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: O'Fallon Surgical Center
Street Address: 741 Insight Avenue
City and Zip Code: O'Fallon, Illinois 62269
County: St. Clair Health Service Area: 11 Health Planning Area:

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

Exact Legal Name: O'Fallon Surgical Center, LLC
Street Address: 5023 North Illinois Street
City and Zip Code: Fairview Heights, Illinois 62208
Name of Registered Agent: Mike Miller
Registered Agent Street Address: 5023 North Illinois Street
Registered Agent City and Zip Code: Fairview Heights, Illinois 62208
Name of Chief Executive Officer: Shakeel Ahmed, M.D.
CEO Street Address: 5023 North Illinois Street, Suite 3
CEO City and Zip Code: Fairview Heights, Illinois 62208
CEO Telephone Number: 618-239-0678

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: Kara Friedman
Title: Attorney
Company Name: Polsinelli PC
Address: 150 North Riverside Plaza, Suite 3000, Chicago, Illinois 60606
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com

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

Name: Shakeel Ahmed, M.D.
Title: Chief Executive Officer
Company Name: O'Fallon Surgical Center, LLC
Address: 5023 North Illinois Street, Fairview Heights, Illinois 62208
Telephone Number: 618-239-0678
E-mail Address: ShakeelAhmedGI@gmail.com

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: O'Fallon Surgical Center
Street Address: 741 Insight Avenue
City and Zip Code: O'Fallon, Illinois 62269
County: St. Clair Health Service Area: 11 Health Planning Area:

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

Exact Legal Name: Haris Assets, LLC
Street Address: 5023 North Illinois Street
City and Zip Code: Fairview Heights, Illinois 62208
Name of Registered Agent: Kim Brokaw
Registered Agent Street Address: 5023 North Illinois Street
Registered Agent City and Zip Code: Fairview Heights, Illinois 62208
Name of Chief Executive Officer: Shakeel Ahmed, M.D.
CEO Street Address: 5023 North Illinois Street
CEO City and Zip Code: Fairview Heights, Illinois 62208
CEO Telephone Number: 618-239-0678

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: Kara Friedman
Title: Attorney
Company Name: Polsinelli PC
Address: 150 North Riverside Plaza, Suite 3000, Chicago, Illinois 60606
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com

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

Name: Shakeel Ahmed, M.D.
Title: Chief Executive Officer
Company Name: O'Fallon Surgical Center, LLC
Address: 5023 North Illinois Street, Fairview Heights, Illinois 62208
Telephone Number: 618-239-0678
E-mail Address: ShakeelAhmedGI@gmail.com

Post Permit Contact

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

Name: Shakeel Ahmed, M.D.
Title: Chief Executive Officer
Company Name: O'Fallon Surgical Center, LLC
Address: 5023 North Illinois Street, Fairview Heights, Illinois 62208
Telephone Number: 618-239-0678
E-mail Address: ShakeelAhmedGI@gmail.com

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Haris Assets, LLC
Address of Site Owner: 5023 North Illinois Street, Fairview Heights, Illinois 62208
Street Address or Legal Description of the Site: 741 Insight Avenue, O'Fallon, Illinois 62269 **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: O'Fallon Surgical Center, LLC
Address: 5023 North Illinois Street, Fairview Heights, Illinois 62208

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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.

O'Fallon Surgical Center, LLC and Haris Assets, LLC (collectively, the "Applicants") propose to add podiatry to an existing ambulatory surgical treatment center ("ASTC") located at 741 Insight Avenue, O'Fallon, Illinois 62269 (the "Healthcare Facility").

The existing ASTC includes one operating room. There will not be any construction or other alterations associated with the project.

This project does not propose to establish a new category of service or a new health care facility as defined in the Illinois Health Facilities Planning Act (the "Planning Act"). Accordingly, this is a non-substantive project.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)	$10,000	$0	$10,000
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$10,000**	**$0**	**$10,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$10,000	$0	$10,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$10,000**	**$0**	**$10,000**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

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

Estimated start-up costs and operating deficit cost is $ _____.

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): December 31, 2023

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

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

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☐ Cancer Registry - NOT APPLICABLE
☐ APORS – NOT APPLCIABLE
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization – NOT APPLICABLE

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT- 10/2019 Edition

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

SIGNATURE

Shakeel Ahmad, M.D.
PRINTED NAME

Sole Member and Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4th day of May, 2023

Signature of Notary

Seal

LAURIE L CRAIG
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 24, 2026

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

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

SIGNATURE

Shahzad Ahmad, M.D.
PRINTED NAME

Sole Member and Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 1st day of May, 2023

Signature of Notary

Seal

LAURIE L CRAIG
Official Seal
Notary Public - State of Illinois
My Commission Expires September 7, 2026

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

*Insert the exact legal name of the applicant.

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

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

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 is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

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

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE: N/A

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: N/A

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.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

G. Non-Hospital Based Ambulatory Surgery

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

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

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X

1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VI. 1120.120 - AVAILABILITY OF FUNDS

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

___$10,000____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any

_____ _____	capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$10,000	**TOTAL FUNDS AVAILABLE**

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION IX. 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, to the extent that it is feasible for an applicant to have such knowledge.

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

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

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

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

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

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

A table in the following format must be provided as part of Attachment 37.

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

SECTION X. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

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

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

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

INDEX OF ATTACHMENTS

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for O'Fallon Surgical Center, LLC and Haris Assets, LLC. (collectively, the "Applicants") are attached at Attachment – 1.

O'Fallon Surgical Center, LLC is the licensee of the Healthcare Facility. As the site owner, Haris Assets, LLC is named as an applicant for this certificate of need ("CON") application.

File Number 0605307-6

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

O'FALLON SURGICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 08, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 2ND *day of* MAY *A.D.* 2023 .

Authentication #: 2312202824 verifiable until 05/02/2024
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

File Number 0751673-8

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

HARIS ASSETS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 31, 2019, 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* 3RD *day of* MAY *A.D.* 2023 .

Authentication #: 2312302568 verifiable until 05/03/2024
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

Attachment – 1

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

By signing the certification pages within this application, the Applicants attest that Haris Assets, LLC controls the site located at 741 Insight Avenue, O'Fallon, Illinois.

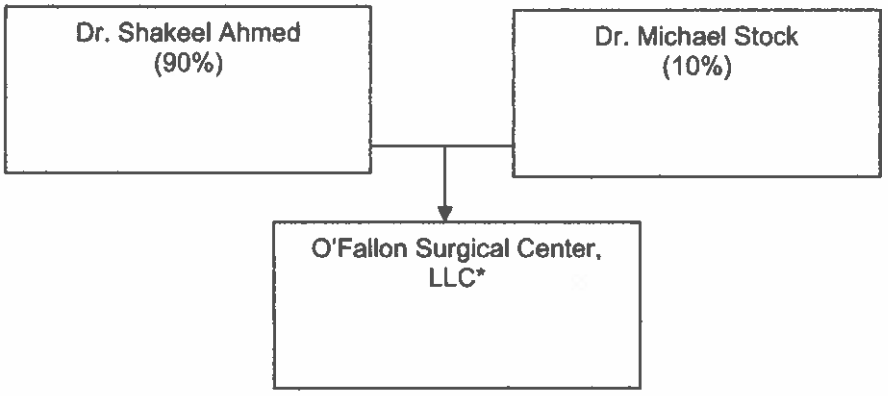
Section I, Identification, General Information, and Certification
Operating Identity/Licensee

O'Fallon Surgical Center, LLC is the licensee and operator of the Healthcare Facility. Copies of the Healthcare Facility's license and accreditation are attached at Attachment- 11.

Section I, Identification, General Information, and Certification

Organizational Relationships

The organizational chart for O'Fallon Surgical Center, LLC is below:



*O'Fallon Surgical Center, LLC is the licensed entity.

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

The proposed project is for the addition of a surgical specialty to an existing ambulatory surgical treatment center ("ASTC"). There will be no construction or modernization associated with the proposed project. Accordingly, this criterion is not applicable.

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

The proposed project is for the addition of a surgical specialty to an existing ASTC. There will be no construction or modernization associated with the proposed project. Accordingly, this criterion is not applicable.

Section I, Identification, General Information, and Certification
Project Costs and Sources of Funds

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Movable and other equipment	$10,000	$0	$10,000
Total Project Costs	**$10,000**	**$0**	**$10,000**

Active CON Permits

The Applicants do not currently have any open permits.

Cost Space Requirements

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
Operating Room	$10,000	2,200				2,200	
Recovery Room		1,160				1,160	
Total Clinical	**$10,000**	**3,360**				**3,360**	
NON CLINICAL							
Mechanical & Other Building Systems, Administrative, Other Non-Clinical Areas		915				915	
Total Non-clinical	**$0**	**915**				**915**	
TOTAL	**$10,000**	**4,275**				**4,275**	

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.110 (a), Project Purpose, Background and Alternatives

Background of the Applicant

1. O'Fallon Surgical Center, LLC owns and operates the following healthcare facility:

   O'Fallon Surgical Center, LLC
   License Number: 7003229
   Accreditation Identification Number: 643948

   Shakeel Ahmed, M.D. owns and operates the following healthcare facility:

   Metroeast Endoscopic Surgery Center
   License Number: 7003185
   Accreditation Identification Number: TJC 508160

   Proof of current licensure and Joint Commission accreditation for O'Fallon Surgical Center, LLC is attached at Attachment – 11A.

2. By signing the certification pages within this application, the Applicants attest that no adverse action has been taken against any facility owned and/or operated by the Applicants during the three years prior to filing this application.

3. By signing the certification pages within this application, the Applicants authorize the State Board and the Illinois Department of Public Health ("IDPH") to access any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations.

The Joint Commission

February 8, 2023

Shakeel Ahmed
Medical Director
O'Fallon Surgical Center LLC
741 Insight Avenue
O Fallon, IL 62269

Joint Commission ID #: 643948
Program: Ambulatory Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 1/27/2023

Dear Dr. Ahmed:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Ambulatory Health Care

This accreditation cycle is effective beginning December 3, 2022, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Deborah A. Ryan

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF127713

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
4/7/2024		7003229

Ambulatory Surgery Treatment Center

Effective: 04/08/2023

O'Fallon Surgical Center, LLC
741 Insight Ave
O'Fallon, IL 62269

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4422001 10M 3/22

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 4/7/2024

Lic Number 7003229

Date Printed 3/31/2023

O'Fallon Surgical Center, LLC

741 Insight Ave
O'Fallon, IL 62269-2193

FEE RECEIPT NO.

Attachment – 11

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.110(b), Project Purpose, Background and Alternatives

Purpose of the Project

The Applicants seek authority from the Illinois Health Facilities and Services Review Board (the "State Board") to add podiatry services to an existing surgery center. The primary purpose of this project is to improve access to this service to residents of the geographic service area and to increase utilization at O'Fallon Surgical Center ("OSC"), which currently has capacity.

The Project will address the following:

A. Patients residing in the GSA are currently leaving the state of Illinois to undergo podiatry procedures at Missouri healthcare facilities

It is well known that many Illinois residents living in the metropolitan St. Louis area travel to St. Louis to get appointments with specialists, including for podiatric surgery. In fact, of the cases identified in the physician referral letter in Appendix 1, 165 cases were Illinois residents who traveled to Missouri to undergo podiatry procedures. And this figure is just for a single podiatrist's patients. The Applicants hope to be able to serve these Illinois residents here in Illinois rather than having them leave Illinois to obtain this health care service. As a general matter, certain parts of Illinois including this area struggle to attract and retain specialists and given that this podiatrist is willing to care for Illinois patients in their resident state, the Applicants hope that the State Board agrees this service should be provided locally in a lower cost setting. While it may be reasonable to expect that patients will have to travel to bigger/more distant cities for tertiary care, minor podiatric surgery is an adjunct to basic primary care, particularly with the elderly population which has more trouble traveling distances for care and should be available very close to home.

B. Patients residing in the GSA are currently undergoing surgical procedures in the hospital setting despite the fact that the ASTC represents a more convenient, lower cost, high quality option

Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce healthcare resources. A 2019 article in Modern Healthcare noted hospital prices are the main driver of inflation in U.S. health care spending. This article highlighted that hospital consolidation has led to growth in market power and an ability to not only raise prices but to resist new, more sensible payment reforms. In fact, from 2007 to 2014, hospital prices for outpatient care increased at over 4 times the rate of physician care (25% increase for hospitals compared to 6% for physician prices). Further, according to the March 2023 MedPac Report to Congress, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments ("HOPDs").

Cases identified in the physician referral letters in Appendix 1 are associated with outpatient procedures that are currently being performed in the hospital setting. By offering additional ASTC services in O'Fallon, the Applicants will allow these patients to obtain this same high-quality care in a more convenient, lower cost setting without the risk for hospital-acquired infections, including MRSA. Doing so aligns with the preferences of patients, providers and insurance companies.

C. There is unused capacity at OSC

OSC currently has unused capacity. Accordingly, healthcare resources such as operating rooms and staff are underutilized. Adding an additional specialty would allow OSC to lower the cost of care by better utilizing its existing space and staffing resources.

1. **Document that the Project will provide health care services that improve the health care or well-being of the market area population to be served.**

   OSC is a convenient location for patients residing in O'Fallon, Shiloh and the nearby Scott Air Force base, as it is centrally located for such residents and service members and their families. Additionally, since it is not part of a hospital campus, OSC is much more easily accessible in terms of parking, wayfinding, family waiting areas and drop-off/pick-up. The addition of a surgical specialty at OSC will provide patients and payors a convenient, high quality, lower cost alternative to hospital outpatient departments for podiatry services.

2. **Define the planning area or market area, or other, per the applicant's definition.**

   OSC serves patients in Metro East Illinois within 17 miles of the ASTC. A map of the market area of OSC is attached at Attachment – 12A. The distance from OSC to the GSA borders are as follows:

   - East: 17 miles to Aviston, IL
   - Southeast: 17 miles to Engelmann, IL
   - South: 17 miles Prairie Du Long, IL
   - Southwest: 17 miles to Columbia, IL
   - West: 17 miles to St. Louis City, MO
   - Northwest: 17 miles to Madison, IL
   - North: 17 miles to Edwardsville, IL
   - Northeast: 17 miles to Highland, IL

3. **Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the Project.**

   As discussed in greater detail above, the Project would allow GSA residents to obtain podiatric care in an in-state ASTC as opposed to the higher cost, less convenient hospital setting or a Missouri surgery center. The Project would also lower the cost of care by increasing use of underutilized resources at OSC. Accordingly, the applicant seeks to provide a high-quality, lower cost option to area residents.

   Access to ambulatory surgical care is essential to the overall well-being of the community, particularly in light of the aging population and the co-morbidities associated with that shifting age cohort. As set forth in a letter from the ASC Advocacy Committee to Secretary Sebelius regarding implementation of a value-based purchasing system for ASTCs, ASTCs are efficient providers of surgical services. ASTCs provide high quality surgical care, excellent outcomes and a high level of patient satisfaction at lower cost than HOPDs. Surgical procedures performed in an ASTC are reimbursed at lower rates than HOPDs and result in lower out-of-pocket expenses to patients. In fact, based on United Healthcare's desire to cover certain procedures only in the ASTC setting, the payor has announced prior authorization guidelines in O'Fallon for certain surgical procedures in outpatient hospital settings that will not apply to ASTCs. OSC expects other payors to follow suit in the near future.

   Furthermore, during the COVID-19 pandemic, the Ambulatory Surgery Center Association urged ASTCs to coordinate with local hospitals and health systems to perform elective urgent surgeries. As hospitals struggled to ensure sufficient capacity, ASCs were able to serve as an alternative setting to provide surgical care for patients who would suffer from a delay. Going forward, it will continue to be important to have a non-hospital option for patients who are at high risk for severe COVID-19 illness, such as older adults or those with co-morbidities.

4. **Cite the sources of the information provided as documentation.**

Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (Mar. 15, 2023) *available at available at* https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf (last visited May 3, 2023).

Alex Kacik, *Hospital Price Growth Driving Healthcare Spending*, MODERN HEALTHCARE, Feb. 4, 2019 *available at* https://www.modernhealthcare.com/article/20190204/NEWS/190209984/ hospital-price-growth-driving-healthcare-spending (last visited May 3, 2023).

Letter from ASC Advocacy Committee to Secretary Sebelius available at http://wasca.net/wp-content/uploads/2010/10/Final-ASCAC-ASCA-VBP-letter-to-Sebelius.pdf (last visited May 3, 2023).

United Healthcare's prior authorization requirements for HOPDs available at https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/pa-requirements/commercial/UHC-Commercial-Advance-Notification-Prior-Authorization-Requirements-1-1-2022.pdf (last visited May 3, 2023).

5. **Detail how the Project will address or improve the previously referenced issues as well as the population's health status and well-being.**

   As discussed in greater detail above, by offering an additional surgical specialty, OSC can better meet the needs of patients residing in the MetroEast St. Louis Region of Illinois. Since the ASTC is the lowest cost and most convenient setting for these procedures, the addition of podiatry will increase access to high quality health services for patients residing in OSC's service area.

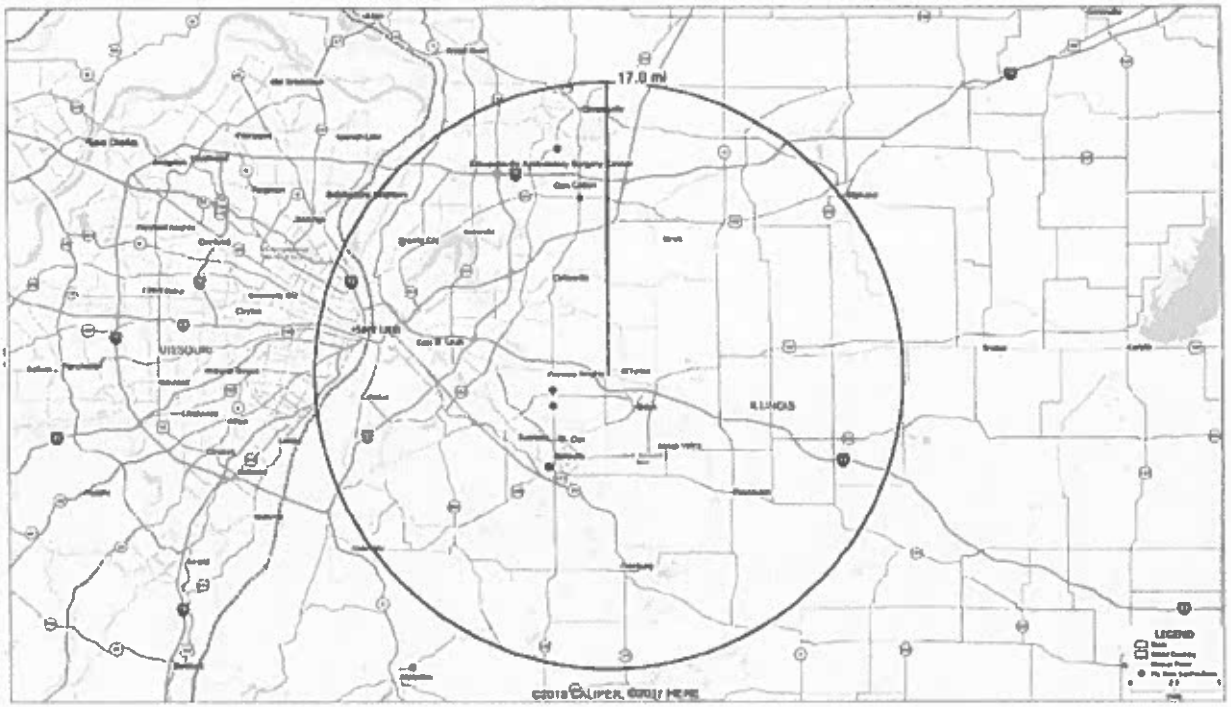
6. **Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.**

   The Applicants' prevailing objectives are to enhance access to ambulatory surgical care for patients and to improve the cost of these services. Specifically, the goals of the Project are:

   - To meet the demand for lower cost ambulatory surgery services in the defined service area.
   - To increase utilization of OSC.

   These goals can be achieved at the time of project completion.

OSC 17-mile Geographic Service Area



Attachment – 12

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.110(d), Project Purpose, Background and Alternatives

Alternatives

The Applicants explored several options prior to deciding to add podiatry to their ASTC. The options considered are as follows:

a. Do nothing;

b. Utilize existing facilities;

c. Add podiatry procedures to the existing ASTC.

After exploring these options, which are discussed in more detail below, the Applicants decided to add podiatry procedures to their ASTC. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

The first alternative considered was to maintain the status quo, whereby the Applicants would continue to perform only gastroenterology, ophthalmology and pain management procedures at OSC. The primary purpose of this project is to improve access to podiatry services to medically underserved residents within the OSC's geographic service area (GSA) and to increase utilization at OSC, which currently has capacity. This alternative would not address these goals, as it would require patients to continue undergoing procedures in Missouri and in the hospital setting. It would not improve access to high-quality, lower cost ASTC care as described throughout this application. Furthermore, doing nothing would not increase utilization at OSC. For these reasons, this alternative was rejected.

Utilize Other Health Care Facilities (Undetermined Cost)

Another alternative the Applicants considered was utilizing existing healthcare facilities to provide an option for podiatric surgery. However, this was not a viable alternative. As previously stated, the projected cases within the physician referral letter in Attachment- 1 are currently being performed in St. Louis, Missouri. OSC is a more convenient destination for these Illinois patients, as it is centrally located near their residences and multiple public transportation options. The addition of a surgical specialty at OSC will provide patients and payors a convenient, high quality, lower cost alternative to Missouri healthcare facilities for podiatry services.

Due to the underutilization of the surgery center and infeasibility of utilizing other providers, this alternative was rejected.

Add Podiatry Procedures to the Existing ASTC ($10,000)

As more fully discussed above, OSC has capacity to add more procedures. To increase utilization at the surgery center while at the same time increasing access to podiatry services in a lower cost setting, OSC decided to request the addition of this surgical specialty to its existing ASTC. After weighing this low cost option against others, it was determined that this alternative would provide the greatest benefit in terms of increased utilization and increased access to healthcare services.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120 – Size of the Project

The Applicants propose to add podiatry services to an existing ASTC. Pursuant to Section 1110, Appendix B of the State Board's rules, the State standard is 2,075 – 2,750 gross square feet per operating room. The total gross square footage of the clinical space of O'Fallon Surgical Center, LLC ("OSC") is 2,200 gross square feet. Accordingly, OSC meets the State standard per operating room.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	2,200	2,075 – 2,750	N/A	Within State Standard

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

The ASTC's annual utilization shall improve to be closer to the State Board's utilization standard. Importantly, O'Fallon Surgical Center ("OSC") is not adding capacity to the planning area, but is trying to increase utilization of its existing surgery center to be closer to the State Board standard by adding cases. OSC performed 1,676 procedures (or 699 surgical hours) in 2022. As documented in the physician referral letter attached at Appendix – 1, Dr. Brown anticipates referring 165 podiatry cases to OSC within the first year after project completion. Based upon the state average for podiatry surgery hours per case, additional estimated surgical hours, including prep and cleanup, in the first year after project completion are as follows:

Surgical Specialty	Projected Referrals	Estimated Surgical Time	Estimated Total Surgical Hours After First Year Project Completion
Podiatry	165	1.83	302

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(d) Unfinished or Shell Space

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(e) Assurances

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(2)(B), Service to GSA Residents

a. Attached at Attachment – 24A is a map outlining the intended GSA for OSC. As set forth in Criterion 1110.110(b), the surgery center serves patients residing in and around O'Fallon. Accordingly, the intended primary GSA consists of those areas within a 17-mile radius of OSC.

b. Pursuant to Section 1100.510(d) of the State Board's rules, the normal travel radius should be based upon the location of the applicant facility. OSC is located in O'Fallon, and therefore the intended GSA is the radius of 17 miles from OSC. A list of all zip codes located, in whole or in part, within a 17-mile radius of OSC as well as the 2018 U.S. Census estimates for each zip code is provided in Table 1110.235(c)(2)(B)(i).

Table 1110.235(c)(2)(B)(i)
Population within Geographic Service Area

Zip Code	City	Population
62239	Dupo	4,715
62260	Millstadt	7,405
62223	Belleville	16,309
62243	Freeburg	5,795
62220	Belleville	18,302
62285	Smithton	4,436
62206	East St. Louis	15,121
62201	East St. Louis	7,570
62090	Venice	1,293
62059	Lovejoy	452
62205	East St. Louis	8,007
62204	East St. Louis	7,954
62207	East St. Louis	8,913
62203	East St. Louis	8,264
62232	Caseyville	6,705
62060	Madison	4,586
62040	Granite City	42,447
62208	Fairview Heights	16,516
62226	Belleville	28,666
62269	O'Fallon	32,029
62034	Glen Carbon	13,667
62062	Maryville	8,008
62234	Collinsville	32,426
62221	Belleville	29,949
62225	Scott Air Force Base	5,128
62258	Mascoutah	9,253
62266	New Memphis	87

Table 1110.235(c)(2)(B)(i) Population within Geographic Service Area		
Zip Code	City	Population
62254	Lebannon	6,292
62294	Troy	14,117
62281	Saint Jacob	2,712
62289	Summerfield	351
62293	Trenton	4,427
62265	New Baden	4,391
62061	Marine	1,671
62025	Edwardsville	34,313
Total		**412,277**

United States Census Bureau, 2018: ACS 5-Year Estimates Data Profiles *available at* https://data.census.gov/cedsci/table?t=Populations%20and%20People&tid=ACSST1Y2019.S0101&hidePreview=false (last visited Oct. 7, 2020).

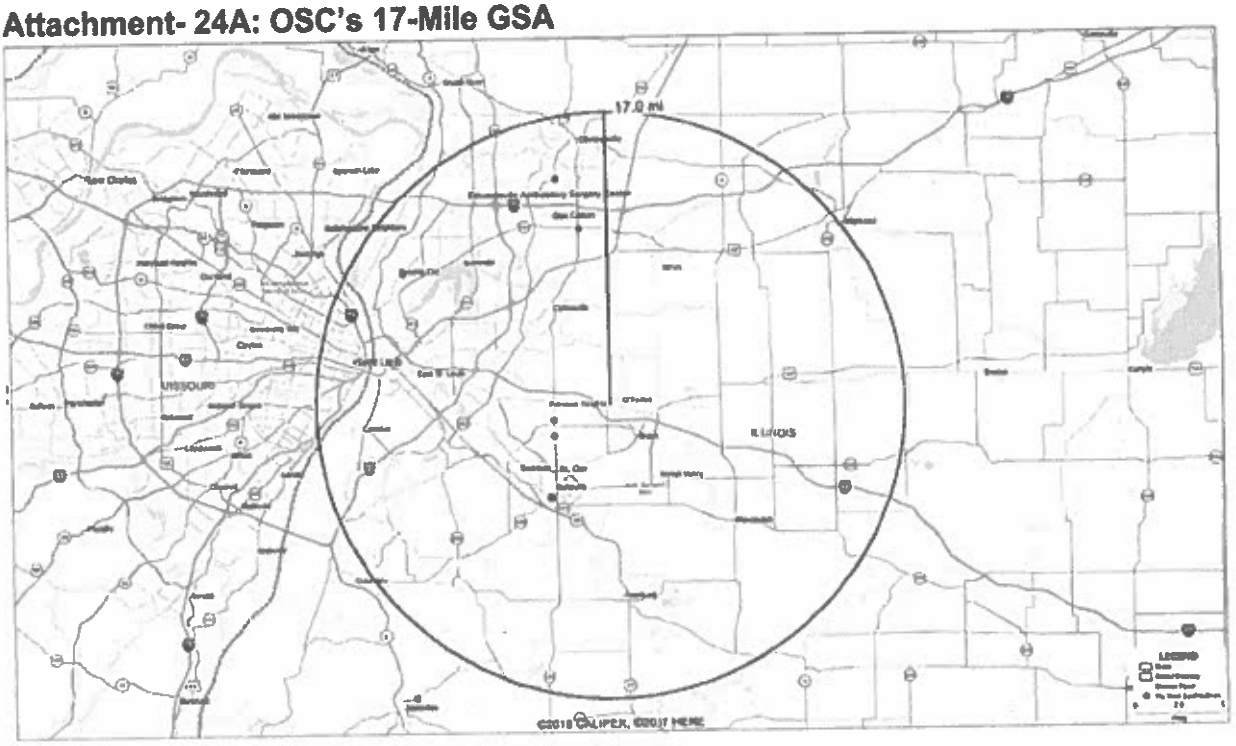
c. Pursuant to Section 1100.510(d) of the State Board's rules, the intended geographic service area shall be a 17-mile radius time from the proposed ASTC. As set forth throughout this application, OSC serves O'Fallon and the surrounding areas within a 17-mile radius of the surgery center. The distance from OSC to the GSA borders are as follows:

- East: 17 miles to Aviston, IL
- Southeast: 17 miles to Engelmann, IL
- South: 17 miles Prairie Du Long, IL
- Southwest: 17 miles to Columbia, IL
- West: 17 miles to St. Louis City, MO
- Northwest: 17 miles to Madison, IL
- North: 17 miles to Edwardsville, IL
- Northeast: 17 miles to Highland, IL

d. Patient origin information by zip code for Dr. Brown's projected surgical cases based on historical cases for the last 12- month period is provided in Table 1110.235(c)(2)(B)(ii) below. As documented in the referral letters, 100% of projected patients reside within the OSC GSA.

Table 1110.235(c)(2)(B)(ii) Patient Origin by Zip Code		
Zip Code	City	Patients
62226	Belleville	42
62221	Belleville	29
62207	East St Louis	35
62201	Fairmont City	35
62223	Belleville	14
62208	Fairview Heights/O'Fallon	10
Total		**165**

Attachment- 24A: OSC's 17-Mile GSA



Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(3) – Service Demand-Additional ASTC Service

The physician referral letter providing the number of patients referred to healthcare facilities within the past 12 months and the projected number of referrals to the surgery center is attached at Appendix - 1. A summary of the physician referral letter is provided in Table 1110.235(c)(3) below.

Table 1110.235(c)(3)		
Hospital/ASTC	**Cases Performed in the Last 12 Months**	**Anticipated Referrals to OSC**
South City Hospital St. Louis, MO	750	165
Total	**750**	**165**

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(5) Treatment Room Need Assessment

a. Pursuant to Section 1100.640(c) of the State Board's rules, ambulatory surgical treatment centers should operate 1,500 hours per room per year (including setup and cleanup time). OSC currently has one operating room with a capacity for 1,500 hours per year. In 2022, 1,676 surgical procedures (or 699 surgical hours) were performed at OSC. Based on Dr. Brown's referral letter, OSC projects that 165 additional cases (or 302 surgical hours) will be referred to OSC.

b. OSC estimates the average length of time will be 1.83 hours per podiatry procedure (including prep and cleanup).[1]

[1] Average surgical times from 2020 Illinois Ambulatory Surgical Treatment Center State Summary *available at* https://hfsrb.illinois.gov/inventoriesdata/facilityprofiles.html (last visited May 3, 2023).

V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(6), Service Accessibility

The applicants seek to add podiatry services at an existing ASTC to improve access to surgical services for medically underserved residents within OSC's geographic service area and to increase utilization at OSC, which currently has capacity. As discussed throughout this application, patients are currently undergoing podiatry procedures in Missouri and in the hospital setting. In fact, of the cases identified in the physician referral letter in Appendix 1, 165 cases were Illinois residents who traveled to Missouri hospitals to undergo podiatry procedures. The Applicants hope to be able to serve these Illinois residents in their communities rather than having them travel outside of Illinois to obtain healthcare.

Offering another ASTC option for patients within the GSA to obtain podiatry services is important for a number of reasons. Not only are hospital outpatient departments (HOPDs) more costly, less efficient, and less convenient than ASTCs, they also carry an increased risk of patients being exposed to hospital-acquired infections. By offering podiatry, OSC will allow physicians to schedule their surgeries to maximize efficiency. Furthermore, ASTCs provide high quality surgical care, excellent outcomes, and high level of patient satisfaction at a lower cost than HOPDs. Surgical procedures performed in an ASTC are reimbursed at lower rates than HOPDs and result in lower out-of-pocket expenses for patients. Additionally, patients often report an enhanced experience at ASTCs compared to HOPDs due, in part, to easier access to parking, shorter waiting times, and ease of access into and out of the operating rooms. Finally, surgeons are more efficient due to faster turnover of operating rooms, designated surgical times without risk of delay due to more urgent procedures, and specialized nursing staff. As a result of these efficiencies, more time can be spent with patients thereby improving the quality of care.

Through OSC, patients residing in the Metro East Illinois area have access to surgical procedures that would cost 3 to 4 times more in local hospitals. Accordingly, it is imperative that OSC provides an additional surgical specialty to extend access to a larger and growing population. Based on the above, this project will improve access to care for residents of the geographic service area.

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(7), Unnecessary Duplication/Maldistribution

1. **Unnecessary Duplication of Services**

a. OSC will remain in its current location at 741 Insight Avenue, O'Fallon, Illinois. A map of OSC's market area is attached at Attachment – 24A. A list of all zip codes located, in whole or in part, within a 17-mile radius of OSC as well as the 2018 U.S. Census estimates figures for each zip code is provided in Table 1110.235(c)(7)(A).

Table 1110.235(c)(7)(A)(I)
Population within Geographic Service Area

Zip Code	City	Population
62239	Dupo	4,715
62260	Millstadt	7,405
62223	Belleville	16,309
62243	Freeburg	5,795
62220	Belleville	18,302
62285	Smithton	4,436
62206	East St. Louis	15,121
62201	East St. Louis	7,570
62090	Venice	1,293
62059	Lovejoy	452
62205	East St. Louis	8,007
62204	East St. Louis	7,954
62207	East St. Louis	8,913
62203	East St. Louis	8,264
62232	Caseyville	6,705
62060	Madison	4,586
62040	Granite City	42,447
62208	Fairview Heights	16,516
62226	Belleville	28,666
62269	O'Fallon	32,029
62034	Glen Carbon	13,667
62062	Maryville	8,008
62234	Collinsville	32,426
62221	Belleville	29,949
62225	Scott Air Force Base	5,128
62258	Mascoutah	9,253
62266	New Memphis	87
62254	Lebannon	6,292
62294	Troy	14,117
62281	Saint Jacob	2,712

Table 1110.235(c)(7)(A)(i) Population within Geographic Service Area		
Zip Code	City	Population
62289	Summerfield	351
62293	Trenton	4,427
62265	New Baden	4,391
62061	Marine	1,671
62025	Edwardsville	34,313
Total		**412,277**

United States Census Bureau, 2018: ACS 5-Year Estimates Data Profiles *available at* https://data.census.gov/cedsci/table?t=Populations%20and%20People&tid=ACSST1Y2019.S0101&hidePreview=false (last visited Oct. 7, 2020)

b. A list of all hospitals and surgery centers located within the OSC geographic service area that offer podiatry are identified in the table below.

Facility	Address	City	Type	Driving Distance (Miles)
HSHS St Elizabeth's Hospital	1 Saint Elizabeth Blvd	O'Fallon	Hospital	0.8
Memorial Hospital East	1404 Cross St.	Shiloh	Hospital	2.0
Metroeast Endoscopic Surgery Center	5023 N Illinois St	Fairview Heights	ASTC	4.5
Memorial Hospital	4500 Memorial Drive	Belleville	Hospital	7.8
Touchette Regional Hospital	5900 Bond Avenue	Centreville	Hospital	13.6
Anderson Hospital	6800 State Route 162	Maryville	Hospital	14.3
Gateway Regional Medical Center	2100 Madison Ave.	Granite City	Hospital	18.6
Edwardsville Ambulatory Surg Ctr, LLC	12 Ginger Creek Parkway	Glen Carbon	ASTC	23.5

2. Maldistribution of Services

Expansion of services at OSC will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of surgical/treatment rooms characterized by such factors as, but not limited to: (1) ratio of surgical/treatment rooms to population exceeds one and one-half times the State Average; (2) historical utilization of existing surgical/treatment rooms is below the State Board's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards.

a. Ratio of operating rooms to population.

As shown in Table 110.235(c)(7)(B)(i), the ratio of population to operating/procedure rooms is 109% of the State Average.

TABLE 110.235(c)(7)(B)(ii)
Ratio of Surgical/Treatment Rooms to Population

	Population	Operating/ Procedure Rooms	Rooms to Population	Standard Met?
Geographic Service Area	412,277	94	1:4,386	YES
State	12,671,821	2,639	1:4,802	

b. Historical Utilization of Existing Health Care Facilities

Since ASTCs offer patients and payors a convenient, high quality, lower cost alternative to hospital outpatient departments for podiatric surgery, it is important that patients within the GSA have access to podiatry services in the ASTC setting. Additionally, since it is not part of a hospital campus, OSC is much more easily accessible in terms of parking, wayfinding, family waiting areas and drop-off/pick-up.

c. Sufficient Population to Provide the Necessary Volume or Caseload

OSC currently operates an ASTC with one operating room and proposes to add podiatric surgery to increase its utilization closer to the State Board's standard of 1,500 surgical hours per operating/procedure room. In 2022, 1,676 surgical procedures (or 699 surgical hours) were performed at OSC. Based on Dr. Brown's referral letter, OSC projects 165 cases (or 302 surgical hours) will be referred to OSC. Accordingly, there is sufficient population to provide the volume necessary to utilize the operating rooms proposed by the project.

3. Impact on Other Health Care Facilities

a. The Project will not have an adverse impact on existing facilities in the GSA or lower utilization of other area providers that are operating below the occupancy standards. The anticipated volumes in Attachment- 15 are all associated with a Missouri hospital. Accordingly, the Applicants do not anticipate that the Project will adversely impact Illinois facilities. It is important to expand access to podiatry within the ASTC setting, so Illinois patients can obtain care in their home state.

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(8), Staffing

OSC is staffed in accordance with all IDPH and Medicare staffing requirements.

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(9) Charge Commitment

a. A list of the procedures to be performed at OSC with the proposed charge is provided in Table 1110.235(c)(9).

Table 1110.235(c)(9)		
Primary CPT	Name of Procedure	Max Charge
10061	Abcess drainage	$4,195
11422	Benign Lesion removal	$4,561
11423	Benign Lesion removal	$6,485
11730	Full or Partial Nail Plate Removal	$4,516
11732	Add on to nail plate removal	$4,106
11750	Full or Partial Nail Plate Removal	$4,516
27612	Achilles lengthening	$18,363
27650	Achilles repair	$18,363
27658	peroneal or post tibial transfer/ repair	$18,363
28035	tarsal tunnel release	$11,420
28119	Heel spur sx with exostectomy and fascial release/excision	$18,363
28240	fusion, tendon lengthening transfer	$18,363
28288	Tendon transfer exostectomy	$18,363
28296	bunionectomy w osteotomy or multiple osteotomy	$18,363
28505	open reduction internal fracture fixation, great toe	$18,363
28525	Open reduction internal fracture fixation, phalanx or phalanges other than great toe	$18,363
28899	Digital arthroplasty fusion	$5,500
28899	Arthroscopic procedures	$5,500
88307	Ankle pathology	$5,500
28296	Metatarsal osteotomy with bunionectomy	$18,363

Table 1110.235(c)(9) above is a non-exhaustive list of the procedures by primary CPT code that will be typically performed within the new specialty. Each line shows anticipated maximum charges for two years for a surgical case with the primary CPT code shown.

b. A letter from Dr. Shakeel Ahmed, Manager, O'Fallon Surgical Center, committing to maintain the charges listed in Table 1110.235(c)(9) is attached below.

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

RE: Non-Hospital Based Ambulatory Surgical Treatment Center Assurances

Dear Chair Savage:

- The charge schedule submitted as part of this certificate of need application will not be increased, at a minimum, for the first two years of operation unless a permit is first obtained pursuant to 77 Ill. Admin. Code § 1130.310(a).
- O'Fallon Surgical Center will continue its existing peer review program that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for surgical services. If outcomes do not meet or exceed those standards, a quality improvement plan will be initiated.
- By the second year of operation after the project completion date, the annual utilization of the surgical/treatment rooms at O'Fallon Surgical Center will meet or exceed the utilization standard specified in 77 Ill. Admin. Code 1100.

Sincerely,

Shakeel Ahmed, MD
President

Notarization:

Subscribed and sworn to before
me this 9th day of May, 2023

Signature of Notary
seal

LAURIE L CRAIG
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 26, 2026

Section V, Service Specific Review Criteria
Non-Hospital Based Ambulatory Surgery
Criterion 1110.235(c)(10), Assurances

A letter from Dr. Shakeel Ahmed, Manager, O'Fallon Surgical Center, attesting that a peer review program exists at O'Fallon Surgical Center is attached above.

Section VI, Availability of Funds
Criterion 1120.120

The Project will be funded through cash on hand. To support the fact that there are sufficient funds to cover the cost of the proposed project, the Applicants provide the letter below noting the sufficiency of cash available for the Project.

BUCKINGHAM
STRATEGIC WEALTH

8182 Maryland Ave.
Suite 500
St. Louis, MO 63105

800.711.2027
314.725.0455

May 9, 2023

To Whom It May Concern:

My name is Aaron Vickar and I serve as the Wealth Advisor for Dr. Shakeel Ahmed. I can confirm that he has well in excess of $10,000 available that has not been earmarked for another project and can be accessed, in cash, within 24 hours.

If you have any questions, please let me know.

Thank you.

Aaron Vickar

Aaron Vickar
Wealth Advisor
BUCKINGHAM STRATEGIC WEALTH
avickar@bamadvisor.com | 314.743.2241 (direct) | 800.711.2027, ext. 241
8182 Mayland Ave. Suite 500, St. Louis, MO 63105

Section VII, 1120.130 Financial Viability
Financial Viability Waiver

The project will be funded through internal resources (cash on hand) and qualifies for the financial viability waiver.

VIII, Economic Feasibility Review Criteria
Criterion 1120.140(A), Reasonableness of Financing Arrangements

By signing the certification pages within this application, the Applicants attest that the total estimated project costs will be funded entirely with cash.

Section VIII, Economic Feasibility Review Criteria
Criterion 1120.140(B), Conditions of Debt Financing

No debt will be necessary to fund the addition of a surgical specialty. Accordingly, this criterion is not applicable.

Section VIII, Economic Feasibility Review Criteria
Criterion 1120.140C, Reasonableness of Project and Related Costs

1. This project will not include any construction. Accordingly, this criterion is not applicable.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below) CLINICAL	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)	
CLINICAL									
Contingency									
TOTAL CLINICAL									
NON-CLINICAL									
Admin									
Contingency									
TOTAL NON-CLINICAL									
TOTAL									
* Include the percentage (%) of space for circulation									

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	**State Standard**	**Above/Below State Standard**
Movable or Other Equipment (Not in Construction Contracts)	$10,000	$551,212 per room	Below State Standard

Section VIII, Economic Feasibility Review Criteria
Criterion 1120.140D, Projected Operating Costs

Operating Expenses:	$57,750
Procedures:	165 procedures
Operating Expense per Procedure:	$350 per procedure

Section VIII, Economic Feasibility Review Criteria
Criterion 1120.140E, Total Effect of Project on Capital Costs

Capital Costs:	$10,000
Procedures:	165 procedures
Capital Costs per Procedure:	$60.61 per procedure

Section IX, Safety Net Impact Statement

The proposed project is non-substantive as it involves the addition of podiatry procedures to an existing ASTC. Accordingly, this criterion is not applicable.

Section X, Charity Care Information

The table below provides charity care information for the most recent three years for O'Fallon Surgical Center, LLC.

CHARITY CARE			
	2020	**2021**	**2022**
Net Patient Revenue	**$104,373**	**$755,813**	**$1,993,695**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

Appendix I – Physician Referral Letter

Attached as Appendix - 1 is a referral letter from Dr. Willie Brown projecting that 165 patients will be referred to OSC within 12 to 24 months of project completion.

John Kniery, Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Kniery:

I am a podiatrist. I am writing in support of the addition of podiatry to O'Fallon Surgical Center. Changes in clinical practice and health care technology have expanded the provision of procedures in ambulatory surgery centers. Further, with increased focused on value-based care, ambulatory surgery centers provide a lower cost alternative to traditional hospital outpatient departments. The addition of podiatry at O'Fallon Surgical Center will allow my patients to receive high quality care at lower cost and with greater convenience than at a hospital outpatient department.

I anticipate referring patients to O'Fallon Surgical Center in the first year after project completion as shown in the table below. Although I currently perform surgical procedures in St. Louis, Missouri, I plan to provide outpatient surgeries to my Illinois patients at O'Fallon Surgical Center upon approval of the pending application to add podiatry. Projected case volume will come from the geographic service area of O'Fallon Surgical Center. Over the past twelve months, I have performed a total of 750 procedures. Patient origin by zip code of residence for patient referrals over the past year is provided in Attachment A.

Name and Location of Licensed Facility	Cases	Projected Referrals to O'Fallon Surgical Center (Cases)
South City Hospital St. Louis, MO	750	165
Total	**750**	**165**

These patient referrals have not been used to support another pending or approved CON application.

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

I support the proposed addition of podiatry at O'Fallon Surgical Center.

Sincerely,

Willie Brown, DPM
3700 N. Belt W
Belleville, IL 62226
Specialty: Podiatry

Subscribed and sworn to me
This 3rd day of May, 2023

Notary Public

LAURIE L CRAIG
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 26, 2026

Attachment A
Historical Illinois Procedures by Zip Code

Zip Code	Patients
62226	42
62221	29
62207	35
62201	35
62223	14
62208	10
Total	165