1,501+ hours of operating room time (procedure time + room turn-over) are required to "justify" the two operating rooms, and the physician letters provided in this application document 1,960 hours projected to be provided by eight physicians (non-gastroenterologists). Consistent with the HFSRB's practice when only a single treatment site, as is the case with the procedure room, is provided, the 1,500 hours per room standard is not applicable. A letter has been provided by Dr. Arun Verma, a gastroenterologist, documenting an intent to refer approximately 95 cases a year to the proposed ASTC.

The projected numbers of patients to be referred to the proposed ASTC by the physicians providing letters were most commonly "converted" to hours, using 2020 specialty-specific state-wide data as provided by ASTCs in their *Ambulatory Surgical Treatment Center Questionnaire for 2020*, published by the HFSRB. The exceptions to this practice were for the patients to be referred by Drs. Dean Toriumi, Paramjit Chopra, and Mohammedumer Nagori. Dr. Toriumi is a plastic surgeon, specializing in complex reconstruction procedures, and as such, an estimated 4.5 hours of OR time will be required for his cases. Drs. Chopra and Nagori are interventional radiologists and pulmonary medicine specialist, respectively, and the HFSRB publication does not provide data for these specialties. On average, 1.63 hours per OR case and 0.68 hours per GI (procedure room) case are anticipated to be utilized.

UNNECESSARY DUPLICATION/MAL-DISTRIBUTION

The proposed project will not cause an unnecessary duplication or mal-distribution of ASTCs, hospitals, or operating rooms.

Within the GSA (10 mile radius from the proposed site), there are four hospitals, with a total of 77 operating rooms and procedure rooms, and 24 ASTCs, with a total of 78 operating rooms and procedure rooms. Two of the ASTCs, having a combined 14 ORs and procedure rooms, operate as “closed staff models”, and are therefore not accessible to the physicians that will be referring patients to the proposed ASTC. In addition, 8 of the ASTCs, having a combined 14 ORs and procedure rooms, are “specialty” facilities (endoscopy, ophthalmology pediatric, orthopedic, fertility, prostate, vascular, or urology procedures, exclusively).

The population of the geographic service area (“GSA”) identified in ATTACHMENT 12, per SearchBug, is 1,178,812. Based on the total number of ORs and procedure rooms (155) in the GSA, the distribution is 1:7,605. However, and as is noted in the table on the following page, fourteen of the ASTC-based ORs are located in facilities with “closed” medical staffs, an unusual occurrence. Therefore, the GSA distribution to “open” facilities is actually 1:8,360 residents. State-wide, there are 2,056 hospital ORs and procedure rooms and 543 ORs and procedure rooms located in ASTCs. Based on a population estimate (2020) of 13,129,233, the resulting state-wide ratio is 1:5,052 residents. As such, the proposed project, which will add only three ORs/procedure rooms will not result in a distribution in excess of 1½ times that of the State, and therefore will not cause or result in a mal-distribution of services. In addition, of the physicians providing letters indicating their intent to refer patients to the proposed ASTC, only one physician is currently referring patients to the providers in the GSA. with that physician, Dr. Candido, referring a total of 50 pain management patients to one of the hospitals in 2021. As

such, there will be minimal impact on one of the area hospitals an no impact whatsoever on the area ASTCs.

Below are listed the hospitals and ASTCs located within 10 miles of the proposed site, as well as the number of ORs/procedure rooms each is approved to provided.

<u>Facility Name</u>	<u>Location</u>	<u># of ORs and Procedure Rms.</u>	<u>Total</u>
<u>Hospitals</u>			
Advent Hospital Hinsdale	Hinsdale	19	
Advent Hospital LaGrange	LaGrange	20	
Advocate Good Samaritan	Downers Grove	17	
Elmhurst Memorial Hospital	Elmhurst	<u>21</u>	
			77
<u>ASTCs</u>			
Aiden Ctr. For Day Surg	Addison	4	
Amb. Surgery Center of D G	Downers Grove	3	
Cadence Amb. Srgery Ctr.	Warrenville	2	
Chicago Prostate Cancr Surg. Ctr.*	Westmont	2	
Chicago Vascular ASC*	Westmont	3	
Children's Memorial*	Westchester	3	
DMG Surgical Center**	Lombard	8	
DuPage Eye Surgery Ctr.*	Wheaton	3	
Elmhurst Outpt. Surgery Ctr.	Elmhurst	4	
Elmwood Park Same Day	Elmwood Park	3	
Eye Surgery Ctr. Of Hinsdale*	Hinsdale	2	
Hinsdale Surgical Center	Hinsdale	4	
Ill. Back & Neck Inst.	Elmhurst	1	
Innovia Surgery Center	Wood Dale	2	
Loyola Amb. Surg. Center	Oakbrook Terrace	3	
Loyola U. Surgery Center	Maywood	6	
Midwest Ctr. For Day Surg.	Downers Grove	5	
Novamed Surgery Ctr.	River Forest	2	
Oak Brook Surgical Ctr.	Oak Brook	4	
Ophthalmology Surg. Ctr.*	Itasca	2	
Orthotec Surgery Center*	Elmhurst	1	
Rush Oak Brook Surg. Ctr.**	Oak Brook	6	
Salt Creek Surgery Center	Westmont	4	
United Urology Centers*	La Grange	<u>1</u>	
			78

*specialty provider

** closed staff

STAFFING

The ASTC will be staffed, at minimum, consistent with all IDPH licensure requirements and the applicable requirements of The Joint Commission. The ASTC is currently accredited by The Joint Commission, is in operation, and the current staff is anticipated to continue in their current positions, following IDPH licensure. Should additional staff be required, recruitment will be done through normal channels, such as advertisements/notices in appropriate professional publications. No difficulties in recruitment are anticipated.

Ibrahim Majzoub, MD, FCCP, ABSM currently serves as the ASTC's Medical Director, and will continue in that role.

Ibrahim Majzoub, MD, FCCP, ABSM

Home Address:

64 Sheffield Lane, Oakbrook , IL. 60523

Cell Phone:

Email: i_majzoub@yahoo.com

Main Office:

1S210 Summit Avenue, Oakbrook Terrace, IL. 60181.

Office Number: (630) 282-6002

Undergraduate Education

Bachelor of Arts (B.A.) , Biology Major

1987

University of Toledo

Toledo, OH.

Medical Education

Medical Degree (M.D.)

1988-1991

Antigua School of Medicine

University of Health Sciences

Antigua

Residency Training

Internal Medicine Residency

1994-1997

Edgewater Medical Center

Chicago, IL.

Fellowship Training

Pulmonary and Critical Care Fellowship

1997-2000

Chicago Medical School

Rosalind Franklin University

Chicago, IL.

Board Certifications

2009 American Board of Sleep Medicine.

Expires 12/2019.

2002 American Board of Critical Care.

Expires 12/2022.

2000 American Board of Pulmonary Medicine.

Expires 12/2020

1997 American Board of Internal Medicine.

Positions

President and Owner	Associates in Pulmonary and Critical Care, LTD.	
current		
CEO and Owner	Summit Center for Health, LLC.	2014-
Current		
CEO and Owner	Summit Ambulatory Surgery Center	2016-
current		
CEO and Owner	Du Page Immediate Care, LLC.	2014-Current
President of Medical Staff	Norwegian American Hospital, Chicago, IL.	2014-2016
Board of Trustees Member	Norwegian American Hospital, Chicago, IL.	2008-2009
Chairman	Department of Internal Medicine.	2006-2008
	Norwegian American Hospital, Chicago, IL.	
Chairman	Department of Primary Care Medicine,	2003-2005
	Internal Medicine, Family Medicine, and Pediatrics.	
	Loretto Hospital, Chicago, IL.	
Medical Director	Intensive Care Unit.	2004-Current
	Norwegian American Hospital, Chicago, IL.	
Attending Physician	Intensive Care Unit.	2004-Current
	Norwegian American Hospital, Chicago, IL.	
Medical Director	Cardiopulmonary Services	2000-Current
	Loretto Hospital, Chicago, IL.	
Consultant	Pulmonary Medicine, Critical Care, Sleep Medicine	
	Norwegian American Hospital	
	St. Mary of Nazareth and St. Elizabeth Medical Center	
	Loretto Hospital, Chicago, IL.	

Kindred Hospital, Chicago, IL.

References are available upon request.

CHARGE COMMITMENT

With the signatures on the Certification pages of this Certificate of Need application, the applicants commit to not increasing the proposed ASTC's charges for, at minimum, two years following the facility's opening.

A "Charge Master" is attached.

CHARGE MASTER

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67039	08/08/2013	15232.32
67040	08/08/2013	15232.32
67107	08/08/2013	12693.6
67108	08/08/2013	15232.32
67112	08/08/2013	15232.32
67115	08/08/2013	8885.52
67120	08/08/2013	8885.52
67121	08/08/2013	8885.52
67141	08/08/2013	5077.44
67218	08/08/2013	10154.88
67227	08/08/2013	5077.44
67250	08/08/2013	10154.88
67255	08/08/2013	12693.6
67311	08/08/2013	8885.52
67312	08/08/2013	10154.88
67314	08/08/2013	10154.88
67316	08/08/2013	10154.88
67318	08/08/2013	10154.88
67320	08/08/2013	5077.44
67331	08/08/2013	5077.44
67332	08/08/2013	5077.44
67334	08/08/2013	5077.44
67335	08/08/2013	5077.44
67340	08/08/2013	5077.44
67350	08/08/2013	0
67400	08/08/2013	11424.24

67405	08/08/2013	11424.24
67412	08/08/2013	12693.6
67413	08/08/2013	12693.6
67415	08/08/2013	1269.36
67420	08/08/2013	12693.6
67430	08/08/2013	12693.6
67440	08/08/2013	12693.6
67450	08/08/2013	12693.6
67550	08/08/2013	11424.24
67560	08/08/2013	10154.88
67715	08/08/2013	1057.8
67808	08/08/2013	6346.8
67830	08/08/2013	740.46
67835	08/08/2013	6346.8
67880	08/08/2013	5077.44
67882	08/08/2013	6346.8
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67902	08/08/2013	11424.24
67903	08/08/2013	8885.52
67904	08/08/2013	8885.52
67906	08/08/2013	11424.24
67908	08/08/2013	10154.88
67909	08/08/2013	10154.88
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67914	08/08/2013	7616.16
67916	08/08/2013	8885.52
67917	08/08/2013	10154.88
67921	08/08/2013	7616.16
67923	08/08/2013	8885.52
67924	08/08/2013	10154.88
67935	08/08/2013	7616.16
67950	08/08/2013	10154.88
67961	08/08/2013	10154.88
67966	08/08/2013	10154.88
67971	08/08/2013	10154.88
67973	08/08/2013	11424.24
67974	08/08/2013	12693.6
67975	08/08/2013	10154.88
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68320	08/08/2013	10154.88
68325	08/08/2013	10154.88
68326	08/08/2013	11424.24
68328	08/08/2013	11424.24
68330	08/08/2013	10154.88
68335	08/08/2013	11424.24
68340	08/08/2013	11424.24
68360	08/08/2013	10154.88

68362	08/08/2013	10154.88
68500	08/08/2013	8885.52
68505	08/08/2013	8885.52
68510	08/08/2013	1057.8
68520	08/08/2013	8885.52
68525	08/08/2013	1057.8
68540	08/08/2013	8885.52
68550	08/08/2013	10154.88
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68750	08/08/2013	11424.24
68770	08/08/2013	6346.8
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68811	08/08/2013	7616.16
68815	08/08/2013	7616.16
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69005	08/08/2013	9162.54
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69105	08/08/2013	1145.32
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69120	08/08/2013	10995.05
69140	08/08/2013	10995.05
69145	08/08/2013	10995.05
69150	08/08/2013	16492.57
69155	08/08/2013	21990.1
69200	01/01/2013	1472.23
69205	08/08/2013	7125.7
69209	01/01/2013	452.45
69210	08/08/2013	2584.51
69220	01/01/2021	488
69222	08/08/2013	7330.03
69300	08/08/2013	10688.54
69310	08/08/2013	16032.82
69320	08/08/2013	21377.09
69399	08/08/2013	7330.03
69420	08/08/2013	1870.69
69421	08/08/2013	7535.42
69424	08/08/2013	1609.77
69433	08/08/2013	6108.36
69436	08/08/2013	7482.74
69440	08/08/2013	14251.39
69450	08/08/2013	7125.7
69501	08/08/2013	21377.09
69502	08/08/2013	21377.09
69505	08/08/2013	21377.09
69511	08/08/2013	21377.09
69530	08/08/2013	21377.09
69540	01/01/2013	1781.42

69550	08/08/2013	17814.24
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69601	08/08/2013	21377.09
69602	08/08/2013	21377.09
69603	08/08/2013	21377.09
69604	08/08/2013	21377.09
69605	08/08/2013	21377.09
69610	08/08/2013	3054.18
69620	08/08/2013	14660.06
69631	08/08/2013	18325.08
69632	08/08/2013	18325.08
69633	08/08/2013	18325.08
69635	08/08/2013	21990.1
69636	08/08/2013	21990.1
69637	08/08/2013	21990.1
69641	08/08/2013	21990.1
69642	08/08/2013	21990.1
69643	08/08/2013	21990.1
69644	08/08/2013	21990.1
69645	08/08/2013	21990.1
69646	08/08/2013	21990.1
69650	08/08/2013	21990.1
69660	08/08/2013	18325.08
69661	08/08/2013	20157.59
69662	08/08/2013	20157.59
69666	08/08/2013	19595.66
69667	08/08/2013	17814.24
69670	08/08/2013	16032.82
69676	08/08/2013	21377.09
69700	08/08/2013	17814.24
69711	08/08/2013	21377.09
69714	08/08/2013	21377.09
69715	08/08/2013	21377.09
69717	08/08/2013	21377.09
69718	08/08/2013	21377.09
69720	08/08/2013	21377.09
69725	08/08/2013	21377.09
69740	08/08/2013	21377.09
69745	08/08/2013	21377.09
69801	08/08/2013	17814.24
69802	08/08/2013	21377.09
69805	08/08/2013	21377.09
69806	08/08/2013	21377.09
69820	08/08/2013	17814.24
69840	08/08/2013	17814.24
69905	08/08/2013	21377.09
69910	08/08/2013	21377.09
69915	08/08/2013	21377.09
69930	08/08/2013	17814.24

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72275	08/08/2013	1417.19
72285	08/08/2013	3066.27
72291	08/08/2013	2567.94
72295	08/08/2013	2980.14
75809	08/08/2013	504.56
76000	08/08/2013	885.11
76942	08/08/2013	1164.7
76998	08/08/2013	290.22
77002	08/08/2013	570.56
77003	08/08/2013	521.37
77071	08/08/2013	0
77295	08/08/2013	15866.42
86999	08/08/2013	0
92502	01/01/2013	3276.83
95926	08/08/2013	1419.87
95972	01/01/2021	448.11
97597	01/01/2013	8686.76
C1713	08/08/2013	0
C1762	08/08/2013	0
C1763	01/01/2013	0
C1767	01/01/2013	0
C1772	08/08/2013	0
C1776	08/08/2013	0
C1778	08/08/2013	0
C1788	08/08/2013	0
C1789	01/01/2013	0
C1820	08/08/2013	0
C1821	01/01/2013	0
C1889	01/01/2019	0
C1897	01/01/2013	0
C9290	01/01/2013	954
C9355	01/01/2013	0
C9357	08/08/2013	0
C9359	08/08/2013	0
C9361	08/08/2013	0
C9399	01/01/2013	0
C9749	01/01/2013	14515.6
C9757	01/01/2022	47844
G0105	08/08/2013	0
G0121	08/08/2013	0
G0260	08/08/2013	1698.75
G0289	08/08/2013	3246.8
G8907	08/08/2013	0
G8908	08/08/2013	0
G8909	08/08/2013	0
G8910	08/08/2013	0
G8911	08/08/2013	0
G8912	08/08/2013	0

G8913	08/08/2013	0
G8914	08/08/2013	0
G8915	08/08/2013	0
G8916	08/08/2013	0
G8917	08/08/2013	0
G8918	08/08/2013	0
J1040	08/08/2013	0
J2001	08/08/2013	0
J7342	08/08/2013	1700
L8600	01/01/2013	0
L8630	08/08/2013	0
L8641	08/08/2013	0
L8642	08/08/2013	0
L8658	01/01/2013	0
L8659	08/08/2013	0
L8680	08/08/2013	0
L8682	08/08/2013	0
L8699	08/08/2013	0
Q4104	01/01/2022	0
Q4107	08/08/2013	0
Q4125	01/01/2013	0
Q4128	01/01/2013	0
S0157	08/08/2013	0

ASSURANCES

Please see ATTACHMENT 11.

ATTACHMENT 25

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Cost/Sq. Ft.		DGsf		DGsf		Circ.	Mod.	Circ.	New Const. \$	Modernization \$	Total Cost
	New	Mod.	New	Circ.	New	Circ.						
Surg & Endoscopy		\$ 15.00						2,920			\$ 43,800	\$ 43,800
Recovery		\$ 5.00						1,855			\$ 9,275	\$ 9,275
contingency		\$ 1.00						4,775			\$ 4,775	\$ 4,775
		\$ 12.12									\$ 57,850	\$ 57,850

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

Summit Center for Surgery
Year 2 of Operation

Projected Cases:	1,427
Projected Operating Costs:	\$2,553,700
per case:	\$1,790
Projected Capital Costs:	\$114,300
per case:	\$81

SAFETY NET STATEMENT

Due to the nature of the proposed project, that being the establishment of an ASTC, no impact to the safety net services provided in the area are anticipated; and the project will not impact the ability of any other provider to provide or cross-subsidize safety net services. As noted in the ATTACHMENT addressing unnecessary duplication, the physicians providing letters indicating their intent to refer patients to the proposed ASTC are currently doing a minimal number of cases (one physicians performing fifty cases per year) at area hospitals.

The ASTC will not discriminate in any fashion as to the patients that are treated in the facility.