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HEALTH FACILITIES & SERVICES REVIEW BOARD

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: Willow Springs Surgery Center
Street Address: 9050 West 81st Street
City and Zip Code: Justice 60458
County: Cook Health Service Area: 007 Health Planning Area: 031

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

Exact Legal Name: Willow Springs Surgery Center, Ltd.
Street Address: 9050 West 81st Street
City and Zip Code: Justice 60458
Name of Registered Agent: Illinois Corporation Service Company
Registered Agent Street Address: 801 Adlai Stevenson Drive
Registered Agent City and Zip Code: Springfield 62703
Name of President: Arthur Morris, M.D.
President Street Address: 120 West 22nd Street
President City and Zip Code: Oak Brook, 60523
President Telephone Number: (630) 573-5000

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Juan Morado, Jr. and Mark J. Silberman
Title: Partner
Company Name: Benesch, Friedlander, Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4952 & (312) 212-4967
E-mail Address: JMorado@beneschlaw.com MSilberman@beneschlaw.com
Fax Number: (312) 767-9192

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

Facility Name: Willow Springs Surgery Center		
Street Address: 9050 West 81st Street		
City and Zip Code: Justice 60458		
County: Cook	Health Service Area: 007	Health Planning Area: 031

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

Exact Legal Name: Nephrology Associates of Northern Illinois, Ltd.
Street Address: 120 West 22nd Street
City and Zip Code: Oak Brook 60523
Name of Registered Agent: Brian J. O'Dea
Registered Agent Street Address: 120 West 22nd Street
Registered Agent City and Zip Code: Oak Brook 60523
Name of Chief Executive Officer: Brian J. O'Dea
CEO Street Address: 120 West 22nd Street
CEO City and Zip Code: Oak Brook 60523
CEO Telephone Number: (630) 573-5000

Type of Ownership of Applicants

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

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E-mail Address: JMorado@beneschlaw.com MSilberman@beneschlaw.com
Fax Number: (312) 767-9192

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: William Brennan
Title: Special Projects
Company Name: Nephrology Associates of Northern Illinois, Ltd.
Address: 120 West 22nd Street, Oak Brook, IL 60523
Telephone Number: (630) 974-5233
E-mail Address: bbrennan@nephdocs.com

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: 9050 LLC
Address of Site Owner: P.O. Box 658, Lockport, IL 60441
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee [Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Willow Springs Center, Ltd. d/b/a Willow Springs Surgery Center

Address: 9050 West 81st Street Justice, IL 60458

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements
[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org. This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**. **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

Historic Resources Preservation Act Requirements [Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Willow Springs Surgery Center, Ltd. ("Willow Springs"), an ambulatory surgical treatment center ("ASTC") seeks to discontinue its facility at 9050 West 81st Street in Justice, Illinois 60458. Willow Springs is a multi-specialty ASTC with two (2) operating rooms.

The discontinuation of the facility is being proposed as part of the relocation of Willow Springs Surgery Center. The Applicant has filed an application for the relocated facility as Project #24-005. If approved, the new facility would operate as NANI Vascular South ASC.

The project is classified as substantive, in that it involves a discontinuation of a health care facility. 77 Ill. Admin. Code Sec. 1110.20(c)(1)(B)(ii).

There are no costs associated with the discontinuation.

Project Costs and Sources of Funds – NOT APPLICABLE

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)			
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			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
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: $ N/A

Fair Market Value: $ N/A

The project involves the establishment of a new facility or a new category of service

☐ Yes ☒ No

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

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

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): July 1, 2026 or upon licensure of NANI Vascular South ASC

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): **NOT APPLICABLE**

☐ 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)] – **NOT APPLICABLE**

Are the following submittals up to date as applicable?

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements – NOT APPLICABLE

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

		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

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: Willow Springs Surgery Center, Ltd.		**CITY: Justice**			
REPORTING PERIOD DATES:		**From: January 1, 2022**		**to: December 31, 2022**	
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 (operating rooms)	2	747	N/A	-2	0
TOTALS:	2	747	N/A	-2	0

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 Willow Springs Surgery Center Ltd., and Nephrology Associates of Northern Illinois LTD. 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

Manish Tanna M.D.
PRINTED NAME

Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 17 day of January, 2024

Signature of Notary

Seal

Official Seal
Victoria Bryant
Notary Public State of Illinois
My Commission Expires 12/29/2026

SIGNATURE

Arthur Morris, M.D.
PRINTED NAME

Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11 day of January, 24

Signature of Notary

Seal

Official Seal
Victoria Bryant
Notary Public State of Illinois
My Commission Expires 12/29/2026

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this Application for Discontinuation https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm**

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the **geographic service area**.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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.

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)**

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS – NOT APPLICABLE

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]:**

_____ 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.

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.
	TOTAL FUNDS AVAILABLE

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY – NOT APPLICABLE

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY – NOT APPLICABLE

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

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 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.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**
Charity (cost in dollars)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	**$0**	**$0**	**$0**
MEDICAID			
Medicaid (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	93	144
Total	0	93	144
Medicaid (revenue)			
Inpatient	$0	$0	$0
Outpatient	$0	$43,501	$71,056
Total	$0	$43,501	$71,056

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

SECTION X. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE			
	2020	**2021**	**2022**
Net Patient Revenue	**$0**	**$0**	**$0**
Amount of Charity Care (charges)	**$0**	**$0**	**$0**
Cost of Charity Care	**$0**	**$0**	**$0**

APPEND DOCUMENTATION AS ATTACHMENT 39, 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

Attachment NO.		Pages
1	Applicant Identification including Certificate of Good Standing	22-24
2	Site Ownership	25-26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	27-28
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	n/a
6	Historic Preservation Act Requirements	n/a
7	Project and Sources of Funds Itemization	n/a
8	Financial Commitment Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	30-51
11	Background of the Applicant	52-53
12	Purpose of the Project	54
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
		n/a
	Financial and Economic Feasibility:	
33	Availability of Funds	n/a
34	Financial Waiver	n/a
35	Financial Viability	n/a
36	Economic Feasibility	n/a
37	Safety Net Impact Statement	55-56
38	Charity Care Information	57
39	Flood Plain Information	n/a

ATTACHMENT 1
Certificate of Good Standing

Included with this attachment are:

1. The Certificate of Good Standing for Willow Springs Surgery Center, Ltd. (Facility)
2. The Certificate of Good Standing for Nephrology Associates of Northern Illinois, Ltd.

ATTACHMENT 1
Certificate of Good Standing
Willow Springs Surgery Center, Ltd.

File Number 6124-611-8

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*

WILLOW SPRINGS SURGERY CENTER, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 19, 2000, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION 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* FEBRUARY *A.D.* 2024 .

Authentication #: 2403400480 verifiable until 02/03/2025
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Nephrology Associates of Northern Illinois, Ltd.

File Number 5112-723-4

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*

NEPHROLOGY ASSOCIATES OF NORTHERN ILLINOIS, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 01, 1977, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* APRIL *A.D.* 2024 .

Authentication #: 2409603360 verifiable until 04/05/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 2
Site Ownership

The current owner of the building is 9050, LLC. A copy of the property tax bill is enclosed as evidence of control over the site.

ATTACHMENT 2
Site Ownership

TOTAL PAYMENT DUE	2023 First Installment Property Tax Bill - Cook County Electronic Bill					
$0.00 By 03/01/2024	Property Index Number (PIN)	Volume	Code	Tax Year	(Payable In)	Township	Classification
	18-34-200-006-0000	084	21078	2023	(2024)	LYONS	5-97

IF PAYING LATE, PLEASE PAY	03/02/24-04/01/24 $0.00	04/02/24-05/01/24 $0.00	05/02/24-06/01/24 $0.00	LATE INTEREST IS 0.75% PER MONTH, BY STATE LAW

TAXING DISTRICT DEBT AND FINANCIAL DATA

Your Taxing Districts	Money Owed by Your Taxing Districts	Pension and Healthcare Amounts Promised by Your Taxing Districts	Amount of Pension and Healthcare Shortage	% of Pension and Healthcare Costs Taxing Districts Can Pay
Des Plaines Valley Mosq Abat Dist Lyons	$58,457	$4,319,419	-$58,457	101.35%
Metro Water Reclamation Dist of Chicago	$4,189,829,820	$3,082,008,000	$1,046,664,000	66.04%
Roberts Park Fire (Hickory Hls/Justice)	$308,376	$27,300,037	$17,892,750	34.46%
Justice Public Library Dist	$72,776	$970,947	$113,066	88.36%
Justice Park District	$520,213	$166,620	$120,932	22.29%
Moraine Valley Comm Coll 524 (Palos Hls)	$85,270,538	$17,830,139	$17,830,139	0.00%
Argo Community HS District 217 (Summit)	$59,410,223	$585,946	$0	100.00%
Indian Springs School Dist 109 (Justice)	$26,459,226	$22,558,516	-$1,501,146	106.66%
Village of Justice	$11,940,245	$30,383,957	$16,601,185	46.60%
Town of Lyons	$1,525,040	$917,055	-$228,096	124.87%
Cook County Forest Preserve District	$214,441,242	$617,834,550	$382,643,760	38.07%
County of Cook	$8,693,862,550	$27,096,852,844	$12,816,326,282	52.71%
Total	$13,262,498,704	$30,901,677,030	$14,294,403,415	

For a more in-depth look at government finances and how they affect your taxes, visit *cookcountytreasurer.com*

PAY YOUR TAXES ONLINE
Pay at cookcountytreasurer.com from your bank account or credit card.

IMPORTANT MESSAGES

TAX CALCULATOR

2022 TOTAL TAX		176,421.78
2023 ESTIMATE	X	55%
2023 1st INSTALLMENT	=	97,031.98

The First Installment amount is 55% of last year's total taxes. All exemptions, such as homeowner and senior exemptions, will be reflected on your Second Installment tax bill.

PROPERTY LOCATION	MAILING ADDRESS
9050 81ST ST JUSTICE IL 60458	9060 LLC PO BOX 658 LOCKPORT IL 604410658

**** Please see 2023 First Installment Payment Coupon next page ****

ATTACHMENT 3
Operating Entity/Licensee

Willow Springs Surgery Center, Ltd. is licensed by the Illinois Department of Public Health. The license is in Good Standing with the Illinois Department of Public Health and the corporate entity is in Good Standing with the Illinois State's Secretary of State. Enclosed as evidence is the Certificate of Good Standing for the licensed entity.

ATTACHMENT 3
Operating Entity/Licensee
Certificate of Good Standing Willow Springs Surgery Center, Ltd.

File Number **6124-611-8**

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*

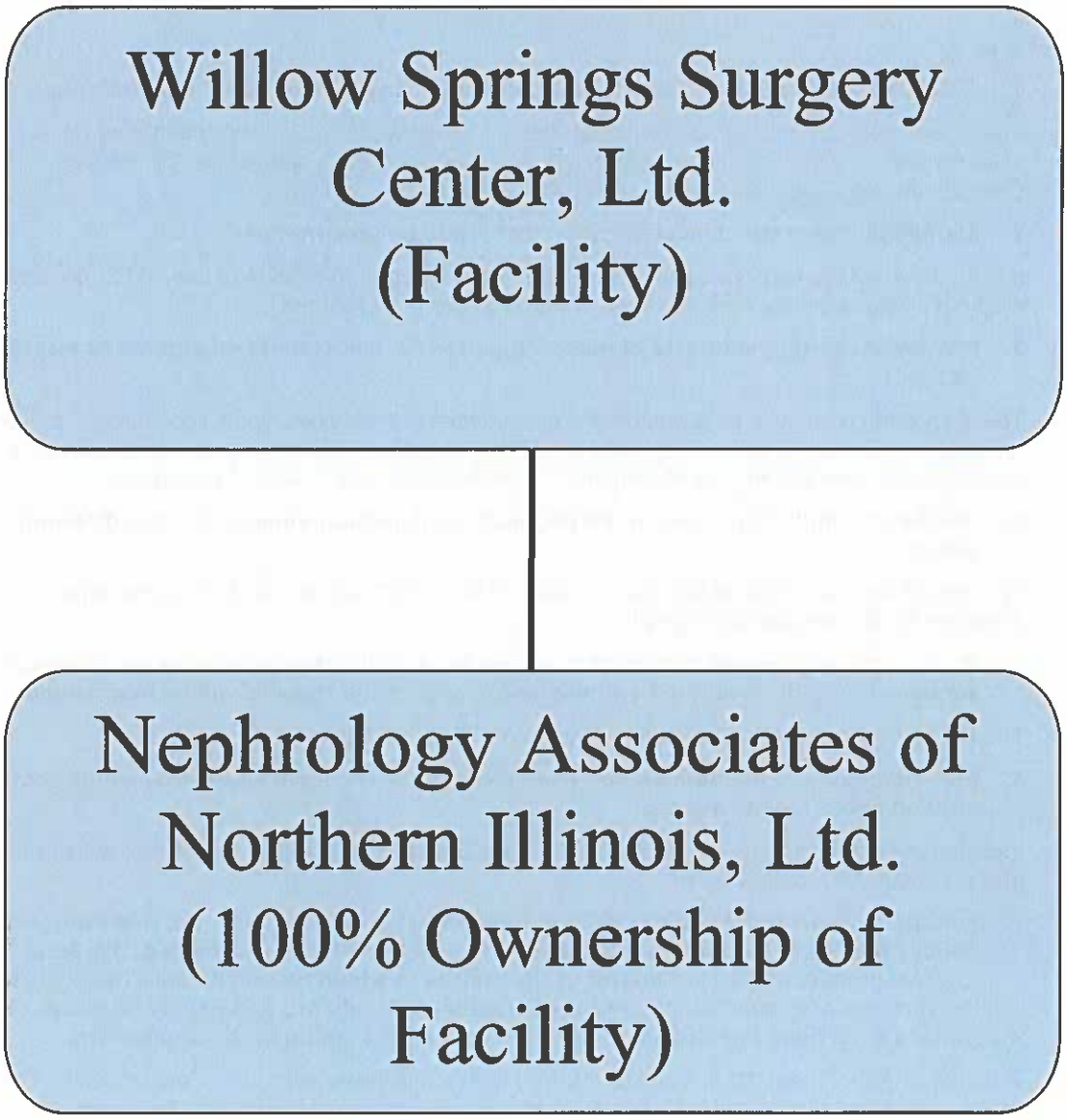
WILLOW SPRINGS SURGERY CENTER, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 19, 2000, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE 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* FEBRUARY *A.D.* 2024 .

Authentication #: 2403403480 verifiable until 02/03/2025
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 4
Organizational Chart



ATTACHMENT 10
Discontinuation

General:

1. **Categories of service and the number of beds, if any that are to be discontinued.**

There are two (2) operating rooms at the Ambulatory Surgical Treatment Center that will be discontinued. The facility is approved for the following categories of service: Podiatry, Gastroenterology, General Surgery, Pain Management, and Urology.

2. **Identify all the other clinical services that are to be discontinued.**

It is the intent of the facility to discontinue and relocate. Upon relocation of the ASTC the new facility will be a single specialty ASTC offering General Surgery procedures.

3. **Provide the anticipated date of discontinuation for each identified service or for the entire facility.**

The Applicant proposes to permanently discontinue the services upon licensure of the proposed replacement facility which will operate as NANI Vascular ASC South. If the proposed project is approved, the anticipated date of discontinuation would be July 1, 2026 if not earlier.

4. **Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.**

Following Board approval of the discontinuation, the ASTC will be repurposing the equipment for the proposed NANI Vascular ASC South.

5. **Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.**

The medical records will be maintained by the ASTC for a period of 10 years.

6. **Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.**

Included in Attachment 10 is a copy of the Notice provided to the local media that would routinely be notified about the facilities events.

7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**

Included in Attachment 10 are copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district the health care facility is located, the Director of Public Health, and the Director of Healthcare and family Services.

ATTACHMENT 10
Discontinuation

8. **For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.**

Included in Attachment 10 is a certification from the Applicant that all required data will be submitted no later than 90 days following the date of discontinuation.

ATTACHMENT 10
Discontinuation

Reasons For Discontinuation

The reasons for discontinuation are that the provision of services at the current location are not economically feasible. The reason for discontinuation of the facility is to allow for the orderly relocation within the geographic service area. The current facility is on a short-term lease and the physical site requires modernization and capital investment. The proposed discontinuation allows for the Applicant to discontinue several categories of services that the facility is approved for but is not currently offering. The relocation will also allow for the consolidation of operations of the existing facility and a nearby office-based lab also operated by the Applicant.

Impact of Access

1. **Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.**

The discontinuation will not have an adverse effect upon access of care for residents of the facility's market area. Willow Springs Surgery Center, Ltd. does not believe the discontinuation will have a negative effect on area facilities as there are other ASTC's in the GSA that offer General Surgery services and the Applicants intend to relocate the facility within the GSA.

2. **Document that a written request for an impact statement was received by all existing approved health care facilities (that provide the same services as those being discontinued) located within the geographic service area.**

Included in Attachment 10 are copies of the notification letter sent to area facilities within the geographic service area and maps indicating the distance and drive times to the facilities.

ATTACHMENT 10
Discontinuation
Media Notice

The applicants will publish the notice below in the Chicago Tribune, a local newspaper that routinely notifies the public about facility events. The notice below is schedule to be published in a single time in the classified ad section of the news paper on May 10, 2024. The Chicago Tribune has a print circulation of 106,156, and an online presence. The Chicago Tribune is a newspaper of general circulation throughout Cook County and surrounding areas, and is a newspaper as defined by 715 ILCS 5/5.

"Willow Springs Surgery Center, Ltd. has filed a Certificate of Need application with the Illinois Health Facilities and Services Review Board to discontinue its ambulatory surgical treatment center located at 9050 West 81st Street, Justice, IL 60458, in the third quarter of 2026. After submission of the application to discontinue the facility to the HFSRB, the application for the proposed discontinuation may be found on the HFSRB website at https://www2.illinois.gov/sites/hfsrb/Pages/default.aspx. If you are or have been a patient at Willow Springs Surgery Center, Ltd., and have questions about accessing your medical records, please call (708) 594-3500."

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 19, 2024

Hon. Nicole La Ha
106 Stephen Street, Suite 102B.
Lemont, Illinois 60439

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

Dear Representative La Ha:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as the operators have filed a Certificate of Need application to relocate the facility within the geographic service area and the new facility proposes to offer the same General Surgery services.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing the notice to our State Representative and State Senator in which the facility is located, the Village President of Justice, the Director of Department of Public Health and the Director of the Department of Healthcare and Family Services.

Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Hon. John Curran
1011 State St., Suite 205
Lemont, Illinois 60439

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

Dear Senator Curran:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458.

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Pursuant to the above provision of the Health Facilities Planning Act, we are providing the notice to our State Representative and State Senator in which the facility is located, the Village President of Justice, the Director of Department of Public Health and the Director of the Department of Healthcare and Family Services.

Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Hon. Krzysztof Wasowicz
7800 Archer Road
Justice, IL 60458

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

Dear Mayor Wasowicz:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458.

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Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Elizabeth Whitehorn
Director
Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, IL 62763

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

Dear Director Whitehorn:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458.

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Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Sameer Vohra, MD, JD, MA
Director
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62761

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

Dear Director Vohra:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458.

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Pursuant to the above provision of the Health Facilities Planning Act, we are providing the notice to our State Representative and State Senator in which the facility is located, the Village President of Justice, the Director of Department of Public Health and the Director of the Department of Healthcare and Family Services.

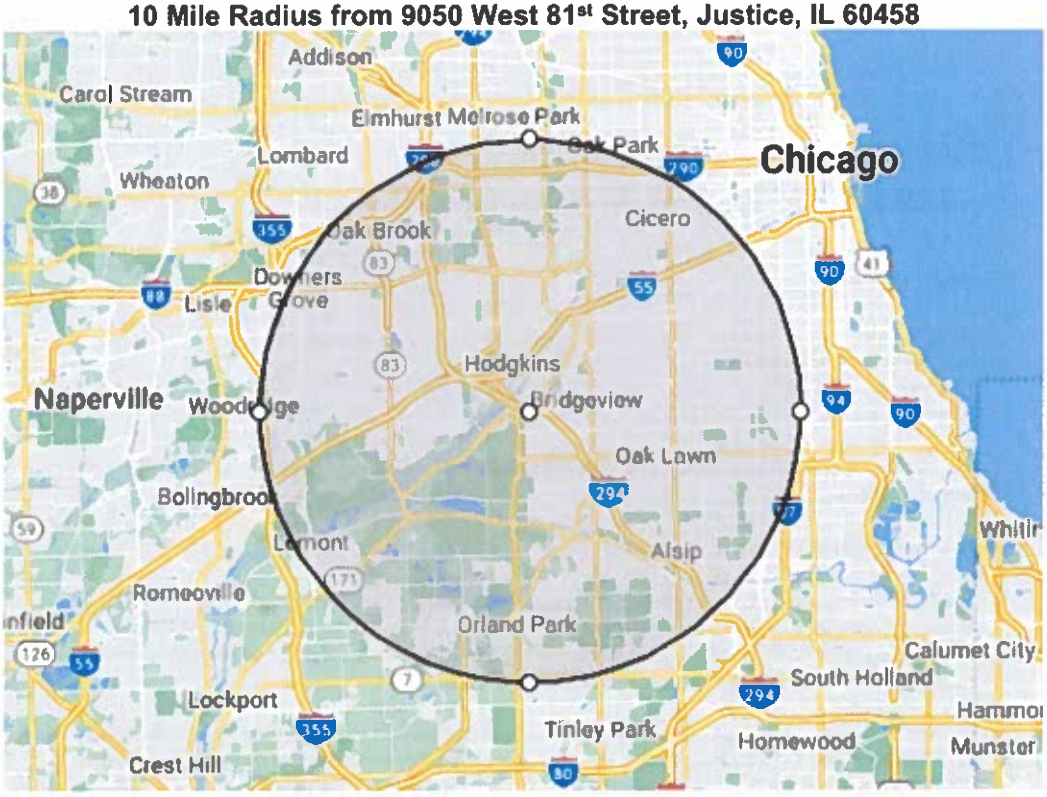
Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Area Facilities

10 Mile Radius from 9050 West 81st Street, Justice, IL 60458



Facility Name	Facility Address
Hinsdale Surgical Center	10 Salt Creek Lane, Hinsdale, IL 60521
Southwestern Medical Center, LLC	7456 S. State Road, Suite 300, Bedford Park, IL 60638
Palos Hills Surgery Center	10330 S. Roberts Road, Suite 300, Palos Hills, IL 60465
Center for Reconstructive Surgery	6311 W. 95th Street, Oak Lawn, IL 60453
Palos Surgicenter LLC	7340 W. College Drive, Palos Heights, IL 60463
Preferred Surgicenter, LLC	10 Orland Square Drive, Suite 10C, Orland Park, IL 60462

ATTACHMENT 10
Discontinuation
Notices to Nearby Facilities

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Administrator
Hinsdale Surgical Center
10 Salt Creek Lane
Hinsdale, IL 60521

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

To Whom It May Concern:

This letter is to notify you that Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated in the Third Quarter of 2026.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as the operators have filed a Certificate of Need application to relocate the facility within the geographic service area and the new facility proposes to offer the same General Surgery services.

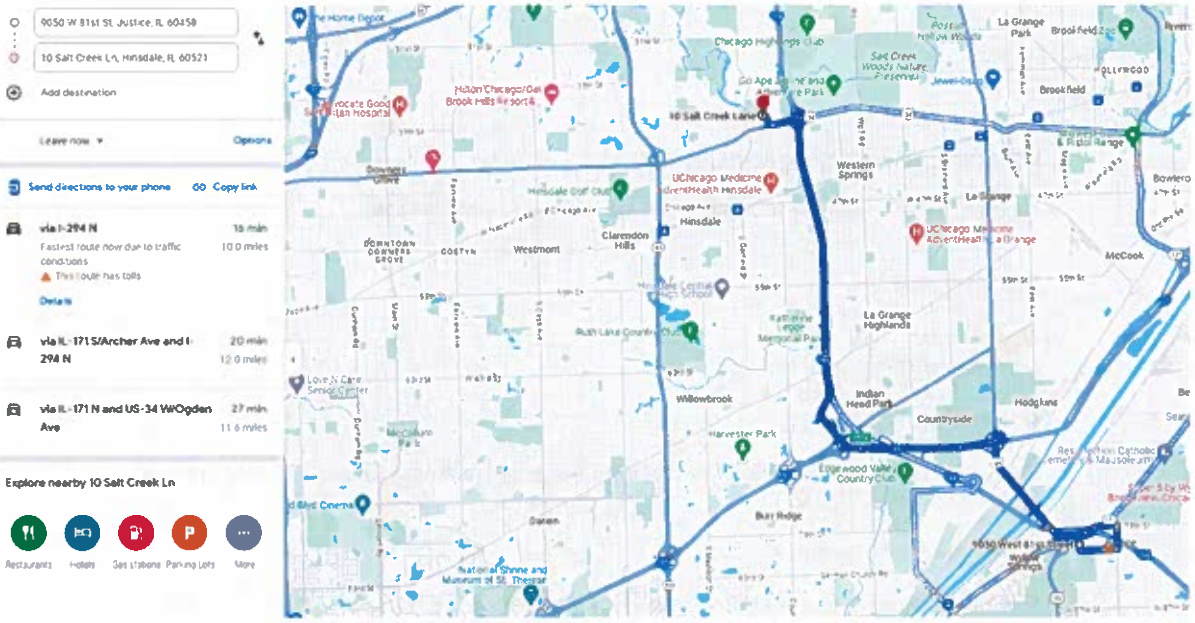
Pursuant to the Health Facilities Planning Act, we are providing this notice. Please respond in writing if you anticipate an adverse impact of this proposed discontinuation on your facility.

Sincerely,

Andrew Krass

Andrew Krass
VP Vascular and Surgical Services
Willow Springs Surgery Center, Ltd.

ATTACHMENT 10
Discontinuation
Notices to Nearby Facilities



ATTACHMENT 10
Discontinuation
Notices to Nearby Facilities

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Administrator
Southwestern Medical Center, LLC
7456 S. State Road, Suite 300
Bedford Park, IL 60638

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

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Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Administrator
Palos Hills Surgery Center
10330 S. Roberts Rd., Suite 300
Palos Hills, IL 60465

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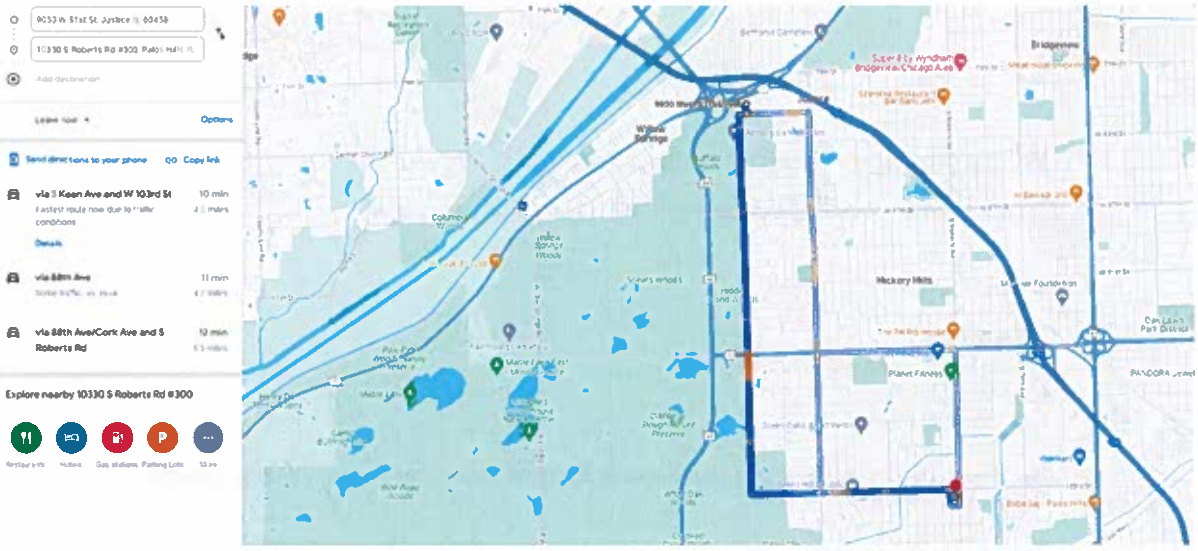

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Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Administrator
Center for Reconstructive Surgery
6311 W. 95th Street
Oak Lawn, IL 60453

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Willow Springs Surgery Center, Ltd.

120 W 22nd Street • Oak Brook, IL 60523 • Phone 630-573-5000 • Fax 630-368-0280

March 18, 2024

Administrator
Palos Surgicenter, LLC
7340 W. College Dr.
Palos Heights, IL 60463

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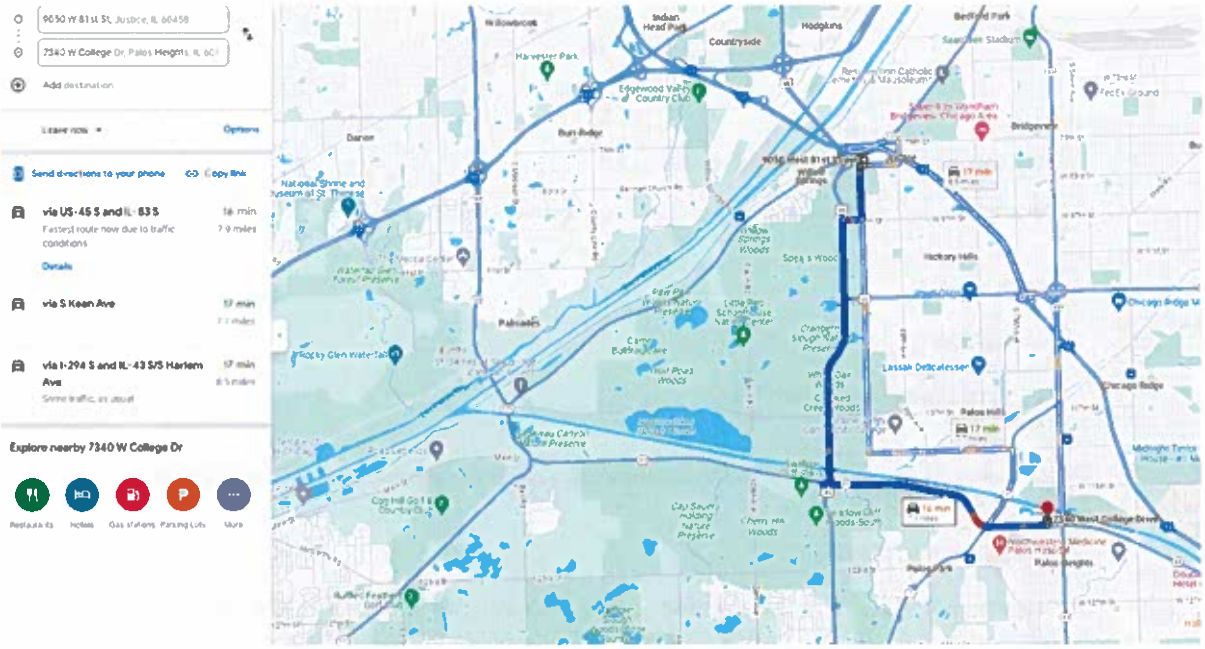

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Notices to Nearby Facilities

Willow Springs Surgery Center, Ltd.

120 W 22nd Street · Oak Brook, IL 60523 · Phone 630-573-5000 · Fax 630-368-0280

March 18, 2024

Administrator
Preferred Surgicenter, LLC
10 Orland Square Drive, Suite 10C
Orland Park, IL 60462

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Willow Springs Surgery Center, Ltd.

To Whom It May Concern:

This letter is to notify you that Willow Springs Surgery Center, Ltd., located at 9050 West 81st Street, Justice, IL 60458, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated in the Third Quarter of 2026.

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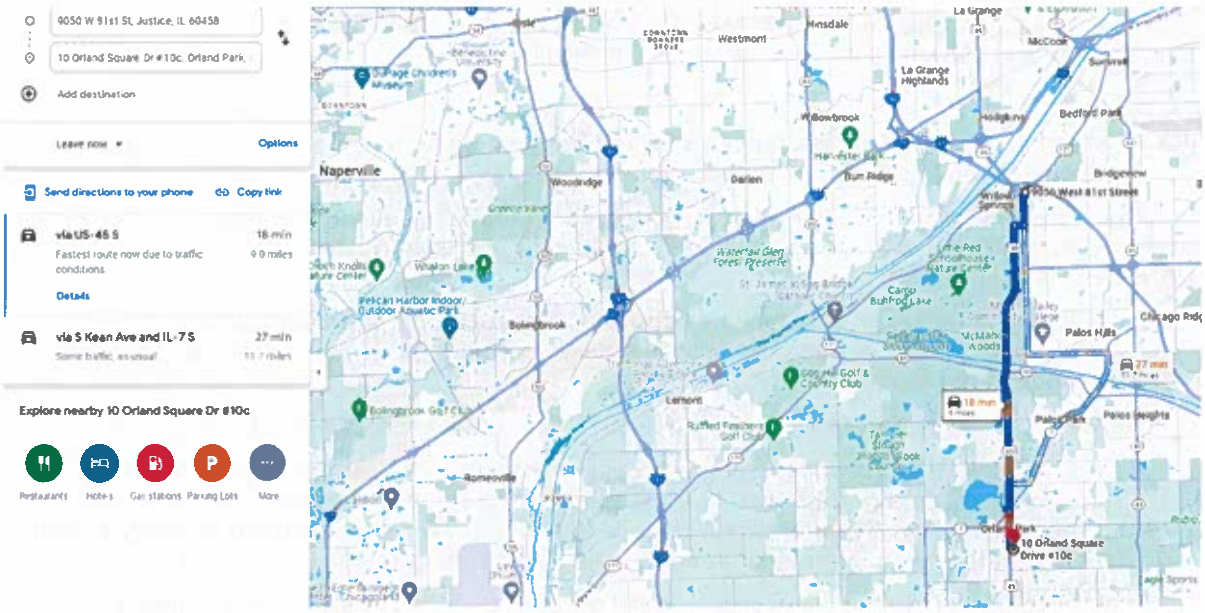

ATTACHMENT 11
Background of the Applicants

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

1. **A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

The Applicant owns no other licensed ambulatory surgical treatment centers, but was recently approved for two facilities that are not complete at the time of this application, NANI Sycamore Dialysis, NANI Vascular ASC North.

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.**

The officers or members of the Applicant do not own any other healthcare facilities in Illinois.

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.**

The officers or members of the Applicant do not own any other healthcare facilities in Illinois.

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.**

Pursuant to the certification executed with the submission of this application, the Applicant certifies that there have been no adverse action taking against any facility owned and/or operated by the Applicant during the three years prior to 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.**

Pursuant to the certification executed with the submission of this application, the Applicant certifies that there have been no individuals 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.

ATTACHMENT 11
Background of the Applicants

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

Pursuant to the certification executed with the submission of this application, the Applicant certifies that no person has 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.

Pursuant to the certification executed with the submission of this application, the Applicant certifies that they do not have 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.

Pursuant to the certification executed with the submission of this application, the Applicant certifies that they do not have an 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.

The Applicant permits the 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.

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.

Not Applicable.

ATTACHMENT 12
Purpose of the Project

Reasons For Discontinuation

The reasons for discontinuation are that the provision of services at the current location are not economically feasible. The reason for discontinuation of the facility is to allow for the orderly relocation within the geographic service area. The current facility is on a short-term lease and the physical site requires modernization and capital investment. The proposed discontinuation allows for the Applicant to discontinue several categories of services that the facility is approved for but is not currently offering. The relocation will also allow for the consolidation of operations of the existing facility and a nearby office-based lab also operated by the Applicant.

ATTACHMENT 37
Safety Net Impact Statement

1. The project will not have a material impact, 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.

The Applicant facility will cease operations upon licensure of a replacement facility and thus there will be no adverse material impact on the essential safety net services that it provides. Additionally, the discontinuation of its facility will not impact existing providers.

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.

The project should not have any impact on the ability of another provider or health care system to cross subsidize safety net services.

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.

The discontinuation of the facility will not impact remaining safety net providers as the licensee proposes to relocate less than a mile away.

ATTACHMENT 37
Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**
Charity (cost in dollars)			
Inpatient	$0	$0	**$0**
Outpatient	$0	$0	**$0**
Total	$0	$0	**$0**
MEDICAID			
Medicaid (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	93	144
Total	0	93	144
Medicaid (revenue)			
Inpatient	$0	$0	$0
Outpatient	$0	$43,501	$71,056
Total	$0	$43,501	$71,056

ATTACHMENT 38
Charity Care Information

CHARITY CARE			
	2020	**2021**	**2022**
Net Patient Revenue	**$0**	**$0**	**$0**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

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

INDEX OF ATTACHMENTS

Attachment NO.		Pages
1	Applicant Identification including Certificate of Good Standing	22-24
2	Site Ownership	25-26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	27-28
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	n/a
6	Historic Preservation Act Requirements	n/a
7	Project and Sources of Funds Itemization	n/a
8	Financial Commitment Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	30-51
11	Background of the Applicant	52-53
12	Purpose of the Project	54
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
		n/a
	Financial and Economic Feasibility:	
33	Availability of Funds	n/a
34	Financial Waiver	n/a
35	Financial Viability	n/a
36	Economic Feasibility	n/a
37	Safety Net Impact Statement	55-56
38	Charity Care Information	57
39	Flood Plain Information	n/a