E-013-17

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

FEB 17 2017

HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Associated Surgical Center, LLC	
Street Address:	129 W. Rand Rd.	
City and Zip Code:	Arlington Heights, IL 60004	
County: Cook	Health Service Area 7	Health Planning Area:

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

Exact Legal Name:	Associated Surgical Center, LLC
Street Address:	129 W. Rand Rd.
City and Zip Code:	Arlington Heights, IL 60004
Name of Registered Agent:	James M. Sultzer
Registered Agent Street Address:	20 N. Walker Drive - Suite 2250
Registered Agent City and Zip Code:	Chicago, IL 60006
Name of Chief Executive Officer:	Dr. Yelena Levitin
CEO Street Address:	129 W. Rand Rd.
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
- xx Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Dr. Yelena Levitin, MD
Title:	sole member
Company Name:	Associated Surgical Center, LLC
Address:	129 W. Rand Rd, Arlington Heights, IL 60004
Telephone Number:	(847) 215-0530
E-mail Address:	ylevitinmd@yahoo.com
Fax Number:	(847) 215-0530

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

Name:	Susan Bogart
Title:	owner
Company Name:	Law offices of Susan Bogart
Address:	70 W. Madison Street - Suite 1400
Telephone Number:	(312) 214-3271
E-mail Address:	sbogart@susanbogart.com
Fax Number:	(866) 567-1199

Post Exemption 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:	sole member
Company Name:	Associated Surgical Center, LLC
Address:	129 W. Rand Rd. Arlington Heights, IL 60004
Telephone Number:	(847) 215-0530
E-mail Address:	ylevitinmd@yahoo.com
Fax Number:	(847) 215-0951

Site Ownership

[Provide this information for each applicable site]

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

Address of Site Owner: 129 W. Rand Rd, Arlington Heights, IL, 60004

Street Address or Legal Description of the Site:

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

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

Operating Identity/Licensee

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

Exact Legal Name: Associated Surgical Center, LLC

Address: 129 W. Rand Rd., Arlington Heights, IL, 60004

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

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

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

Organizational Relationships NA

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 NA

[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

[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 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

xx Change of Ownership Among Related Persons

☐ Discontinuation of an Existing Health Care Facility or of a category of service

☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The Applicant seeks an exemption for Change in Ownership Among Related Persons by transferring ownership of the existing IDPH licensed ambulatory surgical treatment center (ASTC) from Chicago Surgical Clinic, Ltd., of which Yelena Levitin, M.D. is sole owner and president, to Associated Surgical Center, LLC, of which Yelena Levitin, M.D. is the sole member; and granting permission to the Illinois Department of Public Health to change the ASTC License accordingly.

There are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only) NA

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

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

The project involves the establishment of a new facility or a new category of service
☐ Yes xx 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:

xx None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): June 13 2017 for Change in Ownership Among Related Persons

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

☐ 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:

XX Cancer Registry
XX APORS
XX All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
xx All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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. Levitin	
SIGNATURE	SIGNATURE
Yelena Levitin	
PRINTED NAME	PRINTED NAME
Sole Member	
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me this 14 day of FEBRUARY, 2017	Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

OFFICIAL SEAL
IGOR KROIN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/17

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION N/A

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- ☐ Discontinuation of an Existing Health Care Facility
- ☐ Discontinuation of a category of service

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The

supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

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

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

NA

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

Background

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 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership) N/A

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 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 N/A

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. SERVICE SPECIFIC REVIEW CRITERIA (Neonatal Intensive Care Services Only) N/A

Criterion 1130.531 Requirements for Exemptions for the Establishment or Expansion of Neonatal Intensive Care Service and Beds

This Section is applicable to all projects proposing the establishment, or expansion of Neonatal Intensive Care Service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements, as well as charts for the service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1130.531 - Neonatal Intensive Care Services

1. Applicants proposing to establish, expand and/or modernize the Neonatal Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Neonatal Intensive Care		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand
1130.531(a) - A description of the project that identifies the location of the neonatal intensive care unit and the number of neonatal intensive care beds proposed;	X	X
1130.531(b) - Verification that a final cost report will be submitted to the Agency no later than 90 days following the anticipated project completion date;	X	X
1130.531(c) - Verification that failure to complete the project within the 24 months after the Board approved the exemption will invalidate the exemption.	X	X

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

SECTION V. CHANGE OF OWNERSHIP (CHOW)

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the	X

compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	
1130.520(b)(2) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

Application for Change of Ownership Among Related Persons

When *a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership.* [20 ILCS 3960/8.5(a)]

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

VI. 1120.120 - AVAILABILITY OF FUNDS (Neonatal Intensive Care Services only)

NA

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

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
		TOTAL FUNDS AVAILABLE

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY

N/A

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

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

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

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

2. 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 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY N/A

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

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY) NA

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]:

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 40.

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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 41.

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

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	23-24
2	Site Ownership	25-26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	27-28
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	30
6	Historic Preservation Act Requirements	31
7	Project and Sources of Funds Itemization	N/A
8	Financial Commitment Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	N/A
11	Background of the Applicant	32-35
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
	Service Specific:	
14	Neonatal Intensive Care Services	N/A
15	Change of Ownership	36-57
	Financial and Economic Feasibility:	
16	Availability of Funds	N/A
17	Financial Waiver	N/A
18	Financial Viability	N/A
19	Economic Feasibility	N/A
20	Safety Net Impact Statement	N/A
21	Charity Care Information	58

ASSOCIATED SURGICAL CENTER, LLC

CERTIFICATE OF GOOD STANDING

Attached is a copy of the Illinois Secretary of State Certificate of Good Standing for Associated Surgical Center, LLC

ASC ATTACHMENT 001

File Number 0591967-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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* 10TH *day of* FEBRUARY *A.D.* 2017 .

Authentication #: 1704101848 verifiable until 02/10/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ASC ATTACHMENT 001 - 1

ASSOCIATED SURGICAL CENTER, LLC

SITE OWNERSHIP

Attached as Attachment 002-1 is proof of ownership for the site, owned by Rand Road Center, LLC in the form of a Cook County Assessor's Office tax assessor's document for the Tax year 2016.

ASC ATTACHMENT 002

Property Characteristics for PIN: Back to Search Results

03-18-401-167-1001

PROPERTY ADDRESS

129 W RAND RD
ARLINGTON HEIGHTS
60004
Township: WHEELING

MAILING ADDRESS

RAND RD CTR LLC
201 E STRONG ST 7
WHEELING, IL 60090

INFO FOR TAX YEAR 2016

Estimated Property Value:	
Total Assessed Value:	48,416
Lot Size (SqFt):	92,975
Building (SqFt):	
Property Class:	5-99
Tax Rate (2015):	11.065
Tax Code (2016):	38023

TAX BILLED AMOUNTS & TAX HISTORY

2016: $7,862.67* Pay Online: $7,862.67 due
2015: $14,295.76 Paid in Full
2014: $13,878.29 Payment History
2013: $13,529.37 Payment History
2012: $13,749.60 Payment History
*=(1st Install Only)

EXEMPTIONS

2016: Not Available
2015: 0 Exemptions Received
2014: 0 Exemptions Received
2013: 0 Exemptions Received
2012: 0 Exemptions Received

APPEALS

2016: Not Available
2015: Appeal Filed
2014: Appeal Filed
2013: Not Accepting Appeals
2012: Appeal Filed

REFUNDS AVAILABLE

No Refund Available

TAX SALE (DELINQUENCIES)

2016: Tax Sale Has Not Occurred
2015: Tax Sale Has Not Occurred
2014: No Tax Sale
2013: No Tax Sale
2012: No Tax Sale

DOCUMENTS, DEEDS & LIENS

1525939102 - FINANCING STATEMENT - 09
1517613079 - RELEASE - 06/25/2015
1517613078 - RELEASE - 06/25/2015
1515249010 - MODIFICATION - 06/01/2015
1422549006 - ASSIGNMENT - 08/13/2014

All years referenced herein denote the applicable tax year (i.e., the year for which taxes were assessed). Parcels may from time to time be consolid subdivided. If information regarding a particular PIN appears to be missing for one or more tax years, it is possible that the PIN has changed du consolidation or subdivision. Users may contact the Cook County Clerk's Office for information regarding PIN lineage. Users should also note th information displayed on this site does not include special assessments (which are billed and collected by municipalities) or omitted taxes (which are asse an ad hoc basis by the Cook County Assessor's Office). Please direct inquiries regarding the status of special assessments to your municipality. Qu regarding omitted taxes should be directed to the Assessor's Office.

Note: This printout cannot be used as a tax bill.

ASC ATTACHMENT 002-1

OPERATING IDENTITY & OWNERSHIP INTEREST

Certificate of Good Standing from the Illinois Secretary of State for Associated Surgical Center, LLC is attached as ATTACHMENT 003-1

Associated Surgical Center, LLC, (the proposed operating licensee) is solely (100%) owned by Yelena Levitin, M.D.

ASC ATTACHMENT 003

File Number 0591967-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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* 10TH *day of* FEBRUARY *A.D.* 2017 .

Authentication #: 1704101848 verifiable until 02/10/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ASC ATTACHMENT 003-1

ORGANIZATIONAL RELATIONSHIP

There are no related persons or entities

FLOOD PLAIN REQUIREMENTS

This project complies with the requirements of the Flood Plain Rule under Illinois Executive Order # 2006-5 (http://hfsrb.illinois.gov) in that the facility and property is located outside of the 500-year frequency floor elevation as determined by FEMA.

There has been no change since the ASTC opened.

ASC ATTACHMENT 005

HISTORICAL PRESERVATION ACT REQUIREMENTS

The proposed project does not involve or include the demolition of any structures; the construction of any new buildings; or the modernization of any existing buildings and will not affect historic resources.

This criterion is NA

BACKGROUND OF THE APPLICANT

1. Listing of healthcare facilities: Chicago Surgical Clinic, Ltd owns and operates an ambulatory surgical treatment center (ASTC) licensed by the Illinois Department of Public Health and to be changed to Associated Surgical Center, LLC.

   A copy of IDPH ASTC License No 7003204 is attached.

2. None - Also attached is a copy of the most recent IDPH site survey dated 06/03/2016 finding that the facility was found to be in compliance with all licensure requirements with no cited deficiencies. The facility opened in June 2016.

3. See attached signed authorization letter as ASC ATTACHMENT 011-3

4. NA

Illinois Department of PUBLIC HEALTH

HF111127

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	ID NUMBER
6/2/2017		7003204

Ambulatory Surgery Treatment Center

Effective: 06/03/2016

Chicago Surgical Clinic Ltd
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. #4012320 10M 3/12

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ASC ATTACHMENT 01-1

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003204	27125	6/3/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Surgical Clinic Ltd.	129 W. Rand Road, Arlington Heights, Il., 60004

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A001	An Initial Licensure Survey was completed at Northwestern Chicago Surgical Clinic Ltd. 6/3/16. The Facility was found to be in compliance with Illinois Administrative Code: Title 77, Chapter 1, Subpart b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

ASC ATTACHMENT 011-2

BACKGROUND OF THE APPLICANT

AUTHORIZATION

I, Yelena Levitin, M.D., as sole owner of Chicago Surgical Center, Ltd., do hereby authorize and permit the Illinois Health Facilities and Services Review Board (HFSRB) and the Illinois Department of Public Health (IDPH) to access any documents they deem necessary to verify the information submitted in this application, including, but not limited to:

a) Official records of IDPH or other State agencies
b) The licensing or certification records of other states when applicable; and
c) The records of nationally recognized accreditation organizations.

A copy of this signed document shall serve as an original authorization and permit.

Signed this 10th Day of February, 2017 by:

Yelena Levitin, M.D., Sole Owner

ASC ATTACHMENT 011-3

CHANGE OF OWNERSHIP

This is a change in ownership among related persons, and there are no other changes being proposed at the healthcare facility that would otherwise require a permit or exemption under the ACT.

1. Name of Facility: Currently Chicago Surgical Clinic, Ltd. ASTC; after change in name among related persons it will be Associated Surgical Center LLC
2. Background of the party: The ASTC is licensed in State of Illinois and no adverse action has been taken against the healthcare facility. See Certificate of Good Standing (attached) and latest IDPH Licensure Survey showing no deficiencies and stating that "The Facility was found to be in compliance with...Ambulatory Surgical treatment Center Licensing Requirements" (attached)
3. Structure of the transaction: Change of ownership among related persons
4. Name of Entity to be licensed: Associated Surgical Center, LLC
5. List of ownership: Sole member is Yelena Levitin, MD
6. Fair Market Value of the ASC assets to be transferred: $525,000.00
7. N/A
8. The CON Permit for Chicago Surgical Clinic, Ltd., Project No 12-076, has been completed
9. N/A
10. N/A
11. N/A
12. Infection control plan, policy defining quality, incident reporting and quarterly review is appended as ASC ATTACHMENT 015-12.
13. N/A There is no change in the facility's governing body
14. N/A
15. N/A

File Number 0591967-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

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.

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Authentication #: 1704101848 verifiable until 02/10/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ASC ATTACHMENT 015-1

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003204	27125	6/3/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Surgical Clinic Ltd.	129 W. Rand Road, Arlington Heights, Il., 60004

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A001	An Initial Licensure Survey was completed at Northwestern Chicago Surgical Clinic Ltd. 6/3/16. The Facility was found to be in compliance with Illinois Administrative Code: Title 77, Chapter 1, Subpart b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

- 38 - ASC ATTACHMENT 015-2

SUBJECT: PERFORMANCE IMPROVEMENT PLAN	REFERENCE #7001
	PAGE: 1 OF: 15
DEPARTMENT: AMBULATORY SURGICAL CENTER Associated Surgical Center	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE/OBJECTIVE:

- The Ambulatory Surgical Center (ASC) participates in a facility wide performance improvement (PI) program designed to monitor, evaluate and improve the quality, appropriateness and outcomes of clinical services by:
    - Planning, designing, measuring, assessing, improving new or revised processes of patient care and service,
    - Identifying opportunities through continuous assessment of systems and processes of care through a collaborative, interdisciplinary focus,
    - Implementing solutions and actions which will bring about the designed change, to
    - Facilitate a positive patient outcome, while
    - Maintaining a safe environment for staff, patients and visitors.
- The number and scope of distinct improvement projects conducted annually reflects the scope and complexity of the ambulatory surgical center's services and operations.
- The Ambulatory Surgical Center implements preventive strategies throughout the facility targeting adverse patient events and makes certain that all staff are familiar with these strategies.

RESPONSIBILITY:

- The Governing Body ensures that the Performance Improvement Plan:
    - Is defined, implemented and maintained by the ASC
    - Addresses the ASC's priorities and that all improvements are evaluated for effectiveness
    - Specifies data collection methods, frequency and details
    - Clearly establishes its expectations for safety
    - Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program

ASC ATTACHMENT 015-3

- The ASC Director of Nursing, in coordination with the Medical Director is responsible for establishing and implementing an Ambulatory Surgical Center Performance Improvement Plan. The plan shall integrate Ambulatory Surgical Center quality assessment/ improvement, continuous quality improvement (CQI) and quality control activities into a system that will foster improvement of patient care. The ASC DON also shall delegate responsibilities for monitoring, action, evaluation and reporting.

- The ASC DON will report all Ambulatory Surgical Center performance improvement activities to the medical staff and the Governing Body for their review and recommendations.

GOALS OF PERFORMANCE IMPROVEMENT:

- The primary goals of the Ambulatory Surgical Center Performance Improvement Plan are to continually and systematically plan, design, measure, assess and improve performance of priority focus areas, improve healthcare outcomes and reduce and prevent medical/health care errors. To achieve these goals the plan strives to:

  - Incorporate quality planning;

  - Provide a systematic mechanism for the facility's appropriate individuals, departments and professions to function collaboratively in their efforts toward performance improvement, providing feedback and learning throughout the facility;

  - Provide for a program that assures the department designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others. Process design contains the following focus elements:

    - Consistency with the facility's mission, vision, goals and objectives, and plans

    - Meets the needs of individuals served, staff and others

    - Use of clinically sound and current data sources (for instance, use of practice guidelines, information from relevant literature and clinical standards)

ASC ATTACHMENT 015-4

- Is based upon sound business practices
- Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this situation
- Utilizes the results of performance improvement, patient safety and risk reduction activities

- The Ambulatory Surgical Center incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions or services.
- The status of identified problems is tracked to assure improvement or problem resolution.
- Information and the findings of discrete performance improvement activities and adverse patient events are used to detect trends, patterns and performance or potential problems.
- The objectives, scope, organization and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation and problem-solving activities in the Performance Improvement Plan are evaluated annually and revised as necessary.
- Treatment and services affecting the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences or deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families or staff.

SCOPE OF CARE:

- The Ambulatory Surgical Center provides services for operative and other invasive procedures and immediate postoperative care. The Ambulatory Surgical Center is staffed to operate 2 operating room suites and 1 GI suite Monday through Friday 6 AM to 12 PM.
- The PACU is staffed Monday through Friday 6 AM to 2 PM.
- Registered nurses and operating room technicians, under the guidance of the registered nurse, provides care to patients with the clerical support.

PERFORMANCE ACTIVITIES:

- The Performance Improvement Plan for the Ambulatory Surgical Center monitors priority focus areas and processes of care which are felt to be high-risk, high volume, have demonstrated a trend toward potential negative patient outcome (problem prone) and/or that involve risks that may result in sentinel events or have been identified through the continuous quality improvement (CQI) process as an area where a system or process of patient care may be improved.
    - Surgical Risk Assessments for surgical site infections shall be performed every 3 Months (quarterly) minimum. Surgical site infection measures using best practices or evidence-based guidelines shall be selected. Compliance with best practices or evidence-based guidelines shall be monitored and the effectiveness of prevention activities shall be evaluated.
    - Surveillance may be targeted to certain procedures, based on the risk assessment.
- Additional indicators will be identified and chosen for monitoring through a collaborative effort utilizing information obtained from all areas of Nursing Services, administration, regulatory body reports, medical staff evaluation, patient care questionnaires and other clinical services throughout the facility, as appropriate.
- Proposed processes for assessment include, but are not limited to:
    - Medical necessity of procedures
    - The appropriateness of care
    - Management of the surgical patient: General Surgery, ENT, GI, GU, GYN, Oral/Maxillary, Orthopedics, Ophthalmology, Plastics, other
    - Management of the pediatric patient
    - Management of the geriatric patient
    - Management of patient pain
    - Education and preparation of the surgical patient

ASC ATTACHMENT 015-6

- Nursing standards of care and practice
- Nursing assessments, observations, interventions and routine care
- Patient/family education and instruction
- Patient confidentiality
- Surgical site infections
- Patient/visitor/staff safety management
- Hazard awareness, prevention and control
- Medication administration error reduction and elimination
- Surgical site identification
- Sentinel event reduction and elimination

- Performance monitoring of identified processes are subject to change due to the collaborative process outlined above.

PERFORMANCE MEASURES:

- Performance measures with related performance outcomes will be established as a means to systematically monitor the identified processes for review in an ongoing manner, and to provide operational linkages between the risk management functions related to the clinical aspects of patient care and safety and the performance improvement functions.

- Performance expectations will be established for any new or revised processes undertaken by the Ambulatory Surgical Center staff. Performance measures will be specific and measurable. Performance measures will be structured and related to both the processes and outcomes of patient care.

ASC ATTACHMENT 015-7

- Performance measures will pertain directly to the Ambulatory Surgical Center practices and will use objective criteria that reflect current knowledge and clinical practice.
  - The following criteria will be utilized to assure that the indicator chosen for data collection is the most appropriate for monitoring the performance of a patient care or service process, system or function:
    - The measure can identify the events it was intended to identify.
    - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable.
    - The measure has defined data elements and allowable values.
    - The measure can detect changes in performance over time.
    - The measure allows for comparison over time within the organization or between the organization and other entities.
    - The data intended for collection is available and attainable.
    - Results can be aggregated and reported in away that is useful to the organization and other interested parties.
  - Examples of Ambulatory Surgical Center Performance Measures:
    - Operative or other procedures that place patients at risk of disability or death
    - All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
    - Adverse events related to using moderate or deep sedation or anesthesia
    - The use of blood and blood components
    - All confirmed transfusion reactions
    - Significant medication errors

ASC ATTACHMENT 015-8

- Significant adverse drug reactions
- Patient burns from treatment/equipment
- Failure to obtain physician assistance when patient condition deteriorates
- Patient falls
- Incorrect or absent patient ID band
- Injury during transfer between gurney and OR table
- Tubes pulled out by patient
- Patient identification
- Surgical site identification - wrong site, side, patient, procedure, implant
- The administration and time of prophylactic antibiotics
- Appropriate surgical site hair removal
- IV errors - wrong solution, patient, rate or additives
- IV infiltration requiring treatment
- Medication errors
- Mishandled specimens
- Healthcare Associated Infections (HAIs) - Surgical Site Infections
- Patient temperature management during the perioperative period

- Improper Consent Form:
  - Surgical
  - Procedure omitted
  - Wrong procedure listed
  - Sterilization
- Incomplete Consent Form:
  - Surgical
  - Procedure
  - Sterilization
  - Blood
- No consent signed
- Arrests/Death:
- Hospital Transfers/Admission
- Unexpected Outcomes:
  - Motor deficit - not present on admission
  - Aphasia
  - Dysphasia
  - Foot drop

- Nerve Damage:
  - Ulnar
  - Brachial
  - Sciatic
  - Peripheral
- Sensory Deficit - not present on admission:
  - LOC
  - After anesthesia
  - Hearing loss
  - Seizures
- Vascular Deficit - not present on admission:
  - Circulatory impairment
  - Hematoma
  - Necrotizing enterocolitis
  - Occlusion
  - Thrombosis
- System Failure - not present on admission:
  - Hemorrhage
  - Pneumothorax
  - Renal Failure

ASC ATTACHMENT 015-11

- Incorrect controlled substance count
- Security incident
- Defaced, tampered, altered or damaged medical records
- Patient outcomes, long and short range
- Education of patient and family
- Staffing effectiveness
- National Patient Safety Goals

THRESHOLDS:

Measurement of performance measures will be structured to focus on an improvement in patient care and safety. Thresholds will represent either pre-established levels, that when reached trigger an intensive evaluation of the measure under review, or benchmarks that have been identified by facility experience, that require an in-depth evaluation of the proposed performance aspect and related performance measures. Thresholds will also serve as a means to identify targeted areas for further study.

ASC ATTACHMENT 015-12

METHODOLOGY:

- The Ambulatory Surgical Center utilizes the Plan, Do, Check, Act (PDCA) methodology to plan, design, measure, assess and improve functions and processes related to major patient care related activities.
  - **Plan:**
    - Performance measures are based on current knowledge and experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.
    - The following data sources will be reviewed for use in the development of performance measures:
      - Staff opinions and needs
      - Staff perceptions of risks to patients and suggestions for improving patient safety
      - Staff willingness to report medical/health care errors
      - Outcomes of processes or services, including adverse events
      - Autopsy results
      - Performance measures from facility-approved internal and external databases
      - Infection control surveillance and reporting
      - Satisfaction surveys
      - Risk management

- ♦ Utilization management
- ♦ Quality control
- ♦ Customer demographics and diagnoses

- Benchmarks or thresholds that trigger intensive assessment and evaluation are established.

- **Do:**
  - Data is collected to determine:
    - ♦ Whether the design specifications for new processes were met
    - ♦ The level of performance and stability of existing processes
    - ♦ Priorities for possible improvement of existing processes

- **Check:**
  - The ASC DON and Medical Director reviews and evaluates the data presented for analysis of outcome.
  - Appropriate statistical methodology is employed to analyze and display data. Evaluation focuses on identifying opportunities to improve both the processes of patient care and actual identified problem areas that effectuate a negative outcome, as well as the reduction and/or elimination of real or potential sentinel events.
  - Comparisons with both internal, historical data and external data will be performed in the evaluation process, with undesirable patterns or trends in performance and sentinel events requiring intensive analysis. Conclusions will be drawn regarding the evaluation of data presented with recommendations considered.

- **Act:**
  - Upon review of the data presentation, conclusions and recommendations, the Ambulatory Surgical Center will take actions to resolve identified problems and will direct efforts to those areas which have the greatest potential for improving patient care and reducing the risk of sentinel events.
  - The Ambulatory Surgical Center utilizes existing resources, committees, and problem-solving techniques to resolve identified problems and improve patient care and safety.
  - The Ambulatory Surgical Center performs follow-up monitoring to assure that actions taken are effective and that any progress achieved is sustained. The criteria used for follow-up monitoring should be the same or similar to those used in the initial identification of the problem/opportunity for improvement, however, the sample size may vary or focused monitoring may be utilized for effectiveness.

COMMUNICATION/INTEGRATION OF INFORMATION:

- The Ambulatory Surgical Center documents the improvement projects it is conducting. The documentation includes, at a minimum, the reason(s) for implementing the project and a description of the project's results.
- The ASC/OPS Nurse Manager and Medical Director ensures that documentation of the results of the outcomes performance improvement and patient safety activities are maintained and that reports are forwarded as prescribed.
- The Medical staff committee and Nursing Services committee reviews the outcome of the Ambulatory Surgical Center's ongoing performance improvement activities. The frequency of reporting will be as defined in the facilitywide performance improvement plan, on a monthly/bimonthly/quarterly basis as designated. Documentation and reports shall include:
  - Findings from monitoring activities
  - Conclusions regarding identified opportunities for improvement

- Recommendations concerning potential actions
- Actions taken to effectuate change
- Outcome of action effectiveness (results of follow-up monitoring performed to determine extent of effectiveness and that improvements made are sustained)

- Surgical site infection rates data and prevention outcome measures shall be communicated to ASC Governing Body, licensed independent practitioners, nursing staff and other clinicians on a quarterly basis.

ANNUAL EVALUATION OF PERFORMANCE IMPROVEMENT PLAN:

The Ambulatory Surgical Center shall evaluate the effectiveness of the performance improvement monitoring and evaluation program at least annually and revise as necessary. The evaluation shall be documented and forwarded to the Governing Body.

CONFIDENTIALITY:

- All information related to performance improvement activities performed by the medical staff or ASC staff in accordance with the plan is confidential.
  - Confidential information may include, but is not limited to: the medical staff committee minutes, Performance Improvement Executive Report, electronic data gathering and reporting, untoward incident reporting and clinical profiling.
  - Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank or any individual or agency that proves a "need to know basis" as approved by the Medical Staff Committee and the Governing Body.

SUBJECT: PERFORMANCE IMPROVEMENT PLAN	REFERENCE #7001
	PAGE: 15 OF: 15
DEPARTMENT: AMBULATORY SURGICAL CENTER Associated Surgical Center	EFFECTIVE:
APPROVED BY:	REVISED:

AMBULATORY SURGICAL CENTER PI PLAN APPROVAL:

Barbara L Ramsey RN
Director of Nursing

2/14/17
Date

G Law
Medical Director

2/14/17
Date

Mary R Mayo
Administrator

02/14/2017
Date

ASC ATTACHMENT 015-17

Associated Surgical ASC
Infection Control Plan
Year 2016

The Purpose/ Plan

The Associated Surgical Center has established an infection control plan that is designed, monitored and organization-wide in scope.

The infection control plan is designed and implemented to work within the overall quality improvement activities of the center and assist in accomplishing the overall mission and strategic plan of the organization.

The goals of this plan are to provide the center with a mechanism for monitoring, assessing, and reducing the center's rate of infection and establishing benchmarks to obtain these goals.

The objective is to reduce/ control the overall number of infections that may occur among patients, employees, physicians and others within the center. The center accomplishes this by implementing systems and programs to survey, trend, report, and prevent infections in accordance with state, federal, and recognized national standards and guidelines.

The center has established guidelines to reduce the risk of infectious patients within the center. Since the center is not equipped to handle an influx of infectious patients, and since it is a freestanding facility, it has been determined that should an influx of infectious patients present at the center, these patients would be immediately referred to the primary care physicians, urgent care centers or hospital emergency rooms depending upon the presenting condition of surgical patient, for further treatment.

Mission Statement:

Our Infection Control Mission is to promote a healthy and safe environment by preventing transmission of infectious agents among patients, staff and visitors. This is accomplished in an efficient and cost effective manner by continually assessing, and modifying our services based on regulations, standards, studies, and guidelines.

Description of Facility

Associated Surgical Center is a freestanding multi-specialty ambulatory surgery facility licensed by the Illinois Department of Public Health. Facility consists of class C operating rooms, A GI Endoscopy Procedure Room, a recovery area, clinical support areas, business office area and a waiting area.

Staff of the facility includes surgeons, registered nurses, surgical technicians, Sterile Processing Technicians, medical assistants and business office personnel.

Infection Control Program Goals

The goal of Associated Surgical's infection control program is to identify and reduce the risks for acquiring and transmitting infections among all internal and external customers by applying scientifically and epidemiological based surveillance, prevention and control of infection functions. Additionally, Associated Surgical's infection control program goals include the establishment and

maintenance of collaborative relationships with external organization support systems in order to reduce the organization's risk of infection from the environment.

Components of Plan

The Infection Control plan is based, in part on the American Association for Accreditation of Ambulatory Surgery Facilities standards as outlined in the AAAASF Regular Standards and Checklist for accreditation of ambulatory surgery facilities (current edition)

The Quality Council (a component of the QAPI Committee and Consultation Committee), through the Infection Control Practitioner overseas the Infection Control Program. The Infection Control Program is multidimensional and includes components of surveillance, identification, prevention and control of infections and reporting. The Infection Control Practitioner on a quarterly basis presents reports to the facility's Quality Council Committee (QAPI). Through the Infection Control Practitioner the Quality Council address issues that are important to the organization, including:

- Device-related infections;
- Surgical site infections;
- Clinically important and antibiotic-resistant organisms; and
- Communicable disease, especially vaccine-preventable infections.
- Healthcare related infections that result in a sentinel event

Also, the facility has established liaison relationships and cooperation with the Illinois Department of Public Health to help ensure continuity of care, appropriate follow-up, and prevention of transmission of communicable diseases

Categories

- Surveillance
- Identification
- Prevention and Control of Infection
- Reporting

Surveillance: The center has developed a method to survey and collect data to determine if any post-operative infections have occurred with patients. Educational efforts will also be made available to staff members to assist in the surveillance of infection. Types of surveillance will be total, targeted and problem-oriented or outbreak surveillance.

Identification: The center upon identification of an infection or any potential infection will begin an investigation into factors associated to determine if it is center or community specific.

Prevention and Control of infection: The center develops policies and procedures that provide guidance to the staff and others on methods to prevent occurrences of infection. The management of the center also provides support and ongoing training/ in-servicing of the staff on prevention and control of infection within and outside of the workplace. Protocols

limiting types of infectious cases, or potentially infectious patients have also been established.

Reporting: Tracking in areas where potential infections could occur will be completed by the staff members in specific departmental areas. Any reports of infections or potential issues will be reported to the Quality Council (QAPI Committee, Consulting Committee) on a primary level and brought up through the appropriate bodies for additional recommendations. Community related cases will be reported to the appropriate authorities. All sentinel events relating to healthcare acquired infections will be handled per the center's sentinel event policies as well as by following by the National Patient Safety Goals.

Responsibility for Implementation

Staff members are responsible for reporting and complying with protocols.

Infection Control Officer – responsible for monitoring and surveillance of program, and updating needs based on that of the organization.

The Quality Council is responsible for gathering data and analyzing any trends.

The Governing Board is responsible for analyzing any trends, making recommendations, and responsible for the overall oversight and management.

Program Assessment/ Risk Analysis

(See attached Grid)

The Center completed a Risk Analysis Summary of the areas identified as risks after completing the risk analysis. Refer to center's Risk Analysis Report.

Monitoring Activities

Daily:	Hand washing practices, biological indicators, chemical indicators, staffing patterns, housekeeping practices, sterilizers, traffic patterns, operative techniques, products
Weekly:	Biologicals, Cidex monitoring (if applicable), housekeeping practices,
Monthly:	Infection Letters to physicians, Waste manifests, incident reports, sterilizer logs/ graphs,
Quarterly:	ICT Magazine articles, IDPH updates, CDC updates, new accreditation standards, human resource reports, state and/or national ASC Association, infection benchmarks, laundry services, medication / pharmacy monitoring
Yearly:	OSHA training, vaccinations, human resource summaries, environmental monitoring, education activities, review of all policies and procedures
As needed:	Construction Activities and building maintenance

Implementation Guidelines 2016

Short-term goals:

Ongoing: Monitoring Flash Sterilizing
Ongoing: Quality Council reporting/ monitoring
Ongoing: Incorporate new goals if necessary based on AAAASF recommendations.
Evaluate protocols after performing risk analysis

Mid-term goals:

Identify what new Instrument trays have been added at year-end in comparison to budget requests.
Determine what additional inoculations for staff members- monitor county health issues
Track quarterly summaries # of sick days

Long-term goals:

APPROVAL AND REVIEW OF INFECTION CONTROL PLAN AND ACTIVITIES

ADMINSITRATOR
INFECTION CONTROL OFFICER
GOVERNING BOARD

INFECTION CONTROL OFFICER SIGNATURE: Barbara L Ramsey RN

ADMINISTRATOR SIGNATURE Mary G Mays

GOVERNING BOARD CHAIRMAN: _____

Date Approved:

CHARITY CARE INFORMATION

Chicago Surgical Clinic, Ltd. ASTC had pledged to provide 3% charity care. The facility has not yet completed its first year of operations, and, therefore, has no audited statement. The change in ownership among related persons will not change this commitment.

ASC ATTACHMENT 021