

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

25-048

**RECEIVED**

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

DEC 8 2025

**This Section must be completed for all projects.**

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

**Facility/Project Identification**

Facility Name: NovaMed Surgery Center of Chicago – Northshore		
Street Address: 3034 West Peterson Avenue		
City and Zip Code: Chicago 60659		
County: Cook	Health Service Area: 006	Health Planning Area: 030

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

Exact Legal Name: NovaMed Surgery Center of Chicago – Northshore, LLC
Street Address: 310 Seven Springs Way, Suite 500
City and Zip Code: Brentwood, Tennessee 37027
Name of Registered Agent: Illinois Corporate Service Company
Registered Agent Street Address: 801 Adlai Stevenson Drive
Registered Agent City and Zip Code: Springfield 62703
Name of Chief Executive Officer: J. Eric Evans
CEO Street Address: 310 Seven Springs Way, Suite 500
CEO City and Zip Code: Brentwood, Tennessee 37027
CEO Telephone Number: 615-234-5900

**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

- 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.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967
E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a>
Fax Number: 312-767-9192

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: NovaMed Surgery Center of Chicago – Northshore		
Street Address: 3034 West Peterson Avenue		
City and Zip Code: Chicago 60659		
County: Cook	Health Service Area: 006	Health Planning Area: 030

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

Exact Legal Name: Surgery Partners, Inc.
Street Address: 310 Seven Springs Way, Suite 500
City and Zip Code: Brentwood, Tennessee 37027
Name of Registered Agent: Illinois Corporate Service Company
Registered Agent Street Address: 801 Adlai Stevenson Drive
Registered Agent City and Zip Code: Springfield 62703
Name of Chief Executive Officer: J. Eric Evans
CEO Street Address: 310 Seven Springs Way, Suite 500
CEO City and Zip Code: Brentwood, Tennessee 37027
CEO Telephone Number: 615-234-5900

**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

- 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.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967
E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a>
Fax Number: 312-767-9192

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

Name: Kelly T. Whelan
Title: SVP and General Counsel
Company Name: Surgery Partners, Inc.
Address: 340 Seven Springs Way, Suite 600 Brentwood, TN 37027
Telephone Number: 615-234-5900
E-mail Address: <a href="mailto:kwhelan@surgerypartners.com">kwhelan@surgerypartners.com</a>
Fax Number: N/A

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: NovaMed Surgery Center of Chicago – Northshore		
Street Address: 3034 West Peterson Avenue		
City and Zip Code: Chicago 60659		
County: Cook	Health Service Area: 006	Health Planning Area: 030

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

Exact Legal Name: Lawrence D. Wolin, M.D.
Street Address: 2433 N Greenview
City and Zip Code: Chicago, 60614
Name of Registered Agent: N/A
Registered Agent Street Address: N/A
Registered Agent City and Zip Code: N/A
Name of Chief Executive Officer: N/A
CEO Street Address: N/A
CEO City and Zip Code: N/A
CEO Telephone Number: N/A

**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 type="checkbox"/> Limited Liability Company	<input checked="" type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

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

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

**Primary Contact** [Person to receive ALL correspondence or inquiries]

Name: Juan Morado, Jr.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967
E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a>
Fax Number: 312-767-9192

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: NovaMed Surgery Center of Chicago – Northshore		
Street Address: 3034 West Peterson Avenue		
City and Zip Code: Chicago 60659		
County: Cook	Health Service Area: 006	Health Planning Area: 030

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

Exact Legal Name: Gerstein ASC Interests, LLC
Street Address: 3042 West Peterson Avenue
City and Zip Code: Chicago, 60659
Name of Registered Agent: Leslee Cohen
Registered Agent Street Address: 600 West Jackson Boulevard, Sute 100
Registered Agent City and Zip Code: Chicago, 60661
Name of Managing Member: Craig H. Gerstein, M.D.
Managing Member Street Address: 3042 West Peterson Avenue
Managing Member City and Zip Code: Chicago, 60659
Managing Member Telephone Number: 773-973-3223

**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

- 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.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967
E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a>
Fax Number: 312-767-9192

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: NovaMed Surgery Center of Chicago – Northshore		
Street Address: 3034 West Peterson Avenue		
City and Zip Code: Chicago 60659		
County: Cook	Health Service Area: 006	Health Planning Area: 030

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

Exact Legal Name: David M. Greenberg, M.D.
Street Address: 3042 West Peterson Avenue
City and Zip Code: Chicago, 60659
Name of Registered Agent: N/A
Registered Agent Street Address: N/A
Registered Agent City and Zip Code: N/A
Name of Chief Executive Officer: N/A
CEO Street Address: N/A
CEO City and Zip Code: N/A
CEO Telephone Number: N/A

**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 type="checkbox"/> Limited Liability Company	<input checked="" type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

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

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

**Primary Contact [Person to receive ALL correspondence or inquiries]**

Name: Juan Morado, Jr.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967
E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a>
Fax Number: 312-767-9192

**Post Permit Contact**

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

Name: Kelly T. Whelan
Title: SVP and General Counsel
Company Name: Surgery Partners, Inc.
Address: 340 Seven Springs Way, Suite 600 Brentwood, TN 37027
Telephone Number: 615-234-5900
E-mail Address: <a href="mailto:kwhelan@surgerypartners.com">kwhelan@surgerypartners.com</a>
Fax Number: N/A

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Melvyn A. Gerstein
Address of Site Owner: 1662 McGovern Street, Highland Park, IL 60035
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.
<b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Operating Identity/Licensee**

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

Exact Legal Name: NovaMed Surgery Center of Chicago – Northshore, LLC
Address: 310 Seven Springs Way, Suite 500, Brentwood, TN 37027
<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"> <li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>o 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.</li> <li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**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.

<b>APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>
---

### 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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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.

NovaMed Surgery Center of Chicago – Northshore, 3034 W. Peterson Ave., Chicago, IL 60659 ("NovaMed") hereby seeks approval of the Board to discontinue operations of the facility as licensed ambulatory surgical treatment center ("ASTC"). NovaMed primarily offers ophthalmology services and is approved for one (1) operating room, one (1) procedure room, and one (1) recovery station.

NovaMed will cease operations upon discontinuation approval by the Board, and any resulting ophthalmologic service demand will be met by other nearby ASTC's.

This project is classified as substantive, in that it involves a discontinuation of a health care facility per 77 Ill. Admin. Code Sec. 1110.20(b).

There will be no cost associated with discontinuing operations in this location.

**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.

<b>Project Costs and Sources of Funds</b>			
<b>USE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
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)			
<b>TOTAL USES OF FUNDS</b>			
<b>SOURCE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>			
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

### Related Project Costs

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

Land acquisition is related to project  Yes  No  
Purchase Price: **NOT APPLICABLE**  
Fair Market Value: **NOT APPLICABLE**

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

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

Estimated start-up costs and operating deficit cost is **NOT APPLICABLE**

### Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

- None or not applicable  Preliminary  
 Schematics  Final Working

Anticipated project completion date (refer to Part 1130.140): Upon approval of the Board for discontinuation or December 31, 2025

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

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

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

### State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?

- Cancer Registry  
 APORS  
 All formal document requests such as IDPH Questionnaires and Annual Bed Reports have 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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON-REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-Clinical							
<b>TOTAL</b>							

**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**.


<b>FACILITY NAME: NovaMed Surgery Center of Chicago – Northshore</b>			<b>CITY: Chicago</b>		
<b>REPORTING PERIOD DATES: From: January 2022 to: December 2022</b>					
<b>Category of Service</b>	<b>Authorized Beds</b>	<b>Admissions</b>	<b>Patient Days</b>	<b>Bed Changes</b>	<b>Proposed Beds</b>
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 (Ophthalmology)	-	2,548 (surgeries)	-	-	-
<b>TOTALS:</b>	-	2,548 (surgeries)	-	-	-

**CERTIFICATION**

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

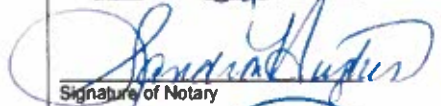
- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- o in the case of a partnership, two of 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 Surgery Partners, Inc. and NovaMed Surgery Center of Chicago – Northshore, 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	_____
Jennifer Baldock PRINTED NAME	_____
Exec. Ch. of Legal & Development SICOR PRINTED TITLE	_____

Notarization:  
Subscribed and sworn to before me  
this 17<sup>th</sup> day of Sept

Notarization:  
Subscribed and sworn to before me  
this \_\_\_ day of \_\_\_\_\_

  
Signature of Notary

\_\_\_\_\_  
Signature of Notary

Seal

Seal



\*Insert the EXACT legal name of the applicant

**CERTIFICATION**

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

- 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 Lawrence D. Wolin, 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]*  
SIGNATURE  
Lawrence D. Wolin  
PRINTED NAME  
\_\_\_\_\_  
PRINTED TITLE

*Jennifer Anne Colatos*  
SIGNATURE  
Jennifer Colatos  
PRINTED NAME  
Office Manager  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 9<sup>th</sup> day of October 2025

Notarization:  
Subscribed and sworn to before me  
this 9<sup>th</sup> day of October 2025

\_\_\_\_\_  
Signature of Notary

*Jennifer Anne Colatos*  
Signature of Notary

Seal

Seal



\*Insert the EXACT legal name of the applicant

**CERTIFICATION**

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

- 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 Gerstein ASC Interests, 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.

*Craig H. Gerstein*  
SIGNATURE  
CRAIG H. Gerstein  
PRINTED NAME  
President  
PRINTED TITLE

\_\_\_\_\_  
SIGNATURE  
\_\_\_\_\_  
PRINTED NAME  
\_\_\_\_\_  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 22<sup>nd</sup> day of October, 2025

Notarization:  
Subscribed and sworn to before me  
this \_\_\_ day of \_\_\_\_\_

*Jaelyn M. Simon*  
Signature of Notary  
Seal

\_\_\_\_\_  
Signature of Notary  
Seal

Jaelyn M. Simon  
\*Insert the EXACT legal name of the applicant



27508745 v1  
27534874 v1

## SECTION II. DISCONTINUATION

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

### Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

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

#### REASONS FOR DISCONTINUATION

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

#### IMPACT ON ACCESS

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

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

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

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

#### 1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

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

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

## Criterion 1110.110(b) & (d)

### PURPOSE OF PROJECT

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

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

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

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

### ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
  - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
  - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
  - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
  - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

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

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

## 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]:

<p>_____</p>	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>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</li> <li>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.</li> </ol>
<p>_____</p>	<p>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.</p>
<p>_____</p>	<p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.</p>
<p>_____</p>	<p>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:</p> <ol style="list-style-type: none"> <li>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.</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate.</li> <li>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.</li> <li>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.</li> </ol>

	<p>5) For any option to lease, a copy of the option, including all terms and conditions.</p>
_____	<p>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.</p>
_____	<p>f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.</p>
_____	<p>g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.</p>
	<b>TOTAL FUNDS AVAILABLE</b>

**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
<b>Enter Historical and/or Projected Years:</b>				
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)	2020	2021	2022
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
Charity (cost in dollars)			
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
MEDICAID			
Medicaid (# of patients)	2020	2021	2022
Inpatient	-	-	-
Outpatient	273	277	440
<b>Total</b>	273	277	440
Medicaid (revenue)			
Inpatient			-
Outpatient	\$96,158	\$121,896	\$236,668
<b>Total</b>	\$96,158	\$121,896	\$236,668

**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	2021	2022
<b>Net Patient Revenue</b>	<b>\$3,110,062</b>	<b>\$3,519,375</b>	<b>\$3,551,944</b>
Amount of Charity Care (charges)	-	-	-
Cost of Charity Care	-	-	-

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

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

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant Identification including Certificate of Good Standing	27-30
2	Site Ownership	31
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	32-33
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	34
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	35-52
11	Background of the Applicant	53-58
12	Purpose of the Project	59
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
	<b>Service Specific:</b>	N/A
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
	<b>Financial and Economic Feasibility:</b>	
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	60-61
38	Charity Care Information	62
39	Flood Plain Information	N/A

## **ATTACHMENT 1**

### **Type of Ownership of Applicant**

Included with this attachment are:

1. The Certificate of Good Standing for the Applicant, NovaMed Surgery Center of Chicago - Northshore.
2. The Certificate of Good Standing for Surgery Partners, Inc.
3. The Certificate of Good Standing for Gerstein ASC Interests, LLC.
4. Drs. Greenberg and Wolin, hold their interest in the licensee in their individual capacity as sole proprietors and thus no Certificate of Good Standing is available.

**ATTACHMENT 1**  
**Certificate of Good Standing**  
**NovaMed Surgery Center of Chicago - Northshore LLC**

---

*File Number*                      0081288-9



***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***

**NOVAMED SURGERY CENTER OF CHICAGO - NORTHSHORE, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON NOVEMBER 21, 2002, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.**



Authentication #: 2524802840 verifiable until 09/05/2026  
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 5TH day of SEPTEMBER A.D. 2025 .***

  
SECRETARY OF STATE

**ATTACHMENT 1  
Certificate of Good Standing  
Surgery Partners, Inc.**

**Delaware**  
The First State

Page 1

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SURGERY PARTNERS, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIFTH DAY OF SEPTEMBER, A. D. 2025.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "SURGERY PARTNERS, INC." WAS INCORPORATED ON THE SECOND DAY OF APRIL, A. D. 2015.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.



5722138 8300  
SR# 20253886737  
You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

*C. P. Sanchez*

Charuni Patibanda-Sanchez, Secretary of State  
Authentication: 204664423  
Date: 09-05-25

**ATTACHMENT 1**  
**Certificate of Good Standing**  
**Gerstein ASC Interests, LLC**

*File Number*                      0084871-9



***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***

**GERSTEIN ASC INTERESTS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON  
JANUARY 21, 2003, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE  
LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD  
STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.**



Authentication #: 2533600424 verifiable until 12/02/2026  
Authenticate at: <https://www.isos.gov>

***In Testimony Whereof, I hereto set***  
***my hand and cause to be affixed the Great Seal of***  
***the State of Illinois, this    2ND***  
***day of DECEMBER A.D.    2025 .***

  
SECRETARY OF STATE

## ATTACHMENT 2 Site Ownership

The current owner of the building is Melvyn A. Gerstein. A copy of the property tax bill is enclosed as evidence of control over the site.

TOTAL PAYMENT DUE		2024 First Installment Property Tax Bill - Cook County Electronic Bill						
<b>\$0.00</b>	<b>By 10/01/28</b>	Property Index Number (PIN) 13-01-125-052-0000	Volume 316	Code 71001	Tax Year 2024	(Payable In) (2025)	Township JEFFERSON	Classification 5-17
<b>IF PAYING LATE, PLEASE PAY</b>		10/02/2025 - 11/01/2025 \$0.00	11/02/2025 - 12/01/2025 \$0.00	12/02/2025 - 01/01/2026 \$0.00		<b>LATE INTEREST IS 0.75% PER MONTH, BY STATE LAW</b>		

TAXING DISTRICT DEBT AND FINANCIAL DATA				
Your Taxing Districts	Money Owed by Your Taxing Districts	Pension and Healthcare Amounts Promised by Your Taxing Districts	Amount of Pension and Healthcare Shortage	% of Pension and Healthcare Costs Taxing Districts Can Pay
Metro Water Reclamation Dist of Chicago	\$3,126,243,000	\$3,161,727,000	\$1,449,923,000	64.00%
Chicago Park District	\$1,773,304,000	\$1,309,150,000	\$943,304,000	27.95%
Board of Education Chicago	\$14,118,485,000	\$30,219,209,213	\$18,454,267,332	38.93%
Chicago Community College Dist	\$457,196,847	\$54,896,086	\$54,896,086	0.00%
City of Chicago	\$39,807,764,800	\$60,336,513,845	\$39,219,495,200	22.09%
Cook County Forest Preserve District	\$214,441,242	\$617,834,550	\$382,643,760	38.07%
County of Cook	\$8,262,580,154	\$26,512,008,772	\$14,493,276,944	45.33%
<b>Total</b>	<b>\$67,760,017,043</b>	<b>\$112,201,337,466</b>	<b>\$74,997,806,322</b>	

For a more in-depth look at government finances and how they affect your taxes, visit [cookcountytreasurer.com](http://cookcountytreasurer.com)

**PAY YOUR TAXES ONLINE**  
Pay at [cookcountytreasurer.com](http://cookcountytreasurer.com) from your bank account or credit card.

IMPORTANT MESSAGES	TAX CALCULATOR				
	<p><b>2023 TOTAL TAX</b> <span style="float: right;">25,526.02</span></p> <p><b>2024 ESTIMATE</b>      <b>X</b>      <b>55%</b></p> <p><b>2024 1st INSTALLMENT</b>      <b>=</b>      <b>14,039.31</b></p> <p style="font-size: x-small;">The First Installment amount is 55% of last year's total taxes. All exemptions, such as homeowner and senior exemptions, will be reflected on your Second Installment tax bill.</p>				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #0056b3; color: white;">PROPERTY LOCATION</th> <th style="background-color: #0056b3; color: white;">MAILING ADDRESS</th> </tr> </thead> <tbody> <tr> <td style="font-size: x-small;">3034 W PETERSON AVE CHICAGO IL 60659</td> <td style="font-size: x-small;">MELVYN A GERSTEIN 1662 MCGOVERN ST HIGHLAND PK IL 60035-3529</td> </tr> </tbody> </table>	PROPERTY LOCATION	MAILING ADDRESS	3034 W PETERSON AVE CHICAGO IL 60659	MELVYN A GERSTEIN 1662 MCGOVERN ST HIGHLAND PK IL 60035-3529
PROPERTY LOCATION	MAILING ADDRESS				
3034 W PETERSON AVE CHICAGO IL 60659	MELVYN A GERSTEIN 1662 MCGOVERN ST HIGHLAND PK IL 60035-3529				

\*\*\* Please see 2024 First Installment Payment Coupon next page \*\*\*

## **ATTACHMENT 3 Operating Entity/Licensee**

NovaMed Surgery Center of Chicago - Northshore is licensed by the Illinois Department of Public Health. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

**ATTACHMENT 3**  
**Operating Entity**  
**Certificate of Good Standing – NovaMed Surgery Center of Chicago –**  
**Northshore, LLC**

---

*File Number*                      0081288-9



***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***

**NOVAMED SURGERY CENTER OF CHICAGO - NORTHSHORE, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANACT BUSINESS IN ILLINOIS ON NOVEMBER 21, 2002, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANACT BUSINESS IN THE STATE OF ILLINOIS.**

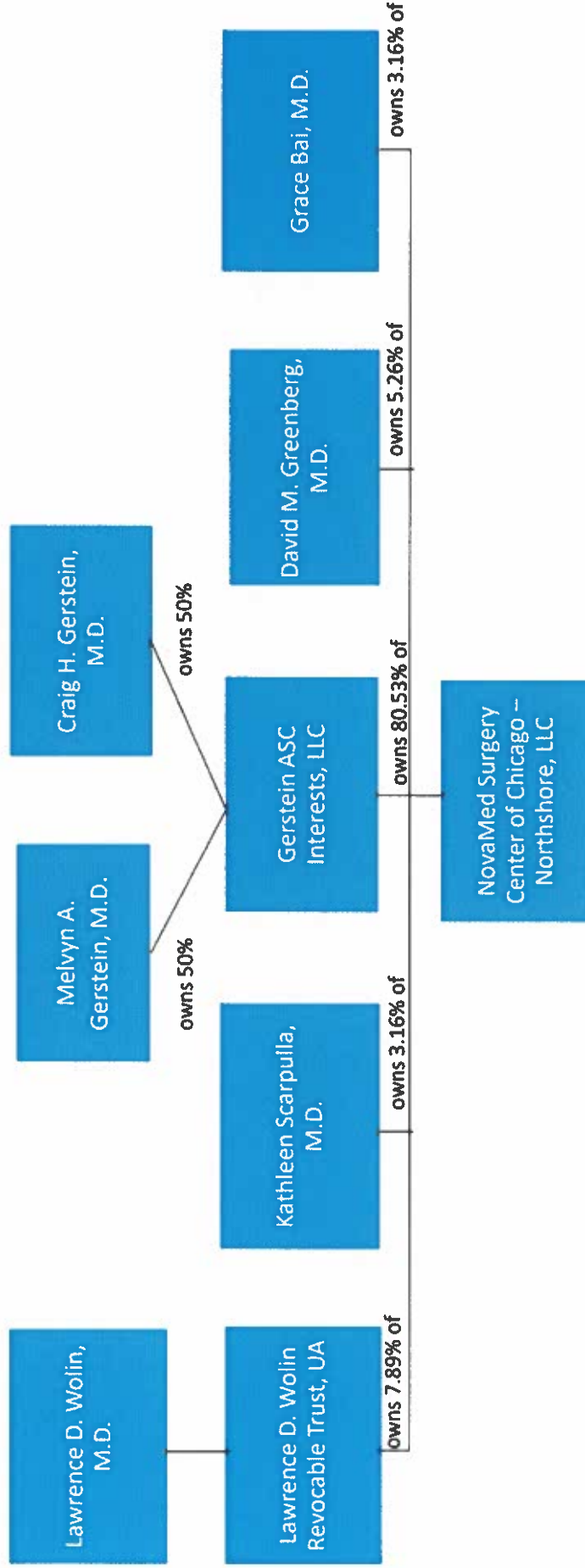
***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of SEPTEMBER A.D. 2025 .***



Authentication #: 2524802840 verifiable until 09/05/2026  
Authenticate at: <https://www.isos.gov>

  
ALEXI GIANNOULIS  
SECRETARY OF STATE

## ATTACHMENT 4 Organizational Chart



**\*Drs. Scarpulla and Bai do not maintain an ownership interest in excess of 5% or more and thus are not applicants to this application.**

## **ATTACHMENT 10 Discontinuation**

### **General:**

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

The facility is approved for one (1) operating room, and one (1) procedure room at the ASTC that will be discontinued.

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

The category of services currently offered at the facility include ophthalmology services, which will be discontinued upon approval of the application.

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

The Applicant proposes to permanently discontinue services upon approval of the Board.

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

The anticipated use of the physical plant has not been determined as the licensee does not own the structure.

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

The medical records will be maintained at an offsite secure location for a period of 10 years.

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

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

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

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

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

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

# ATTACHMENT 10

## Discontinuation

### Reasons For Discontinuation

The Applicants propose to discontinue NovaMed Surgery Center of Chicago–Northshore because continued operation at the existing site is no longer practicable, sustainable, or justified based on the State Board's discontinuation criteria.

#### **1. Insufficient Volume and Declining Demand**

Utilization of the facility has consistently decreased over multiple years, demonstrating a sustained lack of patient demand for the services provided at this location. Procedure volumes from the physician owners have fallen to a level that no longer supports efficient operations or the ongoing allocation of clinical and administrative resources.

#### **2. Economic Infeasibility**

The combination of declining surgical volumes and rising fixed operating costs has rendered the facility no longer economically feasible. Continued operation would require the licensee to subsidize ongoing losses, which would impair the overall financial viability and strategic allocation of resources within the organization.

### Impact of Access

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

Although the existing facility is no longer feasible to operate, patient access will not be adversely affected. There are ASTCs located within a short distance that offer the same or broader range of services. Therefore, all remaining patient need should be able to be safely and effectively absorbed by neighboring providers.

#### **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.**

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

## **ATTACHMENT 10 Discontinuation Media Notice**

The Applicants will publish the notice below in the Chicago Tribune, a local newspaper that routinely notifies the public about facility events. The notice below is scheduled to be published a single time in the classified ad section of the newspaper on December 4, 2025. The Chicago Tribune has a print circulation of 439,731, and an online presence. The Chicago Tribune is a newspaper of general circulation throughout the Cook and DuPage County and surrounding areas, and is a newspaper as defined by 715 ILCS 5/5.

"NovaMed Surgery Center of Chicago – Northshore has filed a Certificate of Need application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue their Ambulatory Surgical Treatment Center located at 3034 W. Peterson Ave., Chicago, Illinois 60659 in the fourth quarter of 2025. If you are or have been a patient at NovaMed Surgery Center of Chicago - Northshore and have questions about accessing your medical records, please call 708-907-3066."

**ATTACHMENT 10**  
**Discontinuation**  
**Notices to Elected Officials and Agency Heads**



NOVAMED OF CHICAGO  
NORTHSHORE

September 16, 2025

Hon. Michael Kelly  
Illinois State Representative (District 15)  
4200 W. Lawrence Ave.  
Chicago, IL 60630

**RE: Notice of Discontinuation of Ambulatory Surgical Treatment Center -  
NovaMed Surgery Center of Chicago - Northshore**

Dear Representative Kelly:

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"), NovaMed Surgery Center of Chicago – Northshore, 3034 W Peterson Ave., Chicago, IL 60659.

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 there are numerous other ASTC's in the service area that can adequately serve the patient population.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, the local Alderman, the Director of Public Health and the Director of the Healthcare and Family Services.

Sincerely,

Jennifer Baldoek  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

**ATTACHMENT 10**  
**Discontinuation**  
**Notices to Elected Officials and Agency Heads**



**NOVAMED OF CHICAGO  
NORTHSHORE**

September 16, 2025

Hon. Ram Villivalam  
Illinois State Senator (District 8)  
3851 W. Devon Ave.  
Chicago, IL 60659

**RE: Notice of Discontinuation of Ambulatory Surgical Treatment Center -  
NovaMed Surgery Center of Chicago - Northshore**

Dear Senator Villivalam:

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"), NovaMed Surgery Center of Chicago - Northshore, 3034 W Peterson Ave., Chicago, IL 60659.

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 there are numerous other ASTC's in the service area that can adequately serve the patient population.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, the local Alderman, the Director of Public Health and the Director of the Healthcare and Family Services.

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

**ATTACHMENT 10**  
**Discontinuation**  
**Notices to Elected Officials and Agency Heads**



NOVAMED OF CHICAGO  
NORTHSHORE

September 16, 2025

Hon. Debra Silverstein  
Chicago Alderperson (50<sup>th</sup> Ward)  
2949 W. Devon Ave.  
Chicago, IL 60630

**RE: Notice of Discontinuation of Ambulatory Surgical Treatment Center -  
NovaMed Surgery Center of Chicago - Northshore**

Dear Alderperson Silverstein:

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"), NovaMed Surgery Center of Chicago – Northshore, 3034 W Peterson Ave., Chicago, IL 60659.

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 there are numerous other ASTC's in the service area that can adequately serve the patient population.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, the local Alderman, the Director of Public Health and the Director of the Healthcare and Family Services.

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

**ATTACHMENT 10**  
**Discontinuation**  
**Notices to Elected Officials and Agency Heads**



**NOVAMED OF CHICAGO  
NORTHSHORE**

September 16, 2025

Sameer Vohra, M.D., J.D., M.A.  
Director  
Illinois Department of Public Health  
525 West Jefferson Street  
Springfield, IL 62761

**RE: Notice of Discontinuation of Ambulatory Surgical Treatment Center -  
NovaMed Surgery Center of Chicago - Northshore**

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"), NovaMed Surgery Center of Chicago – Northshore, 3034 W Peterson Ave., Chicago, IL 60659.

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 there are numerous other ASTC's in the service area that can adequately serve the patient population.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, the local Alderman, the Director of Public Health and the Director of the Healthcare and Family Services.

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

**ATTACHMENT 10**  
**Discontinuation**  
**Notices to Elected Officials and Agency Heads**



NOVAMED OF CHICAGO  
NORTHSHORE

September 16, 2025

Elizabeth Whitehorn  
Director  
Illinois Department of Healthcare and Family Services  
201 S. Grand Ave., East  
Springfield, IL 62763

**RE: Notice of Discontinuation of Ambulatory Surgical Treatment Center -  
NovaMed Surgery Center of Chicago - Northshore**

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"), NovaMed Surgery Center of Chicago - Northshore, 3034 W Peterson Ave., Chicago, IL 60659.

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 there are numerous other ASTC's in the service area that can adequately serve the patient population.

Pursuant to the above provision of the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, the local Alderman, the Director of Public Health and the Director of the Healthcare and Family Services.

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

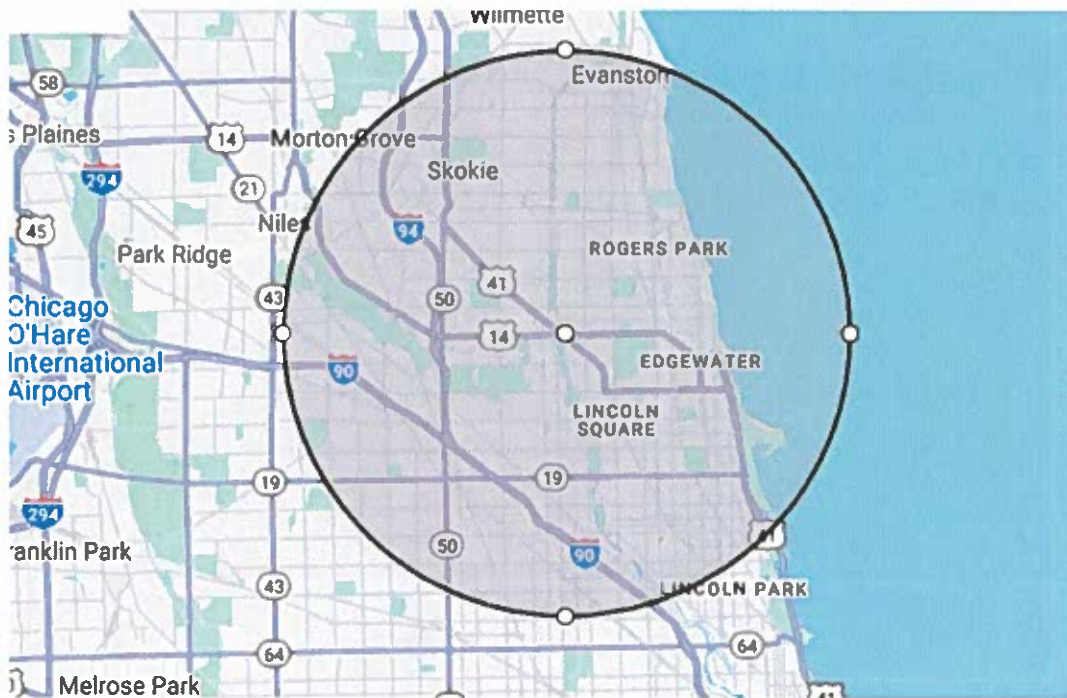
Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

## ATTACHMENT 10 Discontinuation Notice to Area Facilities

The following notification letters were sent to area facilities within the geographic service area as determined by the distance and drive times to the facilities. Also listed on the following pages in accordance with 77 Illinois Admin Code Section 1110.235(c)(2)(8) is the GSA consisting of all zip code areas that are located within a 5-mile radius of the proposed site of the ASTC. The zip codes and areas within a 5-mile radius of the proposed facility are listed below. We have included a map of the multi-directional travel radii of the proposed ASTC site.

### 5 Mile Radius from 3040 W. Peterson Ave., Chicago, IL 60659



**ATTACHMENT 10**  
**Discontinuation**  
**Notice to Area Facilities**

<b>Facility Name</b>	<b>Facility Address</b>
Lakeshore Surgery Center	7200 N. Western Ave. Chicago, IL 60645
North Shore Surgery Center	3725 W. Touhy Ave. Lincolnwood, IL 60712
Rogers Park One Day Surgery Center, Inc.	7616 N. Paulina St., Chicago, IL 60626
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

**ATTACHMENT 10  
Discontinuation  
Notice to Area Facilities**



**NOVAMED OF CHICAGO  
NORTHSHORE**

September 16, 2025

Lakeshore Surgery Center  
7200 N. Western Ave.  
Chicago, IL 60645

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – NovaMed  
Surgery Center of Chicago – Northshore**

To Whom It May Concern:

This letter is to notify you that NovaMed Surgery Center of Chicago – Northshore, located at 3040 W. Peterson Ave., Chicago, IL 60659 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 to occur upon approval of HFSRB, expected in the 4<sup>th</sup> Quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the service at this location as there are other ASTC’s in the region providing similar services.

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

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

# ATTACHMENT 10

## Discontinuation Notice to Area Facilities

○ 3040 W Peterson Ave, Chicago, IL 60659

○ 7200 N Western Ave, Chicago, IL 60645

+ Add destination

---

Options

📱 Send directions to your phone    🔗 Copy link

🚶 **via N Sacramento Ave and W Touhy Ave**    **50 min**  
2.3 miles  
Details    Preview

🚶 **via N Francisco Ave and W Touhy Ave**    **51 min**  
2.3 miles

All routes are mostly flat



**ATTACHMENT 10  
Discontinuation  
Notice to Area Facilities**



NOVAMED OF CHICAGO  
NORTHSHORE

September 16, 2025

North Shore Surgery Center  
3725 W. Touhy Ave.  
Lincolnwood, IL 60712

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – NovaMed  
Surgery Center of Chicago – Northshore**

To Whom It May Concern:

This letter is to notify you that NovaMed Surgery Center of Chicago – Northshore, located at 3040 W. Peterson Ave., Chicago, IL 60659 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 to occur upon approval of HFSRB, expected in the 4<sup>th</sup> Quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the service at this location as there are other ASTC’s in the region providing similar services.

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

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

# ATTACHMENT 10 Discontinuation Notice to Area Facilities

3040 W Peterson Ave, Chicago, IL 60659

3725 W Touhy Ave, Lincolnwood, IL 60712

Add destination

Leave now Options

Send directions to your phone Copy link

via N Lincoln Ave Best route	9 min 2.5 miles
Details <a href="#">Preview</a>	
via W Pratt Ave	9 min 2.5 miles
via N Lincoln Ave and N Crawford Ave Some traffic, as usual	10 min 2.7 miles



**ATTACHMENT 10**  
**Discontinuation**  
**Notice to Area Facilities**

---



**NOVAMED OF CHICAGO  
NORTHSHORE**

September 16, 2025

Rogers Park One Day Surgery Center, Inc.  
7616 N Paulina St.  
Chicago, IL 60626

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – NovaMed  
Surgery Center of Chicago – Northshore**

To Whom It May Concern:

This letter is to notify you that NovaMed Surgery Center of Chicago – Northshore, located at 3040 W. Peterson Ave., Chicago, IL 60659 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 to occur upon approval of HFSRB, expected in the 4<sup>th</sup> Quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the service at this location as there are other ASTC’s in the region providing similar services.

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

Sincerely,

Jennifer Baldock  
EVP, Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

# ATTACHMENT 10 Discontinuation Notice to Area Facilities

3040 W Peterson Ave, Chicago, IL 60659

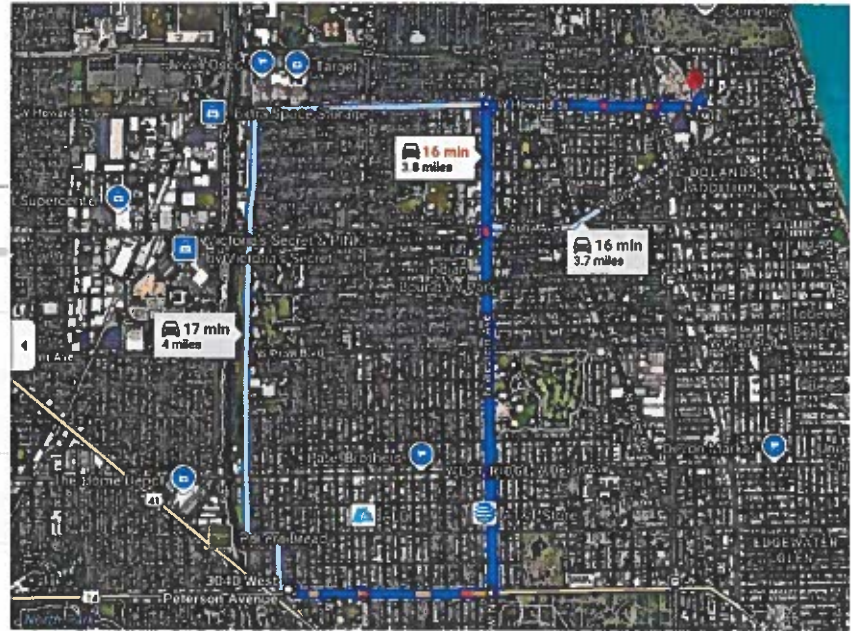
7616 N Paulina St, Chicago, IL 60626

Add destination

Leave now Options

Send directions to your phone Copy link

via N Western Ave	16 min
Fastest route, despite the usual traffic	3.8 miles
Details Preview	
via N Kedzie Ave and W Howard St	17 min
	4.0 miles
via W Peterson Ave and N Western Ave	16 min
	3.7 miles



**ATTACHMENT 10  
Discontinuation  
Notice to Area Facilities**



NOVAMED OF CHICAGO  
NORTHSHORE

September 16, 2025

Western Diversey Surgical Center  
2744 N Western Ave.  
Chicago, IL 60647

**Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center – NovaMed  
Surgery Center of Chicago – Northshore**

To Whom It May Concern:

This letter is to notify you that NovaMed Surgery Center of Chicago – Northshore, located at 3040 W. Peterson Ave., Chicago, IL 60659 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 to occur upon approval of HFSRB, expected in the 4<sup>th</sup> Quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the service at this location as there are other ASTC’s in the region providing similar services.

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

Sincerely,

Jennifer Baldock  
EVP/Chief Administrative & Development Officer  
Surgery Partners, Inc.

Vice President & Secretary  
Surgery Center Holdings, Inc.

27508745 v1

# ATTACHMENT 10 Discontinuation Notice to Area Facilities

○

3040 W Peterson Ave, Chicago, IL 60656

↕

📍

2744 N Western Ave, Chicago, IL 60647

+
Add destination

---

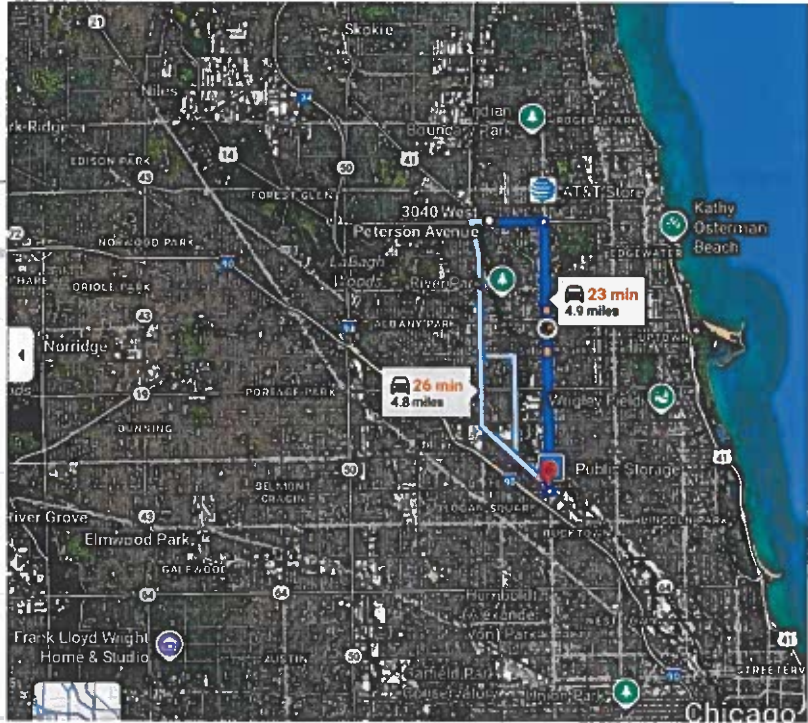
🕒 Leave now ▾
Options

---

📱 Send directions to your phone
🔗 Copy link

---

🚗	<b>via N Western Ave</b> Fastest route, despite the usual traffic Details   Preview	<b>23 min</b> 4.9 miles
🚗	<b>via N Kedzie Ave and N California Ave</b> Some traffic, as usual	<b>25 min</b> 5.1 miles
🚗	<b>via N Kedzie Ave and N Elston Ave</b> Some traffic, as usual	<b>26 min</b> 4.8 miles



## **ATTACHMENT 11**

### **Background of the Applicants**

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

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

The Applicants have no ownership in other health care facilities.

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

The Applicants have no ownership in other health care facilities.

**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.**

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

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

Pursuant to the certification executed with the submission of this application, the Applicants certify that there have been no individuals cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding.

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

Pursuant to the certification executed with the submission of this application, the Applicants certify that no person has been charged with fraudulent conduct or any act involving moral turpitude.

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

Pursuant to the certification executed with the submission of this application, the Applicants certify that they do not have any unsatisfied judgments against him or her.

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

Pursuant to the certification executed with the submission of this application, the Applicants certify that they do not have any Applicants who are 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.

## **ATTACHMENT 11**

### **Background of the Applicants**

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

The Applicant permits the HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

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

a. Not Applicable.

# ATTACHMENT 11

## Background of the Applicants



September 15, 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 - NovaMed Surgery Center of Chicago - Northshore**

Dear Mr. Kniery,

As a representative of NovaMed Surgery Center of Chicago – Northshore, LLC and Surgery Partners, Inc., I, Jennifer Baldock, 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 NovaMed Surgery Center of Chicago - Northshore LLC has no ownership interest in other healthcare facilities. This ambulatory surgical treatment center has had no adverse actions to report for the past three (3) years. Surgery Partners, Inc. has an ownership interest in several healthcare facilities including:

- Valley Ambulatory Surgery Center (St. Charles, IL)
- Gold Coast Surgicenter (Chicago, IL)
- Duly Surgery Center Lombard (Lombard, IL)
- Duly Surgery Center Westmont (Westmont, IL)

I further verify that the healthcare facilities owned by Surgery Partners, Inc. have had no adverse actions to report for the past three (3) years.

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,

Jennifer Baldock  
Executive Vice-President and Chief Administrative & Development Officer

340 Seven Springs Way • Suite 600 • Brentwood, IN 37027 • Phone: 615.234.5900 • Fax: 615.234.5999

# ATTACHMENT 11

## Background of the Applicants

September 15, 2023

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 - NovaMed Surgery Center of Chicago - Northshore**

Dear Mr. Kniery,

I, David M. Greenberg, M.D., 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 I hold no ownership interest in any other healthcare facilities. In addition, I affirm that this ambulatory surgical treatment center has had no adverse actions to report within the past three (3) years.

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,



David M. Greenberg, M.D.

27508745 v  
27536874 v1

# ATTACHMENT 11

## Background of the Applicants

September 15, 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 - NovaMed Surgery Center of Chicago - Northshore**

Dear Mr. Kniery,

As a representative of Gerstein ASC Interests, LLC, I, Craig H. Gerstein, M.D., 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 Gerstein ASC Interests, LLC holds no ownership interest in any other healthcare facilities. In addition, I affirm that this ambulatory surgical treatment center has had no adverse actions to report within the past three (3) years.

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,



Craig H. Gerstein  
Managing Member  
Gerstein ASC Interests, LLC

27308745 v1  
27334674 v1

# ATTACHMENT 11

## Background of the Applicants



LAWRENCE D. WOLIN, M.D.

September 15, 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 – NovaMed Surgery Center of Chicago – Northshore

Dear Mr. Kniery,

I, Lawrence D. Wolin, M.D., 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 I hold no ownership interest in any other healthcare facilities. In addition, I affirm that this ambulatory surgical treatment center has had no adverse actions to report within the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty for perjury and in accordance with 735 ILCS 3/1-109.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Wolin".

Lawrence D. Wolin, M.D.

1602 W. CENTRAL ROAD, ARLINGTON HEIGHTS, IL 60005  
T: 847-255-3515 • F: 847-255-8727  
www.wollneye.com

# ATTACHMENT 12

## Purpose of Project

### Reasons For Discontinuation

The Applicants propose to discontinue NovaMed Surgery Center of Chicago–Northshore because continued operation at the existing site is no longer practicable, sustainable, or justified based on the State Board’s discontinuation criteria.

#### **1. Insufficient Volume and Declining Demand**

Utilization of the facility has consistently decreased over multiple years, demonstrating a sustained lack of patient demand for the services provided at this location. Procedure volumes from the physician owners have fallen to a level that no longer supports efficient operations or the ongoing allocation of clinical and administrative resources.

#### **2. Economic Infeasibility**

The combination of declining surgical volumes and rising fixed operating costs has rendered the facility no longer economically feasible. Continued operation would require the licensee to subsidize ongoing losses, which would impair the overall financial viability and strategic allocation of resources within the organization.

### Impact of Access

#### **3. 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.**

Although the existing facility is no longer feasible to operate, patient access will not be adversely affected. There are ASTCs located within a short distance that offer the same or broader range of services. Therefore, all remaining patient need should be able to be safely and effectively absorbed by neighboring providers.

#### **4. 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.**

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

## **ATTACHMENT 37**

### **Safety Net Impact Statement**

**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 Applicants do not anticipate that discontinuation of the facility will have any material impact on essential safety net services in the community, including any measurable impact on racial or health care disparities. The facility will cease operations upon approval of the discontinuation, and all remaining patient need can be fully absorbed by nearby ASTCs, each of which already serves a broad demographic mix of patients.

Based on available information and the facility's declining utilization, the discontinuation will not adversely affect access for Medicaid, uninsured, or otherwise vulnerable populations. No essential safety net service will be eliminated, and the Applicant is not aware of any unmet need that would be created by the project.

**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 Applicants do not expect the project to have any impact on the ability of other providers or health systems in the community to cross-subsidize safety net services. The volume associated with the facility is low and declining, and its discontinuation will not meaningfully alter the financial position, payer mix, or service demand for other area providers. The project is not expected to affect their ability to maintain or support existing safety net programs.

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

Discontinuation of the facility is not expected to negatively affect remaining safety net providers in the community. The services performed at NovaMed Surgery Center of Chicago–Northshore are available at other ASTCs in the service area, all of which have documented capacity to serve patients.

Given the facility's declining utilization and the proximity of alternative providers, the discontinuation will not create a gap in access or impose an increased burden on safety net institutions.

## Attachment 37 Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
NovaMed Surgery Center of Chicago - Northshore			
Charity (# of patients)	2020	2021	2022
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
Charity (cost in dollars)			
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
MEDICAID			
Medicaid (# of patients)	2020	2021	2022
Inpatient	-	-	-
Outpatient	273	277	440
<b>Total</b>	273	277	440
Medicaid (revenue)			
Inpatient			-
Outpatient	\$96,158	\$121,896	\$236,668
<b>Total</b>	\$96,158	\$121,896	\$236,668

## Attachment 38 Charity Care Information

<b>CHARITY CARE</b>			
<b>NovaMed Surgery Center of Chicago - Northshore</b>			
	Year	2021	2022
<b>Net Patient Revenue</b>	<b>\$3,110,062</b>	<b>\$3,519,375</b>	<b>\$3,551,944</b>
<b>Amount of Charity Care (charges)</b>	-	-	-
<b>Cost of Charity Care</b>	-	-	-

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

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant Identification including Certificate of Good Standing	27-30
2	Site Ownership	31
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	32-33
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	34
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	35-52
11	Background of the Applicant	53-58
12	Purpose of the Project	59
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
	<b>Service Specific:</b>	N/A
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
	<b>Financial and Economic Feasibility:</b>	
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	60-61
38	Charity Care Information	62
39	Flood Plain Information	N/A