

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT

26-008  
**RECEIVED**

FEB 19 2026

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

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

This Section must be completed for all projects.

**Facility/Project Identification**

|                                                      |                        |                           |
|------------------------------------------------------|------------------------|---------------------------|
| Facility Name: Schaumburg Plastic Surgery Center LLC |                        |                           |
| Street Address: 1321 Tower Road                      |                        |                           |
| City and Zip Code: Schaumburg 60173                  |                        |                           |
| County: Cook                                         | Health Service Area: 7 | Health Planning Area: 031 |

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

|                                                                    |  |
|--------------------------------------------------------------------|--|
| Exact Legal Name: Schaumburg Plastic Surgery Center LLC            |  |
| Street Address: 2517 W. Shakespeare Avenue                         |  |
| City and Zip Code: Chicago 60647                                   |  |
| Name of Registered Agent: Northwest Registered Agent Service, Inc. |  |
| Registered Agent Street Address: 2501 Chatham Road, Ste. N         |  |
| Registered Agent City and Zip Code: Springfield 62704              |  |
| Name of President: Sameer Kapadia, M.D.                            |  |
| President Street Address: 2517 W. Shakespeare Avenue               |  |
| President City and Zip Code: Chicago 60647                         |  |
| President Telephone Number: 312-872-8514                           |  |

**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 |
| Other                                                                                                                                                                                                                                                                                                                                            |                                              |
| <ul style="list-style-type: none"><li>Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li><li>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.</li></ul> |                                              |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                                                                                                                            |                                              |

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

|                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name: Juan Morado, Jr. and Mark J. Silberman                                                                                                                    |
| Title: CON Counsel                                                                                                                                              |
| Company Name: Benesch Friedlander Coplan & Aronoff, LLP                                                                                                         |
| Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606                                                                                                      |
| Telephone Number: 312-212-4967 and 312-212-4952                                                                                                                 |
| E-mail Address: <a href="mailto:JMorado@beneschlaw.com">JMorado@beneschlaw.com</a> and <a href="mailto:MSilberman@beneschlaw.com">MSilberman@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: Sameer Kapadia, M.D.                                                                     |
| Title: President                                                                               |
| Company Name: Schaumburg Plastic Surgery Center                                                |
| Address: 1321 Tower Road, Schaumburg, IL 60173                                                 |
| Telephone Number: 312-872-8515                                                                 |
| E-mail Address: <a href="mailto:sk@kapadiaplasticsurgery.com">sk@kapadiaplasticsurgery.com</a> |
| Fax Number: N/A                                                                                |

**Site Ownership** [Provide this information for each applicable site]

|                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Exact Legal Name of Site Owner: ZSSM Schaumburg LLC                                                                                                                                                                                                                                                                                                          |
| Address of Site Owner: 2517 W. Shakespeare Avenue, Chicago, IL 60647                                                                                                                                                                                                                                                                                         |
| Street Address or Legal Description of the Site:<br>Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease. |
| APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.                                                                                                                                                                                                                                               |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Exact Legal Name: Schaumburg Plastic Surgery Center LLC                                                                                                                                                                                                                                                                                                                                                                                         |                                                                       |
| Address: 1321 Tower Road, Schaumburg, IL 60173                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                       |
| <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>Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>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>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</li></ul> |                                                                       |
| APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.                                                                                                                                                                                                                                                                                                                                  |                                                                       |

**Organizational Relationships**

|                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution. |
| APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.                                                                                                                                                                                                                              |

**Flood Plain Requirements** [Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](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.

Schaumburg Plastic Surgery Center LLC, located at 1321 Tower Road, Schaumburg, IL 60173 ("Applicant") seeks to establish an ambulatory surgical treatment center ("ASTC") with one (1) operating room and to provide Plastic Surgery services.

This project is classified as substantive, in that it involves the establishment of an ambulatory surgical treatment center pursuant to 77 Ill. Admin. Code 1110.20(c)(1)(A)(i).

## Project Costs and Sources of Funds

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

| Project Costs and Sources of Funds                                                                                                                    |                    |                    |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------|--------------------|
| USE OF FUNDS                                                                                                                                          | CLINICAL           | NONCLINICAL        | TOTAL              |
| Preplanning Costs                                                                                                                                     | -                  | -                  | -                  |
| Site Survey and Soil Investigation                                                                                                                    | -                  | -                  | -                  |
| Site Preparation                                                                                                                                      | \$10,748           | \$4,502            | \$15,250           |
| Off Site Work                                                                                                                                         | -                  | -                  | -                  |
| New Construction Contracts                                                                                                                            | \$851,649          | \$356,703          | \$1,208,352        |
| Modernization Contracts                                                                                                                               | -                  | \$-                | -                  |
| Contingencies                                                                                                                                         | \$52,860           | \$22,140           | \$75,000           |
| Architectural/Engineering Fees                                                                                                                        | \$35,240           | \$14,760           | \$50,000           |
| Consulting and Other Fees                                                                                                                             | \$211,441          | \$88,559           | \$300,000          |
| Movable or Other Equipment (not in construction contracts)                                                                                            | \$500,000          | \$300,000          | \$800,000          |
| Bond Issuance Expense (project related)                                                                                                               | -                  | -                  | -                  |
| Net Interest Expense During Construction (project related)                                                                                            | \$-                | \$-                |                    |
| Fair Market Value of Leased Space or Equipment                                                                                                        | \$414,268          | \$173,512          | \$587,780          |
| Other Costs to Be Capitalized                                                                                                                         | \$140,960          | \$59,040           | \$200,000          |
| Acquisition of Building or Other Property (excluding land)                                                                                            | -                  | -                  | -                  |
| <b>TOTAL USES OF FUNDS</b>                                                                                                                            | <b>\$2,217,166</b> | <b>\$1,019,216</b> | <b>\$3,236,382</b> |
| SOURCE OF FUNDS                                                                                                                                       | CLINICAL           | NONCLINICAL        | TOTAL              |
| Cash and Securities                                                                                                                                   | \$104,735          | \$43,867           | \$148,602          |
| Pledges                                                                                                                                               |                    |                    |                    |
| Gifts and Bequests                                                                                                                                    |                    |                    |                    |
| Bond Issues (project related)                                                                                                                         |                    |                    |                    |
| Mortgages                                                                                                                                             | \$1,698,163        | \$801,837          | \$2,500,000        |
| Leases (fair market value)                                                                                                                            | \$414,268.33       | \$173,511.67       | \$587,780          |
| Governmental Appropriations                                                                                                                           |                    |                    |                    |
| Grants                                                                                                                                                |                    |                    |                    |
| Other Funds and Sources                                                                                                                               |                    |                    |                    |
| <b>TOTAL SOURCES OF FUNDS</b>                                                                                                                         | <b>\$2,217,166</b> | <b>\$1,019,216</b> | <b>\$3,236,382</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 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Purchase Price: \$                     | N/A                          |                                        |
| Fair Market Value: \$                  | N/A                          |                                        |

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

☒ Yes ☐ No

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

Estimated start-up costs and operating deficit cost is \$ 2,500,000

### Project Status and Completion Schedules

|                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>For facilities in which prior permits have been issued please provide the permit numbers.</b>                                                                                                                                       |
| Indicate the stage of the project's architectural drawings:                                                                                                                                                                            |
| <input type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary                                                                                                                                                   |
| <input checked="" type="checkbox"/> Schematics <input type="checkbox"/> Final Working                                                                                                                                                  |
| Anticipated project completion date (refer to Part 1130.140): December 31, 2027                                                                                                                                                        |
| Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):                                                                                                                      |
| <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.                                                                                                                            |
| <input checked="" type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies |
| <input type="checkbox"/> Financial Commitment will occur after permit issuance.                                                                                                                                                        |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>                                                                                                                  |

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

|                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Are the following submittals up to date as applicable?                                                                                        |
| <input type="checkbox"/> Cancer Registry <b>NOT APPLICABLE</b>                                                                                |
| <input type="checkbox"/> APORS <b>NOT APPLICABLE</b>                                                                                          |
| <input type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted <b>NOT APPLICABLE</b> |
| <input type="checkbox"/> All reports regarding outstanding permits <b>NOT APPLICABLE</b>                                                      |
| <b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b>                    |

## Cost Space Requirements

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

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

| 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>                                                                                                     |                    |                   |              |                                                     |            |          |               |
| ASTC- One Operating Room                                                                                              | \$2,217,166        | -                 | 1,688        | 1,688                                               | -          | -        | -             |
| Total Clinical                                                                                                        | \$2,217,166        | -                 | 1,699        | 1,699                                               | -          | -        | -             |
| <b>NON-REVIEWABLE</b>                                                                                                 |                    |                   |              |                                                     |            |          |               |
| Administrative                                                                                                        | \$1,0190,216       | -                 | 707          | 707                                                 | -          | -        | -             |
| Total Non-clinical                                                                                                    | \$1,0190,216       | -                 | 707          | 707                                                 | -          | -        | -             |
| <b>TOTAL</b>                                                                                                          | <b>\$3,236,382</b> | <b>-</b>          | <b>2,395</b> | <b>2,395</b>                                        | <b>-</b>   | <b>-</b> | <b>-</b>      |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b> |                    |                   |              |                                                     |            |          |               |

**Facility Bed Capacity and Utilization – NOT APPLICABLE**

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

|                                       |                        |                   |                     |                    |                      |
|---------------------------------------|------------------------|-------------------|---------------------|--------------------|----------------------|
| <b>FACILITY NAME:</b>                 |                        | <b>CITY:</b>      |                     |                    |                      |
| <b>REPORTING PERIOD DATES:</b>        |                        | <b>From:</b>      |                     | <b>to:</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 ((identify)                     |                        |                   |                     |                    |                      |
| <b>TOTALS:</b>                        |                        |                   |                     |                    |                      |

## CERTIFICATION

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

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

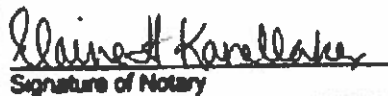
This Application is filed on the behalf of Schaumburg Plastic Surgery Center LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant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

  
SIGNATURE

SAMEER M. KARADIA  
PRINTED NAME

OWNER, PRESIDENT  
PRINTED TITLE

Notarization  
Subscribed and sworn to before me  
this 13<sup>th</sup> day of January 2026

  
Signature of Notary



\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED TITLE

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

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

Seal

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

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

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

## Criterion 1110.110(b) & (d)

### PURPOSE OF PROJECT

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

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

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

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

### ALTERNATIVES

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

#### SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
  - c. The project involves the conversion of existing space that results in excess square footage.
  - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

| SIZE OF PROJECT         |                    |                              |            |               |
|-------------------------|--------------------|------------------------------|------------|---------------|
| DEPARTMENT/SERVICE      | PROPOSED BGSF/DGSF | STATE STANDARD               | DIFFERENCE | MET STANDARD? |
| ASTC (1 Operating Room) | 1,688              | 2,750 GSF per treatment room | 1,062      | YES           |

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

#### PROJECT SERVICES UTILIZATION:

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

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

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

| UTILIZATION |                |                                                         |                       |                |                |
|-------------|----------------|---------------------------------------------------------|-----------------------|----------------|----------------|
|             | DEPT./ SERVICE | HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC. | PROJECTED UTILIZATION | STATE STANDARD | MEET STANDARD? |
| YEAR 1      | ASTC           | 496                                                     | 496                   | 1500 hours     | YES            |
| YEAR 2      | ASTC           | 496                                                     | 510                   | 1500 hours     | YES            |

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

**UNFINISHED OR SHELL SPACE:**

Provide the following information:

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

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

**ASSURANCES:**

Submit the following:

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

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

### G. Non-Hospital Based Ambulatory Surgery

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

| ASTC Service                                                  |
|---------------------------------------------------------------|
| <input type="checkbox"/> Cardiovascular                       |
| <input type="checkbox"/> Colon and Rectal Surgery             |
| <input type="checkbox"/> Dermatology                          |
| <input type="checkbox"/> General Dentistry                    |
| <input type="checkbox"/> General Surgery                      |
| <input type="checkbox"/> Gastroenterology                     |
| <input type="checkbox"/> Neurological Surgery                 |
| <input type="checkbox"/> Nuclear Medicine                     |
| <input type="checkbox"/> Obstetrics/Gynecology                |
| <input type="checkbox"/> Ophthalmology                        |
| <input type="checkbox"/> Oral/Maxillofacial Surgery           |
| <input type="checkbox"/> Orthopedic Surgery                   |
| <input type="checkbox"/> Otolaryngology                       |
| <input type="checkbox"/> Pain Management                      |
| <input type="checkbox"/> Physical Medicine and Rehabilitation |
| <input checked="" type="checkbox"/> Plastic Surgery           |
| <input type="checkbox"/> Podiatric Surgery                    |
| <input type="checkbox"/> Radiology                            |
| <input type="checkbox"/> Thoracic Surgery                     |
| <input type="checkbox"/> Urology                              |
| <input type="checkbox"/> Other                                |

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

| APPLICABLE REVIEW CRITERIA                                                                                             | Establish New ASTC or Service | Expand Existing Service |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------|
| 1110.235(c)(2)(B) – Service to GSA Residents                                                                           | X                             | X                       |
| 1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service                                  | X                             |                         |
| 1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service                                                   |                               | X                       |
| 1110.235(c)(5) – Treatment Room Need Assessment                                                                        | X                             | X                       |
| 1110.235(c)(6) – Service Accessibility                                                                                 | X                             |                         |
| 1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution                                                            | X                             |                         |
| 1110.235(c)(7)(B) – Maldistribution                                                                                    | X                             |                         |
| 1110.235(c)(7)(C) – Impact to Area Providers                                                                           | X                             |                         |
| 1110.235(c)(8) – Staffing                                                                                              | X                             | X                       |
| 1110.235(c)(9) – Charge Commitment                                                                                     | X                             | X                       |
| 1110.235(c)(10) – Assurances                                                                                           | X                             | X                       |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b> |                               |                         |

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

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

## SECTION VII. 1120.120 - AVAILABILITY OF FUNDS

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]:

|                                                                                                                        |                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>\$148,602</u>                                                                                                       | a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:                                                                                                                                                                                               |
|                                                                                                                        | 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and                                                                                                                                                                           |
|                                                                                                                        | 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.                                                                                                                                                                               |
| <u>                    </u>                                                                                            | 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.                                                                                |
| <u>                    </u>                                                                                            | c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.                                                                                                                                                                                          |
| <u>\$3,087,780</u>                                                                                                     | d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:                                                       |
|                                                                                                                        | 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated.                                                                                       |
|                                                                                                                        | 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate.                                                                                                                                                                                                                                    |
|                                                                                                                        | 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.                      |
|                                                                                                                        | 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment.                                                                                                                                           |
|                                                                                                                        | 5) For any option to lease, a copy of the option, including all terms and conditions.                                                                                                                                                                                                                                                 |
| <u>                    </u>                                                                                            | 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. |
| <u>                    </u>                                                                                            | f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.                                                                                                                                                                                                             |
| <u>                    </u>                                                                                            | g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.                                                                                                                                                                                                            |
| <u>\$3,236,382</u>                                                                                                     | <b>TOTAL FUNDS AVAILABLE</b>                                                                                                                                                                                                                                                                                                          |
| <b>APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b> |                                                                                                                                                                                                                                                                                                                                       |

## SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

### **Financial Viability Waiver**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

### **Variance**

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

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

## SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

### A. Reasonableness of Financing Arrangements

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

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

### B. Conditions of Debt Financing

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

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

### C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

| COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE   |                         |      |                      |        |                       |        |                      |                    |                       |
|-------------------------------------------------------|-------------------------|------|----------------------|--------|-----------------------|--------|----------------------|--------------------|-----------------------|
| Department<br>(List below)                            | A                       | B    | C                    | D      | E                     | F      | G                    | H                  | Total Cost<br>(G + H) |
|                                                       | Cost/Square Foot<br>New | Mod. | Gross Sq. Ft.<br>New | Circ.* | Gross Sq. Ft.<br>Mod. | Circ.* | Const. \$<br>(A x C) | Mod. \$<br>(B x E) |                       |
| ASTC                                                  | \$504.53                | -    | 1,688                | -      | -                     | -      | \$851,649            | -                  | \$851,659             |
| Contingency                                           | \$31.32                 | -    | 707                  | -      | -                     | -      | \$52,860             |                    | \$52,860              |
| TOTALS                                                | \$535.85                | -    | 2,395                | -      | -                     | -      | \$904,509            |                    | \$904,509             |
| * 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                            | -    | -    | -    |
| Total                                 | -    | -    | -    |
| Charity (cost in dollars)             |      |      |      |
| Inpatient                             | -    | -    | -    |
| Outpatient                            | -    | -    | -    |
| Total                                 | -    | -    | -    |
| MEDICAID                              |      |      |      |
| Medicaid (# of patients)              | 2022 | 2022 | 2022 |
| Inpatient                             | -    | -    | -    |
| Outpatient                            | -    | -    | -    |
| Total                                 | -    | -    | -    |
| Medicaid (revenue)                    |      |      |      |
| Inpatient                             | -    | -    | -    |
| Outpatient                            | -    | -    | -    |
| Total                                 | -    | -    | -    |

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

## SECTION X. CHARITY CARE INFORMATION

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

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

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

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

| CHARITY CARE                     |      |      |      |
|----------------------------------|------|------|------|
|                                  | 2020 | 2021 | 2022 |
| Net Patient Revenue              | -    | -    | -    |
| Amount of Charity Care (charges) | -    | -    | -    |
| Cost of Charity Care             | -    | -    | -    |

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

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

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

1. Applicant: Schaumburg Plastic Surgery Center LLC 1321 Tower Road  
(Name) (Address)
- Schaumburg Illinois 60173 (312) 872-8514  
(City) (State) (ZIP Code) (Telephone Number)
2. Project Location: 1321 Tower Road Schaumburg Illinois  
(Address) (City) (State)
- Cook Schaumburg  
(County) (Township) (Section)

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

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

**IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes \_\_\_ No X**

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

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

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

FIRM Panel Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Official: \_\_\_\_\_ Title: \_\_\_\_\_

Business/Agency: \_\_\_\_\_ Address: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

| INDEX OF ATTACHMENTS |                                                                                                        |         |
|----------------------|--------------------------------------------------------------------------------------------------------|---------|
| ATTACHMENT NO.       |                                                                                                        | PAGES   |
| 1.                   | Applicant Identification including Certificate of Good Standing                                        | 23-24   |
| 2.                   | Site Ownership                                                                                         | 25-35   |
| 3.                   | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | 36-37   |
| 4.                   | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.                  | 38      |
| 5.                   | Flood Plain Requirements                                                                               | 39-40   |
| 6.                   | Historic Preservation Act Requirements                                                                 | 41-46   |
| 7.                   | Project and Sources of Funds Itemization                                                               | 47-51   |
| 8.                   | Financial Commitment Document if required                                                              | 52-53   |
| 9.                   | Cost Space Requirements                                                                                | 54      |
| 10.                  | Discontinuation                                                                                        | N/A     |
| 11.                  | Background of the Applicant                                                                            | 55-62   |
| 12.                  | Purpose of the Project                                                                                 | 63-111  |
| 13.                  | Alternatives to the Project                                                                            | 112     |
| 14.                  | Size of the Project                                                                                    | 113     |
| 15.                  | Project Service Utilization                                                                            | 114-115 |
| 16.                  | Unfinished or Shell Space                                                                              | 116     |
| 17.                  | Assurances for Unfinished/Shell Space                                                                  | 117     |
|                      | <b>Service Specific:</b>                                                                               |         |
| 18.                  | Master Design and Related Project                                                                      | N/A     |
| 19.                  | Medical Surgical Pediatrics, Obstetrics, ICU                                                           | N/A     |
| 20.                  | Comprehensive Physical Rehabilitation                                                                  | N/A     |
| 21.                  | Acute Mental Illness                                                                                   | N/A     |
| 22.                  | Open Heart Surgery                                                                                     | N/A     |
| 23.                  | Cardiac Catheterization                                                                                | N/A     |
| 24.                  | In-Center Hemodialysis                                                                                 | N/A     |
| 25.                  | Non-Hospital Based Ambulatory Surgery                                                                  | 118-138 |
| 26.                  | Selected Organ Transplantation                                                                         | N/A     |
| 27.                  | Kidney Transplantation                                                                                 | N/A     |
| 28.                  | Subacute Care Hospital Model                                                                           | N/A     |
| 29.                  | Community-Based Residential Rehabilitation Center                                                      | N/A     |
| 30.                  | Long Term Acute Care Hospital                                                                          | N/A     |
| 31.                  | Clinical Service Areas Other than Categories of Service                                                | N/A     |
| 32.                  | Freestanding Emergency Center Medical Services                                                         | N/A     |
| 33.                  | Birth Center                                                                                           | N/A     |
|                      | <b>Financial and Economic Feasibility:</b>                                                             |         |
| 34.                  | Availability of Funds                                                                                  | 139     |
| 35.                  | Financial Waiver                                                                                       | N/A     |
| 36.                  | Financial Viability                                                                                    | 140     |
| 37.                  | Economic Feasibility                                                                                   | 141-144 |
| 38.                  | Safety Net Impact Statement                                                                            | 145     |
| 39.                  | Charity Care Information                                                                               | 146     |
| 40.                  | Flood Plain Information                                                                                | 147-148 |

## **ATTACHMENT 1**

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

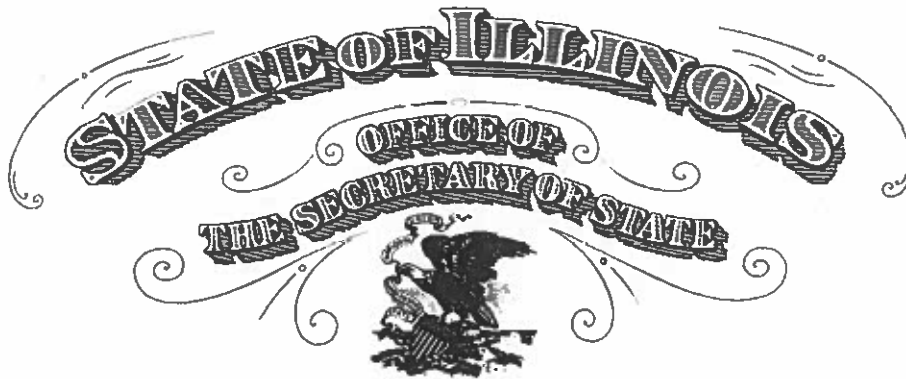
Included with this attachment is:

1. The Certificate of Good Standing for the applicant, Schaumburg Plastic Surgery Center LLC.

**ATTACHMENT 1**  
**Certificate of Good Standing**  
**Schaumburg Plastic Surgery Center LLC**

*File Number*

1677897-4



***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***

**SCHAUMBURG PLASTIC SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 11, 2025, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.**



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of NOVEMBER A.D. 2025 .***

Authentication #: 2532800572 verifiable until 11/24/2026  
Authenticate at: <https://www.ilsos.gov>

  
SECRETARY OF STATE

## **ATTACHMENT 2**

### **Site Ownership**

Attached as evidence of control over the site is a deed for the property held by ZSSM Schaumburg, LLC, a limited liability company wholly owned by Dr. Sameer Kapadia. Additionally, we are including a copy of a letter of intent for a Lease to be used by the Applicant.

## ATTACHMENT 2

### Site Ownership

#### ILLINOIS SPECIAL WARRANTY DEED

##### PREPARED BY:

Sunridge Legal  
5322 Sweetwater Trl  
San Diego, CA 92130-5044

##### WHEN RECORDED RETURN TO:

ZSSM SCHAUMBURG LLC  
2517 W. Shakespeare Ave  
Chicago, IL 60647  
ATTN: Sameer Kapadia

##### MAIL TAX STATEMENTS TO:

  
ZSSM Schaumburg LLC  
2517 W. Shakespeare Ave  
Chicago IL 60647

SPACE ABOVE THIS LINE RESERVED FOR RECORDER'S USE

#### SPECIAL WARRANTY DEED

THIS INDENTURE WITNESSETH THAT Cammy Investments, Inc., a California corporation, whose address is 3525 Del mar Heights Rd # 758, San Diego, CA, 92130 ("Grantor"), for and in consideration of the sum of Ten and No/100 Dollars (\$10.00) and other good and valuable consideration in hand paid, the receipt, adequacy and sufficiency of which is hereby acknowledged, by these presents does GRANT, BARGAIN, CONVEY AND SELL unto ZSSM Schaumburg, LLC, an Illinois limited liability company whose address is 6505 N Longmeadow Ave, Lincolnwood, IL 60712 ("Grantee"), the following described real property located in the County of Cook, State of Illinois and legally described as follows:

## ATTACHMENT 2

### Site Ownership

See Legal Description attached hereto as Exhibit A and hereby made a part hereof.

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

And Grantor, for itself, and its successors, does covenant, promise and agree, to and with Grantee, its successors and assigns, that it has not done or suffered to be done, anything whereby the property hereby granted is, or may be, in any manner encumbered or charged, except as herein recited; and that Grantor will **WARRANT AND DEFEND** said property against all persons lawfully claiming, or to claim the same, by through and under Grantor, but not otherwise.

SUBJECT ONLY TO: taxes not yet due and payable as of the date hereof and the Permitted Exceptions set forth on Exhibit B, attached hereto and made a part hereof.

Permanent Index Number(s): 07-12-300-040-0000

Common Address: 1321 Tower Rd., Schaumburg, IL 60173

[Signature Page Follows]

## ATTACHMENT 2 Site Ownership

IN WITNESS WHEREOF, Grantor has caused this Special Warranty Deed to be executed as of this 13 day of June, 2025.

  
By: J. Mitchell Page  
Name: Mitchell Page  
Title: President

**Note:** Illinois cities and counties have a variety of transfer tax forms. Check with Title Company for specifics. Some cities/counties require inspections to be done prior to recording. Most title companies have a recording service that will do all of this in advance for a fee if requested to do so. IL also has the Bulk Transfer Sales Act if all IL property owned by Grantor is conveyed in a single transaction.

## ATTACHMENT 2 Site Ownership

Affidavit Number: -915-

State of [STATE] Puerto Rico

County of [COUNTY] Dorado

This instrument was acknowledged before me on June 13, 2025 by  
Joseph Mitchell Patridge.

(Seal)



Jaryln González Pérez  
Notary Public

My Commission Expires: does not expires.  
Puerto Rico law.

## **ATTACHMENT 2**

### **Site Ownership**

#### **EXHIBIT A**

#### **LEGAL DESCRIPTION OF REAL PROPERTY**

**Parcel 1:**

Lot 1 in Tower Place Resubdivision, being a Resubdivision of part of Lot 8 in Schaumburg Industrial Park Unit No. 1, and a part of the West Half of the Southwest Quarter of Section 12, Township 41 North, Range 10, East of the Third Principal Meridian, according to the Plat thereof recorded July 31, 2012 as document no. 1221331116 in Cook County, Illinois.

**Parcel 2:**

A non-exclusive ingress and egress easement for the benefit of Parcel 1 as created by Reciprocal Access Easement Agreement dated September 28, 2012 and recorded October 18, 2012 as Document No. 1228201053.

## ATTACHMENT 2

### Site Ownership

#### EXHIBIT B

##### PERMITTED EXCEPTIONS

1. Taxes for the year(s) 2024 and 2025  
2025 taxes are not yet due or payable.  
1A. Note: 2024 first installment was due March 4, 2025  
Note: 2024 final installment not yet due or payable  
Perm tax# Pcl Year 1st Inst Stat  
07-12-300-040-0000 1 of 1 2024 \$37,843.45 Paid
2. Existing unrecorded leases and all rights thereunder of the lessees and of any person or party claiming by, through or under the lessees.
3. Unrecorded lease in favor of Chicago Liposuction LLC, an Illinois limited liability company, dated March 1, 2019, as amended September 22, 2022, and all rights thereunder of, and all acts done or suffered thereunder by, said lessee or by any party claiming by, through or under said lessee. As affected by the Subordination, Non-Disturbance and Attornment Agreement recorded March 23, 2023 as document no. 2308222051, and the terms and conditions thereof.
4. Unrecorded lease in favor of Dr. Victor Sanz, dated December, 2014, as amended September 22, 2022, and all rights thereunder of, and all acts done or suffered thereunder by, said lessee or by any party claiming by, through or under said lessee.
5. As affected by the Subordination, Non-Disturbance and Attornment Agreement recorded March 23, 2023 as document no. 2308222052, and the terms and conditions thereof.
6. A 50 foot building line along the North line of the underlying Land as shown on Plat of Subdivision recorded as document no. 19263036, and also as shown on Tower Place Resubdivision recorded as document no. 1221331116. Affects the Northerly 25 feet.
7. Easement for public utilities, and the easement provisions and grantees, as set forth on the Plat of Subdivision recorded as document no. 19263036 and also as shown on Tower Place Resubdivision recorded as document no. 1221331116, over the West 5 feet of Land and other property.
8. Easement in favor of the Commonwealth Edison Company, the Illinois Bell Telephone Company and Northern Illinois Gas Company, and its/their respective successors and assigns, to install, operate and maintain all equipment necessary for the purpose of serving the Land and other property, together with the right of access to said equipment, and the provisions relating thereto, contained in the plat recorded as document no. 19263036, affecting the West 5 feet of the underlying Land.
9. Covenants and restrictions contained in the Declaration made by Chicago Title and Trust Company, a corporation of Illinois, as Trustee under Trust Agreement dated April 18, 1963 and known as Trust No. 45511, dated October 15, 1963 and recorded October 18, 1963 as document no. 18945804,

## ATTACHMENT 2

### Site Ownership

relating to the use of all of the Land; to the use, height and location of the buildings and improvements to be erected on said premises; to the approval of building plans; to landscaping on the said premises and maintenance of parking areas; and providing that off street parking be provided as in said Declaration provided.

10. 7.5 foot public utility easement, and the easement provisions and grantees, as set forth on Plat of Tower Place Resubdivision recorded as document no. 1221331116, over the South line of the Land.
11. Easement in favor of the Village of Schaumburg, and its/their respective successors and assigns, to install, operate and maintain all equipment necessary for the purpose of serving the Land and other property, together with the right of access to said equipment, and the provisions relating thereto contained in the plat recorded as document no. 1221331116. Affects the South 7.5 feet of the Land.
12. Easements, covenants, conditions and restrictions contained in the Declaration of Easements, Covenants, Conditions and Restrictions made by Chody R.E. Partnership LP and MTower LLC, an Illinois limited liability company, recorded October 18, 2012 as document no. 1229201052. Affects the Land and other property.
13. Easements, terms, provisions and conditions of the Reciprocal Access Easement Agreement made by Meacham 2004 LLC, an Illinois limited liability company, and Chody R.E. Partnership LP, an Illinois limited liability company, recorded October 18, 2012 as document no. 1229201053.  
  
Rights of adjoining owner(s) to the concurrent use of said easements.  
  
Affects the Land and other property.
14. Easement Agreement made by and between Chody R.E. Partnership, LP, an Illinois limited partnership and MTower LLC, an Illinois limited liability company recorded October 18, 2012 as document no. 1229201055, relating to panel on the existing pylon sign on adjoining Lot 2 for the benefit of our insured parcel, and the provisions relating thereto. Affects the Land and other property.
15. Construction Mortgage made by Meacham 2004, LLC, an Illinois limited liability company to Cambridge Bank, dated May 14, 2008 and recorded May 21, 2008 as document no. 0814241036.

As affected by:

Modification of Mortgage recorded August 10, 2009 as document no. 0922247148;

Amendment No. 2 to Construction Mortgage recorded January 1, 2010 as document no. 1001422118;

Amendment No. 3 to Construction Mortgage recorded October 18, 2010 as document no. 1029108390;

Amendment No. 4 to Construction Mortgage recorded June 21, 2012 as document no. 1217322050;

Amendment No. 5 to Construction Mortgage recorded August 5, 2013 as document no. 1321744053; and

## ATTACHMENT 2

### Site Ownership

Amendment No. 6 to Construction Mortgage recorded July 23, 2018 as document no. 1820434059.

Amendment No. 7 to Construction Mortgage recorded June 29, 2023 as document no. 2318028089.

Amendment No. 8 to Construction Mortgage recorded December 13, 2023 as document no. 2334715027.

Affects Parcel 2.

16. Assignment of Rents executed by Meacham 2004, LLC, an Illinois limited liability company in favor of Cambridge Bank, dated May 14, 2008 and recorded May 21, 2008 as document no. 0814241037.

Amendment No. 1 to Assignment of Rents recorded January 14, 2010 as document no. 1001422117; and Amendment No. 2 to Assignment of Rents recorded October 18, 2010 as document no. 1029108389.

Affects Parcel 2.

17. Any consequences, including invalidity or elimination of the Insured's rights under the easement insured in Schedule A (Parcel 2 of the Land), as a result of the failure of Inland Bank f/k/a Cambridge Bank to execute, or otherwise consent to, the non-exclusive ingress and egress easement insured in Schedule A as Parcel 2.
18. Any consequences, including invalidity or elimination of the Insured's rights under the easement insured in Schedule A as Parcel 2, due to the easement insured in Schedule A not being contiguous to the Land, open, and/or in use.

## ATTACHMENT 2

### Site Ownership

**SPSC**

Schaumburg Plastic Surgery Center LLC

Dear Dr. Kapadia,

This Letter of Intent ("LOI") outlines the updated terms and conditions under which ZSSM Schaumburg LLC ("Landlord") is prepared to lease commercial space to Schaumburg Plastic Surgery Center LLC ("Tenant").

**1. Premises** Approximately 2,440 rentable square feet located at 1321 Tower Rd. Schaumburg, IL 60173.

**2. Use** The Premises shall be used for an ambulatory plastic surgery center and related administrative purposes.

**3. Lease Term** The initial term of the lease shall be for a period of 10 years, commencing on June 1, 2026.

**4. Base Rent and Escalation** The starting Base Rent shall be \$22.00 per square foot annually.

- **Initial Annual Base Rent:** \$53,680.00
- **Initial Monthly Base Rent:** \$4,473.33

**Rent Escalation:** Commencing on the first anniversary of the Commencement Date, and on each subsequent anniversary throughout the Term, the Base Rent shall increase by two percent (2%) over the Base Rent payable during the immediately preceding lease year.

**5. Lease Type (Triple Net / NNN)** This shall be a Triple Net (NNN) lease. The Base Rent is net of all costs. Tenant shall be responsible for paying its proportionate share of operating expenses, including but not limited to:

- Real estate taxes;
- Building insurance; and
- Common Area Maintenance (CAM) costs.

**6. Utilities and Services** In addition to the NNN charges listed above, Tenant shall be directly responsible for and pay all charges for utilities and services supplied to the Premises, including but not limited to:

- Electricity;
- Gas;
- Water/Sewer;
- Janitorial services; and
- Internet/Telephone/Data.

**7. Condition of Premises** Tenant accepts the Premises in its "As-Is" condition. Landlord shall have no obligation to perform any alterations, improvements, or repairs to prepare the Premises for Tenant's occupancy, nor shall Landlord provide any tenant improvement allowance.

**8. Security Deposit** Waived.

**SPSC**

1321 Tower Rd, Schaumburg, IL 60173

+1 (312) 872-8514

[schaumburgplasticsurgerycenter.com](http://schaumburgplasticsurgerycenter.com)

## ATTACHMENT 2 Site Ownership

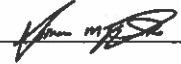
**SPSC**  
Schaumburg Plastic Surgery Center LLC

**9. Formal Lease Agreement** Upon execution of this LOI, the Landlord shall prepare a formal Lease Agreement incorporating these terms.

**10. Signatures** The undersigned acknowledge that this Letter of Intent accurately reflects the general understanding of the proposed transaction.

**AGREED AND ACCEPTED:**

**LANDLORD: ZSSM Schaumburg LLC**

By: 

Name: Sameer Kapadia, M.D.

Title: Managing Member

Date: January 20th, 2026

**TENANT: Schaumburg Plastic Surgery Center LLC**

By: 

Name: Sameer Kapadia M.D.

Title: President, Sole Member

Date: January 20th, 2026

**SPSC**

1321 Tower Rd, Schaumburg, IL 60173

+1 (312) 872-8514

[schaumburgplasticsurgerycenter.com](http://schaumburgplasticsurgerycenter.com)

### **ATTACHMENT 3**

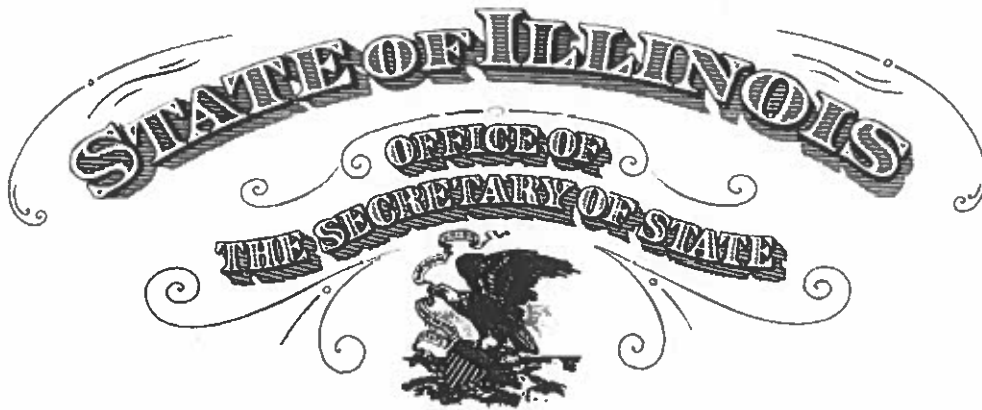
#### **Operating Entity/Licensee**

Schaumburg Plastic Surgery Center LLC will seek licensure by the Illinois Department of Public Health upon approval of this project. 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/Licensee**  
**Certificate of Good Standing for**  
**Schaumburg Plastic Surgery Center LLC**

*File Number*

1677897-4



***To all to whom these Presents Shall Come, Greeting:***

***I, Alexi Giannoulas, 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***

**SCHAUMBURG PLASTIC SURGERY CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 11, 2025, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.**



***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of NOVEMBER A.D. 2025 .***

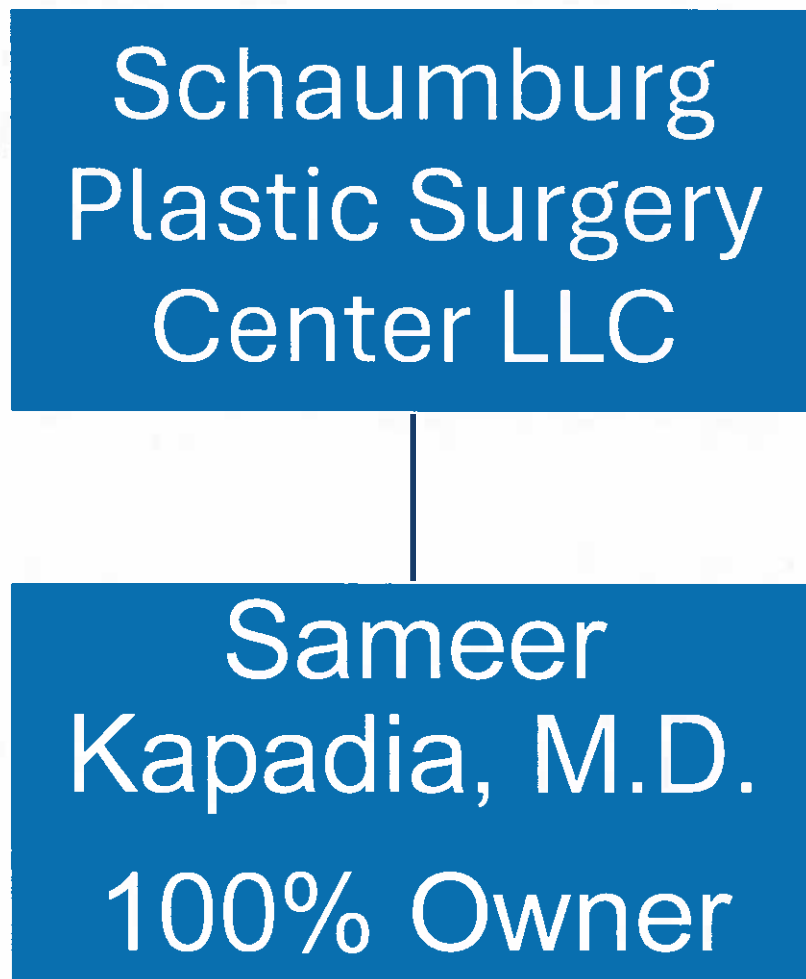
Authentication #: 2532800572 verifiable until 11/24/2026  
Authenticate at: <https://www.ilsos.gov>

  
SECRETARY OF STATE

## **ATTACHMENT 4**

### **Organizational Relationships**

The facility will be owned by Sameer Kapadia, M.D., as identified in the organizational chart below.



## ATTACHMENT 5 Flood Plain Requirements

**SPSC**  
Schaumburg Plastic Surgery Center LLC

January 20th, 2026

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

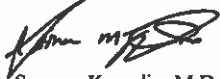
**Re: Schaumburg Plastic Surgery Center LLC - Flood Plain Requirements**

Dear Mr. Kniery:

As representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, M.D., affirm that our facility complies with Illinois Executive Order #2005-5. The facility location at 1321 Tower Road, Schaumburg, IL 60173 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

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

Sincerely,



Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC

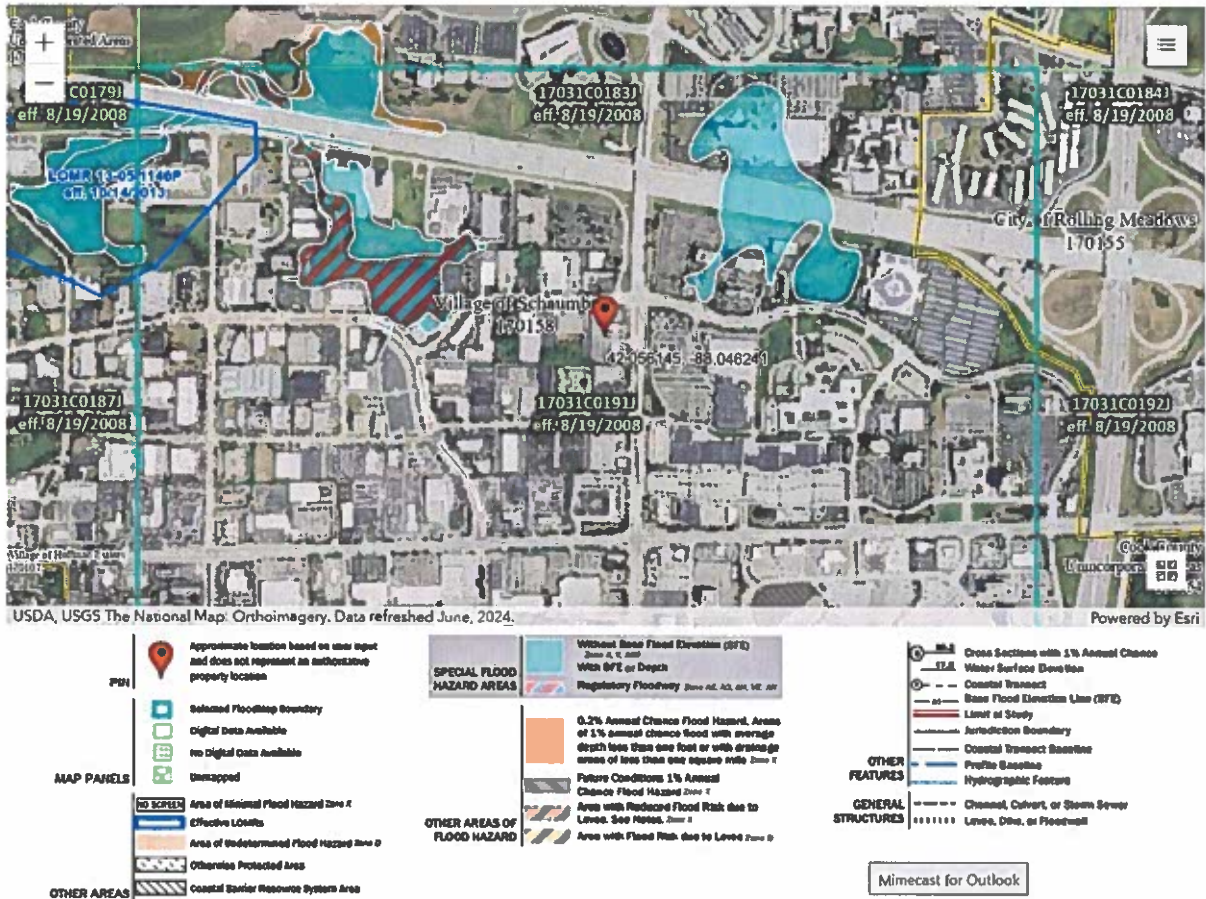
**SPSC**

1321 Tower Rd. Schaumburg, IL 60173

+1 (312) 872-8514

[schaumburgplasticsurgerycenter.com](http://schaumburgplasticsurgerycenter.com)

# ATTACHMENT 5 Flood Plain Requirements



## **ATTACHMENT 6**

### **Historic Preservation Act Requirements**

The applicant submitted a request for determination to the Illinois Department of Natural Resources – Preservation Services Division on January 30, 2026. A final determination has not been received, and with the certification enclosed with this application the Applicant certified that they will not financially commit the project until the clearance letter has been received.

## ATTACHMENT 6

### Historic Preservation Act Requirements



Juan Morado, Jr.  
71 South Wacker Drive, Suite 1600  
Chicago, IL 60606  
Direct Dial: 312.212.4967  
Fax: 312.757.9192  
jmorado@beneschlaw.com

January 30, 2026

**VIA EMAIL**

Jeffrey Kruchten  
Chief Archaeologist  
Preservation Services Division  
Illinois Historic Preservation Office  
Illinois Department of Natural Resources  
1 Natural Resources Way  
Springfield, IL 62702  
SHPO.Review@illinois.gov

**Re: Certificate of Need Application for the Establishment of an Ambulatory Surgical Treatment Center – Schaumburg Plastic Surgery Center LLC**

Dear Jeffrey:

I am writing on behalf of my client, Schaumburg Plastic Surgery Center LLC ("SPSC") to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). SPSC is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. SPSC is proposing to establish an Ambulatory Surgical Treatment Center, to be located at 1321 Tower Road, Schaumburg, IL 60173 (the "Project").

The proposed Project will occupy a portion of an existing building and will contain a patient waiting room, physician office space, nursing station, examination rooms, mechanical space, and one operating room. For your reference, we have included pictures of the topographic maps, areal maps, and existing lot images (Attachments 1-3) showing the general location of the project.

We respectfully request review of the project area and a determination letter at your earliest convenience. Thank you in advance for all of the time and effort that will be going into this review.

**ATTACHMENT 6**  
**Historic Preservation Act Requirements**

Very truly yours.

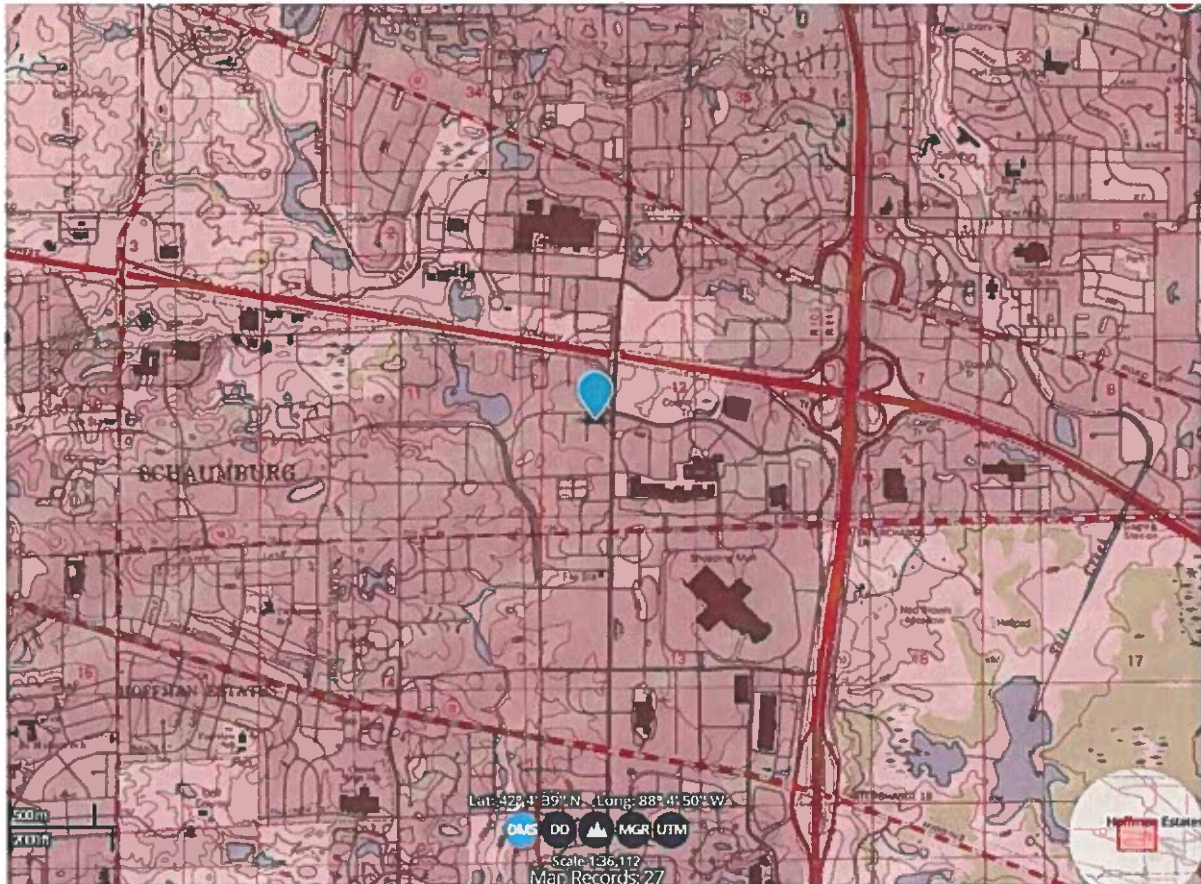
BENESCH, FRIEDLANDER,  
COPLAN & ARONOFF LLP

  
Juan Morado, Jr.

JM:  
Enclosures

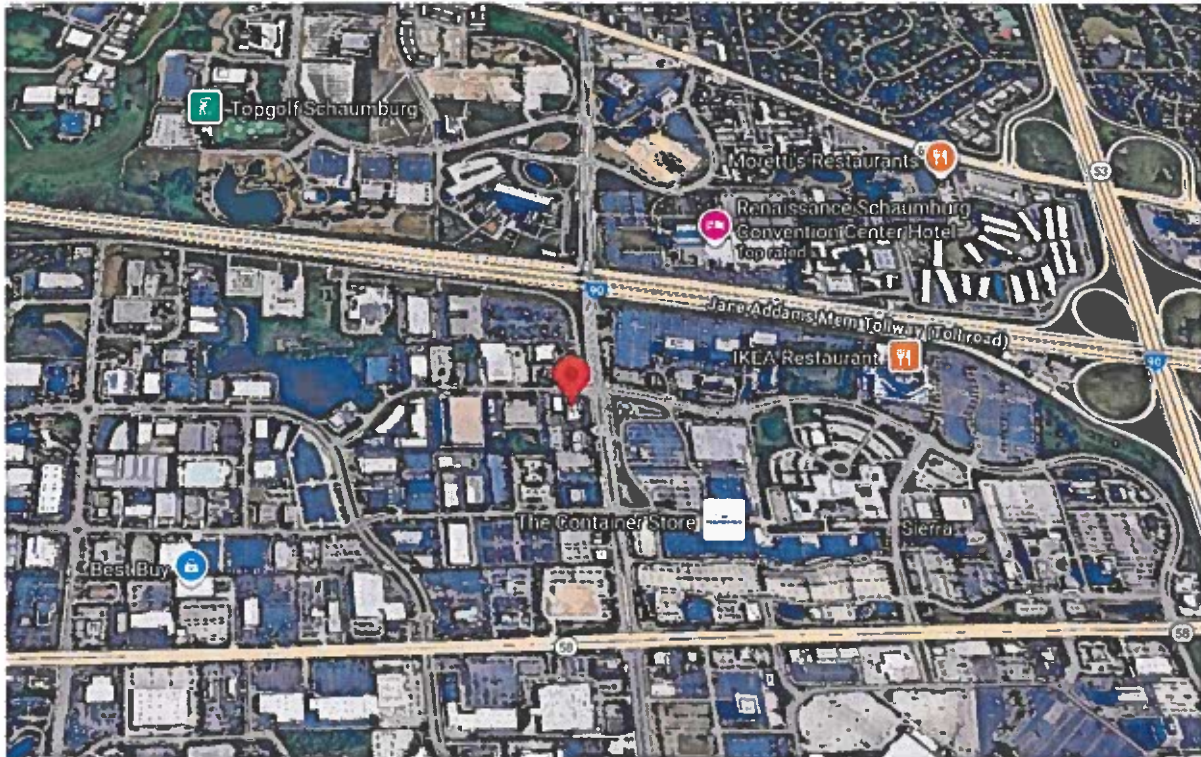
**ATTACHMENT 6**  
**Historic Preservation Act Requirements**

**Topographic Map (1321 Tower Rd., Schaumburg, IL 60173)**



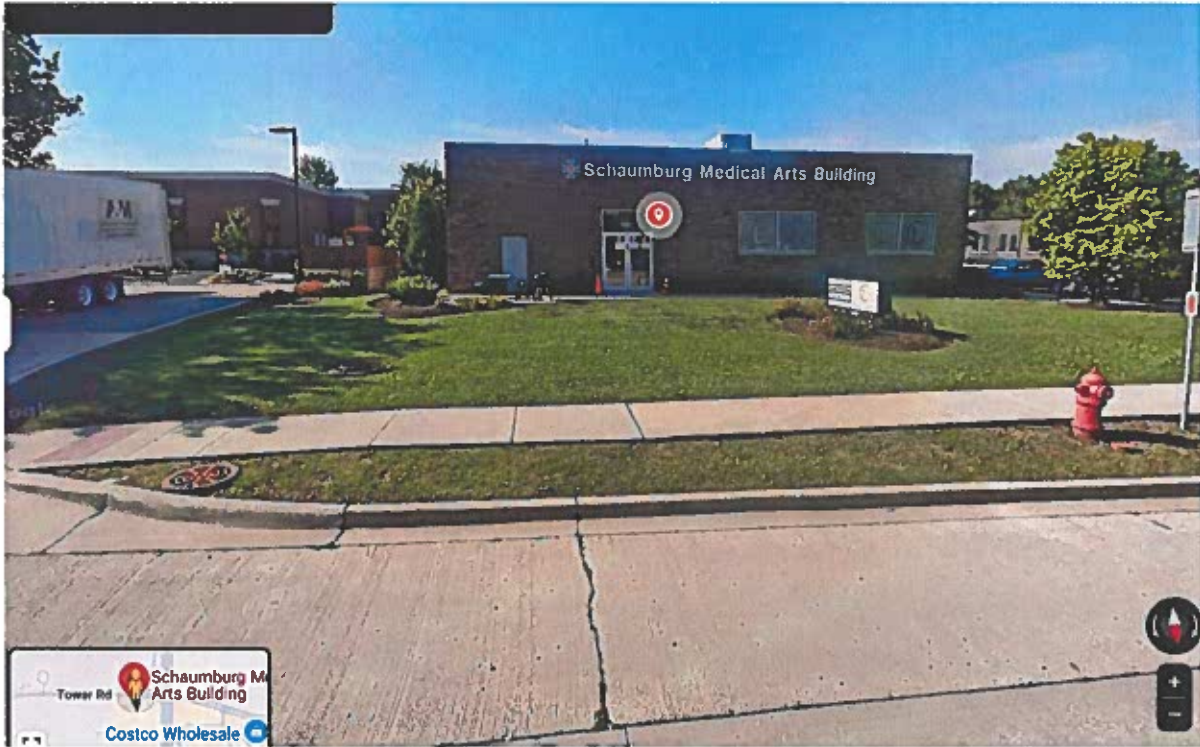
**ATTACHMENT 6**  
**Historic Preservation Act Requirements**

**3D Aerial Map of 1321 Tower Road, Schaumburg, IL 60137**



**ATTACHMENT 6**  
**Historic Preservation Act Requirements**

**Street View of 1321 Tower Road, Schaumburg, IL 60173**



## ATTACHMENT 7

### Project Costs and Sources of Funds

| Project Costs and Sources of Funds                                                                                                                    |                    |                    |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------|--------------------|
| USE OF FUNDS                                                                                                                                          | CLINICAL           | NONCLINICAL        | TOTAL              |
| Preplanning Costs                                                                                                                                     | -                  | -                  | -                  |
| Site Survey and Soil Investigation                                                                                                                    | -                  | -                  | -                  |
| Site Preparation                                                                                                                                      | \$10,748           | \$4,502            | \$15,250           |
| Off Site Work                                                                                                                                         | -                  | -                  | -                  |
| New Construction Contracts                                                                                                                            | \$851,649          | \$356,703          | \$1,208,352        |
| Modernization Contracts                                                                                                                               | -                  | \$-                | -                  |
| Contingencies                                                                                                                                         | \$52,860           | \$22,140           | \$75,000           |
| Architectural/Engineering Fees                                                                                                                        | \$35,240           | \$14,760           | \$50,000           |
| Consulting and Other Fees                                                                                                                             | \$211,441          | \$88,559           | \$300,000          |
| Movable or Other Equipment (not in construction contracts)                                                                                            | \$500,000          | \$300,000          | \$800,000          |
| Bond Issuance Expense (project related)                                                                                                               | -                  | -                  | -                  |
| Net Interest Expense During Construction (project related)                                                                                            | \$-                | \$-                |                    |
| Fair Market Value of Leased Space or Equipment                                                                                                        | \$414,268          | \$173,512          | \$587,780          |
| Other Costs to Be Capitalized                                                                                                                         | \$140,960          | \$59,040           | \$200,000          |
| Acquisition of Building or Other Property (excluding land)                                                                                            | -                  | -                  | -                  |
| <b>TOTAL USES OF FUNDS</b>                                                                                                                            | <b>\$2,217,166</b> | <b>\$1,019,216</b> | <b>\$3,236,382</b> |
| SOURCE OF FUNDS                                                                                                                                       | CLINICAL           | NONCLINICAL        | TOTAL              |
| Cash and Securities                                                                                                                                   | \$104,735          | \$43,867           | \$148,602          |
| Pledges                                                                                                                                               |                    |                    |                    |
| Gifts and Bequests                                                                                                                                    |                    |                    |                    |
| Bond Issues (project related)                                                                                                                         |                    |                    |                    |
| Mortgages                                                                                                                                             | \$1,698,163        | \$801,837          | \$2,500,000        |
| Leases (fair market value)                                                                                                                            | \$414,268.33       | \$173,511.67       | \$587,780          |
| Governmental Appropriations                                                                                                                           |                    |                    |                    |
| Grants                                                                                                                                                |                    |                    |                    |
| Other Funds and Sources                                                                                                                               |                    |                    |                    |
| <b>TOTAL SOURCES OF FUNDS</b>                                                                                                                         | <b>\$2,217,166</b> | <b>\$1,019,216</b> | <b>\$3,236,382</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> |                    |                    |                    |

## ATTACHMENT 7

### Project Costs and Sources of Funds

**Site Preparation** - These clinical costs total \$10,748 (0.5%), consisting of interior demolition and preparation necessary for the conversion of existing space.

**New Construction Contracts** - The clinical costs total \$851,649 or \$504.53 per GSF. These costs include interior buildout, life-safety systems, mechanical, electrical, plumbing, and medical gas infrastructure necessary to comply with ASTC licensure and safety requirements under applicable State and federal standards.

**Contingencies** - The clinical costs total \$52,860, representing 2.4% of clinical costs, which is a conservative allowance appropriate for a healthcare project at the design development stage.

**Architectural and Engineering Fees** - The clinical costs total \$35,240, representing 1.6% of clinical costs, covering design and construction administration services necessary to ensure compliance with State and federal healthcare facility standards.

**Consulting and Other Fees** - The clinical costs total \$211,441, representing 9.5% of clinical costs. These costs include regulatory, planning, commissioning, and other project-related professional services directly attributable to establishing the clinical facility.

**Other Costs to Be Capitalized** - The clinical costs total \$140,960, representing 6.4% of clinical costs, reflecting project-related expenses necessary to bring the clinical facility into operational status.

**Movable or Other Equipment** - The clinical costs total \$500,000, representing 22.5% of total clinical costs. These expenditures include surgical equipment, procedure room furnishings, and other movable clinical assets not included in construction contracts. These investments are essential to delivering medically necessary outpatient plastic surgery services in compliance with licensure standards.

| Medical Equipment Item                                                          | Revised Budget |
|---------------------------------------------------------------------------------|----------------|
| Instrumentation – Surgical instrument sets w/ sterilization trays (starter set) | \$100,000      |
| LED headlights (2)                                                              | \$8,000        |
| Liposuction machine (mid-range)                                                 | \$20,000       |
| OR surgical table                                                               | \$20,000       |
| Stretchers (budget assumes 2 units)                                             | \$7,800        |
| Mayo stands (2)                                                                 | \$1,200        |
| Overhead tables (3)                                                             | \$450          |
| Bedside tables w/ drawers (3)                                                   | \$1,800        |
| Blanket warmer                                                                  | \$5,000        |
| Pre/Post monitors (3)                                                           | \$7,500        |
| Monitor wall mounts (3)                                                         | \$900          |
| Workstation on wheels w/ battery (budget assumes 2 units)                       | \$3,000        |
| Defibrillator                                                                   | \$4,500        |
| Wheelchairs (2)                                                                 | \$600          |

# **ATTACHMENT 7** **Project Costs and Sources of Funds**

| Medical Equipment Item                        | Revised Budget   |
|-----------------------------------------------|------------------|
| Anesthesia machine                            | \$18,000         |
| Patient transfer roller                       | \$350            |
| EKG machine                                   | \$2,500          |
| IV poles (3)                                  | \$900            |
| IV pump(s)                                    | \$3,500          |
| Ultrasound                                    | \$15,000         |
| OR stools (3)                                 | \$900            |
| Patient warmer (Bair Hugger)                  | \$3,500          |
| Monopolar/Bipolar (ValleyLab FT10 w/cart)     | \$14,000         |
| MH cart (with refrigerator)                   | \$7,000          |
| Crash cart                                    | \$3,000          |
| Anesthesia cart                               | \$3,000          |
| OR back table / prep stand / ring stand set   | \$3,500          |
| GlideScope                                    | \$5,000          |
| SPD / Sterile Processing – Washer/Disinfector | \$50,000         |
| Sterilizer (small standup / tabletop)         | \$50,000         |
| V-PRO S2                                      | \$40,000         |
| Triple basin processing sink                  | \$12,000         |
| Pass thru window                              | \$5,100          |
| Single bay sink (knee operated)               | \$6,000          |
| Ultrasonic cleaner                            | \$25,000         |
| Dual light (non-camera ready)                 | \$20,000         |
| Storage rack system (SPD)                     | \$6,000          |
| Ayon body contouring system                   | \$25,000         |
| <b>TOTAL MEDICAL EQUIPMENT</b>                | <b>\$500,000</b> |

## ATTACHMENT 7

### Project Costs and Sources of Funds

| Non-Med Equipment Item                                                         | Revised Budget   |
|--------------------------------------------------------------------------------|------------------|
| Computers/IT devices (PCs, monitors, laptops)                                  | \$15,000         |
| Copiers/Printers (managed print agreement @ \$500/mo × 12 months)              | \$6,000          |
| Office furniture (reception/admin offices/conference)                          | \$65,000         |
| Waiting room furniture & décor                                                 | \$25,000         |
| Telephone/VoIP system + handsets                                               | \$15,000         |
| Networking hardware (switches/firewall/rack/cabling not in construction scope) | \$25,000         |
| Scanners/signature pads/peripherals                                            | \$5,000          |
| Security/access control equipment (non-construction scope)                     | \$20,000         |
| Breakroom/non-clinical appliances (fridge/microwave)                           | \$8,000          |
| Administrative storage/shelving                                                | \$8,000          |
| Interior signage/wayfinding (non-construction)                                 | \$4,000          |
| Opening office supplies/forms (capitalized initial set)                        | \$4,000          |
| HIPAA shredding bins / non-med receptacles                                     | \$2,000          |
| Linen hamper stands (non-clinical)                                             | \$300            |
| Mobile admin/IT carts                                                          | \$1,700          |
| UPS/battery backups                                                            | \$3,000          |
| A/V equipment for staff training                                               | \$2,500          |
| Non-med equipment procurement contingency (pricing variance / additions)       | \$90,500         |
| <b>TOTAL NON-MED EQUIPMENT</b>                                                 | <b>\$300,000</b> |

## **ATTACHMENT 7**

### **Project Costs and Sources of Funds**

**Fair Market Value of Leased Space or Equipment-** The fair market value of the lease equals \$587,781. This allocation reflects the lease terms which include an initial amount of \$53,680 and 2% increase over the 10-year lease obligation. Below is a breakdown of the costs over the 10 year lease period.

|         | Lease     |
|---------|-----------|
| Year 1  | \$53,680  |
| Year 2  | \$54,754  |
| Year 3  | \$55,849  |
| Year 4  | \$56,966  |
| Year 5  | \$58,105  |
| Year 6  | \$59,267  |
| Year 7  | \$60,452  |
| Year 8  | \$61,661  |
| Year 9  | \$62,895  |
| Year 10 | \$64,153  |
|         | \$587,781 |

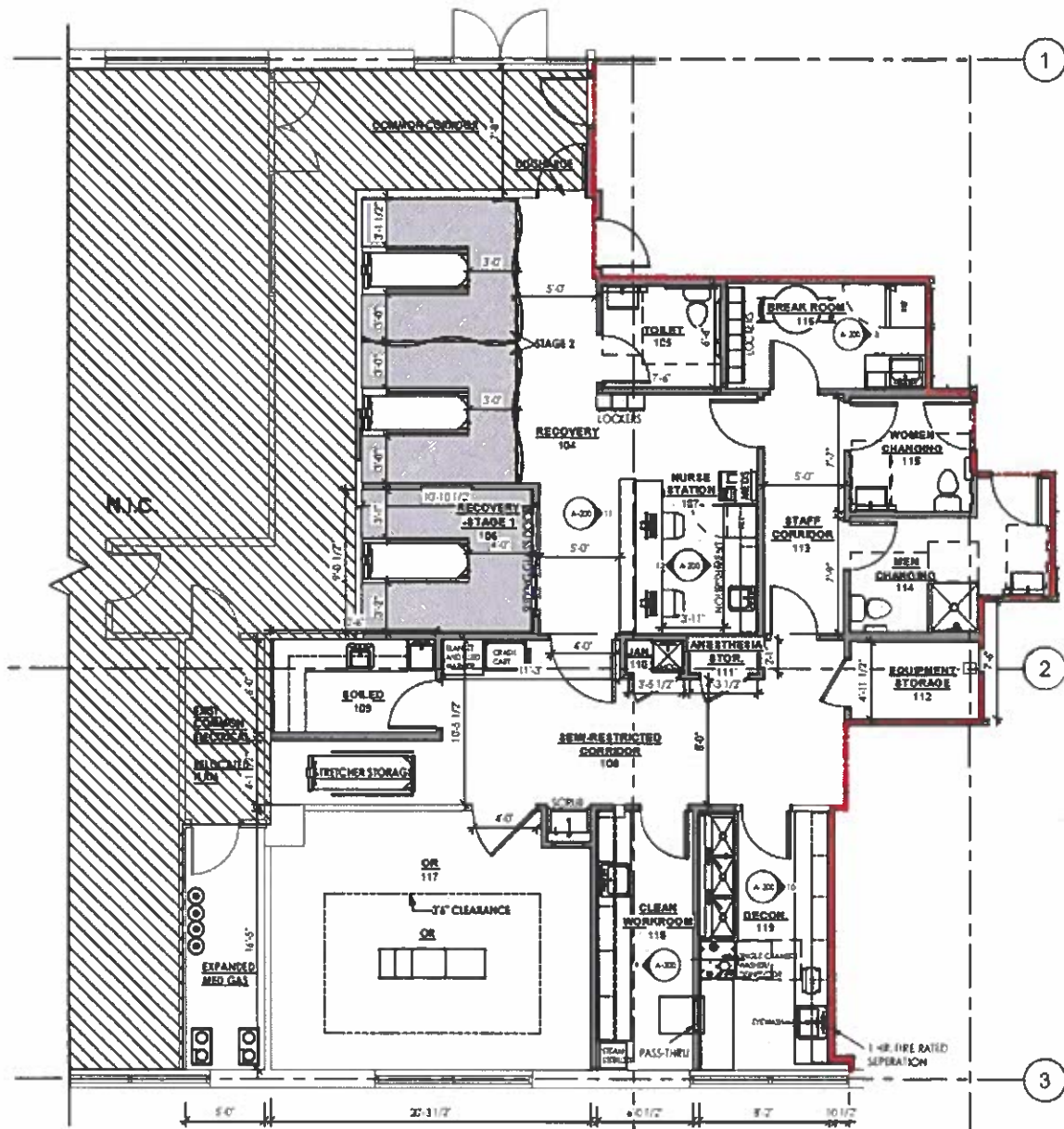
**Other Costs to Be Capitalized-** The clinical costs total \$140,960, representing 6.4% of clinical costs, reflecting project-related expenses necessary to bring the clinical facility into operational status.

## **ATTACHMENT 8**

### **Project Status and Completion Schedules**

The proposed project does not involve construction and no change to the physical layout of the facility as it currently exists. The proposed project completion date following approval by the Illinois Department of Public Health of the facility to perform Plastic Surgery is on or by December 31, 2027.

# **ATTACHMENT 8** **Project Status and Completion Schedules**



## ATTACHMENT 9

### Cost Space Requirements

| COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE   |                         |      |                      |        |                       |        |                      |                    |                       |
|-------------------------------------------------------|-------------------------|------|----------------------|--------|-----------------------|--------|----------------------|--------------------|-----------------------|
| Department<br>(List below)                            | A                       | B    | C                    | D      | E                     | F      | G                    | H                  | Total Cost<br>(G + H) |
|                                                       | Cost/Square Foot<br>New | Mod. | Gross Sq. Ft.<br>New | Circ.* | Gross Sq. Ft.<br>Mod. | Circ.* | Const. \$<br>(A x C) | Mod. \$<br>(B x E) |                       |
| ASTC                                                  | \$504.53                | -    | 1,688                | -      | -                     | -      | \$851,649            | -                  | \$851,659             |
| Contingency                                           | \$31.32                 | -    | 707                  | -      | -                     | -      | \$52,860             |                    | \$52,860              |
| TOTALS                                                | \$535.85                | -    | 2,395                | -      | -                     | -      | \$904,509            |                    | \$904,509             |
| * Include the percentage (%) of space for circulation |                         |      |                      |        |                       |        |                      |                    |                       |

## **ATTACHMENT 11**

### **Background of the Applicant**

The following information is provided to illustrate the qualifications, background and character of the Applicant, and to assure the Health Facilities and Services Review Board that the new ASTC will provide a proper standard of health care services for the community.

#### **Schaumburg Plastic Surgery Center, LLC**

1. The proposed project is brought forth by Schaumburg Plastic Surgery Center LLC. Sameer Kapadia, M.D., will be the sole owner of the facility. The ownership of facility is reflected in Attachment 4.

1. Dr. Kapadia does not have a direct ownership interest in any other health care facility in Illinois. The applicant certifies that there have been no adverse actions taken during the three (3) years prior to the filing of this application. A letter certifying the above information is included at Attachment 11.

2. We have included a letter authorizing access to the HFSRB and IDPH to verify information contained in the application at Attachment 11.

#### **Sameer M. Kapadia, MD, FACS,**

Dr. Kapadia is a board-certified plastic surgeon and the Founder and President of Kapadia Plastic Surgery, PLLC, based in Chicago, Illinois. He is dedicated to delivering the highest quality surgical care through individualized treatment plans that prioritize patient safety, comfort, and long-term outcomes. Dr. Kapadia approaches each patient relationship with a philosophy rooted in trust, accessibility, and respect, fostering a supportive, family-like environment in which patients feel heard, informed, and confident throughout their care journey.

Dr. Kapadia earned his Doctor of Medicine degree from Emory University School of Medicine and completed both his general surgery residency and independent plastic surgery residency at Emory University. His comprehensive training at a nationally recognized academic medical center provided extensive experience across reconstructive, aesthetic, and complex surgical procedures, reinforcing a disciplined, evidence-based approach to patient care. This foundation continues to inform his commitment to meticulous technique, thoughtful surgical planning, and consistently high clinical standards.

He is board-certified by the American Board of Plastic Surgery and the American Board of Surgery and holds an active Illinois medical license. In addition to his private practice, Dr. Kapadia serves as Medical Director for the Plastic Surgery Service Line at Ascension Illinois, reflecting institutional confidence in his clinical judgment, leadership, and commitment to patient safety and quality assurance. His practice philosophy emphasizes personalized care and careful alignment of surgical goals with each patient's overall health and well-being.

Dr. Kapadia brings an artistic sensibility to his surgical practice, viewing each procedure as a balance of technical precision and aesthetic judgment. He focuses on creating results that appear natural, harmonious, and authentic. Ensuring proper function while respecting each patient's individual anatomy. His goal is to align external outcomes with a patient's internal sense of self, ensuring results that are both subtle and enduring, while maintaining a high level of transparency and trust throughout the surgical process.

In addition to his clinical work, Dr. Kapadia maintains a strong academic and scholarly presence. He has authored numerous peer-reviewed publications in leading surgical journals and has presented research at regional and national professional meetings. He currently serves as a Clinical Professor at Ascension Saint Joseph Hospital's Surgery Residency and as a Clinical Associate Professor with the University of Chicago Plastic Surgery Residency, where he is actively involved in training and mentoring the next generation of surgeons.

## **ATTACHMENT 11**

### **Background of the Applicant**

Dr. Kapadia is an active member of several professional organizations, including the American Society of Plastic Surgeons and The Aesthetic Society, and has been recognized as a Castle Connolly Top Doctor since 2024. Dr. Kapadia is deeply committed to ensuring that high-quality surgical care remains accessible to the broader community, regardless of a patient's financial circumstances or ability to pay. His practice philosophy emphasizes inclusivity, ethical stewardship, and responsible resource utilization, with a focus on serving patients based on clinical need rather than payer status. Through transparent financial policies, flexible care planning, and collaboration with hospital partners, Dr. Kapadia seeks to reduce barriers to care and promote equitable access to safe, high-quality surgical services for all patients who seek treatment.

Dr. Kapadia is known for his patient-centered philosophy, clinical rigor, and leadership experience. Dr. Kapadia is well positioned to operate and lead an ambulatory surgery center focused on safe, efficient, and high-quality surgical care that meets both patient expectations and regulatory standards.

## Attachment 11 Background of the Applicant



January 20th, 2026

John P. Kniery  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, Floor 2  
Springfield, Illinois 62761

**Re: Schaumburg Plastic Surgery Center LLC – Certification and Authorization**

Dear Mr. Kniery,

As a representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, 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 Schaumburg Plastic Surgery Center LLC has no ownership interest in any other healthcare facility.

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,

Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC



1321 Tower Rd, Schaumburg, IL 60173

+1 (312) 872-8514

[schaumburgplasticsurgerycenter.com](http://schaumburgplasticsurgerycenter.com)

## ATTACHMENT 11

### Background of the Applicant



#### **Sameer M. Kapadia, MD FACS**

2517 W Shakespeare Ave  
Chicago, IL 60647  
sk@prismplasticsurgery.com

#### EMPLOYMENT

|                                                          |                       |
|----------------------------------------------------------|-----------------------|
| Prism Plastic Surgery d/b/a Kapadia Plastic Surgery pLLC | Chicago, IL           |
| Founder, President                                       | October 2021- present |

#### TRAINING

|                                                 |                      |
|-------------------------------------------------|----------------------|
| Emory University School of Medicine             | Atlanta, GA          |
| Plastic Surgery Residency (Independent Program) | July 2018- June 2021 |
| Emory University School of Medicine             | Atlanta, GA          |
| General Surgery Internship and Residency        | July 2013- June 2018 |

#### EDUCATION

|                                     |              |
|-------------------------------------|--------------|
| Emory University School of Medicine | Atlanta, GA  |
| Doctor of Medicine (MD)             | May 2013     |
| Northwestern University             | Evanston, IL |
| B.S., Communications, Public Health | June 2009    |

#### CERTIFICATIONS/LICENSURES

|                                        |               |
|----------------------------------------|---------------|
| Board Certification in Plastic Surgery | November 2023 |
| American Board of Plastic Surgery      |               |
| Board Certification in Surgery #064768 | June 2019     |
| American Board of Surgery              |               |
| Illinois Medical License #036.157232   | July 2021     |

## **ATTACHMENT 11**

### **Background of the Applicant**

#### **PUBLICATIONS**

**Kapadia SM, Cheng A.** Hidradenitis. SCORE curriculum module. 2019 Nov 19. Surgicalcore.org.

**Kapadia SM, Reitz A, Hart A, Broecker J, Torres MA, Carlson GW, Styblo TM, Losken A.** Time to Radiation After Oncoplastic Reduction. *Ann Plast Surg.* 2019 Jan;82(1):15-18. PubMed PMID: 30211738.

**Trivedi S, Haddad LB, Narvaez J, Walker E, Kapadia S, Jamieson DJ, Lathrop E.** A Comprehensive Evaluation of Obstetrics and Gynecology Residencies' Global Health Training Programs. *Obstet Gynecol.* 2018 Nov;132(5):1143-1151. PubMed PMID: 30303903.

**Losken A, Kapadia S, Egro FM, Baecher KM, Styblo TM, Carlson GW.** Current Opinion on the Oncoplastic Approach in the USA. *Breast J.* 2016 Jul;22(4):437-41. PubMed PMID: 27060905.

**Hugar LA, McCullough CM, Quinn ME, Kapadia SM, Pettitt BJ.** Scaling up short-term humanitarian surgery: a global surgery elective for senior medical students. *J Surg Educ.* 2014 Nov-Dec;71(6):871-7. doi: 10.1016/j.jsurg.2014.04.002. Epub 2014 Jun 7. PubMed PMID: 24913428.

**Pinell-White XA, Kapadia SM, Losken A.** The management of abdominal contour defects following TRAM flap breast reconstruction. *Aesthet Surg J.* 2014 Feb;34(2):264-71. PubMed PMID: 24345798.

**Kapadia SM, Gust MJ, Alghoul MS, Dumanian GA.** Suspension of Leg via a Single Tibial Pin Provides Postoperative Elevation and Pressure Off-loading for Lower Extremity Free Flaps. *Plast Reconstr Surg Glob Open.* 2013 May 7;1(1). pii: e3-e4. PubMed PMID: 25289197

**Kapadia SM, Golinko MS, Williams JK.** Facial nerve paralysis and frey syndrome in an infant following removal of an internal mandibular distraction device. *J Craniofac Surg.* 2013 May;24(3):961-3. PubMed PMID: 23714921.

## **ATTACHMENT 11**

### **Background of the Applicant**

Leeds IL, Engel PM, Derby KS, **Kapadia SM**, Chery MP, Bhatt A. Two cases of restavek-related illness: clinical implications of foster neglect in Haiti. Am J Trop Med Hyg. 2010 Nov;83(5):1098-9. PubMed PMID: 21036844

#### **PRESENTATIONS**

*Disparities in Breast Reconstruction*

Oral Presentation: Georgia Society of Plastic Surgeons Meeting 2019  
August 2019, Lake Oconee, Georgia

*Disparities in Breast Reconstruction*

Oral Presentation: Emory University Surgical Grand Rounds  
December 2017, Atlanta, Georgia

*Time to Radiation after Oncoplastic Reduction*

Oral Presentation: Southeastern Society for Plastic and Reconstructive Surgeons  
Scientific Meeting 2017  
June 2017, Sea Island, Georgia

*The Emory Medishare Surgical Trip to Haiti*

Oral Presentation: Emory University Surgical Grand Rounds  
December 2012, Atlanta, Georgia

#### **PROFESSIONAL MEMBERSHIPS**

**Illinois Society of Plastic Surgeons (ISPS)** Active member 2024

**The Aesthetic Society (ASAPS)** Active Member 2025

**American Society of Plastic Surgeons (ASPS)** Active Member 2025

**Southeastern Society of Plastic Surgeons (SESPRS)**, Active Member 2024

**Chicago Medical Society (CMS)**, member since 2020

**American Medical Association (AMA)**, member since 2009

#### **LEADERSHIP/VOLUNTEER EXPERIENCE**

**Medical Director- Plastic Surgery Service Line**  
Ascension Illinois

2024- present

## ATTACHMENT 11

### Background of the Applicant

|                                                                                                                       |               |
|-----------------------------------------------------------------------------------------------------------------------|---------------|
| <b>Clinical Professor</b><br>Ascension Saint Joseph Hospital Surgery Residency                                        | 2025- present |
| <b>Clinical Associate Professor</b><br>University of Chicago Plastic Surgery Residency                                | 2025- present |
| <b>Emory Global Health Committee</b><br>Representative for Plastic Surgery Division                                   | 2018- 2021    |
| <b>Emory Plastic Surgery Residency Curriculum Committee</b><br>Resident Member                                        | 2018-2021     |
| <b>Emory General Surgery Global Health Committee</b><br>Committee Chair                                               | 2015-2018     |
| <b>Project Medishare for Haiti- Emory Chapter, Haiti</b><br>Executive Director<br>Faculty Mentor: Barbara Pettitt, MD | 2009 - 2013   |
| <b>Emory Plastic Surgery Interest Group, Georgia</b><br>Co-founder<br>Faculty Mentor: Albert Losken, MD               | 2013          |
| <b>Emory School of Medicine Admissions</b><br>Interviewer/Committee Member                                            | 2012 - 2013   |
| <b>Emory University Senate</b><br>University Senator (Medical School Representative)                                  | 2009-2010     |
| <b>Mulago Hospital, Hoima District Hospital, Uganda</b><br>Volunteer                                                  | 2008          |
| <b>Community Health Chicago</b><br>Volunteer                                                                          | 2006-2009     |

#### HOBBIES & INTERESTS

Theater, Singing, Percussion, Martial Arts, Cycling

#### LANGUAGES

English (Native)  
Gujarati (Advanced)  
Hindi (Functionally Native)

## **ATTACHMENT 11**

### **Background of the Applicant**

Urdu (Advanced)  
Spanish (Basic)

#### **AWARDS/ACCOMPLISHMENTS**

|                                                                   |              |
|-------------------------------------------------------------------|--------------|
| Castle Connolly Top Doctor                                        | 2024-present |
| James B. Whitehead Surgery Scholarship                            | 2012         |
| Irene Woodruff Medical Scholars                                   | 2013         |
| Northwestern University Martha Mabie Fellowship for Global Health | 2008         |

## **ATTACHMENT 12**

### **Purpose of the Project**

The Applicant seeks approval from the Illinois Health Facilities and Services Review Board to establish Schaumburg Plastic Surgery Center LLC, an Ambulatory Surgical Treatment Center ("ASTC"), to be located at 1321 Tower Road, Schaumburg, Illinois 60173, for the provision of outpatient plastic surgery services. The purpose of the proposed project is to improve access to safe, high-quality surgical care within the market area by offering a dedicated ambulatory setting designed to meet current and projected demand for medically appropriate plastic surgery procedures, with particular emphasis on addressing access, efficiency, and continuity-of-care challenges experienced by women.

The Applicant defines the market area as a 10-mile radius from the proposed ASTC location, consistent with the Board defined geographic service area. Patients served by the proposed facility primarily reside in Cook County, with additional patients drawn from surrounding northwest suburban communities. This market area reflects existing patient utilization patterns, referral relationships, and the geographic area in which patients currently seek outpatient plastic surgery services. Many patients within this area face access to appropriately licensed ambulatory facilities, resulting in inefficiencies and delays in care.

The Applicant currently performs limited procedures within an office-based surgical setting that is appropriate for minor interventions under applicable regulatory standards. However, office-based laboratories are structurally limited in their ability to accommodate physicians outside of a single practice and are not designed to support higher-acuity outpatient surgical procedures requiring advanced anesthesia services, expanded sterile processing capabilities, or more complex perioperative workflows. This project seeks to establish an open staff model to allow for increased access to the facility for other physicians who are facing similar issues further described in this section. Under Illinois law, outpatient surgical facilities must be licensed as Ambulatory Surgical Treatment Centers in order to accommodate physicians outside of the same practice and to perform procedures that exceed the scope and infrastructure of an office-based setting.

The proposed project transitions the existing office-based surgical environment to a fully licensed ASTC, thereby expanding procedural capabilities, strengthening regulatory compliance, and elevating the level of surgical services that can be safely provided. An ASTC designation permits enhanced anesthesia delivery models, including cases requiring deeper sedation or general anesthesia, expanded recovery capacity, formal sterile processing departments, dedicated life-safety systems, and comprehensive quality oversight consistent with State licensure standards. These capabilities allow the facility to safely perform more complex reconstructive, restorative, and time-intensive outpatient plastic surgery procedures that are not optimally suited to an office-based setting.

In addition, licensure as an ASTC allows the facility to support multiple plastic surgeons within a compliant regulatory framework, thereby improving regional access to specialty surgical services. The Applicant has received expressions of interest from additional plastic surgeons seeking access to a specialty-focused ASTC equipped to manage reconstructive procedures, lipedema surgery, gender-affirmation surgery, and other complex outpatient plastic surgery cases. At present, there are limited plastic-surgery-focused ASTCs within the defined service area that maintain the specialized equipment, staffing competencies, anesthesia capabilities, and workflow design necessary to safely manage these procedures. The proposed ASTC will address this gap by providing a purpose-built, fully licensed environment capable of delivering ASTC-level surgical care consistent with modern safety and quality standards.

## **ATTACHMENT 12**

### **Purpose of the Project**

The proposed project seeks to address existing access and utilization issues, particularly for women requiring plastic surgery procedures that are reconstructive, restorative, or medically indicated in nature. These include, but are not limited to, post-mastectomy and oncoplastic breast reconstruction, breast reduction for symptomatic macromastia, revision surgery following oncologic or reconstructive procedures, treatment of chronic skin and soft-tissue conditions, and corrective interventions that restore physical function. Many of these conditions are associated with chronic pain, mobility limitations, recurrent skin infections, and psychosocial distress that materially affect a patient's ability to work, care for family members, and maintain overall health and well-being.

Women undergoing breast reconstruction following mastectomy often require staged outpatient procedures that can be safely and effectively performed in an ambulatory setting. Timely access to reconstruction plays a meaningful role in emotional recovery, body image, and quality of life following cancer treatment. Similarly, women suffering from symptomatic macromastia frequently experience chronic neck, back, and shoulder pain, postural impairment, and activity limitations that interfere with daily functioning. Breast reduction surgery has been shown to significantly reduce pain and improve mobility and functional capacity, and the ability to perform such procedures in an ASTC setting allows patients to receive needed care without the inefficiencies and higher costs associated with hospital-based operating rooms.

The proposed ASTC will also serve patients requiring revision and reconstructive procedures related to prior surgeries, trauma, or chronic medical conditions. These procedures may include scar revision, correction of asymmetry, treatment of soft-tissue defects, and management of wound related complications. Although often categorized broadly as plastic surgery, such interventions are frequently medically necessary to restore function, alleviate discomfort, and prevent ongoing complications. Without local access to an appropriately licensed ambulatory facility, patients may experience fragmented care, extended wait times, or the need to travel outside the community for services that can be safely provided on an outpatient basis.

While several multispecialty ASCs operate in the region, most are built around orthopedic, ophthalmologic, gastrointestinal, or general surgery service lines. These facilities typically do not invest in or maintain specialized technologies routinely used in plastic surgery, including power-assisted liposuction systems, advanced energy platforms, skin-tightening technologies, and other adjunctive equipment that improve operative efficiency, precision, and recovery. Hospitals similarly do not consistently prioritize or maintain these specialized systems. The proposed ASTC is specifically designed and equipped to support the full scope of plastic and reconstructive procedures offered by the Applicant and participating physicians.

Hospital-based outpatient departments also face operational and structural limitations that disproportionately affect plastic surgery patients. Time intensive reconstructive procedures, including breast reconstruction, lipedema surgery, and gender-affirmation surgery, are often scheduled behind higher-volume service lines and may experience extended delays. These cases require coordinated anesthesia planning, enhanced privacy protections, and postoperative care pathways tailored to the needs of patients undergoing sensitive and complex procedures. A dedicated plastic surgery ASTC provides consistent scheduling, workflow efficiencies, and patient-centered perioperative models that are not always reliably supported in general hospital environments.

## **ATTACHMENT 12**

### **Purpose of the Project**

In addition, hospital billing systems frequently encounter difficulty managing hybrid billing arrangements that combine insurance covered components with self-pay elements. In plastic and reconstructive surgery, it is common for medically necessary services to be partially covered by insurance while certain components are self-pay. Hospital billing departments are not always structured to administer these arrangements efficiently, which can result in inappropriate insurance submissions, excessive patient billing, and prolonged administrative disputes. A specialty focused ASTC is better positioned to administer coordinated and transparent billing practices that reduce financial confusion and improve the patient experience.

Advances in surgical technique, anesthesia, and per-operative care now allow a growing number of medically necessary plastic surgery procedures to be performed safely and efficiently in an ASTC setting. Innovations such as minimally invasive surgical approaches, enhanced recovery after surgery protocols, refined reconstructive techniques, and multimodal pain management strategies have reduced operative risk, shortened recovery times, and improved patient outcomes. The proposed ASTC is specifically designed to support these advancements while maintaining compliance with all applicable licensure, life safety, and quality standards.

Access to medically appropriate plastic surgery services is an important component of women's health equity, as barriers to care disproportionately affect women managing chronic conditions, post-cancer recovery, and caregiving responsibilities. Many of the procedures offered at the proposed ASTC are part of a broader continuum of care that includes primary care, oncology, gynecology, and behavioral health services. The facility will promote continuity of care by providing a consistent, community-based setting for preoperative evaluation, surgical intervention, and postoperative follow-up under the direction of the same clinical team, while coordinating care with referring physicians.

Documentation supporting the proposed project includes historical utilization data from the Applicant's existing practice, conservative volume projections included in the financial feasibility analysis, and letters of referral from Dr. Kapadia are included with this application. These materials demonstrate existing demand for services within the defined market area and support the clinical appropriateness of providing outpatient plastic surgery services in a freestanding ambulatory setting.

The following are the top 30 CPT codes of procedures performed by Dr. Kapadia.

- 19357 – Tissue expander placement in breast reconstruction
- 11970 – Replacement of tissue expander with implant
- 19380 – Revision of reconstructed breast
- 19371 / 19370 – Capsulectomy / capsular revision
- 19342 – Implant placement after mastectomy
- 19350 – Nipple/areolar reconstruction
- 15777 – Biologic implant (acellular dermal matrix)
- 15100 / 15101 – Split thickness skin grafts
- 14301 / 14302 – Adjacent tissue transfer
- 19303 – Simple mastectomy

## **ATTACHMENT 12**

### **Purpose of the Project**

That is a serious reconstructive profile.

This CPT codes reflect Dr. Kapadia, reconstructive surgery experience. These services are related to:

- Post-mastectomy reconstruction
- Staged cancer reconstruction pathways
- Complex revision work
- Use of biologic mesh
- Skin grafting
- Advanced tissue rearrangement

The following CPT codes are associated with intermediate and complex wound care.

- 12031 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
- 12032 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 2.6 cm to 7.5 cm
- 12034 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 7.6 cm to 12.5 cm
- 12035 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 12.6 cm to 20.0 cm
- 12036 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 20.1 cm to 30.0 cm
- 12037 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); over 30.0 cm
- 12041 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
- 12042 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
- 12044 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm
- 12045 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm
- 12046 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm
- 12047 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
- 12051 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
- 12052 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
- 12053 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm

## **ATTACHMENT 12**

### **Purpose of the Project**

- 12054 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
- 12055 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
- 12056 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
- 12057 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm
- 13100 Repair, complex, trunk; 1.1 cm to 2.5 cm
- 13101 Repair, complex, trunk; 2.6 cm to 7.5 cm
- 13102 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to primary procedure) Large intermediate closures

These types of procedure support:

- Surgical oncology collaboration
- Dermatologic oncology reconstruction
- Functional soft tissue restoration
- Post-Mohs repair work

The following CPT codes deal with functional skin excision:

- 15830 – Panniculectomy
- 15832–15837 – Excision of excess skin (thigh, arm, leg, buttock, forearm)
- 15876–15879 – Liposuction (multiple regions)

While these procedures can be cosmetic in nature, many are sought after in relation to:

- Post-bariatric reconstruction
- Functional panniculitis
- Recurrent infection management
- Mobility impairment correction
- Chronic dermatitis and hygiene impairment

## **ATTACHMENT 12**

### **Purpose of the Project**

These are frequently medically necessary, especially in women following weight loss or pregnancy.

Finally, the following CPT Codes are associated with Breast Surgery, and they include:

- 19318 – Breast reduction
- 19316 – Mastopexy
- 19325 – Augmentation
- 19328 / 19330 – Implant removal
- 19300 – Mastectomy for gynecomastia
- 19355 – Correction inverted nipples

The procedures allow Dr. Kapadia to assist patients with the following types of issues:

- Reconstruction
- Revision
- Functional breast reduction
- Implant complication management
- Gender-related procedures
- Post-cancer restoration

This is comprehensive breast surgery capability.

The Applicant's documented case mix further supports the clinical necessity of a dedicated ambulatory surgical environment. The practice's top CPT codes demonstrates a significant volume of reconstructive breast surgery, tissue expander placement and exchange, capsular revision, nipple and areolar reconstruction, adjacent tissue transfer, skin grafting, complex wound repair, and biologic implant placement. These procedures are commonly performed in connection with breast cancer treatment, post-oncologic reconstruction, trauma repair, and medically necessary revision surgery.

The presence of CPT codes for tissue expander placement (19357), implant exchange (11970), revision of reconstructed breast (19380), complete capsulectomy (19371), biologic implant reinforcement (15777), adjacent tissue transfer (14301–14302), and split-thickness skin grafting (15100–15101) reflects a reconstructive surgical profile requiring advanced sterile processing capability, specialized instrumentation, anesthesia support, and postoperative monitoring consistent with ASC-level care.

In addition, the practice performs medically indicated panniculectomy (15830), breast reduction (19318), and excision of excessive skin and soft tissue following weight loss or pregnancy, procedures frequently associated with chronic pain, recurrent infection, mobility impairment, and functional limitations. These services are particularly relevant to women's health equity, as many patients seek reconstructive care following cancer treatment, childbirth, or significant weight change.

The existing office-based laboratory setting does not provide the full infrastructure necessary to safely and efficiently support the breadth of reconstructive and complex outpatient plastic surgery procedures currently being performed. Establishment of the proposed ASTC will allow these medically necessary procedures to be performed in a properly licensed, fully equipped ambulatory setting, thereby improving patient safety, continuity of care, and scheduling access while reducing reliance on hospital outpatient operating rooms.

## **ATTACHMENT 12**

### **Purpose of the Project**

The goals of the proposed project are to improve access to medically appropriate plastic surgery services, enhance continuity of care, and promote efficient utilization of healthcare resources within the market area. Measurable objectives include reducing reliance on hospital-based operating rooms for appropriate cases, improving timeliness of access to care, and ensuring that services are available to all patients regardless of payer status or ability to pay. Collectively, these outcomes will demonstrate that the proposed project improves access, efficiency, and health-related quality of life for the population served.

#### **References:**

- Centers for Medicare & Medicaid Services (CMS). Medicare Conditions for Coverage for Ambulatory Surgical Centers (42 CFR Part 416). Provides federal standards for safety, quality, and appropriateness of procedures performed in ASC settings.
- Agency for Healthcare Research and Quality (AHRQ). Healthcare Cost and Utilization Project (HCUP): Outpatient Surgery and ASC Trends. Documents safety, efficiency, and cost-effectiveness of performing appropriate surgical procedures in ambulatory settings.
- American Society of Plastic Surgeons (ASPS). Evidence-Based Clinical Practice Guidelines and Position Statements. Supports the medical necessity and clinical benefits of procedures such as breast reconstruction, breast reduction for symptomatic macromastia, and reconstructive surgery following cancer or trauma.
- Losken A, Kapadia SM, et al. Current Opinion on the Oncoplastic Approach in the United States. *The Breast Journal*, 2016;22(4):437–441. Supports the role of oncoplastic and reconstructive breast surgery in improving functional and psychosocial outcomes for women following cancer treatment.
- Kapadia SM, Reitz A, et al. Time to Radiation After Oncoplastic Reduction. *Annals of Plastic Surgery*, 2019;82(1):15–18. Demonstrates the integration of reconstructive breast procedures into broader oncology care pathways and continuity of care.
- National Institutes of Health (NIH). Quality of Life Outcomes Following Breast Reconstruction and Reduction Surgery. Documents improvements in pain, physical functioning, and psychosocial well-being following medically indicated plastic surgery procedures.
- American College of Surgeons (ACS). Optimal Resources for Surgical Quality and Safety. Supports the use of specialized outpatient surgical facilities for procedures that do not require inpatient hospitalization.
- Institute of Medicine (National Academy of Medicine). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Provides foundational support for care models that emphasize access, efficiency, continuity of care, and patient-centered outcomes.
- U.S. Department of Health and Human Services (HHS), Office on Women's Health. *Women's Health Equity and Access to Care*. Addresses disparities in access to timely surgical and specialty care for women and supports community-based solutions.
- Enhanced Recovery After Surgery (ERAS) Society. Guidelines for Perioperative Care in Breast and Reconstructive Surgery. Supports the safety and effectiveness of ASC-based procedures using modern anesthesia and recovery protocols.

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#### ASPS Statement on Breast Implant Specimens and Pathology

##### **Background**

Since 2010, approximately 1,400,000 breast augmentation procedures, 475,000 breast reconstruction procedures, and over 195,000 combined augmentation and reconstructive breast implant removals were performed by ASPS member surgeons.<sup>i</sup> Since the introduction of saline and silicone-gel filled breast implants in the 1960's, decades of research related to safety and efficacy have contributed to several generations of improved breast implant devices.<sup>ii,iii,iv,v,vi</sup> Scientific literature continues to research the risks and possible associations of breast implants and clinical complications.

##### **BIA-ALCL**

Breast implant-associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is a rare lesion presenting as a late seroma, a palpable mass, or less commonly, tumor positive lymphadenopathy.<sup>vii</sup> In 2011, the U.S. Food and Drug Administration (FDA) released a safety communication that women with breast implants "may have a very small but increased risk of developing this disease in the scar capsule adjacent to the implant."<sup>viii</sup> An update in 2016 reported that 258 BIA-ALCL adverse event reports have been received to the FDA, and emphasized that physicians should report all confirmed cases to both the FDA and the PROFILE registry. Over 118 distinct case reports of BIA-ALCL have been published, and MD Anderson Cancer Center recognizes 160 pathologically confirmed BIA-ALCL cases worldwide from fifteen countries and the University of California has accumulated approximately 200 BIA-ALCL cases.<sup>9</sup> Currently, all cases with adequate records for confirmation have involved a textured device. Associational research has shown no preference for aesthetic versus reconstructive surgeries or saline versus silicone gel devices.<sup>ix,x</sup> The Plastic Surgery Foundation, the American Society of Plastic Surgeons and the FDA have created the PROFILE Registry (Patient Registry and Outcomes For breast Implants and anaplastic large cell Lymphoma etiology and Epidemiology). This Registry will increase the scientific data on BIA-ALCL, support research characterizing BIA-ALCL, and elucidate the role of breast implants in the etiology of the disease. Treating physicians are encouraged to report confirmed cases to the PROFILE Registry at [www.thepsf.org/PROFILE](http://www.thepsf.org/PROFILE).

##### **Recommendation**

In suspicious or confirmed cases of BIA-ALCL, The American Society of Plastic Surgeons recommends and encourages member surgeons to always submit breast implants, capsule, and effusion to pathology for examination. This is consistent with recommendations from the College of American Pathologists.<sup>xi</sup> Surgeons should request that pathology laboratory perform CD30 immunohistochemistry of effusions and scar capsules in cases suspicious of an ALCL malignancy, such as spontaneous late seromas occurring after implantation.<sup>xii</sup>

<sup>i</sup> American Society of Plastic Surgeons. (2014). 2014 Plastic surgery statistics report. Retrieved from <http://www.plasticsurgery.org/Documents/news-resources/statistics/2014-statistics/plastic-surgery-statistics-full-report.pdf>

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ORIGINAL SCIENTIFIC REPORT

### Health-Related Quality of Life After Breast Reconstruction: Comparing Outcomes Between Reconstruction Techniques Using the BREAST-Q

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#### Abstract

**Background** Reconstruction of the breast following mastectomy can improve patients' health-related quality of life (HRQL). We aimed to assess HRQL in women after mastectomy and breast reconstruction and to identify differences in HRQL related to the reconstruction method used.

**Methods** A cross-sectional study was performed on patients who had undergone breast reconstruction in Helsinki University Hospital between 08/2017 and 7/2019. The postoperative HRQL was assessed using the BREAST-Q (2.0) Reconstruction Module. The results were compared between patients with different reconstruction methods using the Kruskal–Wallis test.

**Results** A total of 146 patients were identified. Microvascular flaps ( $n = 77$ ) were the most common method for primary breast reconstruction, followed by latissimus dorsi (LD) flaps ( $n = 45$ ), fat grafting ( $n = 18$ ) and implant reconstruction ( $n = 6$ ). The satisfaction with breasts was high in all groups (median 61, IQR 49–71). The physical well-being of the chest was high regardless of the reconstructive method (median 100, IQR 80–100). However, women with fat grafting reported more adverse effects of radiation (median 17, IQR 14–17 vs. 18, IQR 17–18 for other groups,  $p = 0.02$ ). Donor site morbidity was low, and patients reported high satisfaction with the back (median 66/100, IQR 57–90) and abdomen (median 9/12, IQR 8–10), and physical well-being of the back (median 61/100, IQR 53–70) and abdomen (median 65/100, IQR 60–86).

**Conclusions** The patient-reported HRQL after breast reconstruction is high. Most women report being satisfied with the reconstruction, irrespective of the reconstruction method used. The reconstruction method can thus be chosen individually in cooperation between the patient and the surgeon.

#### Introduction

Surgery is a significant part of breast cancer treatment. Survival rates are high, accentuating patient satisfaction and health-related quality of life (HRQL) [1]. Breast reconstruction after mastectomy improves satisfaction, and women with reconstructed breast have been shown to score higher in several BREAST-Q scales compared to women with mastectomy alone [2–5].

Increased knowledge of reconstruction techniques and factors affecting surgical results has led to a more patient-centered approach when choosing the reconstructive

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method. These factors include prior radiation therapy to the donor area, donor adipose tissue composition, and microvascular anatomy [6]. Patient-reported outcome measures (PROMs) can be used to assess surgical outcomes and HRQL [1, 7].

Although multiple studies have demonstrated the positive effect of breast reconstruction, these studies often use varying PROMs, focus on a specific reconstruction method or compare autologous and implant-based reconstruction [2, 5, 8]. To our knowledge, no large number of previous studies have compared multiple reconstruction methods and their impact on HRQL using a breast-specific PROM [9].

The BREAST-Q is a psychometrically developed, breast-specific PROM for evaluating patient-reported HRQL and outcomes of breast surgery [10]. Since its development, the BREAST-Q has been translated into more than 30 languages and is widely used globally [11]. It has recently been translated to and validated in Finnish [12]. The BREAST-Q Reconstruction Module evaluates HRQL and satisfaction in patients who are about to, or have undergone, reconstructive surgery [13].

This study aimed to assess HRQL in women with breast reconstruction and evaluate possible differences in the BREAST-Q scores between reconstruction groups, previously unreported in a Finnish population. The setting of reconstruction methods is unique, as most of the patients had undergone autologous reconstruction. Furthermore, our cohort consisted of a large number of reconstructions with either latissimus dorsi (LD) flaps or free fat grafting.

#### Patients and methods

##### Methods

We performed a cross-sectional study on patients who had undergone breast reconstruction between 08/2017 and 7/2019 in Helsinki University Hospital, Department of Plastic Surgery. The patients were identified using operating theatre logs. A questionnaire package including the BREAST-Q questionnaire, a background information form, information on the study, a consent form, and a pre-paid return envelope was sent to the patients. The same questionnaire package was sent a second time if no answer was received.

The indication for mastectomy was either cancer ( $n = 115$ , 79%), or the presence of a cancer-associated gene ( $n = 20$ , 14%). Twelve patients (8.2%) had both cancer and a cancer-associated gene present. The decision

to perform mastectomy was made between the patient and surgeon depending on the presence of cancer-associated genes, tumor size and other individual characteristics of the patient.

The patients' medical records were viewed for health status, diagnosis, treatments given, and surgical therapy. The patients were divided into four groups depending on the primary reconstruction method. Only questions relevant to the operation the patients had undergone were analyzed.

The study protocol was approved by the Helsinki University Hospital ethics committee (HUS/2737/2017). Written consent was obtained from all participants.

##### Study questionnaire

The BREAST-Q Reconstruction Module (version 2.0) was used to assess the patients' HRQL. We used 14 postoperative scales for the study: Psychosocial Well-being, Sexual Well-being, Satisfaction with Breasts, Physical Well-being: Chest, Physical Well-being: Abdomen, Satisfaction with Abdomen, Satisfaction with Nipple Reconstruction, Satisfaction with Back, Physical Well-being: Back and Shoulder, Adverse Effects of Radiation, Satisfaction with Information, Satisfaction with Surgeon, Satisfaction with Medical Team and Satisfaction with Office Staff [14].

##### Statistical analysis

Total scores for the BREAST-Q were rescaled to 0–100 with 0 indicating the worst and 100 the best outcome using the nonlinear Rasch transformation method [15]. Missing values on the scales were replaced with the mean score of the other items if less than 50% of the values were missing. Patients with more than 50% missing values on a scale were excluded from further analysis on that given scale. The scales for satisfaction with the abdomen, satisfaction with the nipple reconstruction and adverse effects of radiation were not rescaled. In these scales the scores on the individual answers were directly converted to the total score on that scale. This is in line with the instructions of the original authors of the BREAST-Q (2.0).

The results presented are given as the median, range, and interquartile range (IQR, 25th and 75th percentiles), if not stated otherwise. The Kruskal–Wallis test was used for groupwise comparison. Post hoc analysis was conducted using the Mann–Whitney U test with Bonferroni correction. All statistical tests were two-tailed and  $p$  values  $< 0.05$  were considered statistically significant.

Statistical analysis was conducted by using IBM SPSS version 27 statistical software [16].

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#### Results

Of 338 patients identified, 146 patients (43%) participated in this study. The median age of the patients was 57 years (range 30–78, IQR 52–63). The median time from the first breast reconstruction until answering the BREAST-Q was 28 months (range 10–174, IQR 21–35), and the median time from the last breast reconstruction procedure until answering the BREAST-Q was 16 months (range 0.2–38, IQR 10–21). Participant characteristics are shown in Tables 1 and 2.

Of all patients, 119 (82%) had undergone more than one reconstructive surgery, including nipple reconstructions and reoperations due to postoperative complications. Sixty-eight patients (47%) experienced no postoperative complications. The most common complications included seromas ( $n = 29$ , 20%) and prolonged wound care ( $n = 13$ , 9%). Seven patients (4.8%) required primary revision surgery, and two patients (1.4%) suffered flap loss. (Table 2).

Microvascular flaps were used for 77 patients (53%), including abdominal flaps ( $n = 64$ , 83%) and gracilis flaps ( $n = 13$ , 17%). Abdominal flaps included the deep inferior epigastric perforator flap, DIEP ( $n = 45$ , 70%), the transverse abdominal rectus muscle flap, TRAM ( $n = 13$ , 20%), the superficial inferior epigastric artery flap, SIEA ( $n = 3$ , 5%), and the lumbar artery perforator flap, LAP ( $n = 3$ , 5%). LD flaps, with or without implant or fat enhancement, were used for 45 patients (31%). Free fat grafts were used for 18 patients (12%). Implants were used for six patients (4%). The satisfaction with implant scale was excluded from further analysis due to low response rate ( $n = 1$ ).

Of the reconstructions performed, 77 (53%) was immediate and 69 (47%) delayed. Radiotherapy was given to 76 patients (52%) postoperatively. Twenty patients (26%) with immediate reconstruction received postoperative radiotherapy. If radiotherapy was given prior to reconstruction, delayed reconstruction was performed 12 months after radiotherapy at the earliest. Forty-three patients (62%) who underwent delayed reconstruction had received radiotherapy prior to the reconstruction. On these

**Table 1** General characteristics of the study cohort

| Variable                                                                  | Median (IQR), range    |          |
|---------------------------------------------------------------------------|------------------------|----------|
| Age (years)                                                               | 57 (52–63), 30–78      |          |
| Time from first reconstructive surgery to answering the BREAST-Q (months) | 28 (21–35), 10–174     |          |
| Time from last operation to answering the BREAST-Q (months)               | 16 (10–21), 0.2–38     |          |
| BMI (kg/m <sup>2</sup> )                                                  | 25 (23–28), 18–34      |          |
| Variable                                                                  | Group                  | N (%)    |
| Active smoker                                                             | Yes                    | 5 (3.4)  |
|                                                                           | No                     | 139 (93) |
|                                                                           | Missing                | 2 (1.4)  |
| ASA-classification <sup>a</sup>                                           | ASA I                  | 74 (51)  |
|                                                                           | ASA II-III             | 72 (49)  |
|                                                                           | Missing                | 2 (1.4)  |
| Reason for surgery                                                        | Cancer                 | 115 (79) |
|                                                                           | Cancer-associated gene | 20 (14)  |
|                                                                           | Both                   | 11 (7.5) |
| Cancer-related gene                                                       | BRCA1                  | 12 (8.2) |
|                                                                           | BRCA2                  | 11 (7.5) |
|                                                                           | PALB2                  | 3 (2.1)  |
|                                                                           | FANCM                  | 2 (1.4)  |
|                                                                           | CHEK2                  | 1 (0.7)  |
|                                                                           | Unknown                | 2 (1.4)  |
|                                                                           | None                   | 115 (79) |
| Prior breast cancer                                                       | Other side             | 15 (10)  |
|                                                                           | Same side              | 6 (4.1)  |
|                                                                           | Both                   | 2 (1.4)  |
|                                                                           | No                     | 123 (84) |

<sup>a</sup>ASA I a normal healthy patient, ASA II a patient with mild systemic disease, ASA III a patient with severe systemic disease

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**Table 2** Surgical descriptive of the study cohort

| Variable                                          | Group                 | N (%)    |
|---------------------------------------------------|-----------------------|----------|
| Type of cancer                                    | DCIS <sup>a</sup>     | 23 (16)  |
|                                                   | Ductal carcinoma      | 66 (45)  |
|                                                   | LCIS <sup>b</sup>     | 2 (1.4)  |
|                                                   | Lobular carcinoma     | 23 (16)  |
|                                                   | Other or undetermined | 12 (8.2) |
|                                                   | Not cancer            | 20 (14)  |
| Bilateral surgery                                 | Yes                   | 81 (56)  |
|                                                   | No                    | 64 (45)  |
| Contralateral surgery for aesthetic reasons       | Reduction mammoplasty | 20 (14)  |
|                                                   | Mastopexy             | 9 (6.2)  |
|                                                   | Mastectomy            | 1 (0.7)  |
|                                                   | None                  | 116 (71) |
| Time of reconstruction                            | Immediate             | 77 (53)  |
|                                                   | Delayed               | 69 (47)  |
| Primary reconstruction method                     | LD                    | 45 (31)  |
|                                                   | With implant          | 3 (6.7)  |
|                                                   | Without implant       | 42 (93)  |
|                                                   | Microvascular flap    | 77 (53)  |
|                                                   | Abdominal flap        | 64 (83)  |
|                                                   | Gracilis flap         | 13 (17)  |
|                                                   | Fat graft             | 18 (12)  |
|                                                   | Implant               | 6 (4.1)  |
|                                                   | 1                     | 27 (18)  |
|                                                   | LD                    | 9 (20)   |
| Total no of reconstructive surgeries <sup>c</sup> | Microvascular flap    | 17 (22)  |
|                                                   | Implant               | 0 (0)    |
|                                                   | Fat graft             | 1 (5.6)  |
|                                                   | 2-3 <sup>d</sup>      | 85 (58)  |
|                                                   | LD                    | 25 (56)  |
|                                                   | Microvascular flap    | 50 (65)  |
|                                                   | Implant               | 2 (33)   |
|                                                   | Fat graft             | 8 (44)   |
|                                                   | 4-5                   | 24 (16)  |
|                                                   | LD                    | 10 (22)  |
|                                                   | Microvascular flap    | 7 (9.1)  |
|                                                   | Implant               | 1 (17)   |
|                                                   | Fat graft             | 6 (33)   |
|                                                   | 5 or more             | 10 (6.8) |
|                                                   | LD                    | 1 (2.2)  |
|                                                   | Microvascular flap    | 3 (3.9)  |
|                                                   | Implant               | 3 (50)   |
|                                                   | Fat graft             | 3 (17)   |

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Table 2 continued

| Variable                                  | Group | N (%)                    |
|-------------------------------------------|-------|--------------------------|
| Clavien-Dindo classification <sup>a</sup> | 0     | 81 (55)                  |
|                                           |       | LD                       |
|                                           |       | 17 (38)                  |
|                                           |       | Microvascular flap       |
|                                           |       | 42 (55)                  |
|                                           | 1     | 4 (67)                   |
|                                           |       | Implant                  |
|                                           |       | 18 (100)                 |
|                                           |       | Fat graft                |
|                                           |       | 40 (27)                  |
|                                           | 2     | 22 (49)                  |
|                                           |       | LD                       |
|                                           |       | 17 (22)                  |
|                                           |       | Microvascular flap       |
|                                           |       | 1 (17)                   |
|                                           | 3a    | 0 (0)                    |
|                                           |       | Implant                  |
|                                           |       | 3 (2.1)                  |
|                                           |       | Fat graft                |
|                                           |       | 2 (4.4)                  |
| Complications                             | 3b    | 1 (2.2)                  |
|                                           |       | LD                       |
|                                           |       | 0 (0)                    |
|                                           |       | Microvascular flap       |
|                                           |       | 1 (17)                   |
|                                           | 3b    | 0 (0)                    |
|                                           |       | Implant                  |
|                                           |       | 0 (0)                    |
|                                           |       | Fat graft                |
|                                           |       | 20 (14)                  |
|                                           | 3b    | 3 (6.7)                  |
|                                           |       | LD                       |
|                                           |       | 17 (22)                  |
|                                           |       | Microvascular flap       |
|                                           |       | 0 (0)                    |
| Reconstruction of the nipple              | Yes   | 0 (0)                    |
|                                           |       | Implant                  |
|                                           |       | 0 (0)                    |
|                                           |       | Fat graft                |
|                                           |       | 0 (0)                    |
|                                           | No    | 13 (8.9)                 |
|                                           |       | Prolonged wound care     |
|                                           |       | 29 (20)                  |
|                                           |       | Seroma                   |
|                                           |       | 2 (1.4)                  |
|                                           | No    | Exploration surgery      |
|                                           |       | 4 (2.7)                  |
|                                           |       | Bleeding                 |
|                                           |       | 9 (6.2)                  |
|                                           |       | Evacuation of hematoma   |
|                                           | No    | 6 (4.1)                  |
|                                           |       | Re-anastomosis           |
|                                           |       | 7 (4.8)                  |
|                                           |       | Primary revision surgery |
|                                           |       | 11 (7.5)                 |
|                                           | No    | 14 (9.6)                 |
|                                           |       | Scar revision            |
|                                           |       | 2 (1.4)                  |
|                                           |       | Removal of the flap      |
|                                           |       | 2 (1.4)                  |
|                                           | No    | Other                    |
|                                           |       | 2 (1.4)                  |
|                                           |       | None                     |
|                                           |       | 68 (47)                  |
|                                           | No    | 67 (46)                  |
|                                           |       | Yes                      |
|                                           |       | 79 (54)                  |
|                                           |       | No                       |

<sup>a</sup>Ductal carcinoma in situ

<sup>b</sup>Lobular carcinoma in situ

<sup>c</sup>Excluding nipple reconstructions and surgery due to complications

<sup>d</sup>Six out of 66 patients had bilateral reconstructions and only one reconstruction surgery per breast

<sup>e</sup>Grade I: Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic, and radiological interventions. Allowed therapeutic regimens are: drugs as antiemetics, antipyretics, analgesics, diuretics, electrolytes, and physiotherapy. This grade also includes wound infections opened at the bedside. Grade II: Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Grade III: Requiring surgical, endoscopic or radiological intervention. IIIa: Intervention not under general anesthesia. IIIb: Intervention under general anesthesia

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patients, reconstruction was performed with microvascular flaps ( $n = 27$ , 63%), fat grafts ( $n = 10$ , 23%) and LD flaps ( $n = 6$ , 14%).

#### Psychosocial and sexual well-being

Psychosocial well-being was similar in all reconstruction groups ( $p = 0.78$ ). The median value for all patients was 64 (range 24–100, IQR 54–80). The scores for sexual well-being had an overall median of 50 (range 0–100, IQR 39–66). No significant difference between reconstruction methods was detected ( $p = 0.77$ ). (Fig. 1, Supplemental Table 1a).

#### Satisfaction with breast and physical well-being: chest

The median score for satisfaction with breast was 61 (range 0–100, IQR 49–71). No significant difference was detected between patients who had undergone breast reconstruction with either microvascular flaps ( $n = 60$ , median 62, IQR 48–73), LD flaps ( $n = 36$ , median 59, IQR 53–67), fat grafts ( $n = 15$ , median 59, IQR 26–69) or implants ( $n = 4$ , median 62, IQR 47–80),  $p = 0.47$ . (Fig. 2, Supplemental Table 1b) The physical well-being of the chest was high (median 100, range 50–100, IQR 80–100). No significant difference was detected among the reconstruction groups ( $p = 0.56$ ), and the results were similar in patients with microvascular flaps ( $n = 77$ , median 100, IQR 83–100), LD flaps ( $n = 45$ , median 100, IQR 83–100), fat grafts ( $n = 18$ , median 92, IQR 75–100) and implants ( $n = 6$ , median 89, IQR 79–100). (Fig. 2, Supplemental Table 1b).

#### Satisfaction with nipple reconstruction

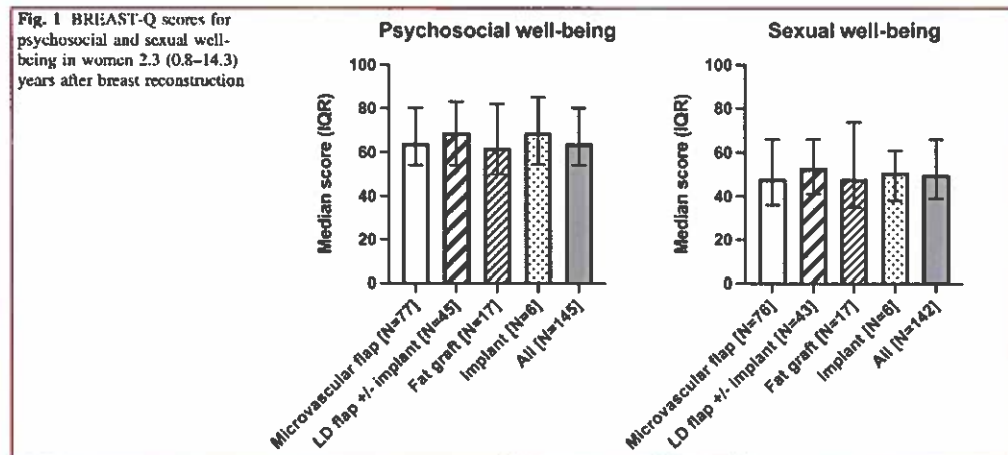
Seventy-eight patients (53%) answered the scale for the satisfaction with nipple reconstruction. The median, on a 1–4-point scale, was 3 (range 1–4, IQR 3–4). There was a significant difference in satisfaction between the reconstruction groups ( $p = 0.04$ ). The patients with microvascular flaps demonstrated the highest satisfaction. In groupwise comparison, no significant difference was detected between microvascular flaps or LD flaps. The implant group ( $n = 4$ , median 2, range 2–3, IQR 2–3) reported lower satisfaction than both patients with LD flaps ( $n = 19$ , median 3, range 1–4, IQR 3–4;  $p = 0.03$ ) and microvascular flaps ( $n = 47$ , median 3, range 1–4, IQR 3–4;  $p = 0.02$ ). However, only four patients (67%) with implant reconstruction answered this scale. (Fig. 2, Supplemental Table 1b).

#### Satisfaction with back and physical well-being: back and shoulder

Forty-one of the 45 patients (91%) with LD flaps answered the Satisfaction with Back scale. The median value was 66 (range 50–100, IQR 57–90). The response rate for the physical well-being of the back and shoulder scale was 93%. The median value was 61 (range 35–100, IQR 53–70). (Supplemental Table 1c).

#### Satisfaction with abdomen and physical well-being: abdomen

Satisfaction with the abdomen and physical well-being of the abdomen were analyzed for patients who had

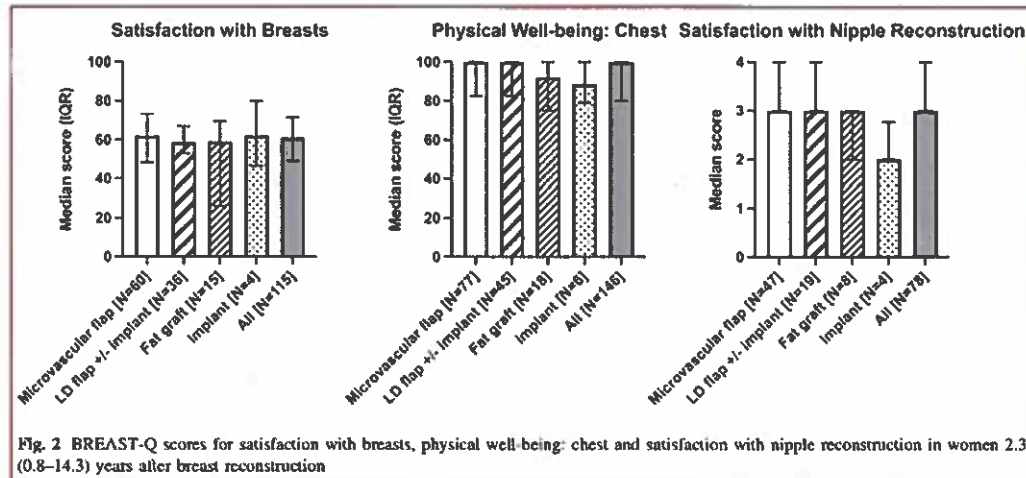


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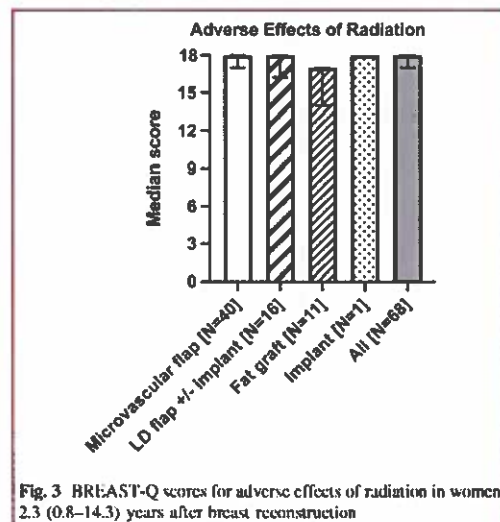
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underwent abdominal flap reconstruction ( $n = 64$ ). The response rate for the Satisfaction with Abdomen scale was 91%. On a 3–12-point scale, the median score was 9 (range 3–12, IQR 8–10). The physical well-being of the abdomen had a median score of 60 (range 47–100, IQR 60–86). The response rate for this scale was 94%. (Supplemental Table 1e).

#### Adverse effects of radiation

Seventy-six patients (52%) had received radiation therapy to the chest. Sixty-eight patients answered the scale on the adverse effects of radiation, which constituted 89% of all women with prior radiation therapy and 47% of all patients. This scale measures possible physical changes of the irradiated skin. These include dryness, lack of pliability, increased sensitivity, increased thickness, soreness and scarring of the skin. Low scores in this scale are associated with adverse effects of radiation. There was a significant difference between the reconstruction groups ( $p = 0.02$ ). The fat graft group reported the lowest scores, with a median score of 17 ( $n = 11$ , range 12–18, IQR 14–17). This group reported lower scores than patients with microvascular flaps ( $n = 40$ , median 18, range 10–18, IQR 17–18;  $p = 0.002$ ) and LD flaps ( $n = 16$ , median 18, range 14–18, IQR 16–18;  $p = 0.02$ ). (Fig. 3, Supplemental Table 1c) The overall median was 18 (range 10–19, IQR 17–18). One patient with implant reconstruction answered this scale and the implant group was thus excluded from the analysis.



#### Satisfaction with care

Scores for the scales regarding the satisfaction with the care were high (Fig. 4, Supplemental Table 1d). No significant difference was detected between the reconstruction groups in satisfaction with information (median 64, range 32–100, IQR 55–81,  $p = 0.64$ ), satisfaction with surgeon (median 100, range 22–100, IQR 86–100,  $p = 0.23$ ), satisfaction with medical team (median 100, range 0–100, IQR 80–100,  $p = 0.35$ ) or satisfaction with office staff (median 100, range 0–100, IQR 73–100,  $p = 0.20$ ).

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**Fig. 4** BREAST-Q scores for satisfaction with information, satisfaction with surgeon, satisfaction with medical team and satisfaction with office staff in women 2.3 (0.8–14.3) years after breast reconstruction

### Discussion

Reconstruction of the breast after mastectomy often improves the HRQL [2, 3, 17, 18]. Autologous reconstruction is associated with higher satisfaction compared to implant-based reconstruction [19]. Our study cohort reported high scores in the BREAST-Q regardless of reconstruction method. The patients with LD or abdominal flaps reported high satisfaction with the back and abdomen.

Breast satisfaction was high in our study population. The median, 61, was in line with prior studies assessing the HRQL in women breast reconstruction (mean range 58–71) [2, 8]. Similar values have been observed in healthy control groups [3]. Interestingly, the score is above the proposed normative mean score, 58, derived from answers of women with no prior history of breast cancer or breast surgery [14].

The median for the physical well-being of the chest was 100, being higher than the estimated normative mean score for this scale, 93 [14]. Autologous reconstruction is associated with greater satisfaction compared to implant-based reconstruction [8]. In our study, the implant group reported lower physical well-being of the chest, although no significant difference was detected. However, with only six patients with implant-based reconstruction, no informative comparison could be made between autologous and implant-based reconstruction.

Microvascular flaps formed the largest group in our study ( $n = 77$ , 53%). These patients reported the highest satisfaction with the breast and physical well-being of the chest, although not statistically significant. The satisfaction with the abdomen and the physical well-being of the abdomen were high. These results are similar to other studies measuring BREAST-Q scores after breast reconstruction using abdominal flaps [20, 21]. However, the physical well-being of the abdomen falls short of the normative mean score for the scale, 78 [14].

Forty-five (31%) patients had undergone LD flap reconstruction, reflecting the popularity of this reconstruction method in Finland and Scandinavia [22, 23]. It is considered favorable for women with small breasts or excess fat tissue in the back [24]. The LD flap has been associated with high patient satisfaction, positive aesthetic results and low complication rates [25, 26]. However, several studies have reported impaired functionality and long-term discomfort after reconstruction [27]. In our cohort, the LD group reported relatively high satisfaction with the breast and the back. These patients scored the highest in psychosocial and sexual well-being as well as the physical well-being of the chest, although no statistically significant difference was detected. Similar BREAST-Q scores have been reported in prior studies [26].

Breast reconstruction with free fat transfer is an increasingly popular option in our patient group [28]. Although previously used for filling tissue defects or as an additional reconstructive method, serial fat grafting is feasible as the sole reconstructive method [29, 30]. Fat grafting is associated with low complication rates and satisfactory cosmetic outcomes [31]. In our study, 18 patients (12%) underwent primary reconstruction using fat grafting. These patients reported relatively high satisfaction with the breast (median 59) and physical well-being of the chest (median 92). Interestingly, the fat graft group reported more adverse effects of radiation than patients with microvascular and LD flaps. While fat transfer has been suggested to reduce the skin effects of irradiation damage [32], this may reflect the presence of only the original, irradiated skin envelope in the breast. Additionally, patients with fat grafts are often informed about the possible effects of radiotherapy on graft retention.

Our study cohort reported high satisfaction with the nipple reconstruction. Nipple reconstruction is associated with improved satisfaction, as well as psychosocial and sexual well-being [33–35]. Nipple reconstruction is

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routinely offered to all our patients, and 78 (53%) of the study participants had a reconstructed nipple. Patients with autologous flaps were more satisfied with the nipple reconstruction than patients with implant reconstructions. However, our results might have been affected by the low number of patients ( $n = 4$ ) with implant-based reconstruction who answered this scale.

Total donor site morbidity in our study was low, and physical well-being of the back and shoulder (median 61) and abdomen (median 9) were high. Our small implant group complicated the comparison between implant-based and autologous reconstruction. However, low donor site morbidity, combined with high overall satisfaction independent of the reconstruction method, could be considered to favor autologous reconstruction methods. This is especially so as autologous reconstructions have been associated with a greater HRQL and patient-reported satisfaction [2, 8, 19].

Study limitations include the cross-sectional design with a lack of a known preoperative HRQL and control groups. The time from surgery was up to four years, therefore enough to surpass the initial postoperative decrease in HRQL [36]. Although our cohort included all patients undergoing breast reconstruction in this hospital in a three-year period, selection bias is possible due to the high number of non-responders. However, the response rate is similar to the average response rate of mail surveys [37]. Further, the cohort included patients of a wide age range and multiple reconstructive procedures. Most of the reconstructions were autologous, and we had a large group of patients with free fat transfer as primary reconstructive method. Even so, some of the reconstruction groups were too small to enable meaningful comparisons between methods. This also entailed that no comparison was possible between different microvascular reconstruction donor sites. Further, with only six patients with implant reconstructions, our study is likely to have been underpowered to demonstrate a potential difference in the HRQL between the implant-based and autologous reconstruction.

The low number of implant-based reconstructions in our study reflects the practice in our department, with implant reconstructions being performed in the Breast Cancer Unit instead of the Plastic Surgery Department. In contrast, our study included several reconstruction methods, and we had a large group of patients with reconstruction using fat grafts in the analysis, a patient group infrequently represented in other similar studies.

In conclusion, women with breast reconstructions reported high satisfaction with the breasts and few adverse effects, irrespective of the reconstruction method used. Therefore, the decision regarding the method of breast reconstruction can be made individually considering the patients' wishes and individual characteristics.

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#### Declarations

**Conflict of Interest** The authors have no conflicts of interest to declare.

**Ethical approval** The study protocol was approved by the Helsinki University Hospital ethics committee.

**Informed consent** Informed consent was obtained from all participants.

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### Consensus Review of Optimal Perioperative Care in Breast Reconstruction: Enhanced Recovery after Surgery (ERAS) Society Recommendations

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#### Abstract

**Background:** Enhanced recovery following surgery can be achieved through the introduction of evidence-based perioperative maneuvers. This review aims to present a consensus for optimal perioperative management of patients undergoing breast reconstructive surgery and to provide evidence-based recommendations for an enhanced perioperative protocol.

**Methods:** A systematic review of meta-analyses, randomized controlled trials, and large prospective cohorts was conducted for each protocol element. Smaller prospective cohorts and retrospective cohorts were considered only when higher level evidence was unavailable. The available literature was graded by an international panel of experts in breast reconstructive surgery and used to form consensus recommendations for each topic. Each recommendation was graded following a consensus discussion among the expert panel. Development of these recommendations was endorsed by the Enhanced Recovery after Surgery Society.

**Results:** High-quality randomized controlled trial data in patients undergoing breast reconstruction informed some of the recommendations; however, for most items, data from lower level studies in the population of interest were considered along with extrapolated data from high-quality studies in non-breast reconstruction populations. Recommendations were developed for a total of 18 unique enhanced recovery after surgery items and are discussed in the article. Key recommendations support use of opioid-sparing perioperative medications, minimal preoperative fasting and early feeding, use of anesthetic techniques that decrease postoperative nausea and

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vomiting and pain, use of measures to prevent intraoperative hypothermia, and support of early mobilization after surgery.

**Conclusion:** Based on the best available evidence for each topic, a consensus review of optimal perioperative care for patients undergoing breast reconstruction is presented.

**CLINICAL QUESTION/LEVEL OF EVIDENCE:** Therapeutic, V.

Recovery can be improved in breast surgery.<sup>1</sup> Enhanced recovery after surgery represents evidenced-based care elements that have revolutionized perioperative care in colorectal surgery,<sup>2</sup> thereby reducing morbidity and length of stay, and improving survival.<sup>3–5</sup> This guideline (Table 1) was developed by an international expert panel of physicians under the guidance of the Enhanced Recovery after Surgery (ERAS) Society ([www.erassociety.org](http://www.erassociety.org)) to formalize enhanced recovery after surgery protocols for breast reconstruction.<sup>1,6</sup>

#### METHODS

An international team of breast reconstruction experts teleconferenced monthly from January through June of 2015. Guideline items were developed and the MEDLINE and Cochrane databases were searched from 1965 through January of 2015. Key words included “breast cancer,” “mastectomy,” “breast neoplasm,” and “breast carcinoma”; combined with “reconstruction,” “reconstructive surgery,” “implant,” “flap,” “expander,” “acellular dermal matrix,” “mesh,” and “graft.” The resulting citations were combined with additional topic-specific key words. Reference lists of all eligible articles were hand-searched for additional studies.

All titles and abstracts were screened to identify potentially relevant articles. Any discrepancies in the interpretation of articles were resolved during working group meetings. Where available, randomized controlled trials and systematic reviews in patients undergoing breast reconstruction were used. Lower level data were considered where no high-level data were available. Only the most recent, highest level evidence is cited. Study quality was assessed using the criteria developed by the Centre for Evidence Based Medicine (Oxford, England).<sup>7</sup>

Recommendations were developed using an evidence-based consensus approach. Using the results of the systematic review, the panel provided expert interpretation of the evidence and discussed and modified each recommendation until no further modifications were required and consensus was reached. Recommendations were graded as “weak” or “strong” according to the Grading of Recommendations, Assessment, Development and Evaluation system.<sup>8</sup>

#### EVIDENCE BASE AND RECOMMENDATIONS

##### ERAS Items

**Preadmission Information, Education, and Counseling**—Providing surgical and anesthetic information preoperatively improves recovery by reducing fear and anxiety.<sup>9</sup> Information about the procedure assists patients in reaching postoperative milestones and

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has been shown to reduce complications by improving perioperative feeding, pain control, and respiratory physiotherapy.<sup>10</sup>

Women value presurgical education about breast reconstruction,<sup>11</sup> yet many feel that they do not receive adequate information,<sup>12</sup> leading to dissatisfaction with their reconstruction decisions.<sup>13,14</sup> Patient involvement in co-decision-making about breast reconstruction leads to higher satisfaction, independent of the reconstruction type.<sup>15</sup> Sufficient information improves knowledge and lessens decision regret.<sup>16,17</sup> Preconsultation educational group interventions are one method of reducing decisional conflict.<sup>17</sup>

1. **Summary and recommendation:** Patients should receive detailed preoperative counseling.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong (low harm).

**Preadmission Optimization**—Smoking predisposes women to postmastectomy reconstruction complications,<sup>18–20</sup> including mastectomy skin flap necrosis, abdominal flap necrosis, and hernias.<sup>21</sup> Former smokers (i.e., those who quit 3 to 4 weeks preoperatively) and nonsmokers have similar complication rates.<sup>22,23</sup>

Obesity (i.e., body mass index  $>30$  kg/m<sup>2</sup>) increases flap loss and donor-site morbidity.<sup>24–27</sup> National Surgical Quality Improvement Program data of 2899 women with free flap reconstructions have revealed a strong correlation between obesity and surgical-site infections, venous thromboembolism, and other complications.<sup>28,29</sup> Patients should therefore be encouraged to lose weight before surgery. Muscle-preserving abdominal flaps [i.e., deep inferior epigastric perforator (DIEP) flap] reduce abdominal wall complications compared with non-muscle-sparing flaps [i.e., free or pedicle transverse rectus abdominis musculocutaneous (TRAM) flap] in obese patients.<sup>27,30</sup>

Regarding diabetes, National Surgical Quality Improvement Program data on 29,736 women with breast reconstruction have linked type 2 diabetes mellitus to surgical complications (OR, 1.51) and type 1 diabetes mellitus to medical (OR, 1.82) and overall complications (OR, 1.85).<sup>31</sup> Poor glycemic control is associated with worse outcomes in primary closure of surgical wounds in high-risk patients.<sup>32</sup>

Heavy alcohol consumption (five or more drinks on each of 5 or more days in the past 30 days) is also associated with poor outcomes, particularly attributable to surgical-site infections. National Surgical Quality Improvement Program data on 9315 patients undergoing immediate reconstruction have revealed heavy alcohol consumption as an independent risk factor for surgical-site infections.<sup>33</sup>

1. **Summary and recommendation:** For daily smokers, 1 month of abstinence before surgery is beneficial. For patients who are obese, weight reduction to achieve a body mass index less than or equal to 30 kg/m<sup>2</sup> before surgery is beneficial. For alcohol abusers, 1 month of abstinence before surgery is

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beneficial. For appropriate groups, referral should be made to resources for these behavior changes.

2. **Evidence level:** Moderate for smoking; high for obesity; low for alcohol.
3. **Recommendation grade:** Strong for all (high benefit, low harm).

**Perforator Flap Planning**—Meta-analysis has shown the benefit of computed tomographic angiography over Doppler ultrasonography in mapping the dominant DIEP perforators; benefits include reduced flap complications, donor-site morbidity, and operative times.<sup>34</sup> Risks include potential contrast allergy, nephrotoxicity, and exposure to radiation.<sup>35</sup> Modern computed tomographic angiography scanning protocols have reduced radiation exposure.<sup>36</sup> Magnetic resonance angiography avoids radiation, but image quality remains a challenge that is improving with a variety of technical refinements.<sup>37–39</sup>

1. **Summary and recommendation:** If preoperative perforator mapping is required, computed tomographic angiography is recommended.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong.

**Preoperative Fasting**—A Cochrane review of 22 randomized controlled trials has shown that drinking clear fluids 2 hours preoperatively is safe and does not increase the risk of regurgitation or aspiration.<sup>40</sup> Existing ERAS guidelines recommend a 6-hour fast for solid foods and a 2-hour fast for clear liquids before general anesthesia.<sup>41</sup> Recommendations have not been applied to patients at increased risk of delayed gastric emptying.

1. **Summary and recommendation:** Preoperative fasting should be minimized and patients should be allowed to drink clear fluids up to 2 hours before surgery.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong.

**Preoperative Carbohydrate Loading**—Taken 2 hours before surgery, maltodextrin-based drinks (400 ml) specifically designed and tested for preoperative use have positive metabolic effects, such as increasing insulin sensitivity and reducing preoperative thirst and anxiety.<sup>42–44</sup> Carbohydrate loading reduces the catabolic effects of surgery, including losses of nitrogen and protein, lean body mass, and muscle strength,<sup>45–48</sup> which has translated into shorter hospital stays.<sup>49</sup> In patients with well-controlled type 2 diabetes, a carbohydrate drink given up to 3 hours before surgery alongside their normal medication does not appear to delay gastric emptying and will allow glucose concentrations the additional time required (i.e., 180 minutes versus 120 minutes in healthy subjects) to return to baseline.<sup>50</sup>

1. **Summary and recommendation:** Preoperative maltodextrin-based drinks should be given to patients 2 hours before surgery.
2. **Evidence level:** Low (based on extrapolated data).

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3. **Recommendation grade:** Strong (low risk of harm) in the general patient population.

**Prophylaxis against Venous Thromboembolism**—National Surgical Quality Improvement Program data on 68,285 patients have shown that venous thromboembolism in reconstruction patients approaches twice that of lumpectomy or mastectomy alone (0.41 percent versus 0.13 percent and 0.29 percent,  $p < 0.0001$ ).<sup>28</sup> Retrospective reviews have reported rates as high as 3.4 percent.<sup>51,52</sup> Nationwide Inpatient Sample data on 35,883 patients undergoing autologous reconstruction have revealed a lower rate of venous thromboembolism (0.13 percent); however, the rate of venous thromboembolism was highest for TRAM flap reconstruction at 0.26 percent.<sup>52</sup> Immediate breast reconstruction is an independent risk factor for venous thromboembolism.<sup>53</sup>

Patients undergoing mastectomy and immediate reconstruction meet the criteria for “higher” risk of venous thromboembolism and may be considered “highest” risk if they are obese or elderly, according to the American Society of Plastic Surgeons Executive Committee–approved Caprini Risk Assessment Module.<sup>54,55</sup> For this patient population, pharmacologic anticoagulation with or without mechanical methods (i.e., intermittent pneumatic compression) is recommended.<sup>55,56</sup> Prophylaxis should begin before surgery and continue for at least 7 to 10 days.<sup>57</sup> Extended prophylaxis up to 4 weeks reduces the risk of radiologically confirmed venous thromboembolism following major abdominopelvic surgery.<sup>58</sup> A prospective cohort and two large retrospective cohorts on low-molecular-weight heparin did not report increased bleeding risk<sup>58–60</sup>; however, in breast surgery specifically, some studies have shown that low-molecular-weight heparin has a higher bleeding risk than unfractionated heparin.<sup>61,62</sup>

1. **Summary and recommendation:** Patients should be assessed for venous thromboembolism risk. Unless contraindicated, and balanced by the risk of bleeding, patients at a higher risk should receive low-molecular-weight heparin or unfractionated heparin until they are ambulatory or discharged. Mechanical methods should be added.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong.

**Antimicrobial Prophylaxis**—Infection rates following mastectomy are higher than those expected for clean surgery (i.e., 3 to 15 percent versus 2 percent).<sup>63,64</sup> The risk of infection is further increased with the addition of a prosthesis or a flap.<sup>65–67</sup> National Surgical Quality Improvement Program data on 2899 patients with flaps and 12,163 patients with tissue expanders have revealed that patient factors such as hypertension, body mass index, and smoking increase infection risk after breast reconstruction.<sup>29,68</sup>

Prophylactic antibiotics reduce surgical-site infections.<sup>69</sup> Antibiotics against common skin organisms (i.e., cephalosporins) should be administered 1 hour before incision.<sup>70,71</sup> The majority of data support the perioperative use of prophylactic antibiotics.<sup>64,65,70–72</sup> Despite the common practice to use postoperative antibiotics until drains are removed, data from

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a well-conducted systematic review have shown that more than 24 hours of antibiotics appears to be associated with higher rates of surgical-site infections in acellular dermal matrix reconstructions.<sup>65</sup> It should be noted that this was a meta-analysis of observational studies and not randomized controlled trials. Aside from this meta-analysis, there are no other published data to inform duration of antibiotic use, and further research is needed. Prolonged use of antibiotics beyond 24 hours has not been proved beneficial.<sup>73–75</sup>

Chlorhexidine-based antiseptics immediately before surgery decrease surgical-site infections.<sup>76,77</sup> In implant reconstruction, bacterial burden can be reduced through antibiotic irrigation of the breast pocket, which may decrease capsular contracture but has not been proven to decrease surgical-site infections.<sup>78</sup> Methicillin-resistant *Staphylococcus aureus* infections are increasing; however, a Cochrane review did not support a switch to glycopeptide antibiotics (i.e., vancomycin).<sup>69</sup>

1. **Summary and recommendation:** Chlorhexidine skin preparation and intravenous antibiotics covering common skin organisms should be given within 1 hour of incision.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong.

**Preoperative and Intraoperative Prophylaxis against Postoperative Nausea and Vomiting**—A meta-analysis demonstrated the superiority of 5-hydroxytryptamine-3 receptor antagonists over placebo in reducing postoperative nausea and vomiting in breast surgery.<sup>79</sup> Steroids reduce postoperative nausea and vomiting and pain, and a combination of 5-hydroxytryptamine-3 antagonists and steroids is superior to either alone.<sup>80–82</sup> Neurokinin-1 receptor antagonists provide even further reduction in postoperative nausea and vomiting compared with 5-hydroxytryptamine-3, but must be given preoperatively.<sup>83–88</sup>

1. **Summary and recommendation:** Women should receive preoperative and intraoperative multimodal medications to mitigate postoperative nausea and vomiting.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong (high benefit, low harm).

**Preoperative and Intraoperative Analgesia**—Gabapentin<sup>89–91</sup> reduces postoperative analgesic requirements and pain in women undergoing mastectomy. Nonsteroidal antiinflammatory drugs offer effective analgesia given preoperatively or intraoperatively, and decrease chronic breast pain without increasing bleeding complications.<sup>92,93</sup> Perioperative cyclooxygenase-2 inhibitors have a similar beneficial effect.<sup>94</sup> Bupivacaine infiltration in the area of planned surgical incision for mastectomy decreases pain intensity and opiate demand after surgery.<sup>95</sup>

Adenosine,<sup>96</sup> systemic magnesium,<sup>97</sup> venlafaxine,<sup>98</sup> and clonidine<sup>99</sup> are effective analgesics given preoperatively. Preoperative ketamine does not moderate postoperative pain.<sup>100</sup> The majority of data were extrapolated from breast surgery, but for longer duration operations

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such as free tissue transfer reconstructions, the preoperative advantage may be diminished, thus, these medications may be best given intraoperatively.

1. **Summary and recommendation:** Women should receive multimodal analgesia to mitigate pain.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong (high benefit, low harm).

**Standard Anesthetic Protocol**—Retrospective data have suggested that the use of regional anesthesia, compared with general anesthesia, lowers the recurrence of subsequent breast cancer,<sup>101</sup> potentially through natural killer T cells.<sup>102</sup> Similar early findings in prostate and colorectal cancer have led to a large prospective, multicenter, randomized, controlled trial that is currently investigating this hypothesis for breast cancer patients.<sup>103–105</sup> The findings from this study, when completed, may have a major impact on the choice of anesthetic technique.

There are three common modalities for maintenance of anesthesia during breast surgery, including general anesthesia with total intravenous anesthesia, general anesthesia with a volatile anesthetic, and regional anesthesia. Regional anesthesia decreases postoperative narcotic use<sup>106–108</sup> but does not decrease pain, nausea, sedation, time to ambulation, or hospital stay duration.<sup>107</sup> General anesthesia is the most frequently used modality of anesthesia for breast surgery; general anesthesia under total intravenous anesthesia decreases postoperative nausea and vomiting compared with a volatile anesthetic.<sup>109,110</sup>

1. **Summary and recommendation:** General anesthesia with total intravenous anesthesia is recommended.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong.

**Preventing Intraoperative hypothermia**—Maintaining a core body temperature over 36°C reduces multiple complications.<sup>111</sup> The Surgical Care Improvement Project linked hypothermia with impaired wound healing, prolonged hospitalization, and three-fold higher wound infection rates.<sup>112</sup> A systematic review in multiple surgery types showed that warming decreases wound infection.<sup>1</sup> Attention to active thermal therapy is required when using intermittent pneumatic compression devices, which move cooled extremity blood to the core.<sup>113</sup> Preoperative patient-warming strategies augment intraoperative warming strategies.<sup>114,115</sup> Simply prewarming the operating room itself is not enough.<sup>116</sup>

Forced-air warming has an excellent safety profile and efficacy in a systematic review of multiple randomized controlled trials.<sup>117</sup> Forced air is superior to resistive underbody warming.<sup>118,119</sup> Circulating water garments,<sup>120</sup> thermal mattresses,<sup>121–123</sup> and circulating-water leg wraps<sup>124</sup> offer some increase in temperature; however, the safety, low cost, and ease of use of forced-air warming supplant other systems.

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Warmed intravenous fluid reduces hypothermia in short surgical procedures,<sup>125</sup> but in orthopedic surgery, warming irrigation fluid is insufficient to prevent hypothermia.<sup>126</sup> In liver transplantation, humidification of inspired gas warms the patient effectively.<sup>127</sup> Amino acid and magnesium infusions reduce shivering.<sup>128,129</sup>

1. **Summary and recommendation:** Preoperative and intraoperative measures, such as forced air, to prevent hypothermia should be instituted. Temperature monitoring is required to ensure the patient's body temperature is maintained above 36°C.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong.

**Perioperative Intravenous Fluid Management**—A randomized controlled trial demonstrated that a restricted IV fluid regimen decreases complications in abdominal surgery by 59 percent.<sup>130</sup> Optimizing fluid balance begins by taking clear fluids orally up to 2 hours preoperatively. Goal-directed therapy (i.e., intensive monitoring and aggressive management of perioperative hemodynamics) improves length of stay and complication rates<sup>131–134</sup>; however, a recent meta-analysis showed that the benefit of goal-directed therapy was muted in patients managed in an enhanced recovery after surgery setting.<sup>135</sup> Measurement of venous oxygen saturation has utility in major surgery, but its use in breast surgery has not been established.<sup>136</sup> Balanced crystalloid solutions are superior to 0.9% saline for electrolyte balance.<sup>137,138</sup>

Overresuscitation contributes to cardiopulmonary events, wound infection, poor wound healing, and increased length of hospital stay.<sup>139–141</sup> It is especially harmful in microvascular reconstruction.<sup>142–145</sup> Underresuscitation increases postoperative microvascular thrombosis.<sup>137</sup> Vasopressors to maintain blood pressure have been historically avoided in flap patients, but have been found to be safe in normovolemic patients.<sup>146–149</sup> Dextran-40, traditionally used to reduce the risk of microvascular thrombosis, lacks efficacy and has a high complication rate.<sup>150</sup>

1. **Summary and recommendation:** Overresuscitation or underresuscitation of fluids should be avoided, and water and electrolyte balance should be maintained. Goal-directed therapy is a useful method to achieve these goals. Balanced crystalloid solutions rather than saline is recommended. Vasopressors are recommended to support fluid management and do not negatively affect free flaps.
2. **Evidence level:** Moderate for all (based on extrapolated data).
3. **Recommendation grade:** Strong.

**Postoperative Analgesia**—Postoperative pain control needs to be adequate to facilitate early mobilization. Reducing the contribution of opioids to the analgesic regimen reduces postoperative nausea and vomiting and constipation, effectively facilitating early mobilization. A meta-analysis of intravenous acetaminophen (paracetamol) has shown that it reduces pain in only 37 percent of patients.<sup>151</sup> Although acetaminophen alone is less

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effective than nonsteroidal antiinflammatory drugs.<sup>152</sup> Cochrane data from three randomized controlled trials have demonstrated that the combination is more effective than either alone.<sup>153</sup>

Nonsteroidal antiinflammatory drugs reduce the need for narcotics with minimal surgical-site bleeding risk in multiple randomized controlled trials.<sup>154–156</sup> Cyclooxygenase-2 inhibitors reduce the potential for gastrointestinal tract bleeding and surgical-site bleeding<sup>157–159</sup> but can increase the risk of stroke or myocardial infarction in patients with ischemic heart disease.<sup>160</sup> Preoperative or postoperative gabapentin reduces narcotic requirements.<sup>161–163</sup>

Regional or local blocks minimize pain and sedation. Continuous bupivacaine infusion catheters reduce opioid requirements in several studies.<sup>164–166</sup> Randomized controlled trial evidence shows that transversus abdominis plane blocks decrease abdominal donor-site pain in flap patients.<sup>106,167</sup> A single injection of liposomal bupivacaine lasts for several days, potentially avoiding the need for catheter-based infusions.<sup>168</sup> Randomized controlled trial data on pulse electromagnetic field therapy in TRAM flap patients have shown decreases in pain and narcotic use.<sup>169</sup>

1. **Summary and recommendation:** Multimodal postoperative pain management regimens are opioid-sparing and should be used.
2. **Evidence level:** High.
3. **Recommendation grade:** Strong.

**Early Feeding**—An early oral or enteral diet within 24 hours of surgery is safe and associated with improved wound healing, reduced infection, and reduced hospital stay.<sup>170</sup> The benefits of early refeeding<sup>171</sup> need to be weighed against the rare risk of a potential urgent return to the operating room, whereby a fed patient is at risk for aspiration. The urgent return arises in 2 to 5 percent of patients who develop a microvascular thrombosis in their free flap breast reconstruction.<sup>172–174</sup> Modern anesthetic techniques should mitigate the risk of aspiration in this uncommon scenario.<sup>175</sup>

1. **Summary and recommendation:** Patients should be encouraged to take fluids and food orally as soon as possible, preferably within 24 hours after surgery.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong.

**Postoperative Flap Monitoring**—Microvascular thrombosis occurs in the anastomosis of the free flap in 2 to 5 percent of cases and usually occurs within the first 72 hours.<sup>172–174</sup> Most commonly (60 to 74 percent), a microvascular thrombosis will occur venously.<sup>173,176</sup> Salvage of a compromised free flap is improved with earlier exploration and return of flow<sup>176,177</sup>; therefore, routine frequent monitoring, including clinical observation (i.e., color, temperature, and capillary refill) and use of devices, is highly warranted.

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Hand-held Doppler is an extension of clinical observation, as it is noninvasive and inexpensive and has widespread use.<sup>178</sup> Frequent monitoring is required in the first 72 hours and a reasonable monitoring protocol may include hourly monitoring for the first 24 hours, every 2 hours for the next 24 hours, then every 3 to 4 hours for the next 24 hours.

Implantable Doppler monitors have excellent sensitivity in detecting flap compromise, but can detach and thus carry a higher false-positive rate than clinical observation.<sup>179</sup> Studies comparing clinical observation with or without implantable Doppler monitors, are equivocal in terms of improved flap salvage.<sup>181,182</sup> For buried flaps, implantable Doppler monitoring offers the only objective measure.<sup>178</sup> Other methods of monitoring flaps include a venous coupler with an embedded implantable Doppler device, laser Doppler monitoring, infrared spectroscopy, tissue oximetry, and microdialysis.<sup>183–185</sup>

1. **Summary and recommendation:** Flap monitoring within the first 72 hours should occur frequently. Clinical evaluation is sufficient for monitoring, with implantable Doppler monitoring recommended in cases of buried flaps.
2. **Evidence level:** Moderate.
3. **Recommendation grade:** Strong (low harm).

**Postoperative Wound Management**—Breast and abdominal incisions following breast reconstruction are generally closed with layered intradermal absorbable sutures.<sup>186</sup> Antimicrobial-coated versus plain sutures do not show a significant reduction in surgical-site infections in randomized controlled trials.<sup>187,188</sup> Other randomized controlled trials evaluating the skin adhesive octyl-2-cyanoacrylate in breast surgery show patient preference for the adhesive but no objective difference in cosmesis or complications.<sup>189–192</sup> A surgical skin closure film has been found to be faster than sutures, but with no difference in complication rates.<sup>193</sup> An ongoing randomized controlled trial is evaluating the effect of dressing wear time (1 day versus 6 days) on surgical-site infections.<sup>194</sup>

Complex wounds associated with mastectomy flap, DIEP flap, or abdominal skin necrosis are recognized complications of breast reconstruction.<sup>195,196</sup> Negative-pressure wound therapy is an effective aid in wound management after surgical débridement, with a systematic review of breast wounds showing that 97 percent receiving negative-pressure wound therapy in conjunction with débridement healed completely.<sup>197</sup>

1. **Summary and recommendation:** For incisional closure, conventional sutures are recommended. Complex wounds following skin necrosis are treatable with débridement and negative-pressure wound therapy.
2. **Evidence level:** High for sutures; moderate for negative-pressure wound therapy.
3. **Recommendation grade:** Strong.

**Early Mobilization**—Early in-hospital mobilization improves muscle strength<sup>198</sup> and reduces pulmonary embolism, pneumonia, and decubitus ulcers. Early mobilization decreases length of hospitalization and improves psychological well-being.<sup>199–205</sup> Conversely, prolonged bed rest has been shown to reduce work capacity.<sup>206</sup> Prolonged

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inactivity combined with a catabolic state (i.e., postoperative stress) exacerbates strength and lean muscle loss.<sup>207</sup>

1. **Summary and recommendation:** Patients should be mobilized within the first 24 hours after surgery.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong (low risk).

**Postdischarge home Support and Physiotherapy**—Early physical rehabilitation improves physical and emotional recovery after mastectomy and axillary dissection.<sup>208,209</sup> Postoperative physical rehabilitation programs in breast cancer patients improve mobility, reduce pain, and improve quality of life.<sup>210</sup> Randomized controlled trial data on the effect of early supervised exercise have demonstrated that exercise leads to quicker recovery, earlier mobility, and enhanced patient comfort, but fails to improve lymphedema.<sup>208,211</sup>

Qualitative studies show that visiting nurses play an important role in providing physical care and delivering education and psychosocial support following TRAM flap reconstruction.<sup>212,213</sup> Postdischarge telephone and mobile application support are “virtual” adjuncts to in-home nursing visits and outpatient visits.<sup>210,214</sup>

1. **Summary and recommendation:** Early physiotherapy, supervised exercise programs, and other supportive care initiatives should be instituted after discharge.
2. **Evidence level:** Moderate (based on extrapolated data).
3. **Recommendation grade:** Strong (low harm).

## CONCLUSIONS

The literature surrounding breast reconstruction has evolved from establishing oncologic safety and optimal timing, refining surgical techniques, and improving cosmesis, to the point where we now use patient-reported outcome measures<sup>215,216</sup> to evaluate what matters to patients. Patient-reported outcome measures show that despite our optimization of procedures, recovery is suboptimal across reconstruction types.<sup>15</sup>

An enhanced recovery experience has been realized in major abdominal surgery through the introduction of ERAS guidelines.<sup>217,218</sup> Most of the recommendations in the colorectal guideline are directly relevant and can be extrapolated to breast reconstruction. Practitioners now avoid long fasting periods, attend to patient temperature, and use multimodal pain and postoperative nausea and vomiting prevention strategies.<sup>219,220</sup>

These 18 recommendations represent a synthesis of the current body of literature by an international group of experts and can be applied to most patients, with the goal of providing a rapid recovery with low complication rates and decreased care time. As with any practice guideline, clinicians should use independent judgment of an individual patient’s clinical circumstances to direct care. This consensus guideline is not intended to be leveraged as a rationale for funding bodies to restrict payment for care based on hospital length of stay.

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Rather, patient safety must be considered first and these practices should be implemented in a measured, thoughtful, and studied manner.

To effectively change practice, guidelines must be supported by strong data. Many of these recommendations can be strengthened with data from patients undergoing breast reconstruction in the setting of an ERAS protocol. For women undergoing implant-based breast reconstruction, the recently demonstrated benefits of an ERAS protocol include reduced length of stay and better quality of recovery, with no differences in complication rates or emergency room visits.<sup>221</sup> Minimizing care time and complications is the goal for this group of women and can be measured through audit of infection rates, deep venous thrombosis, and other outcomes; however, the recovery experience is also important and should be assessed through validated outcome measures, such as the Quality of Recovery-15 scale.<sup>222</sup>

These recommendations will require revision as new evidence emerges. Each recommendation alone is unlikely to change the recovery process, but bundled together and applied with good sense and care, these recommendations may transform the recovery experience for patients and for the health care system.<sup>218</sup>

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Table 1.  
ERAS Society Enhanced Recovery after Surgery Recommendations for Perioperative Care in Breast Reconstruction

| Item                                                   | Recommendation                                                                                                                                                                                                                                                                                                                                                       | Evidence Level                                  | Recommendation Grade       |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| 1. Preadmission information, education, and counseling | Patients should receive detailed preoperative counseling.                                                                                                                                                                                                                                                                                                            | Moderate                                        | Strong                     |
| 2. Preadmission optimization                           | For daily smokers, 1 mo of abstinence before surgery is beneficial. For patients who are obese, weight reduction to achieve a BMI $\leq 30$ kg/m <sup>2</sup> before surgery is beneficial. For alcohol abusers, 1 mo of abstinence before surgery is beneficial. For appropriate groups, referral should be made to resources for these behavior changes.           | Moderate (smoking) High (obesity) Low (alcohol) | Strong<br>Strong<br>Strong |
| 3. Perforator flap planning                            | If preoperative perforator mapping is required, CTA is recommended.                                                                                                                                                                                                                                                                                                  | Moderate                                        | Strong                     |
| 4. Perioperative fasting                               | Preoperative fasting should be minimized and patients should be allowed to drink clear fluids up to 2 hr before surgery.                                                                                                                                                                                                                                             | Moderate                                        | Strong                     |
| 5. Preoperative carbohydrate loading                   | Preoperative malodextrin-based drinks should be given to patients 2 hr before surgery.                                                                                                                                                                                                                                                                               | Low                                             | Strong                     |
| 6. Venous thromboembolism prophylaxis                  | Patients should be assessed for venous thromboembolism risk. Unless contraindicated, and balanced by the risk of bleeding, patients at a higher risk should receive low-molecular-weight heparin or unfractionated heparin until ambulatory or discharged. Mechanical methods should be added.                                                                       | Moderate                                        | Strong                     |
| 7. Antimicrobial prophylaxis                           | Chlorhexidine skin preparation should be performed and intravenous antibiotics covering common skin organisms should be given within 1 hr of incision.                                                                                                                                                                                                               | Moderate                                        | Strong                     |
| 8. Postoperative nausea and vomiting prophylaxis       | Women should receive preoperative and intraoperative medications to mitigate postoperative nausea and vomiting.                                                                                                                                                                                                                                                      | Moderate                                        | Strong                     |
| 9. Preoperative and intraoperative analgesia           | Women should receive multimodal analgesia to mitigate pain.                                                                                                                                                                                                                                                                                                          | Moderate                                        | Strong                     |
| 10. Standard anesthetic protocol                       | General anesthesia with TIVA is recommended.                                                                                                                                                                                                                                                                                                                         | Moderate                                        | Strong                     |
| 11. Preventing intraoperative hypothermia              | Preoperative and intraoperative measures, such as forced air, to prevent hypothermia should be instituted. Temperature monitoring is required to ensure the patient's body temperature is maintained above 36°C.                                                                                                                                                     | Moderate                                        | Strong                     |
| 12. Perioperative intravenous fluid management         | Overresuscitation or underresuscitation of fluids should be avoided and water and electrolyte balance should be maintained. Goal-directed therapy is a useful method of achieving these goals. Balanced crystalloid solutions, rather than saline, is recommended. Vasopressors are recommended to support fluid management and do not negatively affect free flaps. | Moderate                                        | Strong                     |
| 13. Postoperative analgesia                            | Multimodal postoperative pain management regimens are opioid-sparing and should be used.                                                                                                                                                                                                                                                                             | High                                            | Strong                     |
| 14. Early feeding                                      | Patients should be encouraged to take fluids and food orally as soon as possible, preferably within 24 hr after surgery.                                                                                                                                                                                                                                             | Moderate                                        | Strong                     |
| 15. Postoperative flap monitoring                      | Flap monitoring within the first 72 hr should occur frequently. Clinical evaluation is sufficient for monitoring, with implantable Doppler devices recommended in cases of buried flaps.                                                                                                                                                                             | Moderate                                        | Strong                     |
| 16. Postoperative wound management                     | For incisional closure, conventional sutures are recommended. Complex wounds following skin necrosis are treatable with debridement and negative-pressure wound therapy.                                                                                                                                                                                             | High (sutures) Moderate (NPWT)                  | Strong                     |
| 17. Early mobilization                                 | Patients should be mobilized within the first 24 hr after surgery.                                                                                                                                                                                                                                                                                                   | Moderate                                        | Strong                     |

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| Item                                                                                                                                    | Recommendation                                                                                                                 | Evidence Level | Recommendation Grade |
|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|
| 18 Postdischarge home support and physiotherapy                                                                                         | Early physiotherapy, supervised exercise programs, and other supportive care initiatives should be instituted after discharge. | Moderate       | Strong               |
| BMI, body mass index; CTA, computed tomographic angiography; TIVA, total intravenous anesthesia; NPWT, negative-pressure wound therapy. |                                                                                                                                |                |                      |

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## Study Supports Safety of Outpatient Plastic Surgery Procedures

Thursday, March 29, 2018

A study including over 20 years of data and more 26,000 cases supports the safety of outpatient plastic surgery procedures—performed by qualified plastic surgeons, at an accredited outpatient surgical center, reports the April issue of *Plastic and Reconstructive Surgery*®, the official medical journal of the [American Society of Plastic Surgeons](#) (ASPS).

"We conclude that for a majority of patients, the overall risk is very low for performing plastic surgery in the outpatient setting," write Rod J. Rohrich, MD, and colleagues from the Dallas Plastic Surgery Institute. "However, certain precautions should be considered to optimize safety of all patients and reduce adverse outcomes." Dr. Rohrich is Editor-in-Chief of *Plastic and Reconstructive Surgery*®.

### Low Complication Rate after Outpatient Plastic Surgery

The researchers analyzed 26,302 consecutive outpatient plastic surgery procedures performed between 1995 and 2017. All procedures were performed by board-certified plastic surgeons, at the authors' [accredited outpatient surgical facility](#).

Breast surgeries such as breast augmentation were the most common type of procedure, followed by facial cosmetic surgery and liposuction. The researchers analyzed the rates and types of complications, including factors associated with an increased risk of complications. The study focused on complications occurring within the first 48 hours after surgery.

Overall, some type of complication occurred in just under one percent of patients (0.98 percent). This included 203 complications requiring a return to the operating room (OR), a rate of 0.78 percent. More than 80 percent of complications requiring return to the OR were hematoma: a collection of blood under the skin.

Less-common complications included infections, occurring at a rate of 0.06 percent; and blood clot-related complications, 0.05 percent. Two patients died: one of cardiac arrest and one with a blood clot-related complication. Both patients underwent combined procedures and were being monitored in hotel suites at the surgical center when the complications were first detected.

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Patients undergoing combined procedures were at higher risk of complications. Other risk factors were higher body mass index, larger volumes of liposuction, and longer surgical times. Based on their experience, Dr. Rohrich and colleagues recommend postoperative monitoring in a nursing facility—surgical center or hospital—for obese patients (body mass index 30 or higher); surgeries lasting more than four hours; very large liposuction volumes (more than three liters); or combined procedures, especially abdominoplasty with liposuction.

In 2015, more than 90 percent of cosmetic plastic surgery procedures were performed on an outpatient basis, either a freestanding surgical center or office setting. The new study provides needed data on the safety of outpatient cosmetic surgery, when performed by Board-certified plastic surgeons in a surgical center with appropriate staffing and patient monitoring capability.

"Plastic surgery is safe to perform in an accredited outpatient facility for a majority of patients," Dr. Rohrich and colleagues write. Their experience updates a 2003 report, also published in Plastic and Reconstructive Surgery, which outlined a model for optimal patient safety.

Dr. Rohrich adds, "Our study provides evidence-based recommendations for patient safety in the outpatient plastic surgery setting, as well as recommendations to limit postoperative complications and hospital admission rates."

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### About Plastic and Reconstructive Surgery

For over 75 years, Plastic and Reconstructive Surgery® has been the one consistently excellent reference for every specialist who uses plastic surgery techniques or works in conjunction with a plastic surgeon. The official journal of the American Society of Plastic Surgeons, Plastic and Reconstructive Surgery® brings subscribers up-to-the-minute reports on the latest techniques and follow-up for all areas of plastic and reconstructive surgery, including breast reconstruction, experimental studies, maxillofacial reconstruction, hand and microsurgery, burn repair and cosmetic surgery, as well as news on medico-legal issues.

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#### About ASPS

The American Society of Plastic Surgeons (ASPS) is the largest organization of board-certified plastic surgeons in the world. Representing more than 11,000 physician members worldwide, the society is recognized as a leading authority and information source on cosmetic and reconstructive plastic surgery. Founded in 1931, the society represents physicians certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada.

#### About Wolters Kluwer

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## **ATTACHMENT 13**

### **Alternatives**

The Applicant explored several options before submitting this application to the Board requesting these categories of service for Schaumburg Plastic Surgery Center LLC ("SPSC").

Among other options, the Applicant considered maintaining the status quo, seeking out other ASTC's or Hospitals, or the Project as Proposed. For the reasons stated below, Applicant opted to seek the Project as Proposed.

#### **Alternative #1: Maintain the Status Quo (No additional Cost)**

The Applicant currently performs limited procedures within an office-based setting appropriate for minor surgical interventions. Maintaining this model would require no additional capital expenditure. However, this alternative was rejected because an office-based setting is structurally limited in scope. It does not allow for the performance of higher-acuity outpatient procedures requiring enhanced anesthesia capabilities. Without licensure as an ASTC, it would limit the ability to accommodate additional plastic surgeons outside of the same practice. Maintaining the status quo would limit procedural scope and volume growth. In the long term, it would constrain patient access and restrict the Applicant's ability to meet demonstrated demand from referring physicians and additional plastic surgeons. Accordingly, this alternative was not selected.

#### **Alternative #2: Utilization of Existing ASTCs and Hospital Surgical Suites (No financial cost to business / Significant cost to patient and payer)**

The Applicant evaluated relying upon existing multispecialty ASTCs and hospital outpatient departments within the 10-mile service area. While this alternative requires no capital investment by the Applicant, it presents substantial limitations. Most existing ASTCs are built around orthopedic, ophthalmologic, or GI service lines and are not equipped with specialized plastic surgery adjunct technologies. There are also scheduling and access constraints to consider. Complex reconstructive cases are often deprioritized in hospital operating room block scheduling due to longer case times. Finally, hospital outpatient departments carry materially higher facility fees compared to ASC reimbursement rates. Accordingly, this alternative was rejected.

#### **Alternative #3: Project as Proposed**

The Applicant after evaluating all alternatives including maintaining the status quo, outsourcing procedures to hospitals or existing ASTCs, and entering joint venture arrangements, the Applicant determined that the Project as proposed represents the most appropriate and cost-effective method of meeting the identified access gaps within the market area. The proposed ASTC balances capital investment with demonstrable improvements in access, quality, continuity of care, and long-term cost efficiency.

## **ATTACHMENT 14**

### **Size of the Project**

The square footage identified in this application for the proposed project, includes one operating room, multiple recovery stations is necessary, not excessive, and consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below.

| SIZE OF PROJECT         |                       |                                 |            |                  |
|-------------------------|-----------------------|---------------------------------|------------|------------------|
| DEPARTMENT/SERVICE      | PROPOSED<br>BGSF/DGSF | STATE<br>STANDARD               | DIFFERENCE | MET<br>STANDARD? |
| ASTC (1 Operating Room) | 1,688                 | 2,750 GSF per<br>treatment room | 1,062      | YES              |

## ATTACHMENT 15

### Project Service Utilization

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish one operating rooms, making the objective for demonstrating utilization through procedures necessary to utilize this operating room.

| UTILIZATION |                        |                                                               |                          |                   |                   |
|-------------|------------------------|---------------------------------------------------------------|--------------------------|-------------------|-------------------|
|             | DEPARTMENT/<br>SERVICE | HISTORICAL UTILIZATION<br>(PATIENT DAYS)<br>(TREATMENTS) ETC. | PROJECTED<br>UTILIZATION | STATE<br>STANDARD | MEET<br>STANDARD? |
| YEAR 1      | ASTC                   | 496                                                           | 496                      | 1500 hours        | YES               |
| YEAR 2      | ASTC                   | 496                                                           | 510                      | 1500 hours        | YES               |

The number of 496 predicated referrals are derived from patients and procedures emanating directly from current patients of Dr. Kapadia. In the last 12 months there have been 496 patients served through Kapadia Plastic Surgery for a total of 1174 utilized surgical hours. Dr. Kapadia's average procedure time is 142 minutes per procedure. That is broken by facility as follows:

|                                               |              |                           |                     |
|-----------------------------------------------|--------------|---------------------------|---------------------|
| <b>ASC Facilities</b>                         |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Ascension Alexian Brothers, Ambulatory Center | 19           | 1.08                      | 20.46               |
| Associated Surgical Center Arlington Heights  | 14           | 4.35                      | 60.86               |
| MD Brothers                                   | 1            | 5.42                      | 5.42                |
| Oakbrook Surgical Center                      | 8            | 4.73                      | 37.82               |
| <b>ASC Total</b>                              | <b>42</b>    |                           | <b>124.56 hours</b> |
| <b>Hospital Facilities</b>                    |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Advocate Illinois Masonic Medical Center      | 40           | 2.62                      | 104.68              |
| Ascension Alexian Brothers                    | 170          | 2.3                       | 391                 |
| Ascension Saint Alexius                       | 126          | 2.75                      | 345.99              |
| Ascension Saint Joseph                        | 27           | 2.72                      | 73.36               |
| Good Shepherd Surgical Center                 | 7            | 2.42                      | 16.92               |
| Resurrection Medical Center                   | 6            | 2.42                      | 14.5                |
| <b>Hospital Total</b>                         | <b>376</b>   |                           | <b>946.45 hours</b> |
| <b>Office-Based Settings</b>                  |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Elk Grove KPS Office                          | 76           | 1.33                      | 101.85              |
| Sheridan KPS Office                           | 2            | 0.92                      | 1.83                |
| <b>Office Total</b>                           | <b>78</b>    |                           | <b>103.68 hours</b> |

## ATTACHMENT 15

### Project Service Utilization

The projected Year 1 utilization for the proposed ASTC is 496 procedures, which equates to approximately 1,174 operating room hours, based on an average procedure time of 142 minutes per case, inclusive of room preparation and clean-up. In Year 2, projected utilization increases to 510 procedures, equating to approximately 1,209 operating room hours. These projections are derived from documented historical patient volumes and reflect procedures that are currently being performed by Dr. Kapadia within the defined geographic service area. The utilization assumptions incorporate a conservative growth rate of approximately 3% from Year 1 to Year 2, reflecting modest organic expansion rather than aggressive volume assumptions. Notably, these projections do not account for the open staff model of the proposed ASTC or the anticipated participation of additional plastic surgeons who have expressed interest in utilizing the facility. As such, the projections represent a conservative baseline rather than maximum anticipated capacity.

Based on these documented volumes and conservative growth assumptions, the Applicant submits that the proposed project satisfies the applicable utilization standards for operation of one (1) operating room under Illinois Health Facilities and Services Review Board requirements. The projected utilization demonstrates an appropriate balance between demonstrated need and reasonable capacity, thereby justifying approval of the proposed project.

|                                                                       |       |
|-----------------------------------------------------------------------|-------|
| State Standard for One Operating Room (in hours)                      | 1500  |
| Proposed Facility Utilization (in minutes)                            | 70432 |
| Proposed Facility Utilization Year 1 (in hours)                       | 1174  |
| Total Projected Referrals in Year 1                                   | 496   |
| Total Projected Referrals in Year 2                                   | 510   |
| Average Procedure Time (Including Room Prep, Procedure, and Clean-up) | 142   |
|                                                                       |       |
| Operational Days                                                      | 250   |
| Average Hours of Operation                                            | 7.5   |
| Total Available Procedure Hours (Per Operating Room)                  | 1875  |
| Number of Operating Rooms                                             | 1     |
|                                                                       |       |
| First Year Proposed Hours                                             | 1174  |
| First Year Utilization (Operating Room 1)                             | 63%   |
| Second Year Proposed Procedures                                       | 1209  |
| Second Year Utilization (Operating Room 1)                            | 64%   |

## **ATTACHMENT 16**

### **Unfinished or Shell Space**

NOT APPLICABLE – the proposed project does not include plans for shell space.

## **ATTACHMENT 17**

### **Assurances**

NOT APPLICABLE – the proposed project does not include plans for shell space.

## **ATTACHMENT 25**

### **Non-Hospital Based Ambulatory Services to GSA Residents - 1110.235(C)(2)(B)**

The proposed project is necessary to meet the needs of the residents of the planning area as noted in this application. The project involves establishing a new ASTC in Cook County. This sole-service plastic surgery ASTC will have ample capacity to meet the needs of patients in the area.

The proposed project is necessary to meet the needs of residents within the defined Geographic Service Area ("GSA"). The project involves the establishment of a single-operating-room, specialty-focused Ambulatory Surgical Treatment Center ("ASTC") in Cook County. The proposed ASTC is appropriately scaled to serve existing documented demand and will operate with one operating room, consistent with projected utilization and State standards.

The primary purpose of the proposed project is to provide medically necessary outpatient plastic and reconstructive surgical services to residents of the Geographic Service Area in which the ASTC will be physically located. In accordance with 77 Ill. Adm. Code §1110.235(c)(2)(B) and §1100.510(d), the Geographic Service Area consists of all zip code areas located within a 10-mile radius of the proposed ASTC site at 1321 Tower Road, Schaumburg, Illinois. A map depicting the multidirectional travel radius from the proposed site is enclosed with this Attachment.

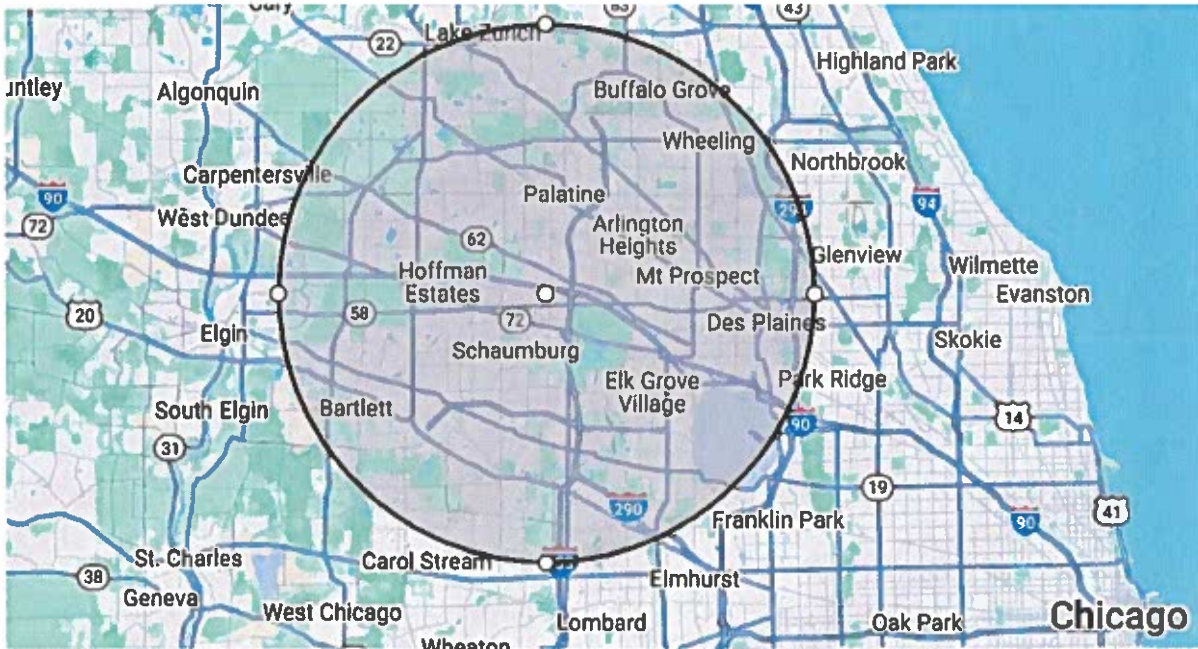
The Applicant has analyzed patient origin data for the most recent twelve-month period. Based on documented case volume totaling 496 procedures, approximately 72 percent of patients reside within zip codes located inside the defined 10-mile Geographic Service Area. High-volume GSA zip codes include:

- 60007 (Elk Grove Village)
- 60107 (Streamwood)
- 60194 and 60195 (Schaumburg)
- 60193 (Roselle)
- 60067 (Palatine)
- 60169 (Hoffman Estates)
- 60010 (Barrington)
- 60103 (Bartlett)
- 60108 (Bloomington)
- 60133 (Hanover Park)
- 60056 (Mount Prospect)
- 60101 (Addison)

This documented patient origin information confirms that well in excess of the required 50 percent threshold of admissions originates from residents of the defined GSA. The data demonstrate that the proposed ASTC is intended primarily to serve local residents rather than to attract patients from distant markets. The documented patient origin data, conservative utilization projections, and concentration of cases within the defined GSA demonstrate that the proposed project is responsive to existing local demand.

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Services to GSA Residents -**  
**1110.235(C)(2)(B)**

10-Mile Radius from 1321 Tower Road, Schaumburg, IL 60173



**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Services to GSA Residents -**  
**1110.235(C)(2)(B)**

| <b>Zip Code</b> | <b>City</b>       | <b>Population<br/>(2020 Census)</b> |
|-----------------|-------------------|-------------------------------------|
| 60173           | Schaumburg        | 13,764                              |
| 60008           | Rolling Meadows   | 22,760                              |
| 60195           | Schaumburg        | 5,150                               |
| 60194           | Schaumburg        | 20,622                              |
| 60005           | Arlington Heights | 30,221                              |
| 60067           | Palatine          | 39,324                              |
| 60007           | Elk Grove Village | 33,670                              |
| 60193           | Roselle           | 40,805                              |
| 60169           | Hoffman Estates   | 34,248                              |
| 60004           | Arlington Heights | 52,546                              |
| 60074           | Palatine          | 37,705                              |
| 60143           | Itasca            | 11,214                              |
| 60157           | Medinah           | 2,668                               |
| 60172           | Roselle           | 24,560                              |
| 60056           | Mount Prospect    | 57,177                              |
| 60191           | Wood Dale         | 14,456                              |
| 60070           | Prospect Heights  | 15,840                              |
| 60107           | Streamwood        | 39,535                              |
| 60133           | Hanover Park      | 37,494                              |
| 60108           | Bloomington       | 23,070                              |
| 60016           | Des Plaines       | 61,888                              |
| 60090           | Wheeling          | 39,017                              |
| 60106           | Bensenville       | 20,562                              |
| 60018           | Des Plaines       | 30,051                              |
| 60101           | Addison           | 37,644                              |
| 60192           | Hoffman Estates   | 16,550                              |
| 60089           | Buffalo Grove     | 43,227                              |
| 60139           | Glendale Heights  | 33,196                              |
| 60010           | Barrington        | 46,365                              |
| 60103           | Bartlett          | 41,740                              |
| <b>TOTAL</b>    |                   | <b>915,269</b>                      |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery Service Demand -**  
**Establishment of an ASTC - 1110.235(C)(3)**

The Applicant documents that the proposed project is necessary to accommodate documented service demand experienced annually. The projected establishment of Schaumburg Plastic Surgery Center LLC ("SPSC") is supported by historical referral patterns, documented procedural volume, and conservative forward-looking projections based on existing caseload. The Applicant has included a physician referral letter and supporting documentation consistent with 77 Ill. Adm. Code §1110.235(c)(3), which substantiates both historical and projected service demand.

During the most recent 12-month period, Dr. Kapadia and referring physicians directed plastic and reconstructive surgical cases to facilities located within the defined Geographic Service Area. Over that period, a total of 496 outpatient procedures were performed at existing licensed facilities within the GSA. These historical referrals establish that the demand underlying this application is not speculative, but rather reflects existing, ongoing utilization of outpatient plastic surgery services.

Referral letters verify the total number of patients, by zip code of residence, who have received outpatient surgical care at facilities located within the GSA during the 12-month period prior to submission of this application. Patient origin analysis demonstrates that approximately 72 percent of projected Year 1 procedures originate from zip codes within the defined Geographic Service Area. This exceeds the required 50 percent threshold and confirms that the project is intended primarily to serve local residents.

Accordingly, the Applicant respectfully submits that the proposed project satisfies the Service Demand criteria set forth in 77 Ill. Adm. Code §1110.235(c)(3).

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery Service Demand -**  
**Establishment of an ASTC - 1110.235(C)(3)**



January 12, 2026

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

**Re: Schaumburg Plastic Surgery Center LLC - Physician Referral Letter**

Dear Mr. Kniery,

My name is Sameer Kapadia, M.D., and I am Plastic Surgeon and CEO of Kapadia Plastic Surgery. This letter contains the referral documentation required per 77 Ill. Admin. Code Section 1110.235(c)(3)(A)-(B). During the 12-month period prior to submission of this letter, I referred a total of 496 outpatient procedures to various healthcare facilities described below.

| Facility Type | Facility                                     |     |
|---------------|----------------------------------------------|-----|
| ASC           | Ascension Alexian Brothers Ambulatory Center | 19  |
|               | Associated Surgical Center Arlington Heights | 11  |
|               | MD Brothers                                  | 1   |
|               | Oakbrook Surgical Center                     | 8   |
| Hospital      | Advocate Illinois Masonic Medical Center     | 40  |
|               | Ascension Alexian Brothers                   | 170 |
|               | Ascension Saint Alexius                      | 126 |
|               | Ascension Saint Joseph                       | 27  |
|               | Good Shepherd Surgical Center                | 7   |
|               | Resurrection Medical Center                  | 8   |
|               | Elk Grove KPS Office                         | 76  |
| Office        | Sheridan KPS Office                          | 2   |

Based on these historical referrals, our doctors anticipate referring 496 surgical cases each year to Schaumburg Plastic Surgery Center. Enclosed with this letter is a list of patient origin by zip code of residence. I certify that the patients we propose to refer reside within the applicant's proposed geographic service area.

We further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and accurate to the best of my knowledge.



1321 Tower Rd, Schaumburg, IL 60173

+1 (312) 872-8514

schaumburgplasticsurgerycenter.com

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery Service Demand -**  
**Establishment of an ASTC - 1110.235(C)(3)**

Thank you,

Sameer Kapadia, M.D.

Physician's Signature  Date 01/12/2026

(Please Print/Type Name) SAMEER M KAPADIA  
Signature of Notary:

Subscribed and sworn to before me

this 13<sup>th</sup> day of January 2026

Elaine H Kanellakis



**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery Service Demand -**  
**Establishment of an ASTC - 1110.235(C)(3)**

| ZIP Code | Patient Volume |
|----------|----------------|
| 60007    | 60             |
| 60107    | 43             |
| 60194    | 33             |
| 60193    | 42             |
| 60010    | 29             |
| 60067    | 39             |
| 60102    | 18             |
| 60657    | 28             |
| 60169    | 27             |
| 60103    | 17             |
| 60640    | 17             |
| 60188    | 27             |
| 60177    | 36             |
| 60108    | 26             |
| 60133    | 16             |
| 60056    | 16             |
| 60195    | 6              |
| 60516    | 6              |
| 60110    | 5              |
| 60101    | 5              |

## ATTACHMENT 25

### Non-Hospital Based Ambulatory Surgery - Treatment Room Assessment 1110.235(C)(4)

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish one operating room, making the objective for demonstrating utilization through procedures necessary to utilize this operating room.

| UTILIZATION |                        |                                                               |                          |                   |                   |
|-------------|------------------------|---------------------------------------------------------------|--------------------------|-------------------|-------------------|
|             | DEPARTMENT/<br>SERVICE | HISTORICAL UTILIZATION<br>(PATIENT DAYS)<br>(TREATMENTS) ETC. | PROJECTED<br>UTILIZATION | STATE<br>STANDARD | MEET<br>STANDARD? |
| YEAR 1      | ASTC                   | 496                                                           | 496                      | 1500 hours        | YES               |
| YEAR 2      | ASTC                   | 496                                                           | 510                      | 1500 hours        | YES               |

The number of 496 predicated referrals are derived from patients and procedures emanating directly from current patients of Dr. Kapadia. In the last 12 months there have been 496 patients served through Kapadia Plastic Surgery for a total of 1174 utilized surgical hours. Dr. Kapadia's average procedure time is 142 minutes per procedure. That is broken by facility as follows:

|                                               |              |                           |                     |
|-----------------------------------------------|--------------|---------------------------|---------------------|
| <b>ASC Facilities</b>                         |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Ascension Alexian Brothers, Ambulatory Center | 19           | 1.08                      | 20.46               |
| Associated Surgical Center Arlington Heights  | 14           | 4.35                      | 60.86               |
| MD Brothers                                   | 1            | 5.42                      | 5.42                |
| Oakbrook Surgical Center                      | 8            | 4.73                      | 37.82               |
| <b>ASC Total</b>                              | <b>42</b>    |                           | <b>124.56 hours</b> |
| <b>Hospital Facilities</b>                    |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Advocate Illinois Masonic Medical Center      | 40           | 2.62                      | 104.68              |
| Ascension Alexian Brothers                    | 170          | 2.3                       | 391                 |
| Ascension Saint Alexius                       | 126          | 2.75                      | 345.99              |
| Ascension Saint Joseph                        | 27           | 2.72                      | 73.36               |
| Good Shepherd Surgical Center                 | 7            | 2.42                      | 16.92               |
| Resurrection Medical Center                   | 6            | 2.42                      | 14.5                |
| <b>Hospital Total</b>                         | <b>376</b>   |                           | <b>946.45 hours</b> |
| <b>Office-Based Settings</b>                  |              |                           |                     |
| <b>Facility</b>                               | <b>Cases</b> | <b>Avg Length (hours)</b> | <b>Total Hours</b>  |
| Elk Grove KPS Office                          | 76           | 1.33                      | 101.85              |
| Sheridan KPS Office                           | 2            | 0.92                      | 1.83                |
| <b>Office Total</b>                           | <b>78</b>    |                           | <b>103.68 hours</b> |

## ATTACHMENT 25

### Non-Hospital Based Ambulatory Surgery - Treatment Room Assessment 1110.235(C)(4)

The projected Year 1 utilization for the proposed ASTC is 496 procedures, which equates to approximately 1,174 operating room hours, based on an average procedure time of 142 minutes per case, inclusive of room preparation and clean-up. In Year 2, projected utilization increases to 510 procedures, equating to approximately 1,209 operating room hours. These projections are derived from documented historical patient volumes and reflect procedures that are currently being performed by Dr. Kapadia within the defined geographic service area. The utilization assumptions incorporate a conservative growth rate of approximately 3% from Year 1 to Year 2, reflecting modest organic expansion rather than aggressive volume assumptions. Notably, these projections do not account for the open staff model of the proposed ASTC or the anticipated participation of additional plastic surgeons who have expressed interest in utilizing the facility. As such, the projections represent a conservative baseline rather than maximum anticipated capacity.

Based on these documented volumes and conservative growth assumptions, the Applicant submits that the proposed project satisfies the applicable utilization standards for operation of one (1) operating room under Illinois Health Facilities and Services Review Board requirements. The projected utilization demonstrates an appropriate balance between demonstrated need and reasonable capacity, thereby justifying approval of the proposed project.

|                                                                       |       |
|-----------------------------------------------------------------------|-------|
| State Standard for One Operating Room (in hours)                      | 1500  |
| Proposed Facility Utilization (in minutes)                            | 70432 |
| Proposed Facility Utilization Year 1 (in hours)                       | 1174  |
| Total Projected Referrals in Year 1                                   | 496   |
| Total Projected Referrals in Year 2                                   | 510   |
| Average Procedure Time (Including Room Prep, Procedure, and Clean-up) | 142   |
|                                                                       |       |
| Operational Days                                                      | 250   |
| Average Hours of Operation                                            | 7.5   |
| Total Available Procedure Hours (Per Operating Room)                  | 1875  |
| Number of Operating Rooms                                             | 1     |
|                                                                       |       |
| First Year Proposed Hours                                             | 1174  |
| First Year Utilization (Operating Room 1)                             | 63%   |
| Second Year Proposed Procedures                                       | 1209  |
| Second Year Utilization (Operating Room 1)                            | 64%   |

## **ATTACHMENT 25**

### **Non-Hospital Based Ambulatory Surgery - Service Accessibility 1110.235(C)(6)**

The proposed ASTC services are necessary to improve access for residents of the defined Geographic Service Area ("GSA"). The Applicant documents that the conditions described in 77 Ill. Adm. Code §1110.235(c)(4)(C) exist within the GSA, specifically that certain ASTC services and specific types of procedures that are components of plastic surgery services are not currently available in a dedicated, appropriately equipped outpatient setting within the GSA.

While several IDPH-licensed ambulatory surgical centers operate within the 10-mile GSA, the majority are multispecialty facilities primarily focused on orthopedics, pain management, gastroenterology, ophthalmology, podiatry, or general surgery. Although some facilities list plastic surgery among their approved service categories, none within the GSA operate as a dedicated plastic surgery-focused ASTC.

Complex reconstructive procedures including staged breast reconstruction following mastectomy, lipedema surgery, revision reconstructive procedures, and gender-affirmation surgery require specialized equipment, anesthesia capabilities, sterile processing infrastructure, and workflow design that are not standard in most multispecialty ASC environments. The absence of a specialty-focused plastic surgery ASC within the GSA limits scheduling availability and reduces access for patients requiring time-intensive or equipment-dependent procedures.

In the absence of a dedicated plastic surgery ASTC, a substantial portion of these procedures are performed in hospital outpatient departments. Historical utilization data demonstrate that more than 80 percent of current procedural hours occur in hospital settings. While hospitals provide necessary surgical capacity, they are not optimized for outpatient plastic surgery cases that combine reconstructive and self-pay components, require extended operating time, or involve specialized adjunct technologies.

Hospitals frequently prioritize higher-volume surgical service lines in operating room scheduling. As a result, complex plastic and reconstructive cases may experience extended scheduling delays. These delays disproportionately affect women undergoing breast reconstruction following cancer treatment, patients with chronic lipedema requiring staged intervention, and individuals seeking medically necessary gender-affirming procedures.

The Applicant has documented that existing facilities within the GSA are not built for plastic surgery workflows; do not routinely maintain specialized plastic surgery technologies and operate within multispecialty scheduling models that may deprioritize longer reconstructive plastic surgery cases. These conditions create functional access barriers even where plastic surgery is technically listed as an approved service.

The proposed ASTC will improve accessibility by providing a dedicated, specialty-focused outpatient environment for reconstructive and restorative plastic surgery procedures and offering predictable scheduling for time-intensive cases. The facility is appropriately scaled with one operating room and conservative utilization projections, ensuring that it responds to documented demand without creating excess capacity. The proposed project directly addresses this gap and improves access for residents of the Geographic Service Area consistent with 77 Ill. Adm. Code §1110.235(c)(4)(C). Accordingly, the Applicant respectfully submits that the proposed ASTC satisfies the Service Accessibility criteria.

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Unnecessary Duplication/Maldistribution, Impact on Area Providers -**  
**1110.235(C)(7)(A)-(C)**

The proposed project will not result in an unnecessary duplication of services within the Geographic Service Area ("GSA"). Based on the 2020 U.S. Census population data for the identified zip codes, the total population of the GSA exceeds 915,269 residents. A list of IDPH-licensed ambulatory surgical centers and hospital outpatient departments that operate within the GSA and provide some level of surgical services are enclosed with this Attachment. Although several of these facilities list plastic surgery among their approved service categories, none operate as a dedicated plastic-surgery-focused ASTC. The majority are multispecialty centers primarily designed for orthopedic, gastrointestinal, ophthalmologic, podiatric, or general surgical services. The proposed project therefore does not duplicate an existing specialty-focused plastic surgery facility, but rather introduces a single operating room dedicated to reconstructive and restorative plastic surgery within a large, established suburban population base.

The GSA population exceeds one million residents. The proposed project adds only one (1) operating room to an area already characterized by large multispecialty facilities serving diverse surgical lines. Given the substantial population base, the addition of a single specialty-focused operating room does not result in an excessive surgical room-to-population ratio and does not approach one and one-half times the State average. The proposed project does not rely on diverting substantial volume from underutilized facilities. Historical case data demonstrate that more than 80 percent of the Applicant's current procedural hours are performed in hospital outpatient departments.

Of the fourteen (14) ASTCs identified within the defined Geographic Service Area, only five (5) list plastic surgery among their approved service categories. Each of these facilities operates as a multispecialty center primarily dedicated to other dominant service lines such as orthopedics, gastroenterology, pain management, or ophthalmology. None functions as a plastic-surgery-focused ASTC. In addition, publicly available payer data reflect low Medicaid participation rates among these facilities, further limiting access for publicly insured patients. Moreover, Northwest Surgicare has transitioned its operational focus exclusively to ophthalmology services; Northwest Community Day Surgery Center functions as an outpatient extension of Endeavor Northwest Community Hospital; and Ashton Center for Day Surgery was recently acquired by an orthopedic-focused ownership group and is expected to concentrate primarily on orthopedic procedures. These structural and operational realities demonstrate that, while plastic surgery may technically appear on certain service lists, the existing ASC landscape within the GSA does not provide a dedicated, broadly accessible, plastic surgery-centered outpatient environment. The proposed project therefore fills a specialty access gap rather than duplicating a comparable facility.

The project primarily shifts cases from hospital-based operating rooms to a lower-cost, appropriately licensed ASC setting. It does not depend on capturing volume from underutilized single-specialty plastic surgery facilities because none exist within the GSA. The size of the GSA population alone provides sufficient volume to support one operating room.

Within 24 months after project completion, the proposed ASTC will not lower the utilization of other area providers below the standards specified in 77 Ill. Adm. Code 1100. The projected volume represents documented historical caseload currently performed in hospital outpatient departments and does not rely on reallocation of cases from specialty-focused ASC competitors. The modest Year 1 and Year 2 projections reflect conservative continuation of existing volume rather than aggressive market capture. The proposed project does not rely upon drawing volume from facilities currently operating below utilization standards. Instead, it provides a specialty-focused setting for cases already being performed within the GSA, primarily in hospital outpatient departments. Accordingly, the Applicant respectfully submits that the proposed project will not result in unnecessary duplication or maldistribution of services within the Geographic Service Area.

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Unnecessary Duplication/Maldistribution, Impact on Area Providers -**  
**1110.235(C)(7)(A)-(C)**

Facilities within 10 miles of 1321 Tower Road, Schaumburg, IL 60173:

| <b>Facility</b>                                                                                      | <b>Distance from ASTC</b> | <b>Services</b>                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Specialty Surgicare, Ltd.<br>500 W. Golf Road, Suite 102<br>Schaumburg, IL 60195                     | 2.8 miles                 | -Orthopedic<br>-Pain Management                                                                                                                                                                                        |
| Schaumburg Surgery Center, LLC<br>929 W. Higgins Road<br>Schaumburg, IL 60195                        | 3.4 miles                 | -Orthopedic<br>-Pain Management<br>-Podiatry                                                                                                                                                                           |
| Illinois Hand & Upper Extremity Center<br>515 W. Algonquin Road<br>Arlington Heights, IL 60005       | 3.4 miles                 | -Orthopedic                                                                                                                                                                                                            |
| Northwest Surgicare<br>1100 W. Central Road<br>Arlington Heights, IL 60005                           | 4.1 miles                 | -General Surgery<br>-Laser Eye Surgery<br>-Neurological<br>-Ophthalmology<br>-Orthopedic<br>-Otolaryngology<br>-Pain Management<br>-Plastic Surgery<br>-Podiatry                                                       |
| Northwest Endo Center LLC<br>1415 S. Arlington Heights Road<br>Arlington Heights, IL 60005           | 4.1 miles-                | -Gastro-Intestinal                                                                                                                                                                                                     |
| Northwest Community Day Surgery Center<br>675 West Kirchoff Road<br>Arlington Heights, IL 60005      | 4.1 miles                 | -Cardiovascular<br>-Gastroenterology<br>-General Surgery<br>-OB/Gynecology<br>-Ophthalmology<br>-Oral/Maxillofacial<br>-Orthopedic<br>-Otolaryngology<br>-Pain Management<br>-Plastic Surgery<br>-Podiatry<br>-Urology |
| Hoffman Estates Surgery Center<br>1555 Barrington Road DOB 3, Suite 400<br>Hoffman Estates, IL 60169 | 5.7 miles                 | -General Surgery<br>-OB/Gynecology<br>-Ophthalmology<br>-Orthopedic<br>-Otolaryngology<br>-Pain Management<br>-Plastic Surgery<br>-Podiatry<br>-Urology                                                                |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Unnecessary Duplication/Maldistribution, Impact on Area Providers -**  
**1110.235(C)(7)(A)-(C)**

| <b>Facility</b>                                                                                           | <b>Distance from ASTC</b> | <b>Services</b>                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Ophthalmology Surgery Center of Illinois<br>1300 N. Arlington Heights Road, Suite 150<br>Itasca, IL 60143 | 6.3 miles                 | -Ophthalmology<br>-Eye Surgery                                                                                                                 |
| Associated Surgical Center<br>129 W. Rand Road<br>Arlington Heights, IL 60004                             | 7.6 miles                 | -Gastroenterology<br>-General Surgery<br>-OB/Gynecology<br>-Orthopedic<br>-Otolaryngology<br>-Pain Management<br>-Plastic Surgery<br>-Podiatry |
| Northwest Community Foot and Ankle Center, LLC<br>1455 Golf Road<br>Des Plaines, IL 60016                 | 8.7 miles                 | -Orthopedic<br>-Podiatry                                                                                                                       |
| Des Plaines Endoscopy Center<br>150 N. River Rd., Suite 215<br>Des Plaines, IL 60016                      | 8.9 miles                 | -Gastro-Intestinal                                                                                                                             |
| Ashton Center for Day Surgery<br>1800 McDonough Road, Suite 100<br>Hoffman Estates 60192                  | 9.3 miles                 | -Orthopedic<br>-Otolaryngology<br>-Pain Management<br>-Plastic Surgery<br>-Podiatry                                                            |
| Innovia Surgery Center, LLC<br>203 E. Irving Park Road<br>Wood Dale, IL 60191                             | 9.3 miles                 | -OB/Gynecology                                                                                                                                 |
| North Suburban Pain and Spine<br>9700 Golf Road<br>Des Plaines, IL 60016                                  | 9.9 miles                 | -Neurological<br>-Orthopedic<br>-Pain Management<br>-General Surgery                                                                           |

## **ATTACHMENT 25**

### **Non-Hospital Based Ambulatory Surgery - Staffing - 1110.235(C)(8)**

The Applicant has carefully evaluated the clinical and professional staffing requirements necessary to operate the proposed Ambulatory Surgical Treatment Center ("ASTC") in full compliance with Illinois Department of Public Health (IDPH) licensure requirements and applicable accreditation standards, including those of The Joint Commission or another nationally recognized accrediting organization.

The proposed ASTC will operate under the direction of Dr. Sameer Kapadia, who will serve as Medical Director. Dr. Kapadia is board certified in plastic surgery and maintains active clinical privileges and professional credentials consistent with nationally recognized standards for competency in plastic and reconstructive surgical services. The Medical Director will be responsible for clinical oversight, peer review, quality assurance, infection control monitoring, and compliance with accreditation standards. This leadership structure ensures that the proposed ASTC will operate in accordance with accepted professional standards and regulatory requirements.

The proposed ASTC will operate one (1) operating room and will be appropriately staffed to support safe, efficient outpatient surgical services. The Applicant anticipates the following core clinical staffing model:

- One (1) Registered Nurse (RN) Circulator assigned to the operating room;
- One to two (1–2) Registered Nurses (RN) assigned to the Post-Anesthesia Care Unit (PACU), depending on daily case volume and acuity;
- One (1) Surgical Assistant;
- One (1) Sterile Processing Department staff member;
- One (1) Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist to provide anesthesia services; and
- PRN clinical and perioperative staff to provide coverage during higher-volume days, extended cases, or staff absences.

This staffing structure reflects standard ambulatory surgical practice for a single-operating-room facility and ensures compliance with patient safety, infection control, anesthesia monitoring, and recovery supervision requirements.

The Applicant has evaluated the availability of qualified nursing, anesthesia, and perioperative personnel within the northwest suburban Cook County labor market. The Applicant anticipates utilizing a combination of direct employment and contracted anesthesia services, consistent with standard ASC operational models. In addition to permanent staff, PRN personnel will be maintained to ensure adequate coverage and compliance with staffing ratios during periods of increased volume. The proposed staffing model satisfies IDPH licensure requirements and is consistent with accreditation standards related to perioperative care, anesthesia administration, infection prevention, emergency preparedness, and quality assurance.

All procedures performed at the proposed ASTC will be conducted under the direction of physicians who are board certified or board eligible in their respective specialties, consistent with applicable professional standards and credentialing requirements. The facility will maintain a formal credentialing and privileging process to ensure that all practitioners meet licensure, training, and competency requirements prior to performing procedures at the ASTC.

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Charge Commitment - 1110.235(C)(9)**



January 20th, 2026

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

**Re: Schaumburg Plastic Surgery Center LLC – Charge Commitment**

Dear Mr. Kniery:

As a representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, M.D., hereby attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I hereby attest that in order to meet the objects of the Illinois Health Facilities Planning Act, which are to improve the financial ability of the public to obtain necessary health services; and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; and cost containment and support for safety net services that we have enclosed a list of CPT codes and a proposed fee schedule. We hereby commit that the charges will not increase, at a minimum, for the first 2 years of operation unless a permit is first obtained pursuant to 77 Ill. Admin. Code §1130.310(a).

Sincerely,

A handwritten signature in black ink, appearing to read "Sameer Kapadia".

Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC

## ATTACHMENT 25

### Non-Hospital Based Ambulatory Surgery - Charge Commitment - 1110.235(C)(9)

A list of the relevant CPT codes, procedures, and charges for the proposed ASTC is included below. In submitting this information, the applicant verifies that it will not increase these charges for a minimum of 24 months.

| CPT Code | Description                                                                                                         | Charge Commitment |
|----------|---------------------------------------------------------------------------------------------------------------------|-------------------|
| 11970    | Replacement of tissue expander with implant                                                                         | \$9,578.28        |
| 12031    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less | \$492.42          |
| 12032    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 2.6 cm to 7.5 cm   | \$554.22          |
| 12034    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 7.6 cm to 12.5 cm  | \$584.91          |
| 12035    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 12.6 cm to 20.0 cm | \$584.91          |
| 12036    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 20.1 cm to 30.0 cm | \$895.65          |
| 12037    | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); over 30.0 cm       | \$2,676.60        |
| 12041    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less                         | \$484.47          |
| 12042    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm                       | \$541.86          |
| 12044    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm                      | \$895.65          |
| 12045    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm                     | \$895.65          |
| 12046    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm                     | \$895.65          |
| 12047    | Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm                           | \$2,676.60        |
| 12051    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less             | \$512.70          |
| 12052    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm           | \$547.14          |
| 12053    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm           | \$584.91          |
| 12054    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm          | \$584.91          |
| 12055    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm         | \$584.91          |
| 12056    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm         | \$584.91          |
| 12057    | Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm               | \$584.91          |
| 13100    | Repair, complex, trunk; 1.1 cm to 2.5 cm                                                                            | \$895.65          |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Charge Commitment - 1110.235(C)(9)**

| <b>CPT Code</b> | <b>Description</b>                                                                                                                                                                                                       | <b>Charge Commitment</b> |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 13101           | Repair, complex, trunk; 2.6 cm to 7.5 cm                                                                                                                                                                                 | \$895.65                 |
| 13102           | Repair, complex, trunk; each additional 5 cm or less (List separately in addition to primary procedure)                                                                                                                  | \$300.00                 |
| 11400           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter 0.5 cm or less                                                                                                         | \$247.98                 |
| 11401           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter 0.6 to 1.0 cm                                                                                                          | \$280.62                 |
| 11402           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter 1.1 to 2.0 cm                                                                                                          | \$311.52                 |
| 11403           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter 2.1 to 3.0 cm                                                                                                          | \$339.75                 |
| 11404           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter 3.1 to 4.0 cm                                                                                                          | \$1,932.33               |
| 11406           | Excision, benign lesion including margins, except skin tag; trunk, arms or legs; excised diameter over 4.0 cm                                                                                                            | \$1,932.33               |
| 14301           | Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq. cm to 60.0 sq. cm                                                                                                                                   | \$5,340.00               |
| 14302           | Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq. cm, or part thereof (Use 14302 in conjunction with 14301)                                                                                  | \$300.00                 |
| 15100           | Split-thickness autograft, trunk, arms, legs; first 100 sq. cm or less, or 1% of body area of infants and children                                                                                                       | \$2,676.60               |
| 15101           | Split-thickness autograft, trunk, arms, legs; each additional 100 sq. cm, or each additional 1% of body area of infants and children, or part thereof (Use 15101 in conjunction with 15100)                              | \$300.00                 |
| 15771           | Grafting autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, legs; 50 cc or less                                                                                                           | \$5,340.00               |
| 15772           | Grafting autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, legs; each additional 50 cc injectate                                                                                         | \$200.00                 |
| 15777           | Biologic implant for soft tissue reinforcement for trunk and breast (eg, acellular dermal matrix)                                                                                                                        | \$1,000.00               |
| 15830           | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy                                                                                                            | \$7,318.11               |
| 15847           | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) | \$8,000.00               |
| 19316           | Mastopexy                                                                                                                                                                                                                | \$7,318.11               |
| 19318           | Breast reduction                                                                                                                                                                                                         | \$7,318.11               |
| 19325           | Breast augmentation with implant                                                                                                                                                                                         | \$8,660.40               |
| 19328           | Removal of intact breast implant                                                                                                                                                                                         | \$4,196.10               |
| 19342           | Insertion of breast implant on separate day of mastectomy                                                                                                                                                                | \$8,660.40               |
| 19357           | Tissue expander placement in breast reconstruction, including subsequent expansion(s)                                                                                                                                    | \$14,506.77              |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Charge Commitment - 1110.235(C)(9)**

| <b>CPT Code</b> | <b>Description</b>                                                                                                                                                 | <b>Charge Commitment</b> |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 19370           | Revision peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy                                                          | \$4,196.10               |
| 19371           | Peri-implant capsulectomy, breast, complete, including removal of all intra-capsular contents                                                                      | \$4,196.10               |
| 19380           | Revision of reconstructed breast                                                                                                                                   | \$7,318.11               |
| 19120           | Excision of cyst/fibroadenoma/other benign or malignant tumor/aberrant breast tissue/duct lesion/nipple or areolar lesion, open, male or female, 1 or more lesions | \$4,196.10               |
| 19330           | Removal of ruptured breast implant, including implant contents                                                                                                     | \$4,196.10               |
| 19303           | Mastectomy, simple, complete                                                                                                                                       | \$7,318.11               |
| 19350           | Nipple/areolar reconstruction                                                                                                                                      | \$4,196.10               |
| 19300           | Mastectomy for gynecomastia                                                                                                                                        | \$4,196.10               |
| 19355           | Correction of inverted nipples                                                                                                                                     | \$4,196.10               |
| 15876           | Suction-assisted lipectomy; head/neck                                                                                                                              | \$5,340.00               |
| 15877           | Suction-assisted lipectomy; trunk                                                                                                                                  | \$5,340.00               |
| 15878           | Suction-assisted lipectomy; upper extremity                                                                                                                        | \$2,676.60               |
| 15879           | Suction-assisted lipectomy; lower extremity                                                                                                                        | \$5,340.00               |
| 15832           | Excision of excessive skin and subcutaneous tissue of thigh                                                                                                        | \$3,279.03               |
| 15833           | Excision of excessive skin and fat of lower leg                                                                                                                    | \$3,279.03               |
| 15834           | Excision of excessive skin and fat of hip                                                                                                                          | \$3,279.03               |
| 15835           | Excision of excessive skin and fat of buttocks                                                                                                                     | \$3,279.03               |
| 15836           | Excision of excessive skin and fat of arm                                                                                                                          | \$3,279.03               |
| 15837           | Excision of excessive skin and fat of forearm                                                                                                                      | \$3,279.03               |
| 13121           | Replacement of tissue expander with implant                                                                                                                        | \$4,789.14               |
| 13132           | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less                                                | \$246.21                 |
| 14020           | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 2.6 cm to 7.5 cm                                                  | \$277.11                 |
| 14021           | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 7.6 cm to 12.5 cm                                                 | \$292.46                 |
| 14040           | Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands/feet); 12.6 cm to 20.0 cm                                                | \$292.46                 |
| 14041           | Repair, complex, trunk; 2.6 cm to 7.5 cm                                                                                                                           | \$484.85                 |
| 14060           | Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm                                                                                                        | \$484.85                 |
| 14301           | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm                                                      | \$484.85                 |
| 15100           | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less                                                                        | \$1,258.91               |
| 15120           | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm                                                                | \$1,448.99               |
| 15200           | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less                     | \$1,448.99               |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Charge Commitment - 1110.235(C)(9)**

| <b>CPT Code</b> | <b>Description</b>                                                                                                                                                | <b>Charge Commitment</b> |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 15220           | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm            | \$1,448.99               |
| 15240           | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less                                                               | \$1,448.99               |
| 15260           | Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm                                                                              | \$2,890.82               |
| 15576           | Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less                                                                                             | \$1,448.99               |
| 15734           | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less               | \$2,890.82               |
| 15738           | Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less                                                                       | \$1,448.99               |
| 15740           | Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less                                                    | \$1,448.99               |
| 15769           | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less | \$1,448.99               |
| 15771           | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less                                            | \$1,448.99               |
| 15772           | Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral                                                           | \$1,448.99               |
| 15773           | Muscle, myocutaneous, or fasciocutaneous flap; trunk                                                                                                              | \$2,890.82               |
| 15820           | Muscle, myocutaneous, or fasciocutaneous flap; lower extremity                                                                                                    | \$2,890.82               |
| 15821           | Flap; island pedicle flap                                                                                                                                         | \$1,448.99               |
| 15822           | Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)                                                               | \$2,890.82               |
| 15823           | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, legs; 50 cc or less                                                 | \$2,890.82               |
| 15825           | Grafting autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, legs; each additional 50 cc injectate                                  |                          |
| 15828           | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less           | \$1,448.99               |
| 15830           | Blepharoplasty, lower eyelid;                                                                                                                                     | \$1,448.99               |
| 15838           | Blepharoplasty, lower eyelid; with extensive herniated fat pad                                                                                                    | \$1,448.99               |
| 15839           | Blepharoplasty, upper eyelid;                                                                                                                                     | \$1,448.99               |
| 15847           | Blepharoplasty, upper eyelid; with excessive skin weighting down lid                                                                                              | \$1,448.99               |
| 15876           | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)                                                                                             | \$2,890.82               |
| 15877           | Rhytidectomy; cheek, chin, and neck                                                                                                                               | \$2,890.82               |
| 15878           | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy                                                     | \$3,961.65               |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Charge Commitment - 1110.235(C)(9)**

| <b>CPT Code</b> | <b>Description</b>                                                                                                                                             | <b>Charge Commitment</b> |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 15879           | Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad                                                                       | \$1,802.85               |
| 17110           | Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area                                                                              | \$1,775.09               |
| 19301           | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) | \$0.00                   |
| 19316           | Suction assisted lipectomy; head and neck                                                                                                                      | \$2,890.82               |
| 19318           | Suction assisted lipectomy; trunk                                                                                                                              | \$2,890.82               |
| 19325           | Suction assisted lipectomy; upper extremity                                                                                                                    | \$1,448.99               |
| 19328           | Suction assisted lipectomy; lower extremity                                                                                                                    | \$2,890.82               |
| 19330           | Destruction of benign lesions, other than skin tags or cutaneous vascular proliferation; up to 14 lesions                                                      | \$154.10                 |
| 19340           | Mastectomy, partial                                                                                                                                            | \$2,271.56               |
| 19342           | Mastopexy                                                                                                                                                      | \$3,961.65               |
| 19350           | Breast reduction                                                                                                                                               | \$3,961.65               |
| 19357           | Breast augmentation with implant                                                                                                                               | \$4,688.30               |
| 19370           | Removal of intact breast implant                                                                                                                               | \$2,271.56               |
| 19371           | Removal of ruptured breast implant, including implant contents                                                                                                 | \$2,271.56               |
| 19380           | Insertion of breast implant on same day of mastectomy                                                                                                          | \$3,961.65               |
| 21295           | Insertion or replacement of breast implant on separate day from mastectomy                                                                                     | \$4,688.30               |
| 30400           | Nipple/areola reconstruction                                                                                                                                   | \$2,271.56               |
| 30410           | Tissue expander placement in breast reconstruction, including subsequent expansion(s)                                                                          | \$7,853.22               |
| 30420           | Revision of peri-implant capsule or surrounding tissue breast                                                                                                  | \$2,271.56               |
| 67900           | Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents                                                                   | \$2,271.56               |
| 67904           | Revision of reconstructed breast                                                                                                                               | \$3,961.65               |
| 67917           | Reduction of masseter muscle and bone                                                                                                                          | \$970.89                 |
| 67924           | Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip                                                                                | \$4,308.65               |
| 10040           | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip                              | \$4,308.65               |
| 10060           | Rhinoplasty, primary; including major septal repair                                                                                                            | \$4,308.65               |
| 10061           | Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)                                                                                         | \$1,515.30               |
| 10080           | Repair of blepharoptosis; (tarso) levator resection or advancement, external approach                                                                          | \$1,515.30               |
| 10081           | Repair of ectropion; extensive                                                                                                                                 | \$1,515.30               |
| 10120           | Repair of entropion; extensive                                                                                                                                 | \$1,515.30               |

**ATTACHMENT 25**  
**Non-Hospital Based Ambulatory Surgery -**  
**Assurances - 1110.235(C)(10)**



January 20th, 2026

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

**Re: Schaumburg Plastic Surgery Center LLC – Assurances**

Dear Mr. Kniery:

As a representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, M.D., hereby attest that the Applicant's full anticipation that, by the end of the second year following the proposed ambulatory surgical treatment center's opening, the proposed facility will operate at or in excess of the utilization standards identified in 77 Ill. Admin. Code §1110, Appendix B

Sincerely,

A handwritten signature in black ink, appearing to read "Sameer Kapadia", is written over a white rectangular background.

Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC



## **ATTACHMENT 34**

### **Availability of Funds**

The total estimated project cost is \$3,236,382 and \$2,648,602 of that amount is attributable to construction and equipment purchases. The balance of the project cost is related to the leasing costs for the new facility. Dr. Kapadia will fund the project costs with cash and a loan from financial institution. Dr. Kapadia has sufficient internal resources to fund the cash portion of the project and a letter of commitment from a financial institution to evidence his ability to obtain financing for the remainder of the project costs.

# **ATTACHMENT 36** **Financial Viability** **Viability Ratios**

| Metric                                         | Year 1      | Year 2      |
|------------------------------------------------|-------------|-------------|
| <b>CURRENT RATIO</b>                           | 4.58        | 7.60        |
| Current Assets                                 | \$516,685   | \$1,008,822 |
| Current Liabilities                            | \$112,873   | \$132,779   |
|                                                |             |             |
| <b>NET MARGIN PERCENTAGE</b>                   | 24.4%       | 38.5%       |
| Net Income                                     | \$246,497   | \$583,523   |
| Net Operating Revenue                          | \$1,009,260 | \$1,513,890 |
|                                                |             |             |
| <b>PERCENT OF DEBT TO TOTAL CAPITALIZATION</b> | 90.9%       | 74.5%       |
| Long-term Debt                                 | \$2,423,509 | \$2,379,734 |
| Shareholders Equity                            | \$246,497   | \$830,020   |
|                                                |             |             |
| <b>PROJECTED DEBT SERVICE COVERAGE</b>         | 1.73x       | 3.32x       |
| Net Income + Depreciation                      | \$366,497   | \$703,523   |

|                              |           |           |
|------------------------------|-----------|-----------|
| Principal + Interest Expense | \$212,034 | \$212,034 |
|                              |           |           |
| <b>DAYS CASH ON HAND</b>     | 144.5     | 336.0     |
| Cash In Bank                 | \$254,463 | \$745,952 |
| Operating Expenses / 365     | \$1,761   | \$2,220   |
|                              |           |           |
| <b>CUSHION RATIO</b>         | 1.20x     | 3.52x     |
| Cash & Investments           | \$254,463 | \$745,952 |
| Maximum Annual Debt Service  | \$212,034 | \$212,034 |

## ATTACHMENT 37 Economic Feasibility



January 20th, 2026

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

**Re: Schaumburg Plastic Surgery Center LLC**  
**III. Admin. Code Section 1120.120(a) Available Funds Certification**  
**III. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements**

Dear Mr. Kniery:

As representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, M.D., hereby attest that the project costs will be \_\_\_\_\_. Dr. Kapadia will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the first full fiscal year. Dr. Kapadia will fund these costs with a loan from a financial institution and existing cash. Dr. Kapadia has sufficient and readily accessible internal resources to fund the obligation required by the project.

I further certify that our analysis of the funding options for this project reflected that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC



1321 Tower Rd, Schaumburg, IL 60173

+1 (312) 872-8514

[schaumburgplasticsurgerycenter.com](http://schaumburgplasticsurgerycenter.com)

**ATTACHMENT 37**  
**Economic Feasibility**  
**Project Operating Costs and**  
**Total Effect of the Project on Capital Costs**

**Projected Operating Costs**

The Applicant has prepared a detailed pro forma reflecting projected direct annual operating costs for the first full fiscal year at target utilization, which occurs in Year 2 of operation. Target utilization reflects 510 outpatient procedures and approximately 1,209 operating room hours.

Total projected operating expenses in Year 2 are \$810,367, inclusive of fully allocated salaries and benefits, medical and surgical supplies, anesthesia-related costs, billing services, utilities, and other direct clinical expenses. When divided by projected target utilization, the direct operating cost equals approximately \$1,589 per procedure.

These projections are based on documented historical volume, conservative 3 percent growth assumptions, and a lean single-operating-room staffing model.

**Total Effect of the Project on Capital Costs**

The total projected annual capital costs for the first full fiscal year at target utilization include debt service and depreciation associated with the \$2,500,000 total project cost. Annual debt service is projected at \$212,034, and annual depreciation expense related to equipment totals \$120,000, resulting in total annual capital costs of \$332,034.

When allocated across projected target utilization of 510 procedures, the capital cost equals approximately \$651 per procedure. The Applicant submits that the total projected capital cost impact per unit of service is reasonable and consistent with State review criteria.

# **ATTACHMENT 37** **Economic Feasibility** **Cost and GSF by Department or Service**

Pursuant to Illinois Administrative Code Section 1120 Appendix A (a)(3), a project's cost must be at or below the RS Means for the new construction of an ASTC. At the time of this application, the RS Means for the new construction of an ASTC in this area of the state is \$510.27 GSF. This project is slated to by December 31, 2027 and the applicable RS Means standard is \$510.27 per GSF. The proposed cost per GSF for this project is \$535.85. The project involves renovation and conversion of an existing space rather than ground-up shell construction, which can result in higher per-square-foot costs due to demolition, reconfiguration, and mechanical system adaptation. The Applicant respectfully submits that the modest variance above the RS Means benchmark is reasonable and directly related to the clinical scope and safety requirements of the proposed ASTC.

| COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE   |                         |      |                      |        |                       |        |                      |                    |                       |
|-------------------------------------------------------|-------------------------|------|----------------------|--------|-----------------------|--------|----------------------|--------------------|-----------------------|
| Department<br>(List below)                            | A                       | B    | C                    | D      | E                     | F      | G                    | H                  | Total Cost<br>(G + H) |
|                                                       | Cost/Square Foot<br>New | Mod. | Gross Sq. Ft.<br>New | Circ.* | Gross Sq. Ft.<br>Mod. | Circ.* | Const. \$<br>(A x C) | Mod. \$<br>(B x E) |                       |
| ASTC                                                  | \$504.53                | -    | 1,688                | -      | -                     | -      | \$851,649            | -                  | \$851,659             |
| Contingency                                           | \$31.32                 | -    | 707                  | -      | -                     | -      | \$52,860             |                    | \$52,860              |
| TOTALS                                                | \$535.85                | -    | 2,395                | -      | -                     | -      | \$904,509            |                    | \$904,509             |
| * Include the percentage (%) of space for circulation |                         |      |                      |        |                       |        |                      |                    |                       |

## ATTACHMENT 37

### Economic Feasibility Proforma

| Line Item                               | Year 1           | Year 2           |
|-----------------------------------------|------------------|------------------|
| <b>REVENUE</b>                          |                  |                  |
| Net Patient Revenue                     | \$1,009,260      | \$1,513,890      |
| <b>OPERATING EXPENSES</b>               |                  |                  |
| Salaries & Benefits                     | \$252,768        | \$290,861        |
| Medical Supplies (20%)                  | \$201,852        | \$302,778        |
| Rent (Base @ \$22/sf + NNN)             | \$77,680         | \$79,234         |
| Billing & Collections (5%)              | \$50,463         | \$75,694         |
| General Admin / Insurance               | \$36,000         | \$37,080         |
| Utilities / Biohazard / Laundry         | \$24,000         | \$24,720         |
| Total Operating Expenses                | \$642,763        | \$810,367        |
| <b>NET OPERATING INCOME (EBITDA)</b>    | <b>\$366,497</b> | <b>\$703,523</b> |
| Less: Depreciation (Equipment)          | (\$120,000)      | (\$120,000)      |
| <b>Net Income (Before Debt Service)</b> | <b>\$246,497</b> | <b>\$583,523</b> |
| Less: Annual Debt Service (P&I)         | (\$212,034)      | (\$212,034)      |
| <b>NET CASH FLOW</b>                    | <b>\$154,463</b> | <b>\$491,489</b> |
| <b>DSCR (Ratio)</b>                     | <b>1.73x</b>     | <b>3.32x</b>     |

| ASSETS                                     | Year 1             | Year 2             |
|--------------------------------------------|--------------------|--------------------|
| Cash in Bank                               | \$254,463          | \$745,952          |
| Accounts Receivable (net)                  | \$242,222          | \$242,870          |
| Inventory                                  | \$20,000           | \$20,000           |
| Current Assets                             | \$516,685          | \$1,008,822        |
| Fixed Assets (net)                         | \$2,380,000        | \$2,260,000        |
| <b>TOTAL ASSETS</b>                        | <b>\$2,896,685</b> | <b>\$3,268,822</b> |
| <b>LIABILITIES AND STOCKHOLDERS EQUITY</b> |                    |                    |
| Accounts Payable                           | \$53,564           | \$67,531           |
| Current Portion LT Debt                    | \$38,245           | \$41,010           |
| Accrued Salaries & Benefits                | \$21,064           | \$24,238           |
| Other Liabilities                          | \$0                | \$0                |
| Total Current Liabilities                  | \$112,873          | \$132,779          |
| Long-term Debt                             | \$2,423,509        | \$2,379,734        |
| Total Liabilities                          | \$2,536,382        | \$2,512,514        |
| Retained Earnings                          | \$246,497          | \$830,020          |
| Total Stockholders Equity                  | \$246,497          | \$830,020          |
| <b>TOTAL LIABILITIES AND EQUITY</b>        | <b>\$2,782,879</b> | <b>\$3,342,534</b> |

## **ATTACHMENT 38**

### **Safety Net Impact Study**

Schaumburg Plastic Surgery Center LLC ("SPSC") is a newly formed entity and therefore has no historical charity care or Medicaid utilization data for the three fiscal years preceding this application. Upon licensure and commencement of operations, the facility will implement and document a financial assistance policy consistent with Board requirements for non-hospital applicants, and will report charity care at cost using an appropriate methodology specified by the Board. Medicaid utilization and revenue by payor source will be reported in a manner consistent with Illinois Department of Public Health reporting standards.

The proposed ASTC is projected to serve a payor mix of approximately 75% commercial insurance, 10% Medicare, 10% private pay, and 5% Medicaid. The anticipated 5% Medicaid participation reflects a meaningful commitment to serving publicly insured patients within the Geographic Service Area ("GSA"). Several existing multispecialty ambulatory surgical centers in the GSA maintain comparatively low Medicaid participation rates for plastic surgery services. By contrast, the proposed facility intends to accept Medicaid patients, enroll in the Medicaid Managed Care Organization insurance products and provide medically necessary reconstructive and restorative procedures without regard to a patient's ability to pay. These services are particularly relevant to women and patients from historically underserved communities and address disparities in access to reconstructive surgical care.

The project does not involve discontinuation of any existing facility or service and is not expected to negatively affect essential safety net services in the community. Historical data indicate that the majority of Dr. Kapadia's procedures are currently performed in hospital outpatient departments. The proposed single-operating-room ASTC will allow appropriate migration of cases to a lower-cost ambulatory setting but does not rely on capturing disproportionate volume from hospital systems. Accordingly, the Applicant does not anticipate that the project will impair the ability of other providers to cross-subsidize safety net services or reduce utilization at area facilities below applicable standards. The Applicant respectfully submits that the proposed project will have a neutral to positive impact on access for Medicaid beneficiaries and underserved populations within the GSA.

## **ATTACHMENT 39**

### **Charity Care**

Schaumburg Plastic Surgery Center LLC ("SPSC") is a newly formed entity and does not have audited financial statements for the latest three fiscal years. Accordingly, historical charity care data is not applicable.

The projected payer mix for the proposed ASTC is approximately 75% commercial insurance, 5% Medicaid, 10% private pay, and 10% Medicare. Based on the pro forma projections for Year 2 (first full fiscal year at target utilization), total net patient revenue is projected to be approximately \$1,538,000. The Applicant conservatively projects that approximately 1% of net patient revenue may qualify as charity care by the end of the second year of operation.

Upon licensure and commencement of operations, SPSC will implement a written financial assistance policy that defines eligibility criteria, application procedures, and documentation standards for charity care determinations. Charity care will be tracked at cost and reported in accordance with Board-specified methodology for non-hospital applicants.

The Applicant respectfully submits that the projected charity care commitment is reasonable and proportionate for a specialty-focused ambulatory surgical treatment center and demonstrates a continued commitment to serving patients without regard to their ability to pay.

## ATTACHMENT 40 Flood Plain Information



January 20th, 2026

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

**Re: Schaumburg Plastic Surgery Center LLC - Flood Plain Requirements**

Dear Mr. Kniery:

As representative of Schaumburg Plastic Surgery Center LLC, I, Sameer Kapadia, M.D., affirm that our facility complies with Illinois Executive Order #2005-5. The facility location at 1321 Tower Road, Schaumburg, IL 60173 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

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

Sincerely,

Sameer Kapadia, M.D.  
President  
Schaumburg Plastic Surgery Center LLC

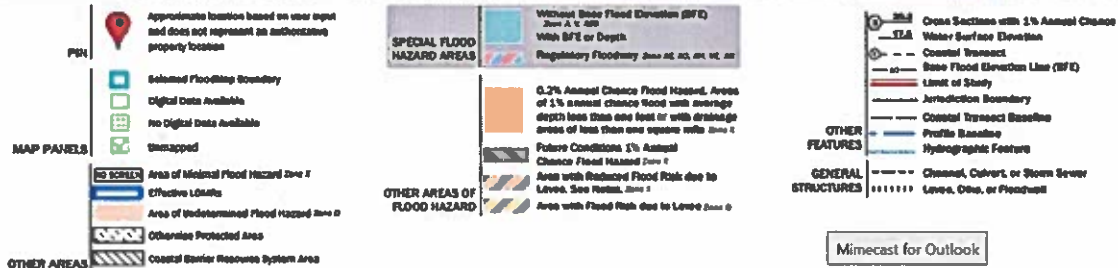


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# ATTACHMENT 40 Flood Plain Information



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