24-039

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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: The Midland Surgical Center, LLC d/b/a Northwestern Medicine Surgery Center Sycamore			
Street Address:	2120 Midlands Court		
City and Zip Code:	Sycamore, IL 60178		
County: DeKalb	Health Service Area: 01	Health Planning Area: B-04	

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

Exact Legal Name:	The Midland Surgical Center, LLC
Street Address:	2120 Midlands Court
City and Zip Code:	Sycamore, IL 60178
Name of Registered Agent:	Julia K. Lynch
Registered Agent Street Address:	211 East Ontario Street Suite 1800
Registered Agent City and Zip Code:	Chicago, IL 60611
Name of Chief Executive Officer:	Maura O'Toole
CEO Street Address:	1 Kish Hospital Drive
CEO City and Zip Code:	DeKalb, IL 60115
CEO Telephone Number:	815-766-7940

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Bridget Orth
Title:	Director, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-8650
E-mail Address:	borth@nm.org
Fax Number:	312-926-0373

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

Name:	Amanda Pulse-Morton
Title:	Manager, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-2846
E-mail Address:	amanda.pulse@nm.org
Fax Number:	312-926-0373

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: The Midland Surgical Center, LLC d/b/a Northwestern Medicine Surgery Center Sycamore	
Street Address: 2120 Midlands Court	
City and Zip Code: Sycamore, IL 60178	
County: DeKalb	Health Service Area: 01 Health Planning Area: B-04

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

Exact Legal Name:	Kishwaukee Community Hospital d/b/a Northwestern Medicine Kishwaukee Hospital
Street Address:	1 Kish Hospital Drive
City and Zip Code:	DeKalb, IL 60115
Name of Registered Agent:	Julia K. Lynch
Registered Agent Street Address:	211 East Ontario Street Suite 1800
Registered Agent City and Zip Code:	Chicago, IL 60611
Name of Chief Executive Officer:	Maura O'Toole
CEO Street Address:	1 Kish Hospital Drive
CEO City and Zip Code:	DeKalb, IL 60115
CEO Telephone Number:	815-766-7940

Type of Ownership of Applicants

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

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Address:	211 East Ontario Street Suite 1750
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Fax Number:	312-926-0373

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

Name:	Amanda Pulse-Morton
Title:	Manager, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-2846
E-mail Address:	amanda.pulse@nm.org
Fax Number:	312-926-0373

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: The Midland Surgical Center, LLC d/b/a Northwestern Medicine Surgery Center Sycamore			
Street Address: 2120 Midlands Court			
City and Zip Code: Sycamore, IL 60178			
County: DeKalb	Health Service Area: 01	Health Planning Area: B-04	

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

Exact Legal Name:	Northwestern Memorial HealthCare
Street Address:	251 East Huron Street
City and Zip Code:	Chicago, IL 60611
Name of Registered Agent:	Julia K. Lynch
Registered Agent Street Address:	211 East Ontario Street Suite 1800
Registered Agent City and Zip Code:	Chicago, IL 60611
Name of Chief Executive Officer:	Howard B. Chrisman, MD
CEO Street Address:	251 East Huron Street
CEO City and Zip Code:	Chicago, IL 60611
CEO Telephone Number:	312-926-0016

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.

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Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Bridget Orth
Title:	Director, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-8650
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Additional Contact [Person who is also authorized to discuss the application for permit]

Name:	Amanda Pulse-Morton
Title:	Manager, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-2846
E-mail Address:	amanda.pulse@nm.org
Fax Number:	312-926-0373

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:	Bridget Orth
Title:	Director, Regulatory Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750
Telephone Number:	312-926-8650
E-mail Address:	borth@nm.org
Fax Number:	312-926-0373

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Kishwaukee Community Hospital d/b/a NM Kishwaukee Hospital

Address of Site Owner: 1 Kish Hospital Drive, DeKalb, IL 60115

Street Address or Legal Description of the Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: The Midland Surgical Center, LLC d/b/a Northwestern Medicine Surgery Center Sycamore

Address: 2120 Midlands Court, Sycamore, IL 60178

☐	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.

The Midland Surgical Center, LLC d/b/a Northwestern Medicine Surgery Center Sycamore (NMSC) proposes to add gastroenterology as an approved surgical specialty. NMSC is multi-specialty ambulatory surgical treatment center (ASTC) wholly owned by NM Kishwaukee Hospital located at 2120 Midlands Court in Sycamore, less than a mile from the hospital. NMSC has three (3) operating rooms and is currently authorized to perform cases in neurology, OB/gynecology, ophthalmology, orthopedic, otolaryngology, pain management, plastic, podiatry, and urology.

The proposed gastroenterology procedures will be performed in the existing operating rooms and there will be no new construction related to this project. There will be additional equipment purchased with a total project cost of $713,000.

The project is classified as non-substantive as it 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 (20 ILCS 3960).

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)	$ 713,000	$ 0	$ 713,000
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	**$ 713,000**	**$ 0**	**$ 713,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 713,000	$ 0	$ 713,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 713,000**	**$ 0**	**$ 713,000**

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: $ 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): : June 30, 2026

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

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

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the 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: NM Kishwaukee Hospital		**CITY:** DeKalb			
REPORTING PERIOD DATES: CY23		**From:** 1/1/23		**to:** 12/31/23	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	70	4,222	20,428	0	70
Obstetrics	16	795	1,699	0	16
Pediatrics	0	0	0	0	0
Intensive Care	12	605	2,266	0	12
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long-Term Care	0	0	0	0	0
Specialized Long-Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	98	5,622	24,393	0	98

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 The Midland 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.**

Maura O'Toole
SIGNATURE

Maura O'Toole
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2024

Carrie M Tucker
Signature of Notary

Seal

"OFFICIAL SEAL"
Carrie M. Tucker
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 5/10/27

Rebecca J. Murphy
SIGNATURE

Rebecca J. Murphy
PRINTED NAME

Vice President, Operations
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2024

Carrie M Tucker
Signature of Notary

Seal

"OFFICIAL SEAL"
Carrie M. Tucker
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 5/10/27

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Kishwaukee Community Hospital * **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

Maura O'Toole
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2024

Signature of Notary

Seal

"OFFICIAL SEAL"
Carrie M. Tucker
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 5/10/27

SIGNATURE

John A. Orsini
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of November 2024

Signature of Notary

Seal

OFFICIAL SEAL
BRIDGET SUZANNE ORTH
NOTARY PUBLIC, STATE OF ILLINOIS
COMMISSION NO. 0998568
MY COMMISSION EXPIRES October 16, 2028

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Northwestern Memorial HealthCare (NMHC) * **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

Howard B. Chrisman, MD
PRINTED NAME

President & CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of November 2024

Signature of Notary

Seal

OFFICIAL SEAL
BRIDGET SUZANNE ORTH
NOTARY PUBLIC, STATE OF ILLINOIS
COMMISSION NO. 0998558
MY COMMISSION EXPIRES October 16, 2026

SIGNATURE

John A. Orsini
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November 2024

Signature of Notary

Seal

OFFICIAL SEAL
BRIDGET SUZANNE ORTH
NOTARY PUBLIC, STATE OF ILLINOIS
COMMISSION NO. 0998558
MY COMMISSION EXPIRES October 16, 2026

*Insert the EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

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

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

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

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

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

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

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:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

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

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

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

_____	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

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

   A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts 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)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			

Outpatient			
Total			

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

SECTION X. CHARITY CARE INFORMATION

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

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

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

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

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

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

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

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

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

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

1. Applicant: Northwestern Medicine HealthCare 251 East Huron Street
   (Name) (Address)
   Chicago Illinois 60611 312-926-3000
   (City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 2120 Midlands Court Sycamore, IL
   (Address) (City) (State)
   DeKalb County DeKalb Township Section 01
   (County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

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

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? No

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

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

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

Signature:_____ Date: _____

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

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

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

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File Number 0084933-2

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*

THE MIDLAND SURGICAL CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 21, 2003, 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* 31ST *day of* OCTOBER *A.D.* 2024 .

Authentication #: 2430503172 verifiable until 10/31/2025

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

Alexi Giannoulias

SECRETARY OF STATE

ATTACHMENT-1

File Number 4962-796-3

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*

KISHWAUKEE COMMUNITY HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 25, 1970, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT 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* 31ST *day of* OCTOBER ***A.D.*** 2024 .

Authentication #: 2430503216 verifiable until 10/31/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT-1

File Number 5257-740-3

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*

NORTHWESTERN MEMORIAL HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT 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* 19TH *day of* NOVEMBER *A.D.* 2024 .

Authentication #: 2432402364 verifiable until 11/19/2025
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT-1

2020010350

DOUGLAS J. JOHNSON
RECORDER - DEKALB COUNTY, IL
RECORDED: 10/5/2020 03:24 PM
REC FEE: 56.00 RHSPS FEE: 9.00

PAGES: 8

SPECIAL WARRANTY DEED
This Deed is exempt pursuant to 35 ILCS 200/31-45(b)(2020) 10/1/20

Property Address:

2120 Midlands Court
Sycamore, IL 60178

PIN: 08-01-476-035

Above Space for Recorder's Use Only

THIS SPECIAL WARRANTY DEED, made this 1ST day of October, 2020 from The Aberdeen Family Limited Partnership, an Illinois limited partnership as to 14/60th interest, Russell J. Bodner as to 7/60th interest; Rajeev Jain as to 7/60th interest; Shane M. York as to 7/60th interest; and Tony Choi as to 7/60th interest, having an address of 3085 Wolf Court, DeKalb, IL 60115 (collectively "Grantor") and KISHWAUKEE COMMUNITY HOSPITAL, an Illinois not-for-profit corporation ("Grantee") having an address of 211 East Ontario Street, Suite 1800, Chicago, IL 60611:

WITNESSETH, that Grantor, for and in consideration of Ten Dollars and other good and valuable consideration in hand paid by Grantee, the receipt whereof is hereby acknowledged, by these presents does REMISE, RELEASE, ALIENATE and CONVEY unto Grantee, and to its successor and assigns, FOREVER, all the following described real estate, situated in the County of DeKalb and State of Illinois known and described as set forth in the attached Exhibit A, made a part hereof by reference.

Together with all and singular the hereditaments and appurtenances thereunto belonging, or in anywise appertaining, and the reversion and reversions, remainder and remainders, rents, issues and profits thereof, and all the estate, right, title, interest, claim or demand whatsoever, of Grantor, either in law or equity, of, in and to the above described premises, with the hereditaments and appurtenances: TO HAVE AND TO HOLD the said premises as above described, with the appurtenances, unto Grantee, its assigns forever.

And Grantor, for itself, and its successors, does covenant, promise and agree, to and with Grantee, its/their assigns, that it has not done or suffered to be done, anything whereby the said premises hereby granted are, or may be, in any manner encumbered or charged, except for the items listed on Exhibit B made a part hereof by reference, but the reference to any item on such Exhibit shall not reimpose the same; and that the said premises, against all persons lawfully claiming, or to claim the same, by, through or under Grantor, but not otherwise, it WILL WARRANT AND DEFEND, subject only to the items listed in Exhibit B made a part hereof by reference.

[Special Warranty Deed Signature Page]

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[2120 Midlands]

ATTACHMENT-2

Grantor has caused its name to be signed to this Special Warranty Deed effective as of the date set forth above.

GRANTOR

The Aberdeen Family Limited Partnership

By: Midwest Sports Management, Inc., its General Partner

By: _____
Name: Steven G. Glasgow
Title: President

CITY OF SYCAMORE
CITY TAX
1858
10/1/2020
DATE
REAL ESTATE TRANSFER TAX
REAL ESTATE TRANSFER TAX
Exempt
6082

_____
Russell J. Bodner

_____
Rajeev Jain

_____
Shane M. York

_____
Tony Choi

State of Illinois)
SS)
County of DeKalb)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Steven G. Glasgow, personally known to me to be the President of Midwest Sports Management, Inc., an Illinois corporation, the General Partner of The Aberdeen Family Limited Partnership, and personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged, he/she signed and delivered the said instrument, pursuant to authority given by the bylaws of the Midwest Sports Management, Inc., pursuant to authority given by the partnership agreement of The Aberdeen Family Limited Partnership to the General Partner, as his/her free and voluntary act, and as the free and voluntary act and deed of The Aberdeen Family Limited Partnership, for the uses and purposes therein set forth.

Given under my hand and official seal, this 23rd day of Sept., 2020. My commission expires 5-17-23, 2020.

_____
NOTARY PUBLIC

JASON EGGERT
Official Seal
Notary Public - State of Illinois
My Commission Expires May 17, 2023

[2120 Midlands]

1028627\306592836.v1

ATTACHMENT-2

State of Illinois)

SS)

County of DeKalb)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Russell J. Bodner, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged, he/she signed and delivered the said instrument, as his/her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 23rd day of Sept., 2020. My commission expires 5.17.23 2020.

NOTARY PUBLIC

JASON EGGERT
Official Seal
Notary Public State of Illinois
My Commission Expires May 17, 2023

State of Illinois)

SS)

County of DeKalb)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Rajeev Jain, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged, he/she signed and delivered the said instrument, as his/her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 23rd day of Sept., 2020. My commission expires 5.17.23 2020.

NOTARY PUBLIC

JASON EGGERT
Official Seal
Notary Public State of Illinois
My Commission Expires May 17, 2023

State of Illinois)

SS)

County of DeKalb)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Shane M. York, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged, he/she signed and delivered the said instrument, as his/her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 23rd day of Sept., 2020. My commission expires 5.17.23 2020.

NOTARY PUBLIC

JASON EGGERT
Official Seal
Notary Public - State of Illinois
My Commission Expires May 17, 2023

State of Illinois)

SS)

County of DeKalb)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Tony Choi, and personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged, he/she signed and delivered the said instrument, as his/her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 23rd day of Sept., 2020. My commission expires 5.17.23 2020.

NOTARY PUBLIC

JASON EGGERT
Official Seal
Notary Public - State of Illinois
My Commission Expires May 17, 2023

THIS INSTRUMENT PREPARED BY:

Blerta Mileti, Esq.
Hinshaw & Culbertson LLP
151 North Franklin, Suite 2500
Chicago, IL 60606

AFTER RECORDING MAIL TO:

Northwestern Memorial HealthCare
Office of the General Counsel
Attn: Tom L. Hefty
211 East Ontario Street, Suite 1800
Chicago, IL 60611

SEND SUBSEQUENT BILLS TO:

Northwestern Memorial HealthCare
Office of the General Counsel
Attn: Tom L. Hefty
211 East Ontario Street, Suite 1800
Chicago, IL 60611

EXHIBIT A

LEGAL DESCRIPTION

LOT 17 IN MIDLANDS PROFESSIONAL CAMPUS SECOND RESUBDIVISION, A RESUBDIVISION OF LOTS 6, 7 AND 8 OF MIDLANDS PROFESSIONAL CAMPUS RESUBDIVISION, BEING A SUBDIVISION IN PART OF THE SOUTHEAST QUARTER OF SECTION 1, TOWNSHIP 40 NORTH, RANGE 4 EAST OF THE THIRD PRINCIPAL MERIDIAN, AND PART OF THE SOUTHWEST FRACTIONAL QUARTER OF SECTION 6, TOWNSHIP 40 NORTH, RANGE 5 EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JULY 14, 2005 T SLIDE 155-B AS DOCUMENT NO. 2005013505, IN DEKALB COUNTY, ILLINOIS.

EXHIBIT B

EXCEPTIONS TO TITLE

1. Taxes for the year 2020, and subsequent years.

2. Declaration of covenants, conditions, restrictions and easements for The Midlands Professional Campus, Sycamore, Illinois; but omitting any covenants or restrictions, if any, including but not limited to those based upon race, color, religion, sex, sexual orientation, familial status, marital status, disability, handicap, national origin, ancestry, source of income, gender, gender identity, gender expression, medical condition or genetic information, as set forth in applicable state or federal laws, except to the extent that said covenant or restriction is permitted by applicable law, relating in part to association, assessment and lien therefor, easements, as set forth in the document set forth below, as amended from time to time recorded on August 14, 2001 as recording no. 2001013999.

   Amendment recorded as document 2003035020.

3. Vehicular access shall be limited to Midlands Court with no direct access to S.B.I. Route 23 as shown on the Plat of Midlands Professional Campus Unit 1.
   Access easement as shown on the Plat of Midlands Professional Campus Second Resubdivision recorded as document 2005013505 affecting the Northwesterly 30 feet of Lot 17.

4. Building Line as shown on the Plat of Midlands Professional Camus Second Resubdivision recorded as Document 2005013505; 50 feet along the Northwesterly line of Lot 17.

5. Utility easement in favor of the City of Sycamore, Illinois, Commonwealth Edison Company, Nicor, Verizon, Comcast and its/their respective successors and assigns, to install, operate and maintain all equipment necessary for the purpose of serving the land and other property, together with the right of access to said equipment, and the provisions relating thereto contained in the Plat of Second Resubdivision recorded the Northwesterly 20 feet and the North 15 feet of Lot 17.

6. Sanitary and drainage easement as shown on the Plat of Midlands Professional Campus Second Resubdivision recorded as document 2005013505; affects the West 15 feet of Lot 17.

7. Watermain, drainage and ingress/egress easement over the East 25 feet of Lot 17 as shown on the Plat of Midlands Professional Campus Second Resubdivison recorded as document 2005013505.

8. Notation on the Plat of Midland Professional Campus Second Resubdivision recorded as document 2005013505:

   1. All easements are previously granted unless otherwise noted.

   2. Operation and maintenance of any common areas and facilities within the subdivision shall be under the control of an Owner's Association in accordance with the laws of the City of Sycamore governing such associations.

9. Exclusive, irrevocable and perpetual easement for ingress and egress for the benefit of subject land as created in access easement agreement dated September 27, 2000 and recorded October 19, 2000 as document 2000014060, made by and between the Aberdeen Family Limited Partnership,

an IL limited partnership, MSI Associates, LLC, an Illinois limited liability company, and Castle Bank, successor in interest to First National Bank in Dekalb over the Land as identified on Plat of survey attached to the instrument as exhibit C, and the terms and conditions therein contained.

10. Easement(s) for the purpose(s) and rights incidental thereto, granted to The Aberdeen Family Limited Partnership, an Illinois limited partnership, for purpose an easement for ingress and egress over upon and across certain portions, as granted in a document recorded on November 2, 2001 as Document No. 2001-019132, affecting the land therein described.

11. Leasehold interest of The Midland Surgical Center, LLC, as subtenant, and The Midland Surgical Center Capital Asset, LLC, as tenant.

2020010351

DOUGLAS J. JOHNSON
RECORDER - DEKALB COUNTY, IL
RECORDED: 10/5/2020 03:24 PM
REC FEE: 56.00 RHSPS FEE: 9.00

PAGES: 3

QUITCLAIM DEED

This Instrument Prepared By And After Recording Return To:

Thomas L. Hefty
Northwestern Memorial HealthCare
Office of General Counsel
211 East Ontario Street, Suite 1800
Chicago, Illinois 60611
Thomas.Hefty@nm.org

This Deed is exempt pursuant to 35 ILCS 200/31-45(e)(2020)

Agent for Grantor, 10/1/20

Grantee's Address and Send Subsequent Tax Bills to

Northwestern Memorial HealthCare
Real Estate Strategy
211 East Ontario Street, Suite 1400
Chicago, Illinois 60611

HEALTH PROGRESS INC., an Illinois corporation company, having an address of 211 East Ontario Street, Chicago, Illinois 60611 ("**Grantor**"), for and in consideration of $10.00 and other good and valuable consideration in hand paid, **CONVEYS** and **QUITCLAIMS** to **KISHWAUKEE COMMUNITY HOSPITAL**, an Illinois not-for-profit corporation, having an address of 211 East Ontario Street, Chicago, Illinois 60611, all of Grantor's right, title and interest in and to the real estate, including all improvements thereto and fixtures thereon, such real estate situated in DeKalb County, Illinois described in the attached Exhibit A, having a street address of 2120 Midlands Court, Sycamore, Illinois 60178 and consisting of property tax parcel 08-01-476-035, having received its interest in a Quitclaim Deed from The Midland Surgical Center Capital Asset, LLC, dated December 16, 2019 and recorded on December 20, 2019 as document 2019 011815 and a Quitclaim Deed from The Midland Surgical Center Land Company, LLC, dated December 16, 2019 and recorded on December 20, 2019 as document 2019 011816.

[signature on following page]

ATTACHMENT-2

This Quitclaim Deed is signed by Grantor's duly authorized signatory, intending to be effective as of October 1, ___, 2020.

HEALTH PROGRESS, INC., an Illinois corporation

By: Kevin Poorten

Name: Kevin Poorten

Title: President

Thomas L. Hefty

Digitally signed by Thomas L. Hefty
DN: cn= Thomas L. Hefty, o=Northwestern Memorial HealthCare, ou=Office of General Counsel, email=thomas-hefty@nmh.org, c=US
Reason: OGC reviewed and approved for NM execution
Location: 111 E. Ontario St. Ste 1600, Chicago, IL 60611
Date: 2020.08.27 16:34:33 -05'00'

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPage)

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Kevin Poorten, personally known to me to be the President of **HEALTH PROGRESS, INC.**, an Illinois corporation, known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that as such officer he/she signed, sealed and delivered said instrument, pursuant to lawful authority, as his/her free and voluntary act, and as the free and voluntary act and deed as an authorized person of said corporation for the uses and purposes therein set forth.

Given under my hand and official seal, this 10th day of September, 2020.

Pamela A Littmann
Notary Public

My Commission Expires: 12/23/23

OFFICIAL SEAL
PAMELA A LITTMANN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/23/23

[HPI to KCH Quitclaim Deed Signature Page]

ATTACHMENT-2

EXHIBIT A
(QUITCLAIM DEED)

An undivided 18/60^{ths} interest in the following:

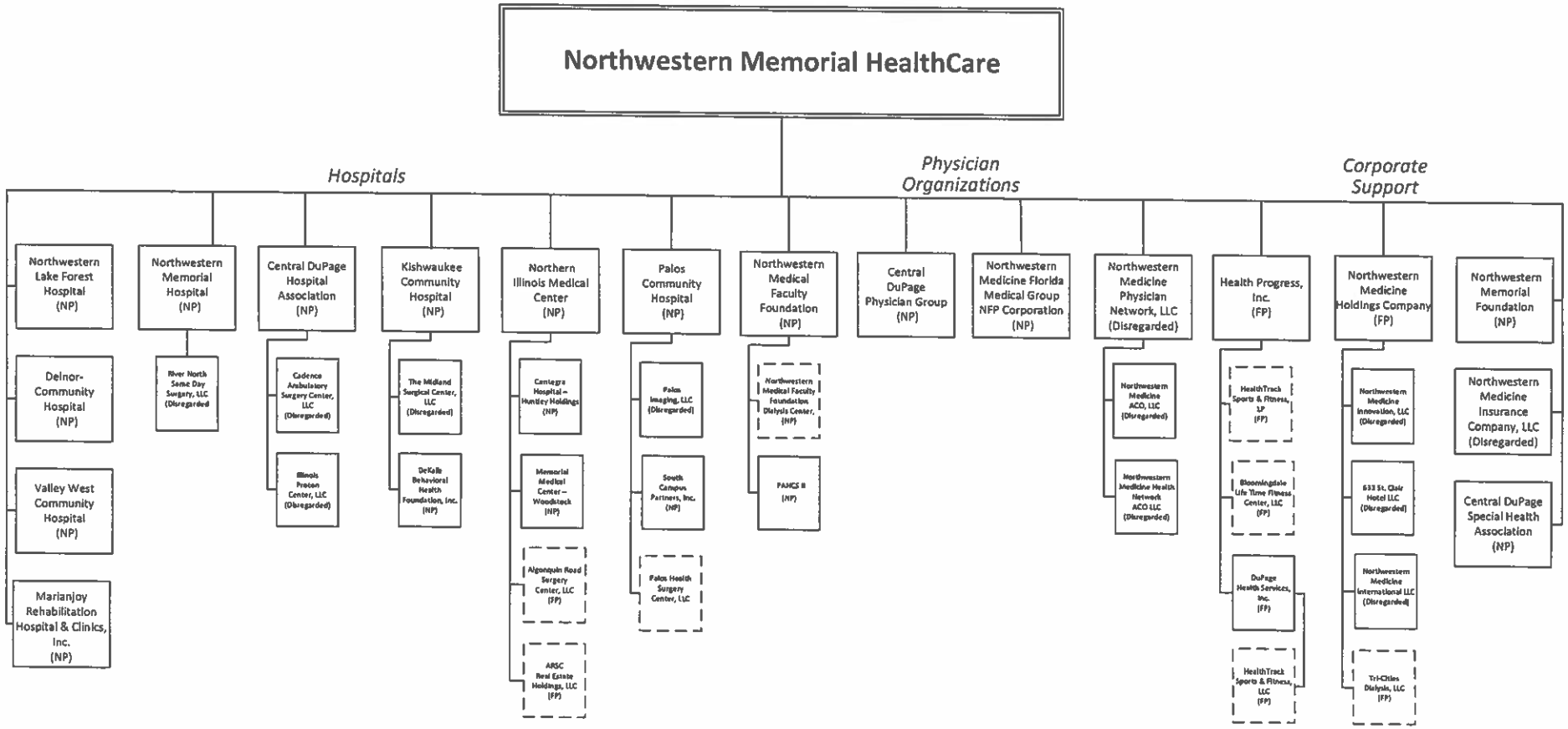
LOT 17 IN MIDLANDS PROFESSIONAL CAMPUS SECOND RESUBDIVISION, A RESUBDIVISION OF LOTS 6, 7 AND 8 OF MIDLANDS PROFESSIONAL CAMPUS RESUBDIVISION, BEING A SUBDIVISION IN PART OF THE SOUTHEAST QUARTER OF SECTION 1, TOWNSHIP 40 NORTH, RANGE 4 EAST OF THE THIRD PRINCIPAL MERIDIAN, AND PART OF THE SOUTHWEST FRACTIONAL QUARTER OF SECTION 6, TOWNSHIP 40 NORTH, RANGE 5 EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JULY 14, 2005, PLAT CABINET 9 AT SLIDE 155-B AS DOCUMENT NO. 2005013505, IN DEKALB COUNTY, ILLINOIS.

PTAX -- 08-01-476-035
Address-- 2120 Midlands Court, Sycamore, Illinois

* * *

[QCD Exhibit A]

ATTACHMENT-2



Effective February 16, 2024

ATTACHMENT 4

Flood Plain Requirements

Not Applicable – the proposed project is for the addition of a specialty to an existing ASTC. There is no construction or modernization associated with this project.

Historic Resources Preservation Act Requirements

Not Applicable – the proposed project is for the addition of a specialty to an existing ASTC. There is no construction or modernization associated with this project.

Project Costs and Sources of Funds

Line 10 – Movable Capital Equipment – ($713,000) – this includes:

The only costs associated with the proposed project are the following equipment items:

Equipment	Approx. Cost
Tower	$ 45,000
Reprocessor	$ 50,000
Channel Dry Cabinet (2)	$ 73,000
Scopes – Colon/EGD (10)	$ 427,000
Leak Tester	$ 1,000
Scope Buddy	$ 3,000
GI Genius	$ 66,000
ERBE	$ 48,000
TOTAL	**$ 713,000**

Project Status and Completion Schedules

Anticipated project completion date: June 30, 2026

Northwestern Memorial HealthCare Open CON/COE Permits

CON #21-008: Old Irving Park Medical Office Building
CON #21-032: Delnor Cancer Center Modernization/Expansion
CON #22-046: Bronzeville Medical Office Building
CON #22-047: Lake Forest Hospital Pavilion Expansion
CON #24-006: Warrenville Cancer Center Expansion
CON #24-027: Huntley Medical Office Building

Cost Space Requirements

Department	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing GSF	Proposed GSF	New Const.	Modern-ized	As Is	Vacated Space
CLINICAL							
ASTC	$ -	12,075	12,075	0	0	12,075	0
TOTAL =	**$ -**	**12,075**	**12,075**	**0**	**0**	**12,075**	**0**
OTHER							
Preplanning Costs	$ -						
Site Survey & Soil Investigation	$ -						
Site Preparation	$ -						
Off-Site Work	$ -						
Contingencies	$ -						
A/E Fees	$ -						
Consulting & Other Fees	$ -						
Movable or Other Equipment	$ 713,000						
Bond Issuance Expense	$ -						
Net Interest Expense During Construction	$ -						
Other Costs To Be Capitalized	$ -						
Acquisition of Building (excluding Land)	$ -						
Other Subtotal =	**$ 713,000**						
GRAND TOTAL =	**$ 713,000**						

ATTACHMENT-9

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

Criterion 1110.110(a)

BACKGROUND OF APPLICANT

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

Northwestern Memorial HealthCare:

	IDPH License No.	Joint Commission Organization No.
Northwestern Memorial Hospital	0003251	7267
Northwestern Lake Forest Hospital	0005660	3918
Central DuPage Hospital Association	0005744	7444
Delnor-Community Hospital	0005736	5291
Marianjoy Rehabilitation Hospital & Clinics	0003228	7445
Kishwaukee Community Hospital	0005470	7325
Valley West Community Hospital	0004690	382957
Northern Illinois Medical Center (McHenry)	0003889	7375
Northern Illinois Medical Center (Huntley)	0003890	7375
Memorial Medical Center (Woodstock)	0004606	7447
Palos Community Hospital	0003210	7306
Grayslake Freestanding Emergency Center	22002	3918
Grayslake ASTC	7003156	n/a
Grayslake Endoscopy ASTC	7003149	n/a
Cadence Ambulatory Surgery Center	7003173	n/a
The Midland Surgical Center	7003148	n/a
Palos Health Surgery Center*	7003224	n/a
River North Same Day Surgery Center	7002090	n/a

*denotes partial ownership > 50%

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

By the signatures on the Certification page of this application, the Applicants attest that no adverse action has been taken against any facility owned and/or operated by Northwestern Memorial HealthCare during the three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.140.

Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, by 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.

By the signatures on the Certification page of this application, the Applicants authorize HFSRB and DPH to access any documentation which it finds necessary to verify any information submitted, including, but not limited to official records of DPH or other State agencies and/or the records of nationally recognized accreditation organizations.

Criterion 1110.110(b)

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.*

   The purpose of this project is to increase access to high quality, convenient, and cost-effective surgical care to NM patients and the residents of Dekalb County and surrounding areas. By adding gastroenterology to NMSC Sycamore, patients will have a non-hospital option for their G.I. procedures. This project will also alleviate projected capacity constraints on the endoscopy suites at NM Kishwaukee Hospital.

2. *Define the planning area or market area.*

   NMSC Sycamore services patients in Dekalb County. Approximately 67% of NMSC Sycamore patients reside within 17 miles of the ASTC. Approximately 87% of NMSC Sycamore patients reside in NM's west region.

3. *Identify the existing problems or issues that need to be addressed.*

   NMSC Sycamore is a multi-specialty surgery center that is currently authorized to perform neurology, OB/gynecology, ophthalmology, orthopedic, otolaryngology, pain management, plastic, podiatry, and urology. In 2014, the Hauser Ross Ambulatory ASC was approved (CON #14-033) and by 2016, the ophthalmology group that had been performing cases at NMSC Sycamore moved all of their cases there. The ophthalmology cases had accounted for 50% of the total volume at NMSC and their relocation created capacity at NMSC.

   Additionally, there is an increasing trend among insurance providers to require certain low-acuity procedures to be done in an ASTC setting. Patients also have expressed the desire to have a more convenient, lower cost alternative for outpatient procedures.

   The COVID-19 pandemic also created a need for increased access to non-hospital-based surgery options. During the height of the pandemic, many hospitals, including NM Kishwaukee, were forced to postpone/reschedule non-time-sensitive ambulatory surgery cases. Even in a post-pandemic world, providing a non-hospital option for low acuity surgical cases increases patient safety by reducing exposure to infectious diseases commonly found in the hospital setting.

4. *Cite the sources of the documentation.*

   Sources of information include:
   - Hospital Records

ATTACHMENT-12

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

   The proposed project will give patients the option of having gastroenterology procedures performed in an ASTC setting. Patients will have options for their care setting based on insurance requirements, patient preference, and optimal physician access. This will also alleviate the projected surgical capacity constraints at NM Kishwaukee.

6. *Provide goals for the proposed project.*

   The goals of the proposed project are to improve access to outpatient G.I. services, to increase utilization at NMSC Sycamore, and to decant volume from NM Kishwaukee to allow for continued growth in more complex surgical procedures at the hospital.

ATTACHMENT-12

Criterion 1110.110(d)

ALTERNATIVES

The following alternatives to the project were considered:

1. Utilize Other Available Health Resources

Alternative 1: Utilize Other Available Health Resources

The patient volume that is included in this proposed project will be performed in an NM facility, mostly at NM Kishwaukee Hospital, if this project is not approved. However, the proposed procedures can be performed in an ASTC at a lower cost and higher efficiency than in a hospital setting. Additionally, moving the proposed procedures to NMSC Sycamore optimizes the ability of the hospital to increase capacity for higher acuity procedures.

While there is one other ASTC within the 17-mile radius of NMSC Sycamore that is authorized for G.I. procedures and may have capacity, treating NM patients in an NM facility improves patient safety and continuity of care as all NM facilities are on the same electronic medical record platform (Epic). It also improves efficiency of NM physicians which increases patient access. Additionally, it allows for better control of protocols, equipment, and staffing which leads to higher quality of care.

This alternative was rejected because it does not provide an optimal patient/physician experience.

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

Criterion 1110.120

SIZE OF PROJECT

Not Applicable – there is no construction or modernization associated with the proposed project.

PROJECT SERVICES UTILIZATION

NMSC Historic Utilization

	CY15	CY16	CY17	CY18	CY19	CY20	CY21	CY22	CY23
Cases	2,999	2,042	1,227	973	975	723	692	1,016	871
Hours	2,866	2,208	1,702	1,365	1,498	1,039	963	1,327	1,102
ORs justified	1.9	1.5	1.1	0.9	1.0	0.7	0.6	0.9	0.7

The loss of ophthalmology cases with the approval of the Hauser Ross ASC in 2014, the effects of the COVID-19 pandemic in 2020, and physician staffing issues in 2023 have resulted in excess capacity at NMSC Sycamore.

With the addition of gastroenterology, NMSC anticipates an additional 995 hours in CY25 which will bring the 3 operating rooms closer to target utilization (1,102 hours + 995 hours = 2,097 hours ÷ 1,500 hours justifies 2 ORs). Assuming 25% annual growth from CY25 – CY27 (with additional physicians performing cases at the ASC in all specialties), NMSC will be able to justify 3 operating rooms.

UTILIZATION				
SERVICE	**HISTORICAL UTILIZATION** *CY22 CY23 OR Hours*	**PROJECTED UTILIZATION** *CY26 CY27 OR Hours*	**STATE STANDARD** *1,500 hours per OR for 3 ORs*	**MET STANDARD?**
ASTC	1,327	2,621	4,500	No
ASTC	1,102	3,277	4,500	No

UNFINISHED OR SHELL SPACE

Not Applicable – there is no unfinished or shell space planned in the project.

ATTACHMENT-16, 17

G. Criterion 1110.235 – Non-Hospital Based Ambulatory Surgery

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_____

The proposed project will add the following surgical specialty to the NMSC Sycamore:

- Gastroenterology

1110.235(c)(2) – Service to GSA Residents

NMSC Sycamore is located in DeKalb County. Pursuant to Section 1100.510(d) of the rules, NMSC's service area (GSA) is defined by a radius of 17 miles around NMSC. Below is a table of the 19 zip codes that comprise the GSA:

NMSC Sycamore GSA Zip Codes			
60111	60112	60113	60115
60119	60124	60129	60135
60140	60144	60145	60146
60150	60151	60175	60178
60520	61049	61052	

In CY23, NMSC serviced patients from the following zip codes:

Zip Code	NMSC Cases
60115	261
60178	167
61068	43
60135	42
60548	39
60112	38
60150	22
60556	17
60145	13
61021	12
61081	12
60552	11
60151	10
60518	9
60140	8
60560	8
60146	7
60111	6
60545	6
60506	4
60551	4
60554	4
61061	4
61109	4
61318	4
60113	3
60119	3
60520	3
60550	3
61008	3
61020	3
61071	3
61353	3
37174	2
60124	2
60129	2
60134	2
60142	2

60152	2
60174	2
60175	2
60403	2
60530	2
60531	2
60541	2
60542	2
60549	2
60553	2
60586	2
61038	2
61043	2
61054	2
61073	2
61107	2
61108	2
61270	2
61310	2
33913	1
53081	1
53190	1
60002	1
60012	1
60033	1
60047	1
60050	1
60051	1
60073	1
60098	1
60120	1
60123	1
60126	1
60144	1
60177	1
60419	1
60436	1
60503	1
60504	1
60505	1
60510	1

60511	1
60537	1
60538	1
60540	1
61006	1
61014	1
61015	1
61016	1
61031	1
61047	1
61049	1
61084	1
61111	1
61283	1
61301	1
61330	1
61341	1
61342	1
61348	1
61372	1
61379	1
68128	1

Approximately 66.7% reside within 17 miles of the ASTC.

1110.235(c)(3) – Service Demand – Additional ASTC Service

There are 2 physician referral letters at the end of this attachment that attest to each physician's total number of cases performed in CY23 NM Kishwaukee Hospital. The letters also include a projected number of cases that will be performed at NMSC if this project is approved.

Below is a summary of the physician referral letters:

Physician	Specialty	CY23 Cases	Projected ASTC Cases
Dr. David Manuel	Gastroenterology	1,466	733
Dr. Neha Kaiser	Gastroenterology	1,022	511
TOTAL		2,488	1,244

Using a conservative estimate of 1,244 additional new procedures, multiplied by the average time/case for outpatient gastroenterology procedures at NM Kishwaukee Hospital, NMSC will improve utilization to closer to target occupancy.

1110.235(c)(5) – Treatment Room Need Assessment

In 2014, CON #14-033 was approved for the establishment of Hauser Ross Eye Institute Ambulatory Surgery Center, a limited specialty ASTC (ophthalmology and otolaryngology), located less than one mile away from NMSC Sycamore. By 2016, all of the ophthalmology cases had been moved to Hauser Ross ASC, thereby creating capacity at NMSC Sycamore. More recently, COVID-19 and physician staffing issues due to medical leaves and retirements have impacted surgical volume at the ASC. Efforts to recruit physicians to continue to perform cases in all of the authorized specialties are underway.

Currently, NM Kishwaukee has two dedicated G.I. procedure rooms but has also been using one operating room for G.I. procedures 2 days a week. Moving G.I. cases to NMSC creates capacity at NM Kishwaukee for higher acuity procedures.

Based on NM Kishwaukee's surgical services data from CY15 – CY23, the average outpatient gastroenterology procedure time was 48 minutes.

It is anticipated that 1,244 gastroenterology procedures will be performed at NMSC Sycamore if this project is approved. This will result in 995 additional hours at NMSC Sycamore.

With the addition of the proposed specialty, NMSC anticipates an additional 995 hours in CY25 which will bring the 3 operating rooms closer to target utilization (1,102 CY23 hours + 995 additional proposed hours = 2,097 hours divided by 1,500 hours equals 1.4 ORs). Assuming 25% annual growth from CY25 – CY27 (with additional physicians performing cases at the ASC in all specialties), NMHC will be able to justify 3 operating rooms.

1110.235(c)(6) – Service Accessibility

NMSC Sycamore is wholly owned by NM Kishwaukee Hospital. The primary purpose of this project is to increase access to non-hospital based surgical services for NM patients and residents of Dekalb County. While these services are provided at NM Kishwaukee, there is an increasing trend among insurance providers that certain low-acuity procedures be performed in an ASTC setting. If this project is not approved, patients who have an insurance carrier with this requirement will not have access to some G.I. services at NM.

Additionally, as experience during the COVID-19 pandemic has shown, hospitals need an ASTC setting in order to provide safe and timely access to ambulatory surgical services during times of high hospital occupancy.

NM Kishwaukee has 6 operating rooms. In CY23, NM Kishwaukee had 8,182 total surgery hours. Using the state standard for operating room utilization of 1,500

hours/operating room, NM Kishwaukee justifies 6 operating rooms. From CY15 – CY23, NM Kishwaukee experienced a 31% increase in surgical hours. While this trend is expected to continue, NM Kishwaukee commits to not increase surgical capacity at NM Kishwaukee until NMSC Sycamore is at the target utilization rate for a period of 12 consecutive months. Additionally, the proposed charges for comparable procedures at NMSC Sycamore will be lower than those of NM Kishwaukee Hospital.

Additionally, since FY21, NMSC Sycamore operates under the same financial assistance programs and Presumptive Eligibility policy as NM Kishwaukee and as such provides ASC access to patients of all insurance types. NMSC Sycamore has a similar payor mix to the hospital which is not typical of most ASCs. The proposed project will further increase access for patients who are uninsured and underinsured.

NMSC Sycamore	# of CY23 Patients	% of Total Patients
Medicare	266	30.5%
Medicaid	111	12.7%
Other Public	51	5.9%
Private Insurance	419	48.1%
Private Payment	1	0.1%
Charity Care	23	2.6%
Total	871	

1110.235(c)(7) – Unnecessary Duplication/Maldistribution

The 2024 total population of NMSC's GSA is in the table below:

Age Group	2024 Total Population	Population % Δ (2024 - 2029)
0-17	39,601	-4.2%
18-44	64,397	+0.8%
45-64	42,965	-2.1%
65+	28,884	+12.6%
Total GSA	175,847	**+0.9%**

The NMSC service area is projected to slightly increase in population over the next five years, with the largest growth in the 65+ age group, which typically account for the largest volume of health care services.

There are 2 ASTCs within the 17-mile radius of NMSC Sycamore. Only Valley Ambulatory Surgery Center is approved for gastroenterology procedures:

#	Facility	City	Specialties	Operating Rooms/ Procedure Rooms	CY22 Surgical Hours
1	Hauser Ross ASC	Sycamore	Ophthalmology	4 2	1,300 10
2	Valley ASC	St. Charles	Multi-specialty	6 2	3,003 1,262

NM Kishwaukee Hospital is the only hospital within the 17-mile radius of NMSC Sycamore:

#	Hospital	City	ORs	CY22 Surgical Hours
1	NM Kishwaukee Hospital	DeKalb	6 3	7,921 3,597

The proposed project will not result in a maldistribution of services. The proposed project does not increase the number of operating rooms at the ASTC and therefore the project will not increase in the number of operating rooms in the GSA. The ratio of surgical/treatment rooms to population remains unchanged.

NMSC anticipates that there will be no adverse impact to other area providers. As demonstrated by the physician referral letters, it is anticipated that the additional procedures proposed for NMSC will come from NM Kishwaukee Hospital only.

1110.235(c)(8) – Staffing

NMSC anticipates needing to hire a full-time RN and full-time Certified Surgical Tech (CST) to accommodate the additional procedures. NMSC does not anticipate issues with hiring for these positions due to NM's strong recruitment and retention efforts.

There is currently a medical director at NMSC Sycamore. There is also a Medical Executive/Quality Committee. The medical director oversees the Medical Executive/Quality Committee which is made up of 3 physicians (including the medical director). It is anticipated that additional physicians will be included on the committee to represent additional specialties.

1110.235(c)(9) – Charge Commitment

The proposed charges for the procedures to be added at NMSC are:

CPT Code	Procedure	Charge
G0105	**HB COLORECTAL SCRN; HI RISK IND**	**$ 2,000**
G0121	**HB COLON CA SCRN NOT HI RSK IND**	**$ 2,000**
45378	**HB DIAGNOSTIC COLONOSCOPY**	**$ 4,100**
45380	**HB COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE**	**$ 4,100**
45381	HB COLONOSCOPY SUBMUCOUS NJX	$ 4,100
45382	HB COLONOSCOPY W/CONTROL BLEED	$ 3,351
45384	HB COLONOSCOPY WITH HOT BIOPSY/BIPOLAR CAUTERY	$ 4,103
45385	HB COLONOSCOPY WITH POLYP SNARE	$ 4,100
45388	HB COLONOSCOPY W/ABLATION	$ 2,871
45390	HB COLONOSCOPY FLX W/ENDOSCOPIC MUCOSAL RESECTION	$ 5,708
43235	HB EGD DIAGNOSTIC BRUSH WASH	$ 2,678
43239	**HB EGD BIOPSY SINGLE/MULTIPLE**	**$ 2,590**
43248	HB EGD GUIDE WIRE INSERTION	$ 1,987
43249	HB ESOPH EGD DILATION <30 MM	$ 3,478
43251	HB EGD REMOVE LESION SNARE	$ 4,246

Procedures in **bold** are projected to have the highest volume.

By the signatures on the Certification page of this application, the applicants attest that the charges for these new procedures will not increase, at a minimum, for the first two (2) years of operation unless a permit is first obtained pursuant to 77 Ill. Adm. Code 1130.310(a).

1110.235(c)(10) – Assurances

By the signatures on the Certification page of this application, the applicants attest that a peer review program exists that evaluates whether patient outcomes are consistent with quality standards established by professional organization for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

By the signatures on the Certification page of this application, the applicants also attest that in the second year of operation after project completion, the annual utilization of the operating rooms will be closer to the utilization standard specified in 77 Ill. Adm. Code 1100.

Northwestern Medicine®

November 7, 2024

Mr. John Kniery
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Kniery:

I am a board-certified physician in gastroenterology. Please accept this letter verifying my anticipated referrals to approve the request to add gastroenterology as an approved specialty at NMSC Sycamore. This letter contains the referral documentation required per Ill. Admin. Code Section 1110.235(c)(3). In CY23, I performed a total of 1,466 procedures at NM Kishwaukee Hospital. With the addition of the gastroenterology service at NMSC, I expect to refer the patient volume listed below.

Procedure Location	# of CY23 Cases	Projected Referrals to NMSC
NM Kishwaukee Hospital	1,466	733

Provided below is patient origin data by zip code of residence for the patients I treated in CY23. I expect that my projected patients will continue to come from NMSC's geographic service area.

Zip Code of Patient Residence	# of Patients (% of Total)
DeKalb (60115)	485 (33.1%)
Sycamore (60178)	417 (28.4%)
Genoa (60135)	90 (6.1%)
Cortland (60112)	69 (4.7%)
Rochelle (61068)	65 (4.4%)
Kingston (60145)	37 (2.5%)
Malta (60150)	28 (1.9%)
Hampshire (60140)	26 (1.8%)
All Other	266 (17.0%)
TOTAL	**1,466**

The information contained in this letter is true and accurate to the best of my knowledge. The anticipated referral volumes noted above have not been used to support another pending or approved CON application.

Sincerely,

MD

David Manuel, MD
1830 Mediterranean Drive
Sycamore, IL 60178

"OFFICIAL SEAL"
Carrie M. Tucker
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 5/10/27

Subscribed and sworn to me

This 7th day of November, 2024

Carrie M Tucker

Notary Public

ATTACHMENT-25

Northwestern Medicine®

November 7, 2024

Mr. John Kniery
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Kniery:

I am a board-certified physician in gastroenterology. Please accept this letter verifying my anticipated referrals to approve the request to add gastroenterology as an approved specialty at NMSC Sycamore. This letter contains the referral documentation required per Ill. Admin. Code Section 1110.235(c)(3). In CY23, I performed a total of 1,022 procedures at NM Kishwaukee Hospital. With the addition of the gastroenterology service at NMSC, I expect to refer the patient volume listed below.

Procedure Location	# of CY23 Cases	Projected Referrals to NMSC
NM Kishwaukee Hospital	1,022	511

Provided below is patient origin data by zip code of residence for the patients I treated in CY23. I expect that my projected patients will continue to come from NMSC's geographic service area.

Zip Code of Patient Residence	# of Patients (% of Total)
DeKalb (60115)	346 (33.9%)
Sycamore (60178)	268 (26.2%)
Genoa (60135)	59 (5.8%)
Cortland (60112)	43 (4.2%)
Rochelle (61068)	27 (2.6%)
Kingston (60145)	19 (1.9%)
Shabbona (60550)	15 (1.5%)
Malta (60150)	15 (1.5%)
All Other	230 (22.5%)
TOTAL	**1,022**

The information contained in this letter is true and accurate to the best of my knowledge. The anticipated referral volumes noted above have not been used to support another pending or approved CON application.

Sincerely,

Neha Kaiser, DO
1850 Mediterranean Drive
Sycamore, IL 60178

"OFFICIAL SEAL"
Carrie M. Tucker
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 5/10/27

Subscribed and sworn to me

This 8th day of November, 2024

Carrie M Tucker
Notary Public

ATTACHMENT-25

SECTION VII. 1120.120 – AVAILABILITY OF FUNDS

Not Applicable – NMHC has a long-term bond rating of AA+ from S&P Global and Aa2 from Moody's Investors Service (see bond rating documents submitted in CON #24-006).

SECTION VIII. 1120.130 – FINANCIAL VIABILITY

Not Applicable – NMHC has a long-term bond rating of AA+ from S&P Global and Aa2 from Moody's Investors Service (see bond rating documents submitted in CON #24-006).

ATTACHMENTS-34, 35, 36

SECTION IX. 1120.140 – ECONOMIC FEASIBILITY

A. Reasonableness of Financing Arrangements

Not Applicable – NMHC has a long-term bond rating of AA+ from S&P Global and Aa2 from Moody's Investors Service (see bond rating documents submitted in CON #24-006).

B. Conditions of Debt Financing

Not Applicable – the proposed project does not involve debt financing.

C. Reasonableness of Project and Related Costs

Not Applicable – the proposed project does not involve construction or modernization.

D. Projected Operating Costs

For the proposed gastroenterology service:

Project Direct Operating Expenses – FY27

Total Direct Operating Costs	$	551,327
G.I. Procedures		1,244
Direct Cost per Procedure	$	443.19

E. Total Effect of the Project on Capital Costs

Projected Capital Costs – FY27

G.I. Procedures		1,244
Total Project Cost	$	713,000
Average Useful Life		7
Total Annual Depreciation	$	101,857
Depreciation Cost per Procedure	$	81.88

SECTION X. SAFETY NET IMPACT STATEMENT

Not Applicable – the proposed project is NON-SUBSTANTIVE and does not involve discontinuation.

SECTION X. CHARITY CARE INFORMATION

During FY21, NMSC Sycamore became wholly owned by NM Kishwaukee Hospital and as such now shares NMHC's financial assistance programs and outreach services that enable NMHC to serve patients with the most socioeconomic needs in our communities. Through our financial assistance programs and Presumptive Eligibility policy, NMHC provides medically necessary health care for those who do not have the resources to pay for it. In DeKalb County, NM Kishwaukee Hospital and NM Valley West Hospital are the leading charity care and Medicaid providers. Increasing access to NMSC Sycamore for gastroenterology services will benefit all patients, including those who are uninsured or underinsured. Unlike most ASCs, the payor mix of NMSC Sycamore is approximately the same as NM Kishwaukee Hospital.

CY23 Cases by Payor Source

	NMSC Sycamore	NM Kishwaukee Hospital
Medicare	30.5%	39.4%
Medicaid	12.7%	15.1%
Other Public	5.9%	2.6%
Insurance	48.1%	41.1%
Private Pay	0.1%	0.3%
Charity Care	2.6%	1.0%

Northwestern Medicine Surgery Center Sycamore

	FY21	FY22	FY23
Net Patient Revenue	$ 2,289,895	$ 2,671,722	$ 2,906,604
Amount of Charity Care (charges)	$ 0	$ 113,468	$ 79,282
Cost of Charity Care	$ 0	$ 39,536	$ 27,610

NM Kishwaukee Hospital

	FY21	FY22	FY23
Net Patient Revenue	$ 292,521,658	$ 318,618,073	$ 361,186,747
Amount of Charity Care (charges)	$ 17,851,009	$ 14,394,471	$ 15,768,843
Cost of Charity Care	$ 2,680,488	$ 3,194,155	$ 2,710,556

Northwestern Memorial HealthCare

	FY21	FY22	FY23
Net Patient Revenue	$6,810,599,673	$7,399,122,793	$8,095,919,536
Amount of Charity Care (charges)	$ 476,740,967	$ 469,227,416	$ 360,059,649
Cost of Charity Care	$ 79,890,361	$ 90,752,502	$ 67,545,943