

25-032
RECEIVED
AUG 15 2025
HEALTH FACILITIES &
SERVICES REVIEW BOARD

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**Facility/Project Identification**

Facility Name: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center		
Street Address: 530 N. Cass Avenue		
City and Zip Code: Westmont 60559		
County: Cook	Health Service Area: 007	Health Planning Area: 043

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

Exact Legal Name: Westmont Surgery Center, LLC
Street Address: 530 N. Cass Avenue
City and Zip Code: Westmont 60559
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 S. LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago 60604
Name of Managing Member: Giridhar Burra, M.D.
CEO Street Address: 530 N. Cass Avenue
President City and Zip Code: Westmont 60559
President Telephone Number: (630) 917-0972

Type of Ownership of Applicants

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois certificate of good standing. o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner. 	
APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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County: Cook	Health Service Area: 007	Health Planning Area: 043

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

Exact Legal Name: IBJI ASC Ventures, LLC
Street Address: 900 Rand Road, Suite 300
City and Zip Code: Des Plaines 60016
Name of Registered Agent: Christopher A. Kantas
Registered Agent Street Address: 900 Rand Road, Suite 300
Registered Agent City and Zip Code: Des Plaines 60016
Name of President: Gregory H. Portland, M.D. (Manager)
President Street Address: 2401 Ravine Way, Suite 200
President City and Zip Code: Glenview 60025
President Telephone Number: (847) 998-5680

Type of Ownership of Applicants

- | | |
|---|--|
| <input type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
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City and Zip Code: Westmont 60559		
County: Cook	Health Service Area: 007	Health Planning Area: 043

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

Exact Legal Name: Illinois Bone and Joint Institute, LLC
Street Address: 900 Rand Road, Suite 300
City and Zip Code: Des Plaines 60016
Name of Registered Agent: Christopher A. Kantas
Registered Agent Street Address: 900 Rand Road, Suite 300
Registered Agent City and Zip Code: Des Plaines 60016
Name of President: Gregory H. Portland, M.D. (Manager)
President Street Address: 2401 Ravine Way, Suite 200
President City and Zip Code: Glenview 60025
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Type of Ownership of Applicants

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Exact Legal Name: IBI Salt Creek ASC, LLC		
Street Address: 900 Rand Road, Suite 300		
City and Zip Code: Des Plaines 60616		
Name of Registered Agent: Christopher A. Kantas		
Registered Agent Street Address: 900 Rand Road, Suite 300		
Registered Agent City and Zip Code: Des Plaines 60016		
Name of President: Andre Blom (Manager)		
President Street Address: 900 Rand Road, Suite 300		
President City and Zip Code: Des Plaines 60016		
President Telephone Number: (847) 998-5680		

Type of Ownership of Applicants

- | | |
|---|--|
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Title: CON Counsel
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Telephone Number: (312) 212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number: (312) 767-9192

Additional Contact [Person who is also authorized to discuss the Application]

Name: Christopher A. Kantas

Title: General Counsel

Company Name: Illinois Bone and Joint Institute

Address: 900 Rand Road, Suite 300, Des Plaines, Illinois 60016

Telephone Number: (847) 324-3090

E-mail Address: ckantas@ibji.com

Fax Number: N/A

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

Name: Jessica Shapley

Title: Administrator

Company Name: Salt Creek Surgery Center

Address: 530 North Cass Avenue, Westmont, Illinois 60559

Telephone Number: (630) 869-4260

E-mail Address: jshapley@saltcreeksurgerycenter.com

Fax Number: (630) 794-8697

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: MPG Westmont Surgery Center, LLC

Address of Site Owner: 530 North Cass Avenue, Westmont, Illinois 60559

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: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

Address: 530 N. Cass Avenue, Westmont, Illinois 60559

☐

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.

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Salt Creek"), an ambulatory surgical treatment center ("ASTC") located at 530 N. Cass Avenue, Westmont, Illinois 60559, seeks to discontinue operations at its current facility. Salt Creek is a multi-specialty ASTC with four (4) operating rooms, offering services in Orthopedic Surgery, Pain Management, and Podiatry.

This discontinuation is proposed as part of a planned relocation of Salt Creek's operations to a new site approximately two (2) miles from the current location. The relocation will allow the facility to modernize and expand its clinical offerings while continuing to serve the same patient population in the surrounding service area.

There are no costs associated with the discontinuation itself. The discontinuation is classified as a substantive project, pursuant to 77 Ill. Admin. Code § 1110.20(c)(1)(B)(ii), because it involves the discontinuation of an existing health care facility.

Salt Creek affirms that all services currently provided at the existing site will be continued at the new location with no disruption in access or availability to patients. There is no reduction in capacity or service lines, and Salt Creek will maintain its physician network, referral patterns, and patient base. The relocation and resulting discontinuation of the current site will not result in any adverse impact on access to care.

Project Costs and Sources of Funds - NOT APPLICABLE

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 NOT APPLICABLE .		

Project Status and Completion Schedules- NOT APPLICABLE

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings:
<input type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): Upon Licensure of Relocated Facility or December 31, 2027.
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): NOT APPLICABLE
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.
<input type="checkbox"/> 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
<input type="checkbox"/> 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 - NOT APPLICABLE

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

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON-REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

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**.

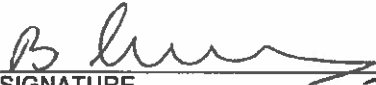
FACILITY NAME: Salt Creek Surgery Center			CITY: Westmont		
REPORTING PERIOD DATES:		From: January 1, 2022		to: December 31, 2022	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	-	-	-	-	-
Obstetrics	-	-	-	-	-
Pediatrics	-	-	-	-	-
Intensive Care	-	-	-	-	-
Comprehensive Physical Rehabilitation	-	-	-	-	-
Acute/Chronic Mental Illness	-	-	-	-	-
Neonatal Intensive Care	-	-	-	-	-
General Long-Term Care	-	-	-	-	-
Specialized Long-Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other (operating rooms)	4	4,349	N/A	-4	0
TOTALS:	4	4,349	N/A	-4	0

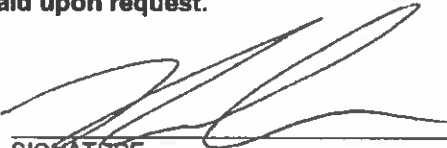
CERTIFICATION

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


- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o 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).
- o 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).
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, IBI Salt Creek ASC, LLC, IBI ASC Ventures, LLC, and Illinois Bone and Joint Institute, LLC* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE
GIRIDHAR BURRA
PRINTED NAME
PRESIDENT
PRINTED TITLE


SIGNATURE
Robert Thorne
PRINTED NAME
Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of July 2025


Signature of Notary

Seal

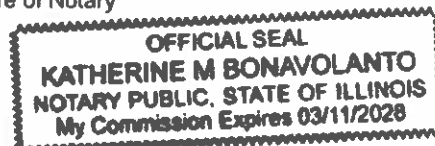


*Insert the EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 25 day of July 2025


Signature of Notary

Seal



SECTION II. DISCONTINUATION

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

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

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

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

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
 - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
 - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.
 - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
 - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
 - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)**PURPOSE OF PROJECT**

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

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

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

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE NOT APPLICABLE

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT: NOT APPLICABLE

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: NOT APPLICABLE

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

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

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

UTILIZATION					
	DEPARTMENT/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: NOT APPLICABLE

Provide the following information:

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

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

ASSURANCES: NOT APPLICABLE

Submit the following:

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

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

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

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

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS - NOT APPLICABLE

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

	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all terms and conditions.
	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY - NOT APPLICABLE

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY - NOT APPLICABLE

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

- 1) That the selected form of debt financing for the project will be at the lowest net cost available.
- 2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community**, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Charity (cost in dollars)			
Inpatient	\$0	\$0	\$0
Outpatient	\$0	\$0	\$0
Total	\$0	\$0	\$0
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Medicaid (revenue)			
Inpatient	\$0	\$0	\$0
Outpatient	\$0	\$0	\$0
Total	\$0	\$0	\$0

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	\$9,191,339	\$23,842,428	\$30,828,075
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

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

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM - NOT APPLICABLE



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: _____
(Name) (Address)

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

2. Project Location: _____
(Address) (City) (State)

(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.

4. 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 ___

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

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

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

Signature: _____ Date: _____

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

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	26-30
2	Site Ownership	31-33
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	34-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36
5	Flood Plain Requirements	n/a
6	Historic Preservation Act Requirements	n/a
7	Project and Sources of Funds Itemization	n/a
8	Financial Commitment Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	37-82
11	Background of the Applicant	83-84
12	Purpose of the Project	n/a
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
Financial and Economic Feasibility:		
33	Availability of Funds	n/a
34	Financial Waiver	n/a
35	Financial Viability	n/a
36	Economic Feasibility	n/a
37	Safety Net Impact Statement	n/a
38	Charity Care Information	86-87
39	Flood Plain Information	88

ATTACHMENT 1

Certificate of Good Standing

Included with this attachment are the Certificates of Good Standing for the following:

1. Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center (Licensee);
2. IBI ASC Ventures, LLC;
3. Illinois Bone and Joint, LLC; and
4. IBI Salt Creek ASC, LLC.

ATTACHMENT 1
Certificate of Good Standing
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

File Number

0051479-9



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

WESTMONT SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 02, 2001, 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 17TH day of JULY A.D. 2025 .

Authentication #: 2519803398 verifiable until 07/17/2026
Authenticate at: <https://www.isos.gov>


SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
IBJI ASC Ventures, LLC

File Number

1000735-6



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

IBJI ASC VENTURES, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 19, 2021, 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.



Authentication #: 2519803440 verifiable until 07/17/2026
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JULY A.D. 2025 .

Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Illinois Bone and Joint, LLC

File Number 0168922-3



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ILLINOIS BONE AND JOINT INSTITUTE, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 29, 2005, 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.



Authentication #: 2519803512 verifiable until 07/17/2026
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JULY A.D. 2025 .

Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
IBJI Salt Creek ASC, LLC

File Number

1065000-3



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

IBJI SALT CREEK ASC, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 05, 2021, 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



Authentication #: 2519803362 verifiable until 07/17/2028
Authenticate at: <https://www.issos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JULY A.D. 2025 .


SECRETARY OF STATE

ATTACHMENT 2

Site Ownership

The site ownership rests with NWI Salt Creek Surgery. Attached as evidence is a copy of the most recent tax bill.

ATTACHMENT 2
Site Ownership**MAKE CHECK PAYABLE TO: DU PAGE COLLECTOR - SEND THIS COUPON WITH YOUR 1ST INSTALLMENT PAYMENT OF 2024 Tax**MAIL PAYMENT TO: P.O. BOX 4203, CAROL STREAM, IL 60197-4203
PAY ON-LINE AT: www.dupagecounty.gov/treasurer
SEE REVERSE SIDE FOR ADDITIONAL INFORMATION09-04-403-058
NWI SALT CREEK SURGERY
71 S WACKER DR NO 3725
CHICAGO IL 60606**1**

ON OR BEFORE:	PAY:
JUN 02, 2025	0.00
PAYING LATE?	PAY THIS AMOUNT:
JUN 3 THRU 30	0.00
JUL 1 THRU 31	
AUG 1 THRU 31	
SEP 1 THRU 30	
OCT 1 THRU 31	
NOV 1 THRU 19	

U.S. POSTMARK IS USED TO
DETERMINE LATE PENALTY.PAYMENT OF THIS 2024 TAX BILL
AFTER OCTOBER 31, 2025,
REQUIRES A CASHIER'S CHECK,
CASH OR MONEY ORDER.☐ CHECK BOX AND
COMPLETE CHANGE OF
ADDRESS ON BACK.**NO PAYMENT WILL BE ACCEPTED AFTER NOV 19, 2025****\$28,851.38 PAID May 15, 2025****1090440305849006000288513841****MAKE CHECK PAYABLE TO: DU PAGE COLLECTOR - SEND THIS COUPON WITH YOUR 2ND INSTALLMENT PAYMENT OF 2024 Tax**MAIL PAYMENT TO: P.O. BOX 4203, CAROL STREAM, IL 60197-4203
PAY ON-LINE AT: www.dupagecounty.gov/treasurer
SEE REVERSE SIDE FOR ADDITIONAL INFORMATION09-04-403-058
NWI SALT CREEK SURGERY
71 S WACKER DR NO 3725
CHICAGO IL 60606**2**

ON OR BEFORE:	PAY:
SEP 02, 2025	28,851.38
PAYING LATE?	PAY THIS AMOUNT:
SEP 3 THRU 30	29,284.15
OCT 1 THRU 31	29,716.92
* NOV 1 THRU 19	30,159.69

U.S. POSTMARK IS USED TO
DETERMINE LATE PENALTY.PAYMENT OF THIS 2024 TAX BILL
AFTER OCTOBER 31, 2025,
REQUIRES A CASHIER'S CHECK,
CASH OR MONEY ORDER.☐ CHECK BOX AND
COMPLETE CHANGE OF
ADDRESS ON BACK.**NO PAYMENT WILL BE ACCEPTED AFTER NOV 19, 2025****2090440305849006000288513842**

Rate 2023	Tax 2023	Taxing District	Rate 2024	Tax 2024
		** COUNTY **		
0.0899	733.74	COUNTY OF DU PAGE	0.0832	738.66
0.0180	146.92	PENSION FUND	0.0165	146.50
0.0291	237.50	HEALTH DEPARTMENT	0.0250	221.98
0.0103	84.08	PENSION FUND	0.0114	101.22
0.1001	816.98	FOREST PRESERVE DIST	0.1213	1,076.94
0.0075	61.22	PENSION FUND	0.0097	86.12
0.0132	107.74	DU PAGE AIRPORT AUTH	0.0122	106.32
		** LOCAL **		
NO LEVY	0.00	DU PAGE WATER COMM	NO LEVY	0.00
0.0315	257.10	DOWNERS GROVE TWP	0.0303	269.02
0.0003	2.44	PENSION FUND	0.0001	0.88
0.0528	430.96	DOWNERS GR TWP RD	0.0506	449.26
0.0008	6.52	PENSION FUND	0.0006	5.32
0.2270	1,852.70	VLG WESTMONT-EX FIRE	0.2223	1,973.64
0.0986	804.74	VLG WESTMONT FIRE	0.0949	842.54
0.4587	3,743.78	PENSION FUND	0.4380	3,888.70
0.2257	1,842.10	VLG WESTMONT LIBRARY	0.2176	1,931.92
0.4070	3,321.80	WESTMONT PARK DIST	0.3922	3,482.08
0.0137	111.82	PENSION FUND	0.0133	118.08
0.0407	332.18	DOWNERS GR SAN DIST	0.0394	349.80
		** EDUCATION **		
4.6639	38,065.34	UNIT SCHOOL DIST 201	4.5049	39,995.84
0.0321	262.00	PENSION FUND	0.0384	323.18
0.1907	1,556.44	COLLEGE DU PAGE 502	0.1794	1,592.78
		** TIF **		

Mailed to:
NWI SALT CREEK
SURGERY
71 S WACKER DR NO 3725
CHICAGO IL 60606Property Location:
530 N CASS AVE
WESTMONT IL 60559-1503

Township Assessor:

DOWNERS GROVE
630-719-6830

Tax Code:

9006

Property Index Number:

09-04-403-058

CHANGE OF NAME/ADDRESS:

CALL: 630-407-5900

* \$ OF A FACTOR 1.0878

1st INST PAID May 15, 2025

2nd INST DUE ON September 02, 2025

TIF Frozen Value	
Fair Cash Value	2,663,800
Land Value	138,988
+ Building Value	748,842
= Assessed Value	887,830
x State Multiplier	1.0000
= Equalized Value	887,830
- Residential Exemption	
- Senior Exemption	
- Senior Freeze	
- Disabled Veteran	
- Disability Exemption	
- Returning Veteran Exemption	
- Home Improvement Exemption	
- House Abatement	
= Net Taxable Value	887,830
x Tax Rate	6.4993
= Total Tax Due	57,702.76
- Less Advance Payment	
- Commercial Abatement	
+ PACE Reimbursement	
= Net Due as of 07/17/25	28,851.38

2024 DuPage County Real Estate Tax Bill
Gwen Henry, CPA, County Collector
421 N. County Farm Road
Wheaton, IL 60187Office Hours - 8:00 am - 4:30 pm, Mon - Fri
Telephone = (630) 407-5900

6.7116 54,778.08 TOTALS 6.4993 57,702.76

2023 816,170 Assessed Value 2024 887,830

ATTACHMENT 2 Site Ownership

CHANGE OF NAME AND/OR MAILING ADDRESS - CHECK BOX ON FRONT OF COUPON

Property Index Number - - -

Name

Mailing Address

City State Zip

Area Code and Phone Number -

I certify that I am the owner and authorize the above name and/or address change.

Signature _____ Date _____

Print Name _____

CHANGE OF NAME AND/OR MAILING ADDRESS - CHECK BOX ON FRONT OF COUPON

Property Index Number - - -

Name

Mailing Address

City State Zip

Area Code and Phone Number -

I certify that I am the owner and authorize the above name and/or address change.

Signature _____ Date _____

Print Name _____

HELPFUL INFORMATION

Failure to receive a bill does not relieve the taxpayer of penalty if payment is late.
This is the only bill you will receive. This bill includes a separate payment coupon for each installment.
All checks are electronically deposited upon receipt, regardless of date on check. Funds must be in U.S. dollars.
Payments returned to us by your bank as unpaid will be subject to a \$25.00 return item fee plus applicable penalties.
Personal checks received after 10/31/25 will be returned.
No payment will be accepted after 11/19/25 regardless of postmark.

CONVENIENT WAYS TO PAY

Banks: Thru 09/02/25 (see website for participating banks)
Mail Thru 09/30/2025:
DuPage County Collector, P.O. Box 4203, Carol Stream, IL 60197
Mail After 09/30/2025:
DuPage County Collector, 421 N. County Farm Rd, Wheaton, IL 60187
Online: Thru 10/31/25 using Bank account transfer or with Visa, Mastercard or Discover.
- 2.10% Credit Card convenience fee to service provider

Drop Box: Thru 11/03/25 by 8:00 am
South Parking Lot, 421 N. County Farm Rd, Wheaton
Phone: Thru 11/18/25 (855)795-3091 (Credit Cards with 2.10% fee)
In Person: Thru 4:30pm on 11/19/25
Treasurer's Office, 421 N. County Farm Rd, Wheaton

SENIOR CITIZEN PROGRAMS - 65 and older
SENIOR ASSESSMENT FREEZE and SENIOR EXEMPTION
Contact Supervisor of Assessments 630-407-5858
SENIOR CITIZEN DEFERRAL
Contact County Treasurer 630-407-5900

IMPORTANT DATES

06/02/25 1st installment due date
09/02/25 2nd installment due date
10/03/25 Payment deadline to avoid publication
10/21/25 Certified delinquent bills mailed
10/31/25 Last day to pay online
11/03/25 Certified funds required for payment
11/03/25 \$10 newspaper publication fee assessment begins
11/19/25 In-office payment deadline 4:30pm
11/20/25 Tax Sale


*EQUALIZATION FACTORS

Equalization factors imposed by the State and by DuPage County are used to insure that assessment levels in all nine townships are at the statutory level of assessment of 33.33% of fair cash value. The Illinois Department of Revenue equalization factor (state multiplier) is shown on the front of the bill. The DuPage County Supervisor of Assessments (S of A) equalization factor is also shown on the front of this tax bill*.

After September 30, 2025: Mail payment to the DuPage County Collector, 421 N. County Farm Rd., Wheaton, IL 60187
DuPage County Treasurer's website: www.dupagecounty.gov/elected_officials/treasurer

ATTACHMENT 3 Operating Entity/Licensee

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center is licensed by the Illinois Department of Public Health. The license is in Good Standing and is attached herein.

		ILLINOIS DEPARTMENT OF PUBLIC HEALTH		HF132073
LICENSE, PERMIT, CERTIFICATION, REGISTRATION				
<small>The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.</small>				
Sameer Vohra, MD,JD,MA			<small>Issued under the authority of the Illinois Department of Public Health</small>	
Director				
<small>EXPIRATION DATE</small>	<small>CATEGORY</small>	<small>LIC NUMBER</small>		
12/30/2025		7003189		
Ambulatory Surgery Treatment Center				
Effective: 12/31/2024				
Westmont Surgery Center LLC dba Salt Creek Surgery Center 530 N Cass Avenue Westmont, IL 60559				
<small>The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24</small>				

← **DISPLAY THIS PART IN A
CONSPICUOUS PLACE**

Exp. Date 12/30/2025

Lic Number 7003189

Date Printed 11/1/2024

Westmont Surgery Center LLC
dba Salt Creek Surgery Center
530 N Cass Avenue
Westmont, IL 60559-1503

FEE RECEIPT NO.

ATTACHMENT 3
Certificate of Good Standing
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

File Number

0051479-9



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

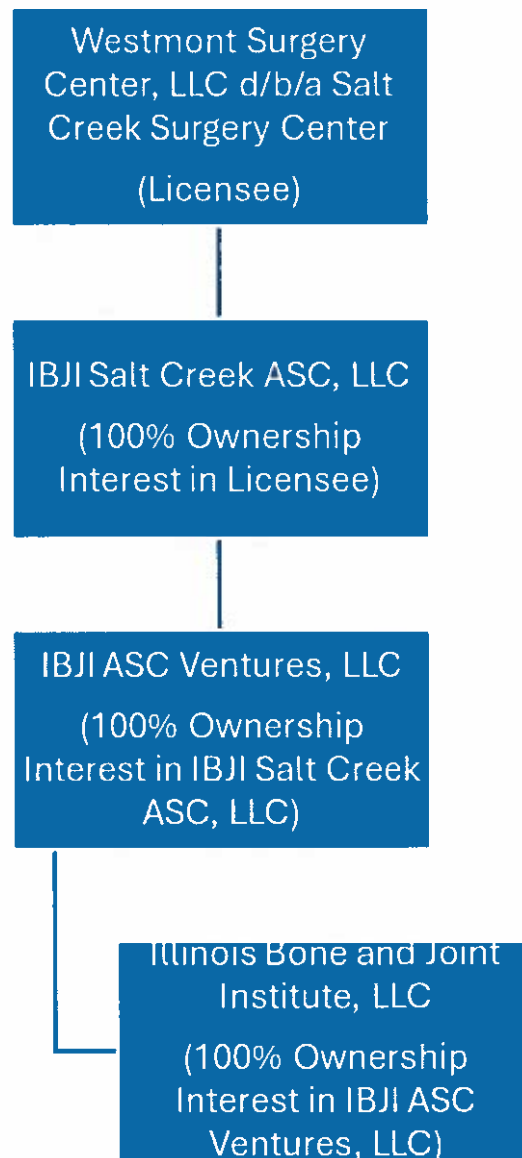
WESTMONT SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 02, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JULY A.D. 2025 .

Authentication # 2519803398 verifiable until 07/17/2026
Authenticate at <https://www.ilsos.gov>


SECRETARY OF STATE

**ATTACHMENT 4
Organizational Chart**

ATTACHMENT 10

Discontinuation

General

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

Salt Creek Surgery Center currently operates as a multi-specialty Ambulatory Surgical Treatment Center (ASTC) with four (4) operating rooms. The services to be discontinued include Orthopedic Surgery, Pain Management, and Podiatry. These services will be permanently discontinued at the current location upon approval of this discontinuation application.

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

NOT APPLICABLE - Salt Creek does not provide any additional clinical services outside of the primary specialties listed above.

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

Salt Creek proposes to discontinue operations at the current site upon issuance of a license for its new facility, which is the subject of a pending CON application for relocation approximately two (2) miles from the current location. The anticipated effective date of discontinuation will coincide with the licensure of the relocated facility to ensure uninterrupted service to patients.

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

Upon approval of the discontinuation, all major equipment and furnishings will be transferred to the new facility and re-deployed for clinical operations at that site. The current facility location will be vacated and is expected to be returned to the property owner or otherwise repurposed for non-healthcare-related use.

5. Provide attestation that the facility provided the required notice of the category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

The Applicant hereby attests that it has provided the required notice of the proposed discontinuation of services to a local media outlet that the facility would routinely notify about facility events.

Supporting Documentation:

- Copy of Notice: See enclosed publication.
- Local Media Outlet: *The Chicago Tribune* (local newspaper of general circulation).
- Date Notice Was Given: August 8, 2025.
- Result of Notice: The notice was published in print and digital editions of *The Chicago Tribune* on August 8, 2025.

This satisfies the requirement to notify a local television station, radio station, or newspaper pursuant to 77 Ill. Admin. Code § 1130.140(b)(6)(C).

ATTACHMENT 10

Discontinuation Media Notice

The applicants will publish the notice below in the Chicago Tribune, a local newspaper that routinely notifies the public about facility events. The notice below is scheduled to be published at a single time in the classified ad section of the newspaper on August 8, 2025. The Chicago Tribune has a print circulation of 172,000, and an online presence. The Chicago Tribune is a newspaper of general circulation throughout Cook County and surrounding areas, and is a newspaper as defined by 715 ILCS 5/5.

"Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center has filed a Certificate of Need application with the Illinois Health Facilities and Services Review Board to discontinue its ambulatory surgical treatment center located at 530 N. Cass Avenue, Westmont, Illinois 60559, in the fourth quarter of 2026. After submission of the application to discontinue the facility to the HFSRB, the application for the proposed discontinuation may be found on the HFSRB website at <https://hfsrb.illinois.gov/project/project-search.html>. There is also an application to relocate the Salt Creek Surgery to 550 West Ogden Avenue, Hinsdale, Illinois 60521. If you are or have been a patient at Salt Creek Surgery Center, and have questions about accessing your medical records, please call (630) 968-1800."

ATTACHMENT 10

Reasons for Discontinuation

Salt Creek Surgery Center proposes discontinuation at its current location due to both operational and physical limitations. The existing site is no longer economically viable due to space constraints that hinder facility expansion and modernization.

The proposed discontinuation and subsequent relocation will support continued service to patients in a modern facility with improved design and increased capacity. The new site, owned and controlled by affiliated physicians of Illinois Bone and Joint Institute, will better accommodate patient volumes and clinical workflow.

The discontinuation will allow for the orderly relocation of the facility to a new site approximately two miles from the existing location. Additionally, the current facility has significant physical limitations that prevent the necessary expansion of operating rooms.

The facility has consistently met the State's utilization standards and requires additional capacity to meet patient demand. Remaining at the current location is not economically sustainable and restricts access for Illinois Bone and Joint Institute patients.

ATTACHMENT 10

Impact on Access

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

The discontinuation will not have an adverse effect upon access of care for residents of the facility's market area. Salt Creek Surgery Center does not believe the discontinuation will have a negative effect on area facilities as this facility will not cease operations until the new relocated site is operational and licensed. Additionally, there are other ASTC's in the GSA that offer these categories of service.

- 2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.**

Included in Attachment 10 are copies of the notification letter sent to area facilities within the geographic service area and maps indicating the distance and drive times to the facilities. The applicant has sent written notice of the proposed discontinuation to all approved health care facilities within the GSA that offer similar services. These notices included a request for impact statements, as required by regulation.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

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

**Re; Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

Dear Director Vohra:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as we have submitted a CON Application to relocate the facility to 550 West Ogden Avenue, Hinsdale, Illinois 60521.

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


Sincerely,

A handwritten signature in black ink, appearing to read "G. Burra", is written over a horizontal line.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY																
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p style="margin-left: 40px;">Sameer Vohra, MD, JD, MA Director II Dept of Public Health 535 W. Jefferson Street Springfield, IL 62761</p> <p style="text-align: center;"> 9590 9402 8886 4064 6270 46</p> <p>2. Article Number (Transfer from service label) 9589 0710 5270 0629 0315 36</p>	<p>A. Signature X <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type</p> <table style="width: 100%; font-size: small;"> <tr> <td><input checked="" type="checkbox"/> Adult Signature</td> <td><input type="checkbox"/> Priority Mail Express®</td> </tr> <tr> <td><input type="checkbox"/> Adult Signature Restricted Delivery</td> <td><input type="checkbox"/> Registered Mail™</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail®</td> <td><input type="checkbox"/> Registered Mail Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail Restricted Delivery</td> <td><input type="checkbox"/> Signature Confirmation™</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery</td> <td><input type="checkbox"/> Signature Confirmation Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery Restricted Delivery</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Insured Mail</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®	<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™	<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery	<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Signature Confirmation™	<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery	<input type="checkbox"/> Collect on Delivery Restricted Delivery		<input type="checkbox"/> Insured Mail		<input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)	
<input checked="" type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®																
<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™																
<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery																
<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Signature Confirmation™																
<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery																
<input type="checkbox"/> Collect on Delivery Restricted Delivery																	
<input type="checkbox"/> Insured Mail																	
<input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)																	

PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®	
OFFICIAL USE	
<p style="font-size: x-small;">Certified Mail Fee</p> <p style="font-size: x-small;">(Use Serviceable & Non-Serviceable rates, add fee as appropriate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$</p> <p><input type="checkbox"/> Return Receipt (electronic) \$</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery \$</p> <p><input type="checkbox"/> Adult Signature Required \$</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery \$</p> <p style="font-size: x-small;">Postage</p>	<p style="font-size: 2em; color: #008000;">40427.7</p> <p style="font-size: x-small; text-align: center;">Postmark Here</p>
<p>Sameer Vohra, MD, JD, MA Director II Dept of Public Health 535 W. Jefferson Street Springfield, IL 62761</p>	
PS Form 3800, January 2022 PSN 7530-02-000-9047 See Reverse for Instructions	

Salt Creek Surgery Center
530 N. Cass Avenue
Westmont, Illinois 60559

Sameer Vohra, MD, JD, MA, Director
II Dept of Public Health
535 W. Jefferson Street
Springfield, IL 62761

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Hon. Greg Hribal
10300 W. Roosevelt Rd.
Westchester, IL 60154

Re; Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

Dear President Hribal:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as we have submitted a CON Application to relocate the facility to 550 West Ogden Avenue, Hinsdale, Illinois 60521.

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


Sincerely,

A handwritten signature in black ink, appearing to read "B. Burra", with a long horizontal flourish extending to the right.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p align="center">Hon. Greg Hribal 10300 W. Roosevelt Road Westchester, IL 60154</p> <p align="center"> 9590 9402 8277 3094 5749 70</p> <p>2. Article Number (Transfer from service label)</p> <p align="center">9589 0710 5270 0629 0315 43</p>		<p>A. Signature X <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input checked="" type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)</p> <p><input type="checkbox"/> Priority Mail Express® <input checked="" type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery</p>	
PS Form 3811, July 2020 PSN 7530-02-000-9053		Domestic Return Receipt	

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®	
OFFICIAL USE	
Certified Mail Fee	484.29.7
<p>Additional Services & Fees (select box, enter fee or approximate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$</p> <p><input type="checkbox"/> Return Receipt (electronic) \$</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery \$</p> <p><input type="checkbox"/> Adult Signature Required \$</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery \$</p> <p>Postage \$</p> <p>Total \$</p> <p>Fee \$</p> <p>Postmark</p>	<p>Hon. Greg Hribal 10300 W. Roosevelt Road Westchester, IL 60154</p>
PS Form 3800, January 2023 PSN 7530-02-000-8047 See Reverse for Instructions	

Salt Creek Surgery Center
530 N. Cass Avenue
Westmont, Illinois 60559

Hon. Greg Hribal
10300 W. Roosevelt Road
Westchester, IL 60154

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

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

**Re; Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

Dear Director Whitehorn:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "B. Burra", with a long horizontal stroke extending to the right.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

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<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature X <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>
<p>1. Article Addressed to:</p> <p align="center">Elizabeth Whitehorn, Director Dept of Healthcare & Family Svcs 201 S. Grand Avenue, East Springfield, IL 62763</p>	<p>B. Received by (Printed Name) C. Date of Delivery</p>
<p>2. Article Number (Transfer from service label)</p> <p align="center">9589 0710 5270 0629 0315 67</p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>3. Service Type</p> <p><input checked="" type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™ <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Certified Mail Restricted Delivery <input checked="" type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)</p>	
<p>PS Form 3811, July 2020 PSN 7530-02-000-6053</p>	<p>Domestic Return Receipt</p>

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®.	
<p>Certified Mail Fee</p> <p>48427.7</p>	<p>Postmark</p>
<p>Extra Services & Fees (Check box, add fee as appropriate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$ <input type="checkbox"/> Return Receipt (electronic) \$ <input type="checkbox"/> Certified Mail Restricted Delivery \$ <input type="checkbox"/> Adult Signature Required \$ <input type="checkbox"/> Adult Signature Restricted Delivery \$</p>	<p>Postage</p> <p>Elizabeth Whitehorn, Director Dept of Healthcare & Family Svcs 201 S. Grand Avenue, East Springfield, IL 62763</p>
PS Form 3800, January 2023 PSN 7530-02-000-6047 See Reverse for Instructions	

Salt Creek Surgery Center
 530 N. Cass Avenue
 Westmont, Illinois 60559

Elizabeth Whitehorn, Director
 Dept of Healthcare & Family Svcs
 201 S. Grand Avenue, East
 Springfield, IL 62763

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Hon. Martha Deuter
1 S. Cass Ave., Suite 104
Westmont, IL 60559

**Re; Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

Dear Representative Deuter:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as we have submitted a CON Application to relocate the facility to 550 West Ogden Avenue, Hinsdale, Illinois 60521.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "G. Burra", is written over a horizontal line.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



Joint Commission

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY		
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mail piece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p align="center">Hon. Martha Dueter 1 S. Cass Avenue, Suite 104 Westmont, IL 60559</p> <p align="center">9590 9402 8277 3094 5749 94</p> <p>2. Article Number (Transfer from service label) 9589 0710 5270 0629 0315 74</p>	<p>A. Signature X <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type</p> <table border="0"> <tr> <td> <input checked="" type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500) </td> <td> <input type="checkbox"/> Priority Mail Express® <input checked="" type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery </td> </tr> </table>	<input checked="" type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)	<input type="checkbox"/> Priority Mail Express® <input checked="" type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery
<input checked="" type="checkbox"/> Adult Signature <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)	<input type="checkbox"/> Priority Mail Express® <input checked="" type="checkbox"/> Registered Mail™ <input type="checkbox"/> Registered Mail Restricted Delivery <input checked="" type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Signature Confirmation Restricted Delivery		

PS Form 3811, July 2020 PSN 7530-02-000-9033 Domestic Return Receipt

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ™.	
OFFICIAL USE	
<p>Certified Mail Fee</p> <p>Extra Services & Fees (price and fee as appropriate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$</p> <p><input type="checkbox"/> Return Receipt (electronic) \$</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery \$</p> <p><input type="checkbox"/> Adult Signature Required \$</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery \$</p>	<p>Postage</p> <p>48427.7</p>
<p>Package</p> <p>Total Post</p> <p>Sent To</p> <p>Street and</p> <p>City, State</p>	<p>Hon. Martha Dueter 1 S. Cass Avenue, Suite 104 Westmont, IL 60559</p>
PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions	

Salt Creek Surgery Center
530 N. Cass Avenue
Westmont, Illinois 60559

Hon. Martha Dueter
1 S. Cass Avenue, Suite 104
Westmont, IL 60559

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Hon. Suzy Glowiak Hilton
17W715 E. Butterfield Road, Suite F
Oakbrook Terrace, IL 60181

**Re; Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

Dear Senator Hilton:

In accordance with Section 8.7(a) of the Illinois Health Facilities and Planning Act (20 ILCS 3960/8.7), I am providing this notice of our intent to file an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue the ambulatory surgical treatment center ("ASTC") Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559.

We are aware of no adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as we have submitted a CON Application to relocate the facility to 550 West Ogden Avenue, Hinsdale, Illinois 60521.

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

Sincerely,

A handwritten signature in black ink, appearing to read "G. Burra", is written over a horizontal line.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 		A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
1. Article Addressed to: Hon. Suzy Glowiak Hilton 17W715 E. Butterfield Road, Suite F Oakbrook Terrace, IL 60181		B. Received by (Printed Name)	C. Date of Delivery
2. Article Number (Transfer from service label) 9589 0710 5270 0629 0315 50		D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
3. Article Addressed to: Hon. Suzy Glowiak Hilton 17W715 E. Butterfield Road, Suite F Oakbrook Terrace, IL 60181		Service Type <input checked="" type="checkbox"/> Adult Signature <input checked="" type="checkbox"/> Adult Signature Restricted Delivery <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)	
PS Form 3811, July 2020 PSN 7530-02-000-9053		Domestic Return Receipt	

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT	
Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®	
Official Use 484277 Postmark None	
Certified Mail Fee \$	Postage \$
Other Services & Fees (check box, add fee as appropriate) <input type="checkbox"/> Return Receipt (hardcopy) <input type="checkbox"/> Return Receipt (electronic) <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Adult Signature Required <input type="checkbox"/> Adult Signature Restricted Delivery \$	Total \$
Hon. Suzy Glowiak Hilton 17W715 E. Butterfield Road, Suite F Oakbrook Terrace, IL 60181	
PS Form 3800, January 2023 PSN 7530-02-000-9041 See Reverse for Instructions	

Salt Creek Surgery Center
530 N. Cass Avenue
Westmont, Illinois 60559

Hon. Suzy Glowiak Hilton
17W715 E. Butterfield Road, Suite F
Oakbrook Terrace, IL 60181

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Pursuant to 77 Ill. Admin. Code § 1110.235(c)(2)(H), the applicant has provided written notice of the proposed discontinuation to all existing, approved health care facilities located within the defined Geographic Service Area (GSA) that offer the same categories of service as those being discontinued.

The GSA has been determined based on a 10-mile radius surrounding the Salt Creek Surgery Center, taking into account actual drive times and multi-directional travel patterns. A list of zip codes encompassed within this 10-mile radius is included below, along with a map depicting the geographic boundaries of the GSA.

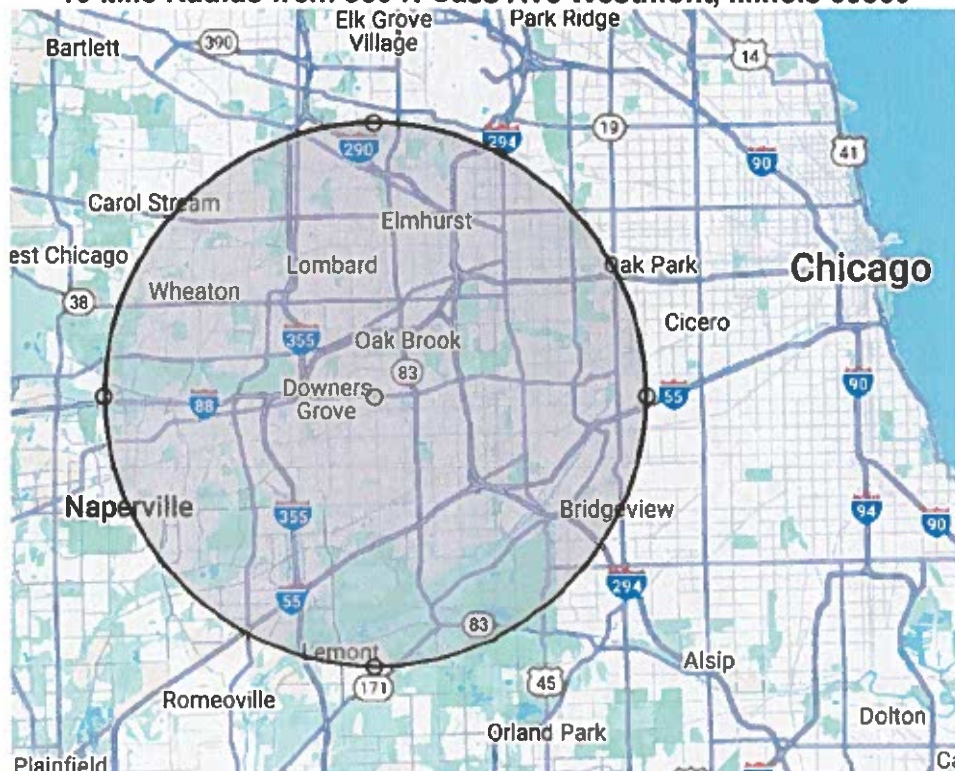
Copies of the notification letters sent to applicable area facilities are included on the following pages.

ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads

10 Mile Radius from 530 N Cass Ave Westmont, Illinois 60559



Facility Name	Facility Address
Chicago Prostate Surgery Center	815 Pasquinelli Drive, Westmont, IL 60559
Chicago Vascular ASC, LLC	700 Pasquinelli Drive, Westmont, IL 60559
Hinsdale Surgical Center	10 Salt Creek Lane, Hinsdale, IL 60521
Rush Oak Brook Surgery Center	2011 York Road, Suite 3000, Oak Brook IL 60523
The Oak Brook Surgical Centre, Inc.	2425 W. 22 nd Street, Suite 101, Oak Brook IL 60523
Midwest Center for Day Surgery	3811 Highland Avenue, Downers Grove, IL 60515
Ambulatory Surgicenter of Downers Grove	4333 Main Street, Downers Grove, IL 60515
Children's Outpatient Services at Westchester	2301 Enterprise Drive, Westchester, IL 60154
Loyola Surgery Center	1S224 Summit Avenue, Suite 201 Oak Brook Terrace, IL 60181
United Shockwave Services, Ltd.	120 N. LaGrange Road, LaGrange, IL 60525
DMG Surgical Center, LLC	2725 Technology Drive, Lombard, IL 60148
Illinois Back and Neck Institute	360 West Butterfield Road, Suite 100, Elmhurst IL 60126
OrthoTec Surgery Center, Inc.	340 West Butterfield Road, Suite 1B, Elmhurst IL 60126
Elmhurst Outpatient Surgery Center, LLC	1200 S. York Road, Suite 1400, Elmhurst IL 60126
Naperville Fertility Center, Inc.	3 N. Washington Street, Naperville IL 60540

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Chicago Prostate Surgery Center
815 Pasquinelli Dr.
Westmont, IL 60559

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

We are aware of no adverse impact upon patient access, and do not anticipate any such impact from the discontinuation of the services as the facility will be relocating to a nearby location without any change of surgical service offerings.

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

Sincerely,

A handwritten signature in black ink, appearing to read "G. Burra", is written over a horizontal line.

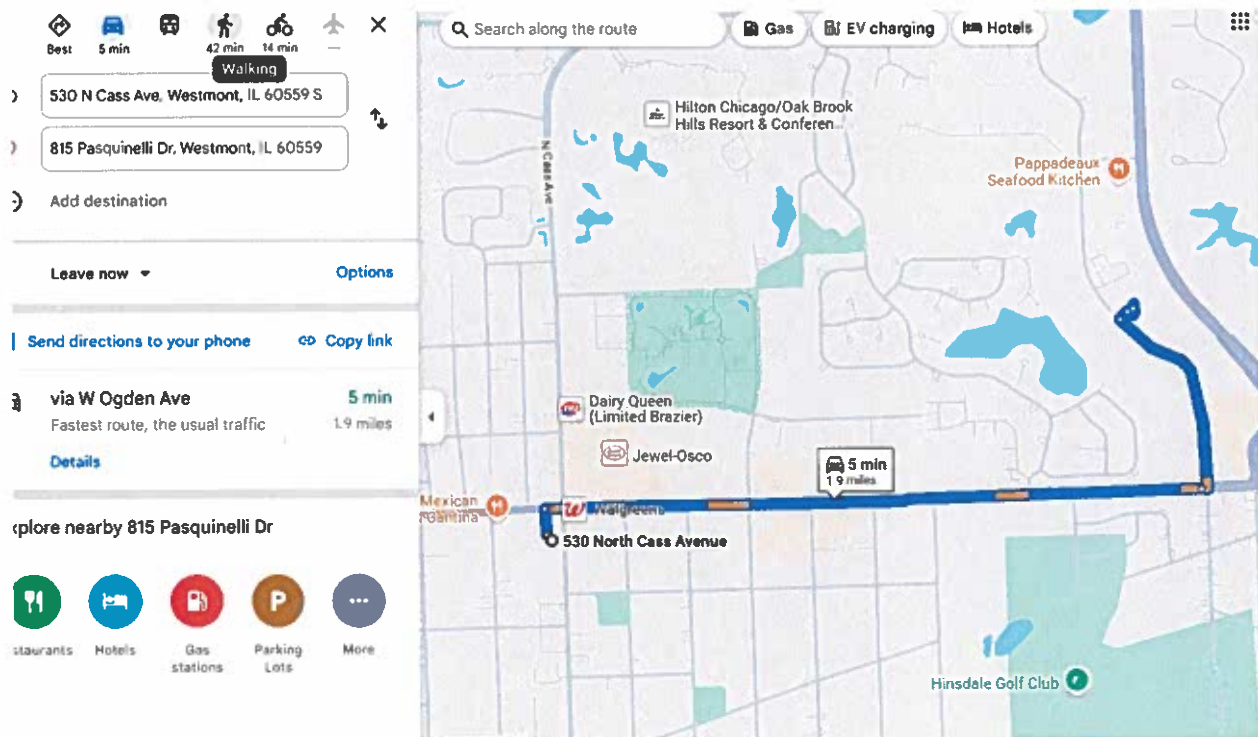
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Chicago Vascular ASC, LLC
700 Pasquinelli Dr.
Westmont, IL 60559

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

We are aware of no adverse impact upon patient access, and do not anticipate any such impact from the discontinuation of the services as the facility will be relocating to a nearby location without any change of surgical service offerings.

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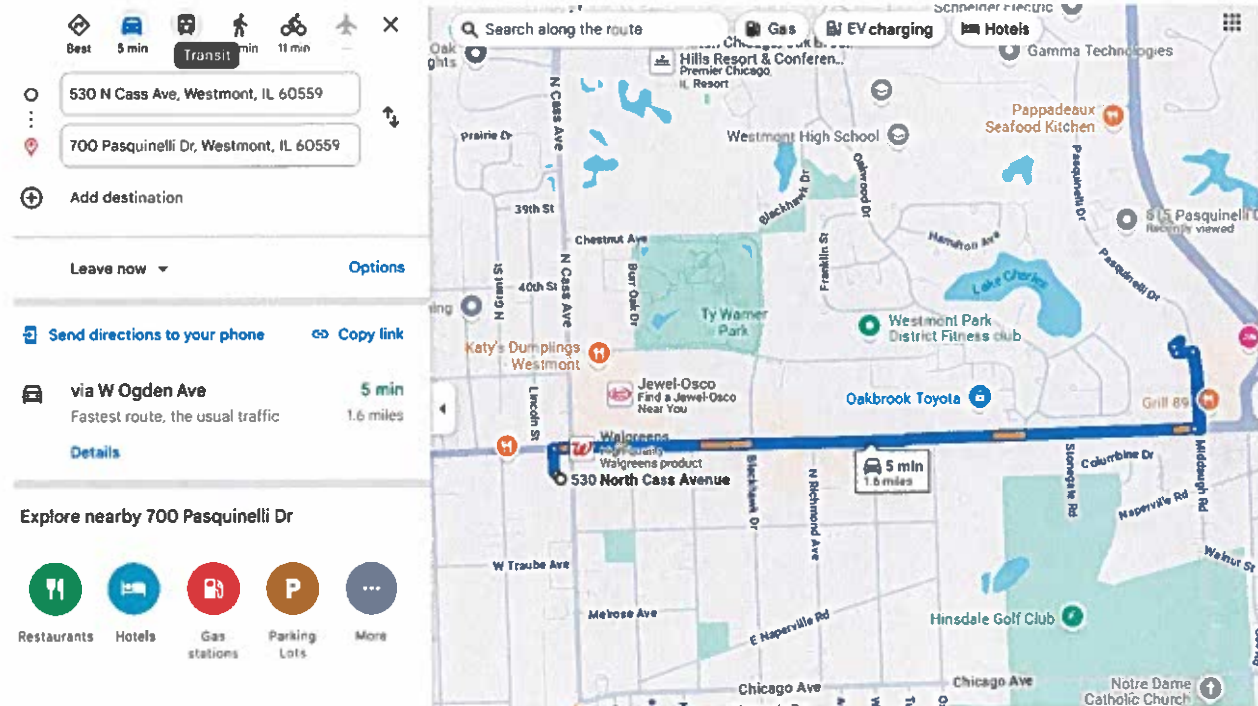
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Hinsdale Surgical Center
10 Salt Creek Ln.
Hinsdale, IL 60521

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

We are aware of no adverse impact upon patient access, and do not anticipate any such impact from the discontinuation of the services as the facility will be relocating to a nearby location without any change of surgical service offerings.

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

Sincerely,

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Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

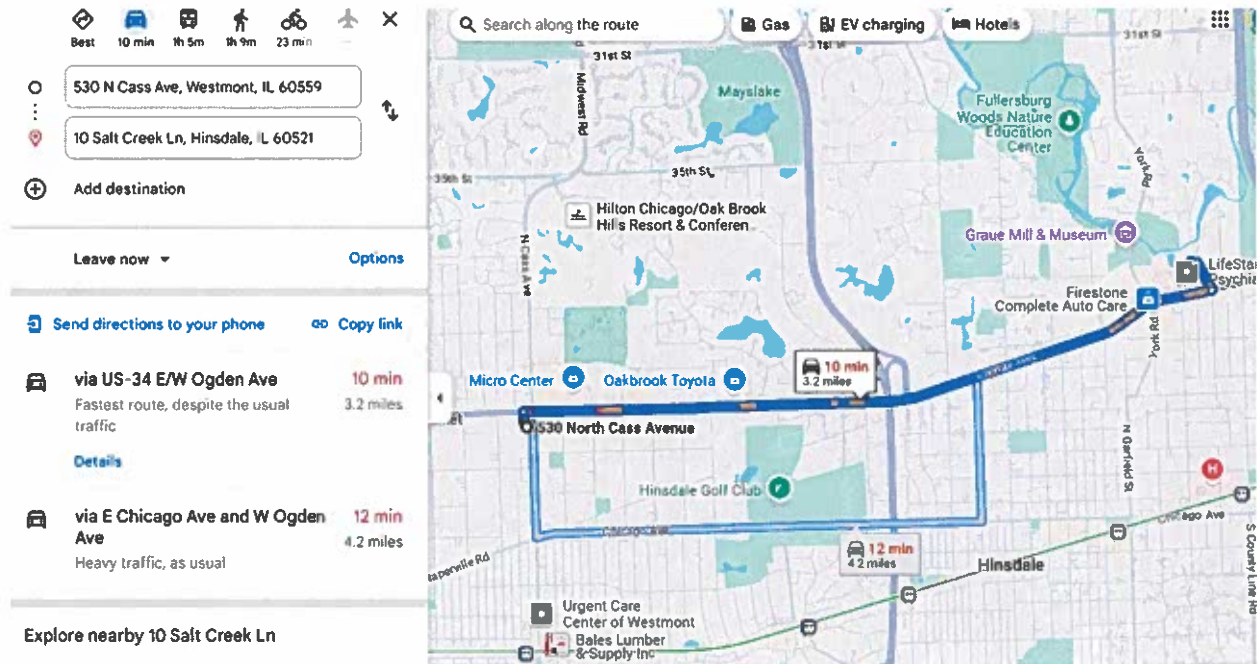


Joint Commission

ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Rush Oak Brook Surgery Center
2011 York Rd., Suite 3000
Oak Brook, IL 60523

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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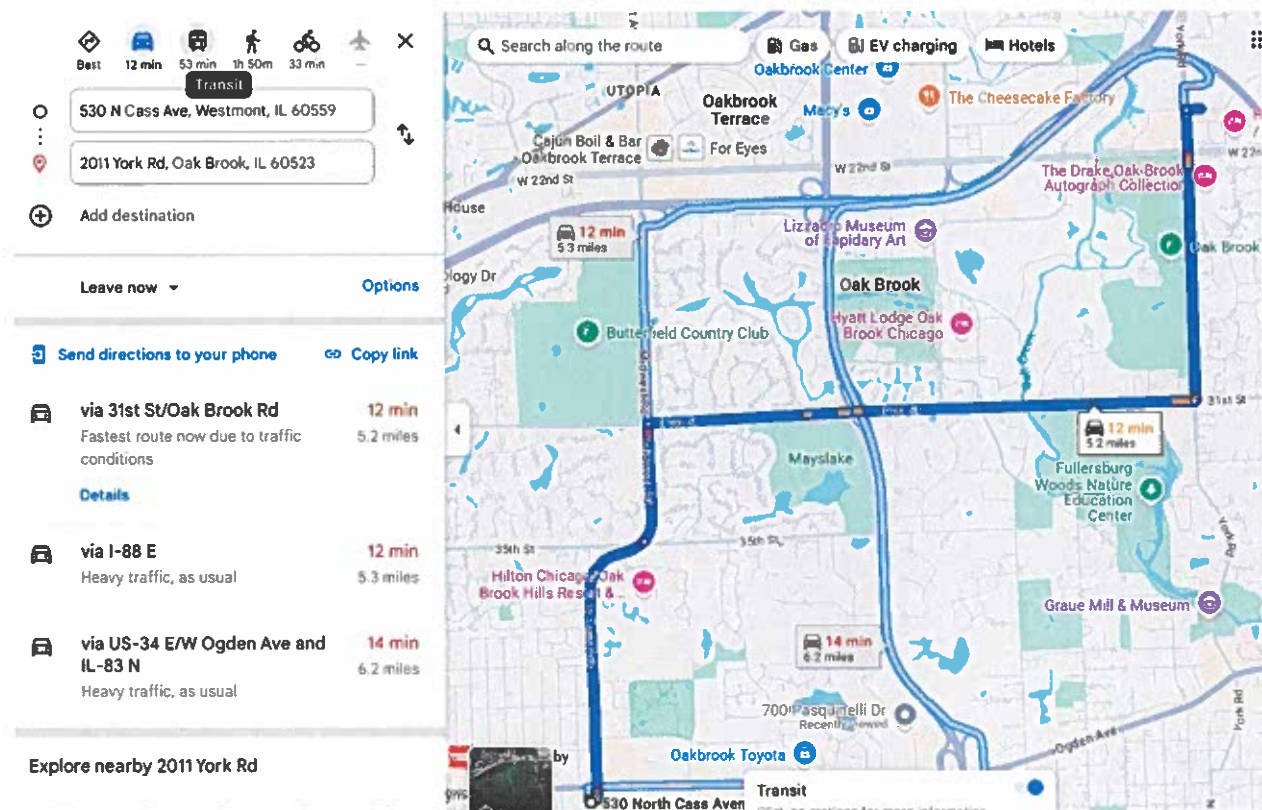
Sincerely,

A handwritten signature in black ink, appearing to read "B. Burra", is written over a horizontal line.

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10 Discontinuation Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
The Oak Brook Surgical Centre, Inc.
2425 W. 22nd St., Suite 101
Oak Brook, IL 60523

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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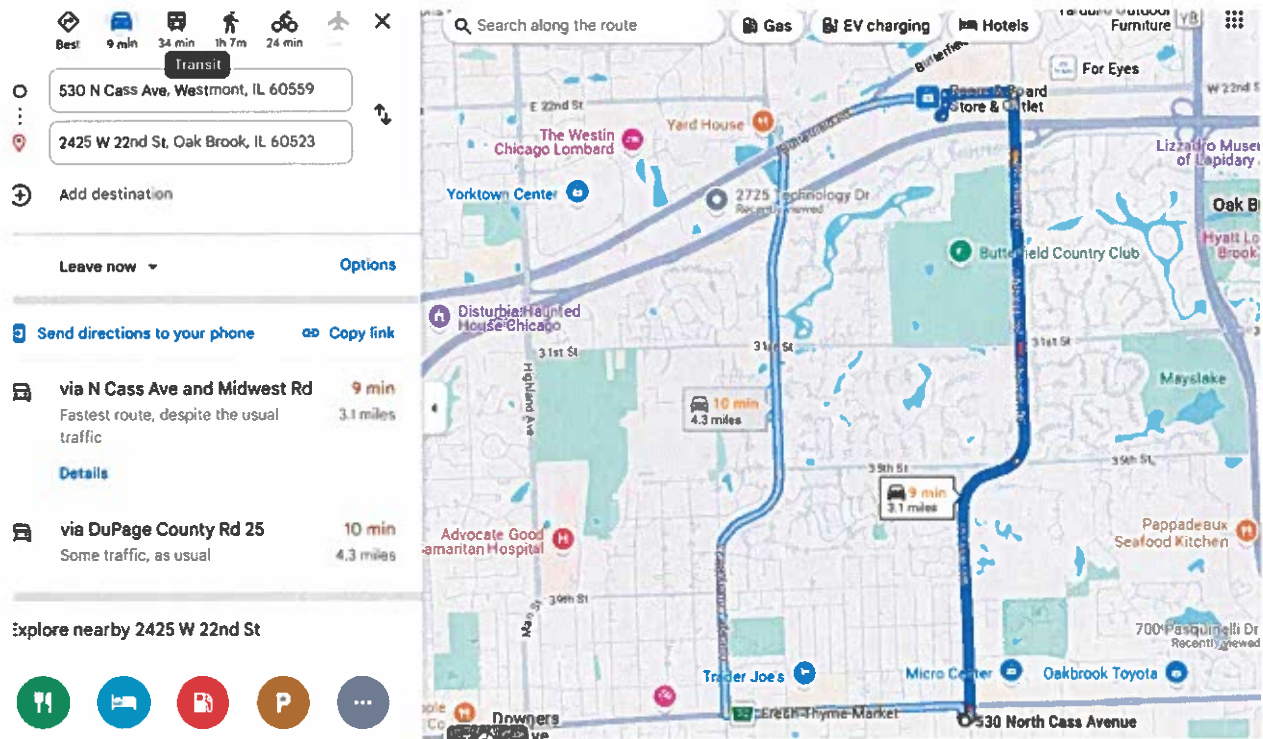
Sincerely,

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Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Midwest Center for Day Surgery
3811 Highland Ave.,
Downers Grove, IL 60515

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

We are aware of no adverse impact upon patient access, and do not anticipate any such impact from the discontinuation of the services as the facility will be relocating to a nearby location without any change of surgical service offerings.

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Sincerely,

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Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

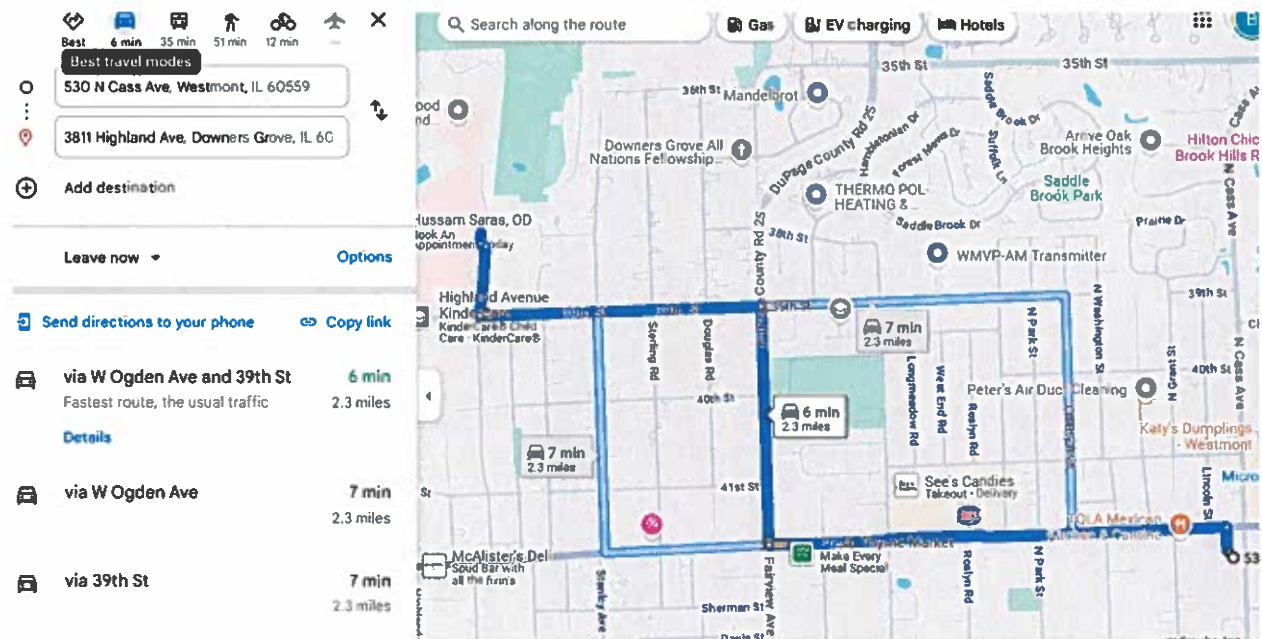


Joint Commission

ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Ambulatory Surgicenter of Downers Grove
4333 Main St.
Downers Grove, IL 60515

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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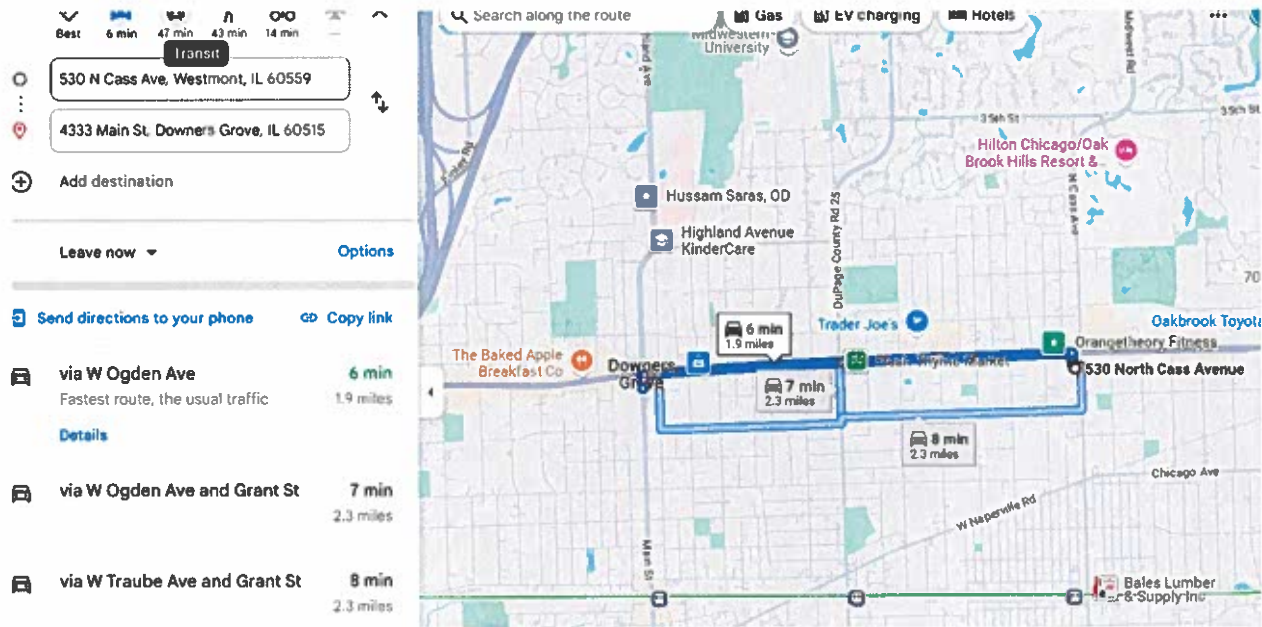
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

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Notices to Elected Officials and Agency Heads



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Children's Outpatient Services at Westchester
2301 Enterprise Dr.
Westchester, IL 60154

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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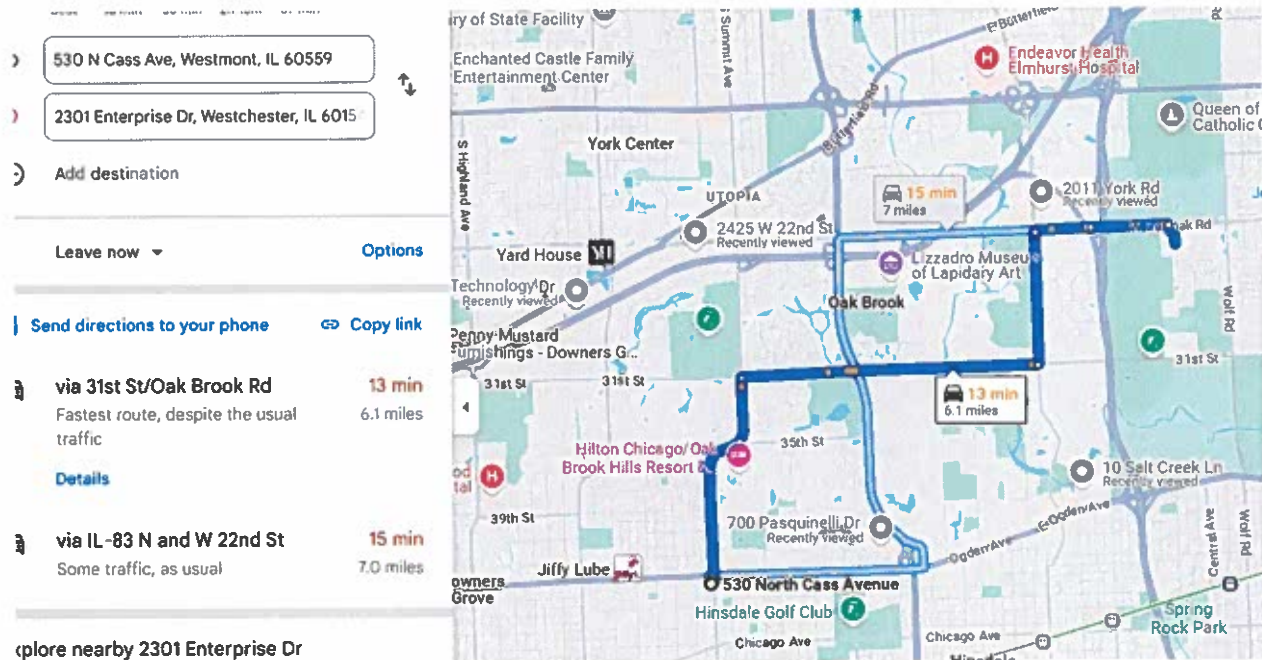
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

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ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fax: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Loyola Surgery Center
15224 Summit Ave., Suite 201
Oak Brook Terrace, IL 60181

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

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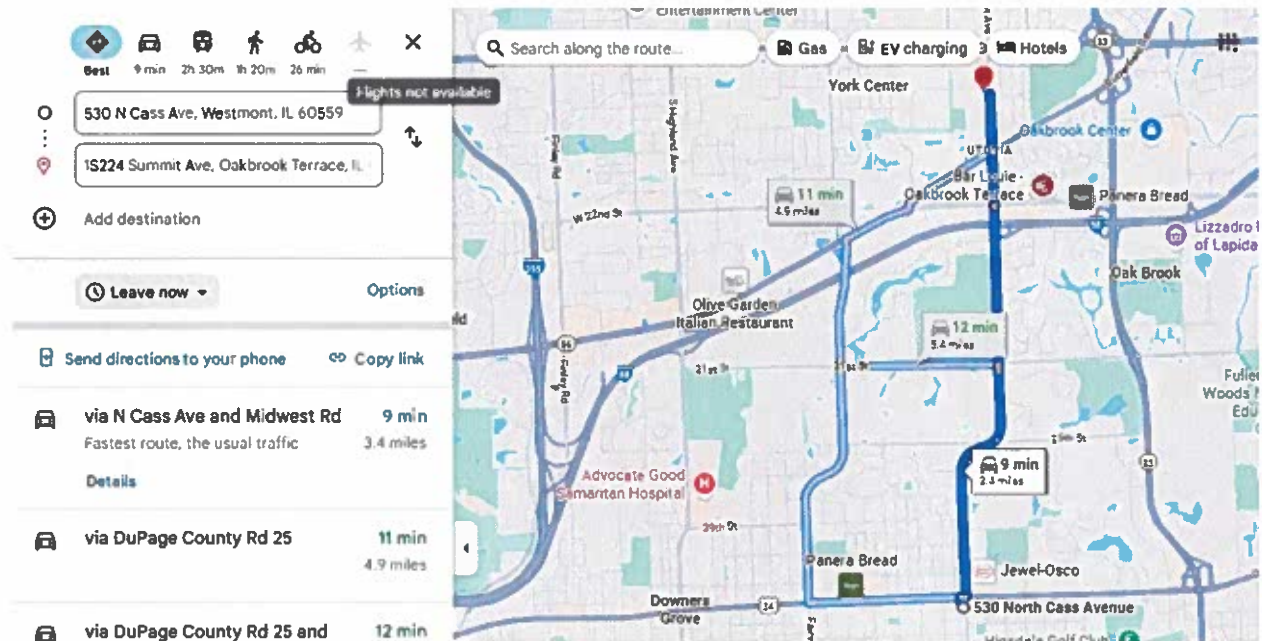
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
United Shockwave Services, Ltd.
120 N. LaGrange Rd.
LaGrange, IL 60525

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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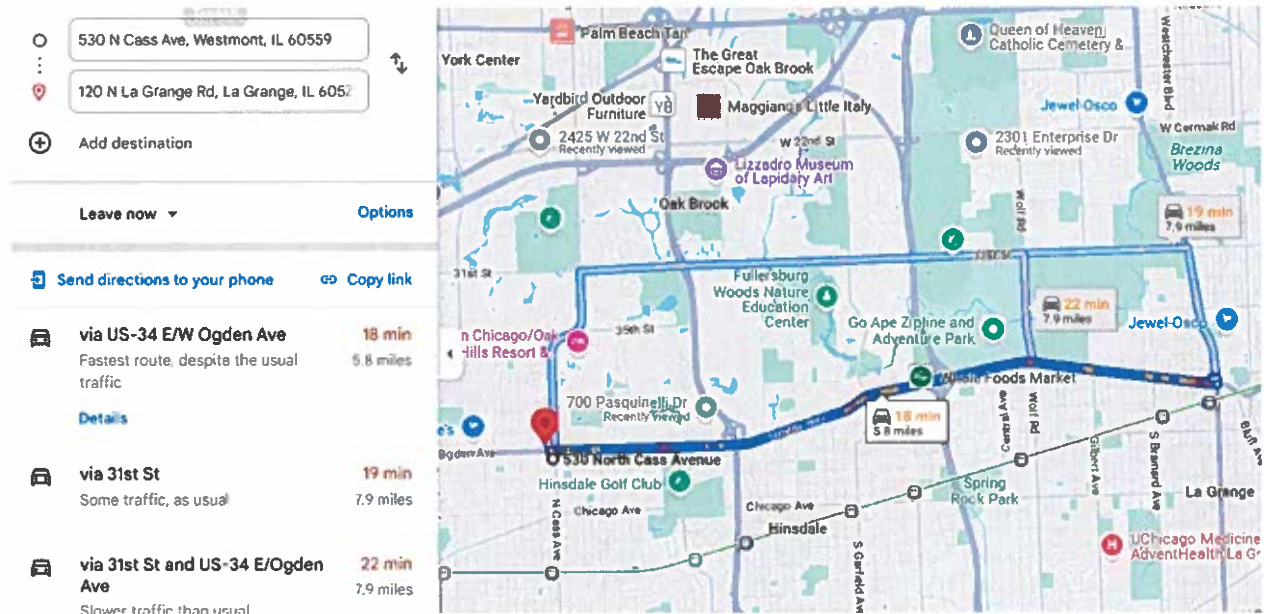
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
DMG Surgical Center, LLC
2725 Technology Dr.
Lombard, IL 60148

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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

Sincerely,

A handwritten signature in black ink, appearing to read "B. Burra", is written over a horizontal line.

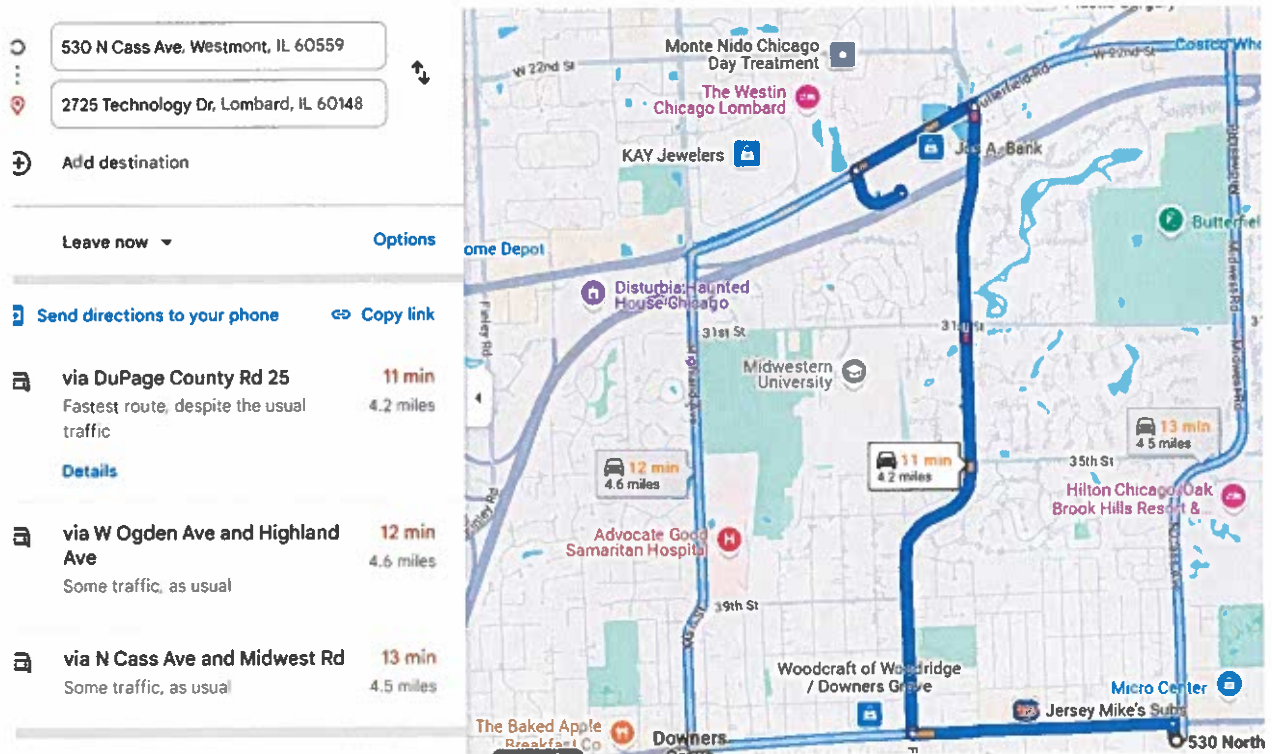
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Illinois Back and Neck Institute
360 West Butterfield Rd., Suite 100
Elmhurst, IL 60126

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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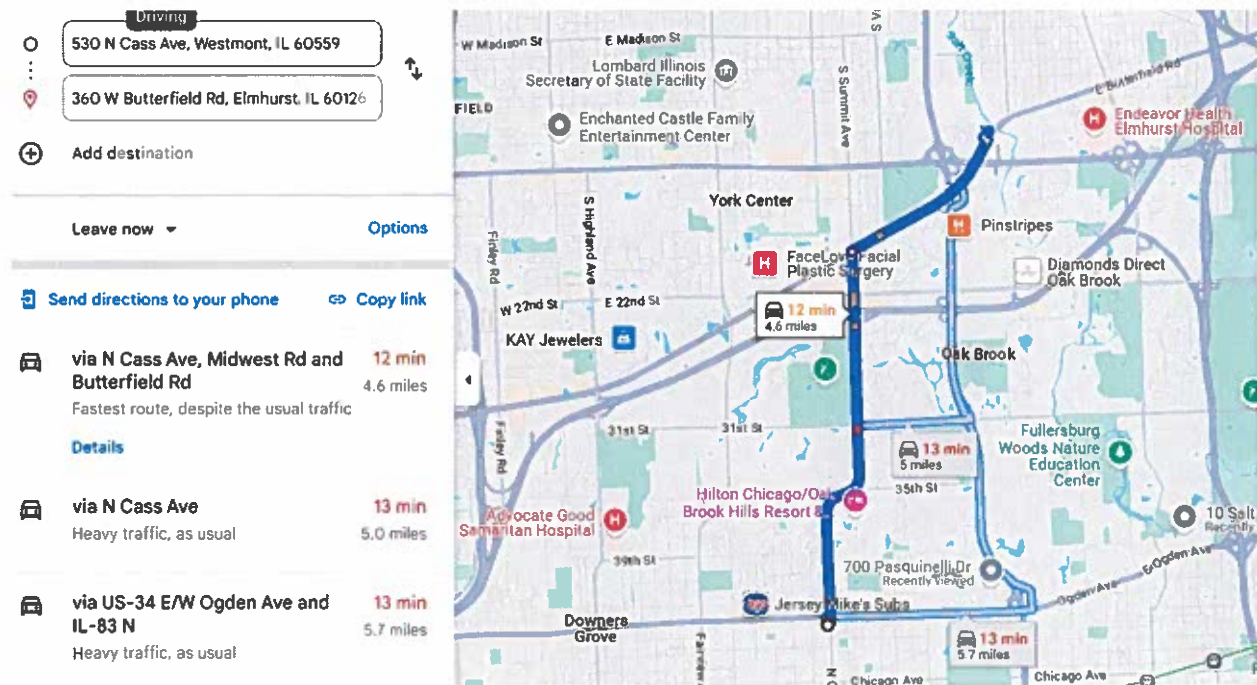
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



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July 22, 2025

Administrator
OrthoTec Surgery Center, Inc.
340 West Butterfield Rd., Suite 1B
Elmhurst IL 60126

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

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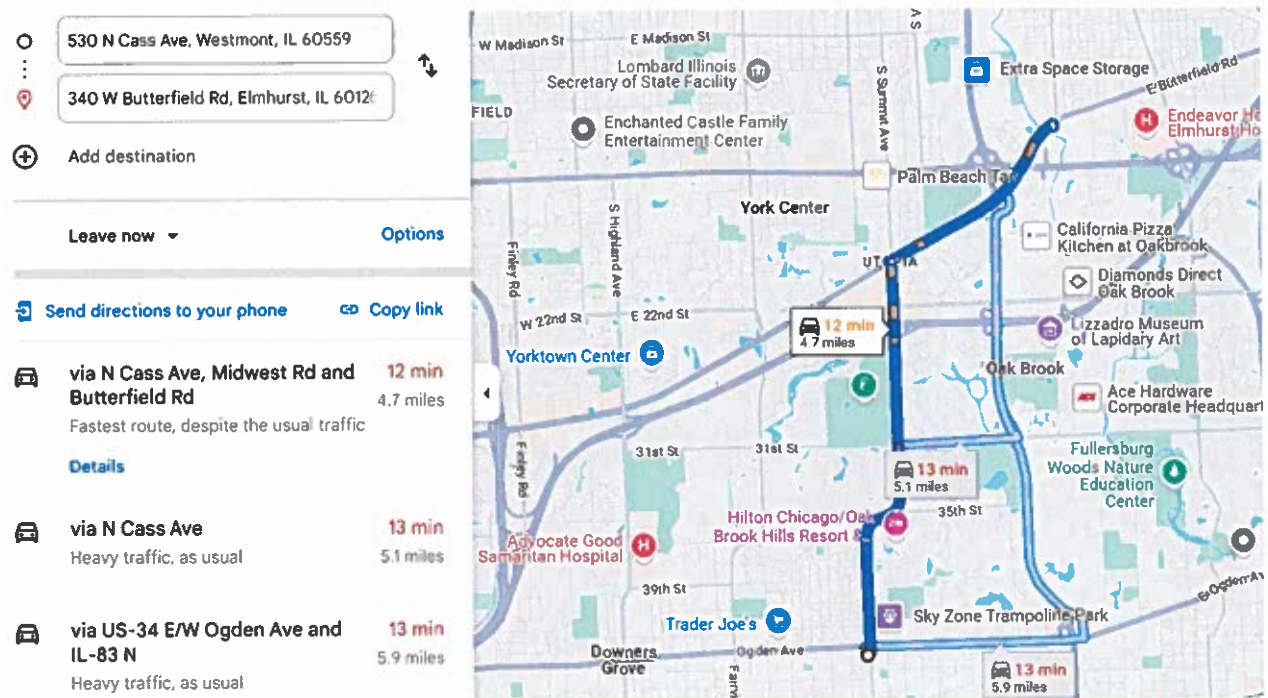
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Elmhurst Outpatient Surgery Center, LLC
1200 S. York Rd., Suite 1400
Elmhurst, IL 60126

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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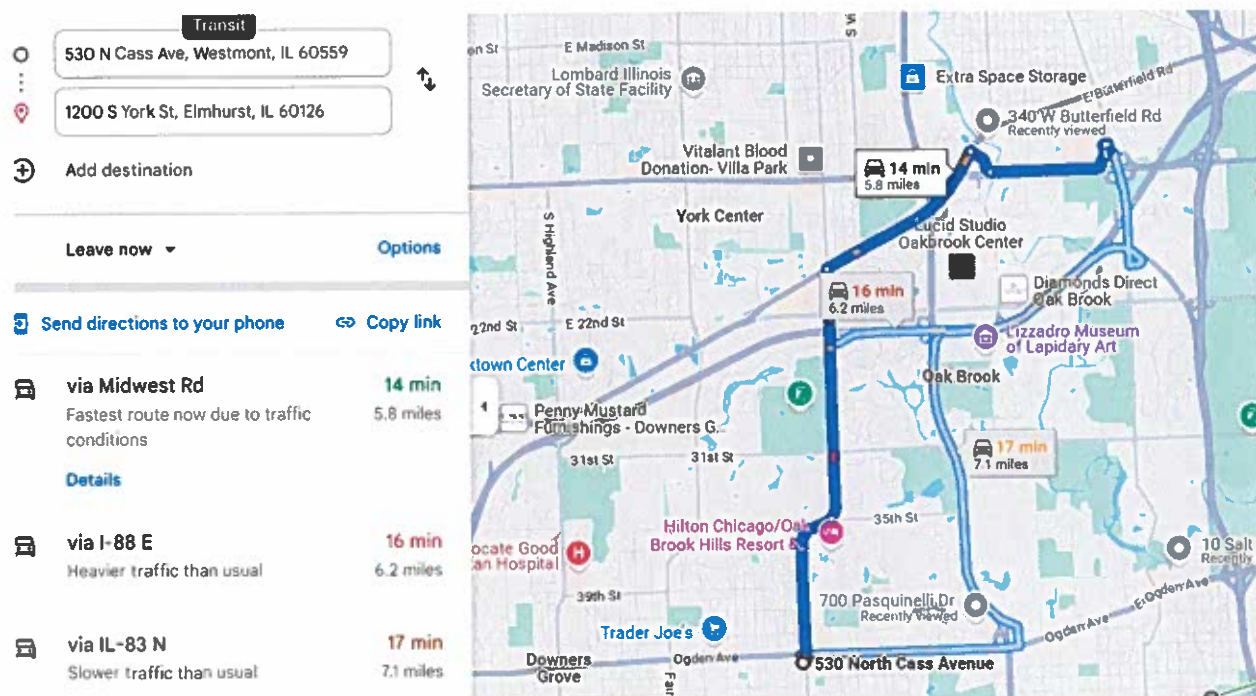
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Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10
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Notices to Elected Officials and Agency Heads



530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

Administrator
Naperville Fertility Center, Inc.
3 N. Washington St.
Naperville, IL 60540

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center**

To Whom It May Concern:

This letter is to notify you that Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N. Cass Ave., Westmont, IL 60559, is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the facility's planned discontinuation of all services. The discontinuation is anticipated by the end of 2027.

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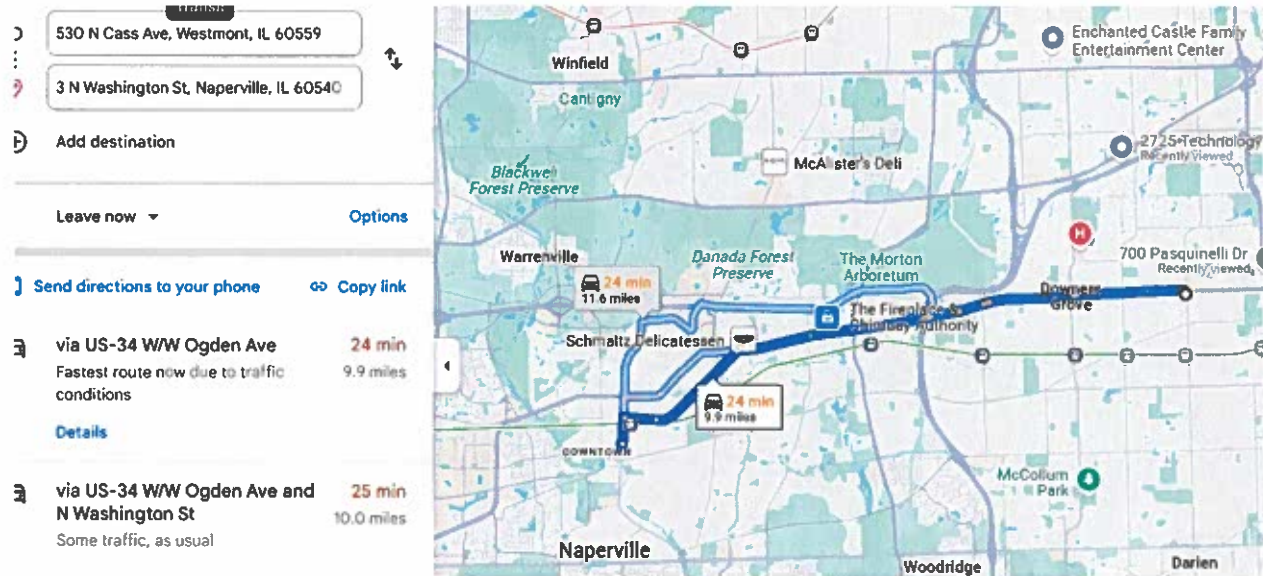
Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center



ATTACHMENT 10

Discontinuation

Notices to Elected Officials and Agency Heads



ATTACHMENT 11

Background of the Applicants

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

Westmont Surgery Center, LLC, IBI Salt Creek ASC, LLC owns no other ambulatory surgical treatment centers. IBI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC do maintain an interest in other ambulatory surgical treatment centers in Illinois and those are listed in the enclosed certification letter.

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

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

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

The Applicant permits the HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to, the 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.

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

Not Applicable.

Salt Creek Surgery Center

530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Certification and Authorization Letter- Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center-

Dear Mr. Kniery,

As a representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, IBI Salt Creek ASC, LLC, IBI ASC Ventures, LLC, Illinois Bone and Joint Institute, LLC, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health ("IDPH") to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that Westmont Surgery Center, LLC and IBI Salt Creek ASC, LLC has no ownership interest in other healthcare facilities. IBI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC own and operate the ASTCs listed below. These facilities have had no adverse actions to report for the past three (3) years. IBI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC have an ownership interest in several healthcare facilities including:

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Applicant")
Plainfield Surgery Center, LLC
Ravine Way Surgery Center
OAK Surgery Center
Illinois Sports Medicine and Orthopedic Surgery Center, LLC

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

Sincerely,



Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center



Joint Commission

**ATTACHMENTS 12-17 and 33-37
NOT APPLICABLE**

ATTACHMENT 38

Safety Net Impact Statement

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.

The project will not have a material impact, on essential safety net services in the community, including the impact on racial and health care disparities in the community, to the extent that it is feasible for an applicant to have such knowledge.

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

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

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

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

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

ATTACHMENT 38

Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2020	2021	2022
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Charity (cost in dollars)			
Inpatient	\$0	\$0	\$0
Outpatient	\$0	\$0	\$0
Total	\$0	\$0	\$0
MEDICAID			
Medicaid (# of patients)	2020	2021	2022
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Medicaid (revenue)			
Inpatient	\$0	\$0	\$0
Outpatient	\$0	\$0	\$0
Total	\$0	\$0	\$0

ATTACHMENT 39
Charity Care Information

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	\$9,191,339	\$23,842,428	\$30,828,075
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	26-30
2	Site Ownership	31-33
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	34-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36
5	Flood Plain Requirements	n/a
6	Historic Preservation Act Requirements	n/a
7	Project and Sources of Funds Itemization	n/a
8	Financial Commitment Document if required	n/a
9	Cost Space Requirements	n/a
10	Discontinuation	37-82
11	Background of the Applicant	83-84
12	Purpose of the Project	n/a
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
Financial and Economic Feasibility:		
33	Availability of Funds	n/a
34	Financial Waiver	n/a
35	Financial Viability	n/a
36	Economic Feasibility	n/a
37	Safety Net Impact Statement	n/a
38	Charity Care Information	86-87
39	Flood Plain Information	88