18-050

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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DEC 31 2018

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects. [ORIGINAL]

Facility/Project Identification

Facility Name:	Associated Surgical Center f/k/a Chicago Surgical Clinic, Ltd.		
Street Address:	129 West Rand Road		
City and Zip Code:	Arlington Heights, IL 60004		
County: Cook	Health Service Area: VII	Health Planning Area: 031	

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

Exact Legal Name:	Associated Surgical Center, LLC
Street Address:	129 West Rand Road
City and Zip Code:	Arlington Heights, IL 60004
Name of Registered Agent:	James M. Sulzer
Registered Agent Street Address:	20 N. Wacker Drive Suite 2250
Registered Agent City and Zip Code:	Chicago, IL 60606
Name of Chief Executive Officer:	Yelena Levitin, MD
CEO Street Address:	129 West Rand Road Suite 1
CEO City and Zip Code:	Arlington Heights, IL 60004
CEO Telephone Number:	847/215-0530

Type of Ownership of Applicants

- [ ] Non-profit Corporation
- [ ] For-profit Corporation
- X Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] Sole Proprietorship
- [ ] Other

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

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

Name:	Yelena Levitin, MD
Title:	Principal
Company Name:	Associated Surgical Center, LLC
Address:	129 West Rand Road Arlington Heights, IL 60004
Telephone Number:	847/215-0530
E-mail Address:	ylevitinmd@yahoo.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Rand Road Center, LLC

Address of Site Owner: 129 West Rand Road Arlington Heights, IL 60004

Street Address or Legal Description of the Site: 129 West Rand Road Arlington Heights, IL 60004

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: Associated Surgical Center, LLC

Address: 129 West Rand Road Arlington Heights, IL 60004

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

Not Applicable

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

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

Historic Resources Preservation Act Requirements

Not Applicable

[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

X 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.

Associated Surgical Center f/n/a Chicago Surgical Clinic, Ltd. was granted a Certificate of Need Permit on December 10, 2012 to operate as a multi-specialty ambulatory surgery treatment center ("ASTC"), and became operational in late 2016.

The proposed project is limited to the addition of orthopedic surgery as an "approved service", and does not involve any construction, renovation, or major equipment. Therefore, the project is classified as non-substantive.

PROJECT COST AND SOURCES OF FUNDS

		Reviewable	Non-Reviewable		Total
Project Cost:					
Preplanning Costs					
Site Survey and Soil Investigation					
Site Preparation					
Off Site Work					
New Construction Contracts					
Modernization Contracts					
Contingencies					
Architectural/Engineering Fees					
Consulting and Other Fees		$ 40,000			$ 40,000
Movable and Other Equipment (not in construction contracts)		$ 80,800			$ 80,800
Net Interest Expense During Construction Period					
Fair Market Value of Leased Space or Equipment					
Other Costs to be Capitalized					
Acquisition of Building or Other Property					
TOTAL USES OF FUNDS		**$ 120,800**			**$ 120,800**
Sources of Funds:					
Cash and Securities		$ 120,800			$ 120,800
Pledges					
Gifts and Bequests					
Bond Issues (project related)					
Mortgages					
Leases (fair market value)					
Governmental Appropriations					
Grants					
Other Funds and Sources					
TOTAL SOURCES OF FUNDS		**$ 120,800**			**$ 120,800**

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

Land acquisition is related to project ☐ Yes X No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes X 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 $ _____.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): __within 60 days of CON Permit_

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

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

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☐ Cancer Registry Not Applicable
☐ APORS Not Applicable
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Not Applicable

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization **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**.

FACILITY NAME:			**CITY:**		
REPORTING PERIOD DATES:	**From:**		**to:**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

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

Y. Levit	
SIGNATURE	SIGNATURE
YELENA LEVITIN	
PRINTED NAME	PRINTED NAME
sole member	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 24 day of SEPTEMBER, 2018	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal OFFICIAL SEAL IGOR KROIN Notary Public - State of Illinois My Commission Expires 5/09/2021	Seal

*Insert the EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. 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 is able to 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** of 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:

Not Applicable

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

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

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

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

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

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE: **Not Applicable**

Provide the following information:

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

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

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

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

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

ASSURANCES: **Not Applicable**

Submit the following:

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

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

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

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

G. Non-Hospital Based Ambulatory Surgery

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

ASTC Service
☐ **Cardiovascular**
☐ **Colon and Rectal Surgery**
☐ **Dermatology**
☐ **General Dentistry**
☐ **General Surgery**
☐ **Gastroenterology**
☐ **Neurological Surgery**
☐ **Nuclear Medicine**
☐ **Obstetrics/Gynecology**
☐ **Ophthalmology**
☐ **Oral/Maxillofacial Surgery**
X **Orthopedic Surgery---proposed to be added**
☐ **Otolaryngology**
☐ **Pain Management**
☐ **Physical Medicine and Rehabilitation**
☐ **Plastic Surgery**
☐ **Podiatric Surgery**
☐ **Radiology**
☐ **Thoracic Surgery**
☐ **Urology**
☐ **Other**_____

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X

1110.235(c)(10) – Assurances	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT 25,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

1. "A" Bond rating or better
2. All of the projects 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.

not applicable, project funded through internal sources

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order 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

not applicable, no debt to be used

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).

not applicable, project does not involve modernization

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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

not applicable, non-substantive project

1. The project's material impact, if any, on essential safety net services 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 a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of 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 38.

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

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

SECTION XI. CHARITY CARE INFORMATION

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

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

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

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

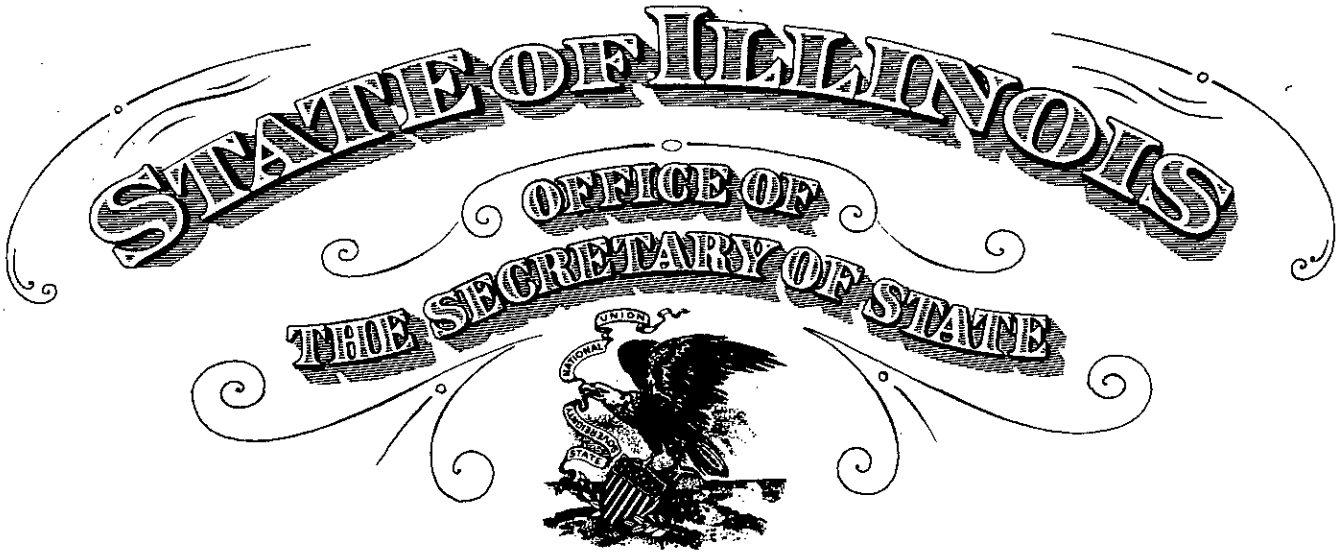
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

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

CHARITY CARE			
	Year	2016	2017
Net Patient Revenue		$34,518	$557,074
Amount of Charity Care (charges)			
Cost of Charity Care		$0	$11,428

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

File Number 0591967-3



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, 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

ASSOCIATED SURGICAL CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 09, 2016, 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* 5TH *day of* JULY *A.D.* 2018 .

Authentication #: 1818601770 verifiable until 07/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site occupied by Associated Surgical Center, and located at 129 West Rand Road in Arlington Heights, Illinois, is owned by Associated Surgical Center, LLC.

Sincerely,

Yelena Levitin, MD

_____ 2018

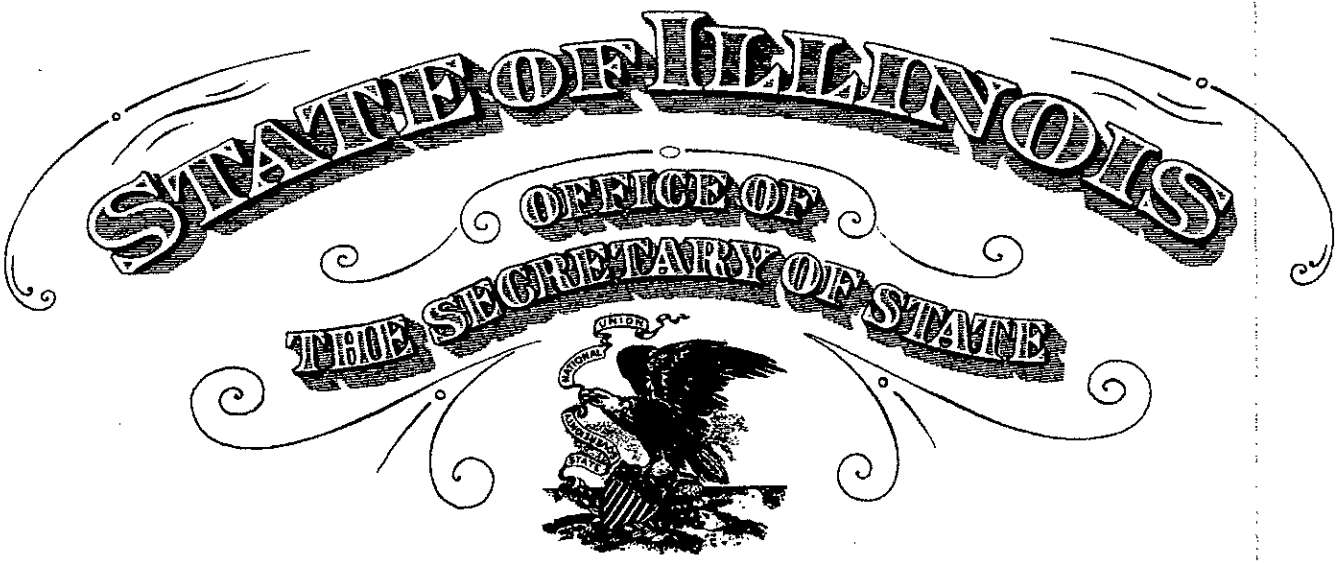
Notarized:

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

Elizabeth D Neary
9/24/18

ATTACHMENT 2

File Number 0591967-3



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In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* JULY *A.D.* 2018 .

Authentication #: 1818601770 verifiable until 07/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 3

OPERATING IDENTITY/LICENSEE

The ASTC's operating entity and licensee is and will continue to be Associated Surgical Center, LLC ("the LLC"). The sole current investor in the LLC is Yalena Levitin, MD. Dr. Levitin will maintain, at minimum, a 50% ownership interest in the LLC for a minimum of two years. As a result of Dr. Levitin's sole ownership, an organizational chart is not provided.

ATTACHMENT 3

PROJECT COSTS AND SOURCES OF FUNDS

Project Costs	
Movable and Other Equipment (list attached)	
Misc. orthopedic surgery equipment	$80,800
Consulting and Other Fees	
CON-Related	$25,000
Legal	$5,000
Misc.	$10,000
Sources of Funds	
Cash and Liquid Assets	$120,800

ATTACHMENT 7

ASSOCIATED SURGICAL CENTER
ORTHOPEDIC EQUIPMENT LIST

ORTHOPEDIC EQUIPMENT TO PURCHASE		COST
Arthroscopy Instrument Tray Sets		$ 5,600
ACL Instrument Tray Sets		$ 2,650
Meniscus Instrument Tray Sets		$ 3,425
Small Joint Instrument Tray Sets		$ 2,875
Carpal Tunnel Intrument Tray Sets & System		$ 3,425
Hand Instrument Tray Sets		$ 3,270
Cervical Instrument Tray Sets		$ 2,375
Lumbar Instrument Tray Sets		$ 4,750
Large Fragment Set		$ 1,930
Cannulated Screw Sets (Various Sizes)		$ 3,000
Carpal Tunnel System		$ 2,760
Bone Intrument Set		$ 2,395
Power Driver/Drill/Saw Set (Zimmer or Other)		$ 5,550
Equipment Cart		$ 2,450
Side Table		$ 1,475
Bipolar Electrocautery Unit		$ 2,000
Fluoroscanner		$ 9,650
Shaver		$ 2,850
Leg Holder		$ 1,930
Shoulder Holder		$ 1,950
Finger Traps		$ 125
Beach Chair		$ 1,825
Cast Saw		$ 2,550
Surgical Headlights		$ 4,850
Image Printer		$ 1,890
Surgical Irrigation System/Arthroscopy Pump		$ 3,250
Total Equipment		$ 80,800

ATTACHMENT 7

Cost Space Requirements

				Amount of Proposed Total Square Feet			
		Gross Square Feet			That is:		
Dept./Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ASTC	$ 120,800	7,700	7,700			7,700	
Non-Reviewable							
None							
TOTAL	$ 120,800	7,700	7,700			7,700	

28

ATTACHMENT 9

Illinois Department of PUBLIC HEALTH

HF115362

DISPLAY THIS PART IN A CONSPICUOUS PLACE

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
3/12/2019		7003214

Ambulatory Surgery Treatment Center

Effective: 03/13/2018

Associated Surgical Center, LLC
129 W. Rand Road Suite 1
Arlington Heights, IL 60004

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

Exp. Date 3/12/2019

Lic Number 7003214

Date Printed 3/8/2018

Associated Surgical Center, LLC

129 W. Rand Road Suite 1
Arlington Heights, IL 60004-3142

FEE RECEIPT NO.

ATTACHMENT 11

29

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Associated Surgical Center LLC

for having met the standards of a CLASS C MEDICARE ambulatory surgery facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital organs.

30

ATTACHMENT 1

AAAASF President
David C. Watts, MD

Secretary/Treasurer
Lawrence S. Reed, MD

Certified: 8/23/2018 to 8/23/2019

Certification Number: 6500

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.
Medicare ASC ■ Medicare RHC ■ Medicare RA/OPT ■ ASF Surgical ■ ASF Oral Maxillofacial ■ ASF Procedural
ACCREDITATION OFFICE: 5101 Washington Street, Suite 2F ■ P.O. Box 9500, Gurnee, Illinois 60031 ■ Toll Free: 1-888-545-5222
Phone: 847-775-1970 ■ Fax: 847-775-1985 ■ Email: reception@aaaasf.org ■ Website: www.aaaasf.org

Re-Accreditation Decision Letter

Date of Notice: August 23, 2018

Director: Yelena Levitin, M.D.

Thank you for participating in this important quality assurance and patient safety process administered by the American Association for Accreditation of Ambulatory Surgery Facilities. The following report contains information relevant to the conclusion of your recent accreditation survey process including your facility accreditation demographic information, accreditation decision, and recent survey history. AAAASF requires that all standards be met in order to achieve accreditation and that 100% compliance must be maintained at all times. AAAASF reserves the right to conduct additional surveys to validate the findings of previous surveys and to ensure continued compliance with standards.

Attached you will find a report containing all of the deficiencies cited during the accreditation survey along with the corrective action plans submitted to AAAASF. The Final Accreditation Decision based on the findings and corrective action taken in response to your recent survey process is Full.

Survey Details Below

Accrediting Organization: AAAASF

Survey Identification Number: 21855

AAAASF Facility Identification Number: 6500

Program Type: ASC

CCN Number: 14C0001169

Provider/Supplier Name and Address:
Associated Surgical Center LLC
129 W Rand Rd Suite 1
Arlington Heights, IL 60004
United States

Survey Request Type: Self-Evaluation

Survey Type: Full Accreditation Survey

ATTACHMENT 11

Survey Began: August 20, 2018 Survey Ended: August 20, 2018

Date Acceptable Plan of Correction Received: N/A

Method of Follow Up: N/A

Accreditation Decision: Full

Effective Date of Accreditation: August 23, 2018

Expiration Date of Accreditation: August 23, 2020

Recommended for Continued Deemed Status: Yes

CMS Condition for Coverage Cited: N/A

Recent Survey History:

Survey	Survey Description	Survey Type	Begin	End	Deficiencies	Corrected	Decision
21855	Full Accreditation Survey	Re-Survey	8/20/2018	8/20/2018	0	0	Full

Sincerely,

Jeanne Henry
Director of Accreditation

ATTACHMENT 11

Facility #	Statement of Deficiency - Final	Survey Date
6500	Associated Surgical Center LLC	8/20/2018
Survey #	129 W Rand Rd Suite 1	
21855	Arlington Heights, IL 60004	
CCN #	14C0001169	Program CMS Surgical

During this survey the facility demonstrated no deficiencies

ATTACHMENT 11

ASC in Arlington Heights earns recognition from AAAASFI as one of the first international healthcare facilities that promotes superior quality and safety standards

AAAASFI issues "Global Accreditation Program" Accreditation Certificate to ASC

Associated Surgical Center (ASC), located in Arlington Heights, IL, is one of the first ambulatory surgical facilities to be accredited by The American Association for Accreditation for Ambulatory Surgery Facilities International (AAAASFI). The global accreditation program has surveyed ASC and found it to exceed superior standards.

"We are very proud to have earned this global accreditation in recognition of the outstanding care given to our patients by the dedicated team of doctors, nurses and support staff who work every day at ASC to provide great care," said Dr. Yelena Levitin, M.D., medical director at Associated Surgical Center.

Patients undergoing surgery in an accredited operating room such as at ASC are assured the same level of care and safety preparedness as those receiving care in a hospital, according to AAAASFI.

AAAASF works with health professionals and organizations that are dedicated to delivering high-quality and innovative care to the communities we serve. Together ASC and AAAASFI work to help increase awareness and promote the efforts of health care organizations to address health care concerns and the delivery of quality care.

Globally, there is a growing need and demand for uniform standards and practices to ensure quality health care and patient safety. AAAASFI and ASC work together to address and meet these high standards of care.

ATTACHMENT 11

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Associated Surgical Center, LLC has not had any adverse actions against any facility owned and operated by the applicant during the three (3) year period prior to the filing of this application, and
2. Associated Surgical Center, LLC authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Yelena Levitin, MD

Date: September 24, 2018

Notarized:

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

Elizabeth D Neary
9/24/18

ATTACHMENT 11

PURPOSE

The purpose of the proposed project is to provide an avenue for orthopedic surgeons to perform cases at the Associated Surgical Center. Following approval, orthopedic surgeons seeking and gaining surgical privileges at the ASTC will provide their patients with greater access to ASTC services, and therein the health care and well-being of their patients, the majority of which reside in the geographic service area ("GSA") described below, will be improved.

It is not anticipated that the addition of orthopedic surgery to the services approved for the ASTC will change the GSA in any appreciable way. As discussed in ATTACHMENT 25c7, the GSA, per IDPH rule, consists of those communities and ZIP Code areas located within ten miles of the proposed site. This area generally covers the communities from Vernon Hills on the north, to Waukegan Road on the east, to O'Hare airport on the south and Schaumburg on the west.

The singular goal of the project is to allow the performance of orthopedic surgery cases in the ASTC within two months of receipt of a Certificate of Need Permit to do so.

As required, Associated Surgical Center provided a patient origin analysis as part of its 2017 Ambulatory Surgical Treatment Center Questionnaire for 2017, and a copy of that analysis is attached. It is not anticipated that the addition of orthopedic surgery will change the facility's patient origin to any appreciable degree. Also attached is a listing of ZIP Codes located within ten miles of Associated Surgical Center. The population of this area is approximately 901,000.

ATTACHMENT 12

7. Patients by Place of Origin - Calendar Year 2017

Preferred Reporting Method:

For your ease of reporting, we have supplied a Microsoft Excel worksheet for the entry of Patient Origin Data:

1. **CLICK HERE to ACCESS THE WORKSHEET.**
2. Save the worksheet to your computer.
3. Follow the directions on the worksheet to enter your data.
4. Email the completed spreadsheet to DPH.FacilitySurvey@illinois.gov.
5. Retain a copy of the worksheet in case follow-up is required.

If you do not wish to use the Patient Origin worksheet, please use the spaces below to report the place of origin of the patients seen at your ASTC during Calendar Year 2017, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county name.

	Zip Code Area	County Name	Number of Patients
1	60625		4
2	60634		8
3	60640		9
4	60106		3
5	60047		7
6	60585		3
7	60439		3
8	60137		7
9	60077		8
10	60004		32
11	60005		8
12	60073		14
13	60173		12
14	60062		11
15	60123		9
16	60002		4
17	60110		8
18	60133		7
19	60056		17
20	60060		20
21	60074		34
22	60047		14
23	60025		9
24	60061		37
25	60015		51

	Zip Code Area	County Name	Number of Patients
26	60090		56
27	60089		14
28	60016		21
29	60018		16
30	53005		1
31	53189		1
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			

ATTACHMENT 12

Searchbug
names..numbers..now

Sign up | Log in
Search Site ...

Home | Find People | Hire Investigator | Tools | Batch | API | Blog

Phone Number | Address | Area Code | ZIP Code | E-Mail | IP Address | Stats | Feedback
Lookup | Maps | By Radius | By County | House Numbers | Carrier Routes

ZIP Codes in a Radius

ZIP: 60004

Radius: 10 Search Clear

About this Tool

- Get the list of ZIP codes within a given radius from entered ZIP Code.
- The list will display city, state, county, population, number of businesses and the distance

ZIP	City	State	County	Population	Businesses	Distance
60004	ARLINGTON HEIGHTS	IL	COOK	52,602.00	1565	0
60006	ARLINGTON HEIGHTS	IL	COOK	0.00	17	1.681
60038	PALATINE	IL	COOK	0.00	1	2.722
60055	PALATINE	IL	COOK	0.00	0	2.722
60078	PALATINE	IL	COOK	0.00	18	2.722
60094	PALATINE	IL	COOK	0.00	1	2.722
60090	WHEELING	IL	COOK	39,989.00	1290	3.025
60070	PROSPECT HEIGHTS	IL	COOK	16,925.00	412	3.028
60095	PALATINE	IL	COOK	0.00	2	3.082
60008	ROLLING MEADOWS	IL	COOK	23,647.00	962	3.494
60074	PALATINE	IL	COOK	40,610.00	757	3.691
60005	ARLINGTON HEIGHTS	IL	COOK	31,144.00	1469	3.767
60089	BUFFALO GROVE	IL	LAKE	42,934.00	1487	4.062
60056	MOUNT PROSPECT	IL	COOK	58,812.00	1444	4.493
60067	PALATINE	IL	COOK	41,030.00	1333	4.509
60173	SCHAUMBURG	IL	COOK	13,773.00	2149	5.317
60069	LINCOLNSHIRE	IL	LAKE	7,721.00	547	5.955
60016	DES PLAINES	IL	COOK	62,757.00	1356	6.243
60015	DEERFIELD	IL	LAKE	27,013.00	1450	6.764
60195	SCHAUMBURG	IL	COOK	5,142.00	362	6.819
60179	HOFFMAN ESTATES	IL	COOK	0.00	42	7.004
60007	ELK GROVE VILLAGE	IL	COOK	34,727.00	2550	7.018
60062	NORTHBROOK	IL	COOK	42,278.00	2850	7.205
60026	GLENVIEW	IL	COOK	14,685.00	515	7.378
60017	DES PLAINES	IL	COOK	0.00	16	7.439
60047	LAKE ZURICH	IL	LAKE	44,183.00	1530	7.448
60009	ELK GROVE VILLAGE	IL	COOK	0.00	9	7.553
60159	SCHAUMBURG	IL	COOK	0.00	8	7.591
60168	SCHAUMBURG	IL	COOK	0.00	10	7.591
60065	NORTHBROOK	IL	COOK	0.00	17	7.876
60019	DES PLAINES	IL	COOK	0.00	1	8.117
60011	BARRINGTON	IL	LAKE	0.00	19	8.335
60194	SCHAUMBURG	IL	COOK	20,792.00	558	8.337

ATTACHMENT 12

60025	GLENVIEW	IL	COOK	41,603.00	1550	8.407
60169	HOFFMAN ESTATES	IL	COOK	35,620.00	638	8.448
60061	VERNON HILLS	IL	LAKE	28,633.00	1019	8.543
60018	DES PLAINES	IL	COOK	30,813.00	1700	8.963
60193	SCHAUMBURG	IL	COOK	40,238.00	1045	9.164
60010	BARRINGTON	IL	LAKE	47,037.00	1987	9.545
60082	TECHNY	IL	COOK	0.00	5	9.548
60192	HOFFMAN ESTATES	IL	COOK	16,791.00	429	9.748
60068	PARK RIDGE	IL	COOK	39,189.00	1462	9.767
				900,688.00	34,582.00	

ATTACHMENT 12

ALTERNATIVES

The scope of this application is limited to the addition of orthopedic surgery as a service to be provided by an existing ASTC, and as such, with the exception of not seeking approval to add the service, there are no alternatives available to the applicant.

ATTACHMENT 13

SIZE

The existing ASTC consists of 7,700 DGSF, and has two Class C surgical suites, one Class B procedure room and six Phase I recovery stations. The proposed project does not involve any changes to the size or configuration of the ASTC.

DEPARTMENT/SERVICE	EXISTING DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	7,700	9,330	-1,630	YES

ATTACHMENT 14

UTILIZATION

Associated Surgical Center opened in 2016, and has three operating rooms. Utilization of the ASTC has not grown as originally anticipated, and the addition of orthopedic surgery is anticipated to increase the utilization. Once the approval to provide the service is secured, it is the desire of the ASTC to recruit additional orthopedic surgeons to perform cases at, and potentially invest in the ASTC.

The projection presented in the table below is very conservative, and assumes no change to current utilization patterns or the adding of additional surgeons to the medical staff. It is anticipated that, while the utilization standard can be met, it will take longer than two years to do so.

	Historical Utilization* (Patient Days) (TREATMENTS)	PROJECTED UTILIZATION* (examinations) YEAR 1	YEAR 2	STATE STANDARD	MET STANDARD?
Year 1	110				
Year 2	204	274	274	3000+	NO

ATTACHMENT 15

SERVICE TO GEOGRAPHIC SERVICE AREA RESIDENTS

The geographic service area ("GSA") of the proposed project, consistent with HFSRB limitations, consists of those communities/ZIP Code areas located with 10 miles of the ASTC site, as identified in Section 1110.235. With the signing of this *Application for Permit*, the applicant certifies that the primary purpose of the proposed project is to provide ASTC services to residents of the GSA, and a listing of the ZIP Code areas included in the GSA is provided at in ATTACHMENT 12. The estimated population of the area is approximately 901,000.

Associated Surgical Center's 2017 patient origin is provided in ATTACHMENT 12. During 2017, 75.7 % of the ASTC's patients were residents of the GSA. That percentage is not anticipated to change in any appreciable fashion as a result of the proposed addition of orthopedic surgery services.

Letters are provided in ATTACHMENT 25c4 from two orthopedic surgeons documenting their desire to refer cases to Associated Surgical Center. Dr. Daniel Ivankovich estimated that he will refer 40 cases a year to the ASTC. During 2017 Dr. Ivankovich performed outpatient surgery on 72 patients residing within ten miles of the ASTC, with none of those cases being performed at a hospital or ASTC located within the HFSRB-designated service area. Similarly, Dr. Tom Poepping estimates that he will refer 30 cases a year to the ASTC. During 2017 Dr. Poepping performed outpatient surgery on 33 patients residing within ten miles of the ASTC. As with Dr. Ivankovich, none of Dr. Poepping's cases were performed in the HFSRB-designated service area. As a result, in excess of 50% of the ASTC's patients will continue to be residents of the 10-mie service area.

ATTACHMENT 25c2

SERVICE DEMAND

The proposed project is limited to the addition of a surgical specialty to an established ASTC, without any addition of operating rooms. As noted elsewhere in this application, the ASTC has the capacity to accommodate the specialty/caseload addressed in this ATTACHMENT.

Referral letters from two orthopedic surgeons, Drs. Daniel Ivankovich and Tom Poepping are provided in this ATTACHMENT. Those two surgeons, together, documented 667 outpatient surgical cases performed in 2017. None of the outpatient surgery cases performed by these surgeons were performed at hospitals or ASTCs located within the HFSRB-designated service area, though both performed cases on residents of the service area. The two surgeons, per the attached letters, together anticipate referring seventy patients to Associated Surgical Center during the second year following approval of this project.

Name (print): Daniel Ivankovich
Specialty: orthopedic Surgery

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.235(c)(3) in support of the proposed application by Associated Surgical Center, LLC for orthopedic CON status for the ambulatory surgical treatment center (ASTC) to be established in Arlington Heights, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following numbers of patients in the hospitals or licensed ASTCs identified below.

ASC or Hospital	2016	2017
Methodist Hospital	150 patients	150 patients
South Shore Hospital	300 patients	325 patients
Thorek Hospital	40 patients	40 patients

I estimate that I will annually refer 40 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 outpatients.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another CON project.

Sincerely,

MD

5025 N Paulina St
Chicago, IL 60640

Notarized:

OFFICIAL SEAL
SAM D REYNISH
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/29/22

Sam D. Reynish
08/11/2018

ATTACHMENT 25c4

Date Range: 01/01/17 - 12/31/17
A:1 Zip Code B:1 Surgical Pts

Zip Code	Surgical Pts
60004	5
60013	9
60014	10
60015	9
60016	5
60019	6
60022	3
60025	6
60026	7
60029	5
60035	11
60040	3
60044	7
60045	5
60047	5
60048	4
60056	3
60061	2
60062	5
60071	2
60074	4
60076	5
60077	6
60089	3
60090	6
60091	4
60193	7
60201	5
60202	3
60204	4
60208	3
60604	7
60605	4
60606	13
60608	7
60609	8
60610	12
60611	11
60613	15
60614	8
60615	10
60618	9
60622	14
60625	11
60630	9

ATTACHMENT 25c4

Date Range: 01/01/17 - 12/31/17
A:1 Zip Code B:1 Surgical Pts

60631	9
60634	8
60640	10
60645	7
60646	11
60647	13
60651	9
60654	12
60657	14
60660	7
O-O-State	17
Unk	98
	515

ATTACHMENT 25c4

Name (print): Dr. Tom Poepping, M.D.
Specialty: Orthopedics

TO: Illinois Health Facilities and Services Review Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.235(c)(3) in support of the proposed application by Associated Surgical Center, LLC for orthopedic CON status for the ambulatory surgical treatment center (ASTC) already established in Arlington Heights, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following numbers of patients in the hospitals or licensed ASTCs identified below.

Name of ASC or Hospital	2016	2017
Illinois Orthopedic Network	50 patients	66 patients
Elmhurst Memorial Hospital	40 patients	55 patients
Lakeshore Surgery Center	15 patients	31 patients

I estimate that I will annually refer/perform 30 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 outpatient cases.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another CON project.

Sincerely,

Notarized:

OFFICIAL SEAL
SAM D REYNISH
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/29/22

07/16/2018

My Office Address is:
G & T Orthopedics
and Sports Medicine
800 Biesterfield Rd
Suite 3005
7-03-18 Elk Grove Village, IL 60007
or 6374 N Lincoln Ave
Suite 301
Chicago, IL 60659

ATTACHMENT 25c4

2017 Patient Origin

Zip Code Summary	# of Patients
60654	66
60126	30
60645	20
60647	3
60181	2
60631	7
60007	23
60004	10
60707	2

ATTACHMENT 25c4

TREATMENT ROOM NEED ASSESSMENT

The proposed project is limited to the addition of a surgical specialty to an existing ASTC, and does not include the addition of any operating rooms or procedure rooms. Therefore, this review criterion is not applicable to the proposed project.

SERVICE ACCESSIBILITY

The proposed project is limited to the addition of orthopedic surgery as a service to be provided at an established ASTC, and because orthopedic surgery is a commonly-provided service, the conditions identified in Section 1110.235.c.6 cannot be met. Taking into account the definition of a GSA, the inability to meet the conditions of this section would likely hold true for any location in the State of Illinois, where orthopedic surgery services were proposed to be added to an existing ASTC.

UNNECESSARY DUPLICATION/MALDISTRIBUTION

The proposed project will not result in unnecessary duplication or a mal-distribution of services, as the project does not involve the establishment of a new facility, or the addition of operating rooms or procedure rooms. As such, and consistent with direction provided by HFSRB staff, review criteria 1110.235 (c)(7) (A) through (C) are not applicable to this project.

STAFFING

Associated Surgical Center is an operating, licensed ASTC, fully staffed, and in compliance with relevant clinical and professional staffing requirements, including those required by for IDPH licensure. In evaluating the potential of adding orthopedic surgery as an additional service to be provided at the ASTC, the applicant determined that additional staffing would not be required.

Dr. Yelena Levitin will continue to serve in her role as Medical Director of the ASTC.

CHARGE COMMITMENT

With the signature placed on the Certification page of this *Application for Permit*, the applicant attests that the charges associated with orthopedic surgery services, and as identified in this ATTACHMENT will not increase for, at minimum, two years following the receipt of the Certificate of Need Permit associated with this Application for Permit.

Ambulatory Surgery Center, LLC
Facility Fee Schedule - Ortho

CPT CODE	ORHTOPEDIC PROCEDURES	ASC OR FEE
20610	Arthrocenteis, Aspiration and/or Injection	$ 250
20816	Replantation Digit	$ 4,000
23020	Surgical I & D Shoulder	$ 5,180
23333	Surgical Removal Foreign Body, Shoulder, Deep	$ 2,250
23405	Tenotomy, Shoulder	$ 8,250
23410	Repair Ruptured Rotator Cuff	$ 8,250
23420	Reconstruction of Rotator Cuff Inc. Acromioplasty	$ 8,250
23460	Revision of Shoulder Arthoplasty	$ 8,250
23480	Osteotomy, Clavicle W W/O Interal Fixation	$ 8,250
23515	Open Treatment of Clavicular Fracture	$ 8,250
23550	Open Treatment of Acromioclavicular Dislocation	$ 8,250
23585	Open treatment of Scapular Fracture	$ 8,250
23700	Manipulation of Shoulder Under General Anesthesia	$ 2,980
23930	I & D Deep Abscess Upper Arm or Elbow	$ 2,250
24006	Arthrotomy of Elbow W Capsular Release	$ 4,300
24100	Arthrotomy Elbow W Synovical Biopsy	$ 5,180
24102	Athrotomy Elbow W Synovectomy	$ 5,180
24155	Arthrectomy Elbow Joint	$ 5,180
24201	Excision Foreign Body Upper Arm or Elbow, Deep	$ 3,225
24300	Manipulation Elbow Under Anesthesia	$ 2,625
24310	Tentomy, Elbow, Open	$ 3,885
24341	Repair Tendon or Muscle, Upper Arm or Elbow	$ 8,250
24343	Repair Lateral Collateral Ligament	$ 8,250
24360	Arthroplasty, Elbow	$ 8,250
24515	Open Treatment of Shaft Fracture W Plates & Screws	$ 18,900
24615	Opent Treatment of Acute or Chronic Elbow Disclocation	$ 8,250
25000	Incision Extensor Tendon Sheath, Wrist	$ 2,980
25040	Arthrotomy of Radiocarpal or Midcarpal Jopint, Wrist	$ 5,180
25085	Capsulotomy Wrist	$ 5,180
25115	Radical Excision of Bursa, Wrist	$ 2,980
25259	Manipulation of Wrist Under Anetshesia	$ 2,625
25320	Arthroplasty Wrist	$ 8,250
23130	Acromioplasty	$ 11,250
25447	Arthroplasty Intercarpal or Carpometatarsal Wrist	$ 5,180
25645	Open Treatment of Carpal Bone Fracture	$ 3,885
26040	Fasciotomy Palmar Fascia	$ 2,980
24371	Revision of Total Elbow Arthroplasty	$ 22,300
26135	Synovectomy, Metacarpophalangeal Joint	$ 3,885
20690	Application of External Fixation System	$ 8,250
26230	Partial Excision Metacarpal Bone	$ 3,885
20973	Osteocutaneous Graft Great Tow W Web Space	$ 8,250
26471	Tenotomy of Proximal Interphalangeal Joint	$ 3,885
26520	Capsulectomy Metacarpophalangeal Joint	$ 3,885
26535	Arthroplasty, Interphalangeal Joint	$ 3,885
26615	Open Treatment of Metacarpal Fracture W W/O Internal Fixation	$ 3,885
26951	Amputation Finger or Thumb	$ 4,475

ATTACHMENT 25C9

Ambulatory Surgery Center, LLC
Facility Fee Schedule - Ortho

26991	I & D Deep Abscess / Bursa Pelvis or Hip	$ 2,980
20924	Tendon Graft	$ 7,000
27041	Biopsy Hip / Pelvis Deep Submuscular	$ 2,200
27052	Arthrotomy W Synovectomy, Hip Joint	$ 2,980
22551	Arthrodesis, Anterior Interbody	$ 14,158
27097	Release or Recession Hamstring	$ 3,885
27301	I & D Deep Abscess / Bursa Thigh or Knee	$ 3,225
27306	Tenotomy of Tendon Femur or Knee	$ 2,980
27327	Excision Tumor Soft Tissue Thigh or Knee	$ 2,200
27330	Arthrotomy Knee W Synovical Biopsy	$ 3,885
27345	Excision of Synovial Cyst, Knee	$ 3,885
27390	Tenotomy, Open, Knee or Hip	$ 3,885
27403	Arthrotomy W Meniscus Repair, Knee	$ 3,885
27409	Repair Collateral & Cruciate Ligaments	$ 8,250
27416	Osteochrondal Autograph, Knee, Open	$ 8,250
27435	Capsulotomy, Posterior Capsular Release, Knee	$ 3,885
27510	Open Treatment of Femoral Shaft Fracture W Plates & Screws	$ 8,250
27537	Open Treatment of Tibial Fracture W W/O Internal Fixation	$ 3,885
27566	Opent Treatment of Kneecap Dislocation W W/O Internal Fixation	$ 8,250
27570	Manipulation of Knee Under General Anesthesia	$ 2,250
27580	Arthodesis of Knee	$ 5,180
27625	Arthrotomy W Synovectomy, Ankle	$ 3,885
27650	Repair Ruptured Achilles Tendon	$ 5,385
27664	Repair Extensor Tendon Leg	$ 8,250
27758	Open Treatment Tibial Shaft Fracture W Plates & Screws	$ 15,375
27784	Opent Treatment of Proximal Fibula or Fracture W Plates & Screws	$ 8,250
27860	Manipulation of Ankle Under General Anesthesia	$ 2,850
27870	Arthrodesis, Ankle, Open	$ 18,500
27892	Decompression Fasciotomy Leg	$ 2,850
28200	Repair of Tendon, Flexor, Foot	$ 3,885
28297	Hallux Valgus Correction	$ 8,250
C1781	Implants & Prosthetics	Cost + 5%
28322	Metatarsals Repair	$ 8,250
28485	Metatarsal Fracture Repair	$ 8,250
28820	Amputation Toe	$ 5,650
29125	Application of Arm Splint	$ 1,900
29405	Application of Short Leg Cast	$ 1,900
29806	Arhtroscopy Shoulder	$ 8,250
29820	Arthoscopy Shoulder	$ 8,250
29827	Athroscopy Shoulder W Rotator Cuff Repair	$ 8,250
29840	Athroscopy of Wrist	$ 3,885
29862	Athroscopy of Hip W Debridement	$ 8,250
29870	Dx Knee Arthroscopy	$ 3,885
29881	Arthroscopy Knee w Meniscectomy	$ 3,885
29888	ACL Reconstruction	$ 10,400
29895	Arthroscopy Ankle Synovectomy	$ 3,885
29892	Ankle Arthroscopy	$ 8,250

ATTACHMENT 25c9

PEER REVIEW

With the signature placed on the Certification page of this *Application for Permit*, the applicant attests that a peer review program exists at Associated Surgical Center, and that the peer review program evaluated 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 is initiated. Further, with the signature placed on the Certification page of this *Application for Permit*, the applicant attests that it anticipates that within two years of the issuance of the requested Certificate of Need Permit, the annual utilization of the ASTC will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

PNC BANK

09/25/2018

ASSOCIATED SURGICAL CENTER LLC
129 W RAND RD
ARLINGTON HEIGHTS
60004

Dear to whom it may concern

In response to your request that PNC Bank, National Association provide written verification concerning your (checking/savings/certificate of deposit) account(s), we are providing the following information:

Account No.	Date Opened	Balance as of date of this letter
4660326688	09/07/2016	$146,569.00

This information is subject to any outstanding items or charges.

Sincerely,

PNC Bank, National Association

Nour Khalil
Financial Consultant

CUSTOMER AUTHORIZATION/ ACKNOWLEDGEMENT

I/we hereby acknowledge that I/we have requested and authorized PNC Bank, National Association to provide this written verification concerning my/our (checking/savings/certificate of deposit) account(s).

Dated this 9 day of 25, 18.

Customer Signature: _____

Customer Signature: _____

BDMS0007-0617

ATTACHMENT 34

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: Proposed Financing of Associated Surgical
Center CON Project

To Whom It May Concern:

The proposed financing of the above-identified project is reasonable and appropriate.

The total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received receipts and funded depreciation.

Sincerely,

Yelena Levitin, MD

Notarized:

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

Elizabeth D Neary
9/24/18

ATTACHMENT 37

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

ASSOCIATED SURGICAL CENTER

YEAR 2 OPERATING COST per SURGICAL CASE

Projected Cases:	2,000		
Salaries			$601,530
Benefits			$223,825
Medical Supplies			$13,990
			$839,345
per Surgical Case:		$	419.67

YEAR 2 CAPITAL COST per SURGICAL CASE

Projected Cases:	2,000		
Interest Expense			
Depreciation & Amort.			
		$	-
per Surgical Case:		$	-

interest, depreciation and amortization to be provided by M. Mayo

ASSOCIATED SURGICAL CENTER LLC
Balance Sheet
September 30, 2018

Assets		
Current Assets		
Cash in Banks	159,407.27	
Total Current Assets		159,407.27
Property, Plant, & Equipment		
Furniture & Fixtures	3,768.23	
Machinery & Equipment	156,285.00	
Sign	8,527.50	
Accumulated Depreciation	(66,815.00)	
Total Property, Plant, & Equipment		101,765.73
Other Assets		
Total Current Assets		0.00
Total Assets		261,173.00
Liabilities		
Current Liabilities		
Credit Cards Payable	10,623.78	
Total Current Liabilities		10,623.78
Long-Term Liabilities		
Due (to)/from Officer	233,343.36	
Total Long-Term Liabilities		233,343.36
Total Liabilities		243,967.14
Capital		
Common Stock	1,000.00	
Retained Earnings	16,205.86	
Total Capital		17,205.86
Total Liabilities and Capital		261,173.00

ATTACHMENT 35

ASSOCIATED SURGICAL CENTER LLC
Income Statement for the Nine Months Ended 09/30/18
September 30, 2018

Income from Operations	
Fees Collected	637,569.78
Total Income from Operations	637,569.78
Operating Expenses	
Clinic Supplies & Lab Expense	60,547.66
Auto Expenses	669.21
Bank Service Charges	2,898.00
Billing Service	16,684.62
Books	881.32
Credit Card Charges	5,344.21
Communication Expense	731.07
Consulting	31,000.00
Data Processing	6,833.61
Depreciation Expense	11,508.91
Education & Seminars	1,719.40
Insurance	7,522.61
Licenses	2,250.00
Maintenance & Repairs	12,854.33
Officers' Salaries	23,076.90
Office Expense	11,136.51
Payroll Service Expense	1,011.32
Payroll Tax Expense	11,626.02
Postage & Delivery	163.77
Professional Fees	1,800.00
Rent	112,500.00
Subcontractors	87,518.00
Surgical Supply	22,610.97
Utilities	11,260.33
Salaries & Wages	134,827.87
Total Operating Expenses	578,976.64
Operating Income (Loss)	58,593.14
Other Income & Expenses	
Interest Expense	1,228.94
Total Other Income & Expenses	1,228.94
Net Income (Loss) Before Income Taxes	57,364.20

ATTACHMENT 35

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

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Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

December 26, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Need ("CON") application addressing the addition of orthopedic surgery as an approved specialty at Associated Surgical center in Arlington Heights, Illinois.

The application is accompanied with a check, in the amount of $2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004