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Clare Connor Ranalli
Attorney at Law
cranalli@mwe.com
+1 312 984 3365

June 5, 2017

Via Federal Express Overnight Delivery

Ms. Courtney Avery
Administrator, Illinois Health Facilities & Services Review Board
525 W. Jefferson St. 2nd Floor
Springfield, Illinois 62761

Re: Fox Valley Orthopaedic Institute Change of Ownership

Dear Ms. Avery:

Enclosed please find a certificate of exemption application requesting approval of a change of ownership of the above referenced ambulatory surgery center. Also enclosed is the required filing fee. If you have any questions do not hesitate to contact me.

As always, thank you.

Sincerely,

Clare Connor Ranalli

Clare Connor Ranalli

Enclosures
CCR/pc

CC: Mike Constantino
Barry Mathews, CEO, Fox Valley Orthopaedic Institute

DM_US 82262240-1.102924.0011

[ORIGINAL] ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

RECEIVED
JUN 06 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Fox Valley Orthopaedic Institute			
Street Address: 2525 Kaneville Road			
City and Zip Code: Geneva 60134			
County: Kane	Health Service Area	008	Health Planning Area: 089

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

Exact Legal Name: Fox Valley Orthopaedic Associates S.C.
Street Address: 2525 Kaneville Road
City and Zip Code: Geneva 60134
Name of Registered Agent: Craig Torosian, M.D.
Registered Agent Street Address: 2525 Kaneville Road
Registered Agent City and Zip Code: Geneva 60134
Name of Chief Executive Officer: Barry Mathews
CEO Street Address: 2525 Kaneville Road
CEO City and Zip Code: Geneva 60134
CEO Telephone Number: (630) 524-0123

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ 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: Clare Connor Ranalli
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 444 West Lake Street Suite 4000 Chicago, IL 60606-0029
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit] None

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Fox Valley Orthopaedic Institute
Street Address: 2525 Kaneville Road
City and Zip Code: Geneva 60134
County: Kane Health Service Area 008 Health Planning Area: 089

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

Exact Legal Name: FVO Administrative Services, S.C.
Street Address: 2525 Kaneville Road
City and Zip Code: Geneva 60134
Name of Registered Agent: Craig Torosian
Registered Agent Street Address: 2525 Kaneville Road
Registered Agent City and Zip Code: Geneva 60134
Name of Chief Executive Officer: Barry Mathews
CEO Street Address: 2525 Kaneville Road
CEO City and Zip Code: Geneva 60134
CEO Telephone Number: (630) 524-0123

Type of Ownership of Applicants

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

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

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Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit] None

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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: Barry Mathews
Title: CEO
Company Name: Fox Valley Orthopaedic Institute
Address: 2525 Kaneville Road Geneva IL 60134
Telephone Number: (630) 524-0123
E-mail Address: bmathews@fvortho.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: The Kaneville Road Joint Venture, LLC
Address of Site Owner: 2525 Kaneville Road Geneva IL 60134
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: Fox Valley Orthopaedic Institute
Address: 2525 Kaneville Road Geneva IL 60134
☐ Non-profit Corporation ☐ Partnership ☒ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ 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 organized and the name and address of each partner specifying whether each is a general or limited partner. o **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 N/A – Change of Ownership

[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.illinois.gov/sites/hfsrb**)**.

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.] **N/A – Change of Ownership**

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:

- ☒ Change of Ownership
- ☐ 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.

Fox Valley Orthopaedic Associates, S.C. d/b/a Fox Valley Orthopaedic Institute ("Licensee") is going to merge into an existing corporate entity, FVO Administrative Services, S.C., with the latter being the surviving entity. As a result, the ambulatory surgery center license held by the Licensee will have to be issued to a new person (i.e. FVO Administrative Services, S.C.). However, the physician shareholders and their respective shareholder interest in the ambulatory surgery center will remain the same in the new entity/new licensee as in the current Licensee. Also, the location of the surgery center and its operations will not change in any way.

NOTE: As part of the merger, FVO Administrative Services, S.C. will change its name to Fox Valley Administrative Associates, S.C. However, this will constitute solely a name change and although it will assume the name of the prior legal entity of the Licensee, FVO Administrative Associates is a distinct legal entity from the Licensee and will remain so after the name change.

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

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	N/A	N/A	N/A
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	N/A	N/A	N/A
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	N/A	N/A	N/A
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	N/A	N/A	N/A
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	N/A	N/A	N/A
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	N/A	N/A	N/A
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 ☒ No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ N/A.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): on or before 08/31/17

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

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

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☐ Cancer Registry
☐ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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

SIGNATURE

Barry Mathews
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of May, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

SIGNATURE

TIM PETSCHE MD
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of May, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

SIGNATURE

Barry Mathews
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of May, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

SIGNATURE

TIM PETSCHE MD
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 30th day of May, 2017

Signature of Notary

Seal

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

*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.

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)

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

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 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 compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(2) - A statement as to the anticipated benefits of	X

the proposed changes in ownership to the community	
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.

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
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3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	18
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5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Financial Commitment Document if required	
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11	Background of the Applicant	20-22
12	Purpose of the Project	
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	Service Specific:	
14	Neonatal Intensive Care Services	
15	Change of Ownership	23-24
	Financial and Economic Feasibility:	
16	Availability of Funds	
17	Financial Waiver	
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19	Economic Feasibility	
20	Safety Net Impact Statement	
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CERTIFICATES OF GOOD STANDING

APPLICANTS

File Number 5043-548-2

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

FOX VALLEY ORTHOPAEDIC ASSOCIATES, S. C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 25, 1974, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION 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* 30TH *day of* MAY *A.D.* 2017 .

Authentication #: 1715002632 verifiable until 05/30/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

File Number 6253-703-5

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

FVO ADMINISTRATIVE SERVICES, S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 27, 2002, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION 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* 30TH *day of* MAY *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1715002638 verifiable until 05/30/2018

Authenticate at: http://www.cyberdriveillinois.com

PROOF OF SITE OWNERSHIP

I, Barry Mathews, CEO, do hereby attest that Fox Valley Orthopaedic Associates, S.C. leases space for the Fox Valley Orthopaedic Institute at 2525 Kaneville Road in Geneva, Illinois. The Lessor is the Kaneville Road Joint Venture, LLC. That lease will be assigned to FVO Administrative Services, S.C. after the proposed change of ownership.

Barry Mathews, CEO

Subscribed and sworn to before me
This 30th day of May, 2017

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

Notary Public

CERTIFICATE OF GOOD STANDING

LICENSEE

File Number 5043-548-2

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

FOX VALLEY ORTHOPAEDIC ASSOCIATES, S. C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 25, 1974, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION 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* 30TH *day of* MAY *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1715002632 verifiable until 05/30/2018

Authenticate at: http://www.cyberdriveillinois.com

ORGANIZATION CHART

N/A – no related party

However, of interest may be the fact that ten physicians have a ten percent (10%) membership (ownership) interest in the current legal entity that owns the Licensee, and the same physicians will have the same membership interest in the new owner of the Licensee.

BACKGROUND OF APPLICANT

Fox Valley Orthopaedic Associates, S.C. owns only one health care facility, which is the ambulatory surgery center at issue.

Attached is the license for Fox Valley Orthopaedic Institute.

Illinois Department of PUBLIC HEALTH

HF111268

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
07/28/2017		7002165

Ambulatory Surgery Treatment Center

Effective: 07/29/2016

Fox Valley Orthopaedic Institute
2525 Kaneville Road
Geneva, IL 60134

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 07/28/2017

Lic Number 7002165

Date Printed 07/08/2016

Fox Valley Orthopaedic Institute

2525 Kaneville Road
Geneva, IL 60134

FEE RECEIPT NO.

update

Fox Valley Orthopaedic Associates, S.C. does hereby attest no adverse action as that term is defined in 77 IAC 1130.140 has been taken against it in the three (3) years preceding this application.

In addition, it authorizes the HFSRB and IDPH to access information necessary to verify information submitted in this application.

Barry Mathews, CEO

Subscribed and sworn to before me
This 30th day of May, 2017

Notary Public

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

FVO Administrative Services, S.C. does hereby attest no adverse action as that term is defined in 77 IAC 1130.140 has been taken against it in the three (3) years preceding this application.

In addition, it authorizes the HFSRB and IDPH to access information necessary to verify information submitted in this application.

Barry Mathews, CEO

Subscribed and sworn to before me
This 30th day of May, 2017

Notary Public

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

APPLICABLE REVIEW CRITERIA – 1130.520

Fox Valley Orthopaedic Services, S.C. shall merge into FVO Administrative Services, S.C. As certified previously, no adverse action has been taken against Fox Valley Orthopaedic Associates d/b/a Fox Valley Orthopaedic Institute within the three years preceding this application. The structure of the transaction is a merger. After the merger, FVO Administrative Services, S.C., under its new corporate name Fox Valley Orthopaedic Associates, S.C., will do business as Fox Valley Orthopaedic Institute and will be the licensee. The owners of the current licensee, Fox Valley Orthopaedic Associates, S.C., are Dr. C. Popp, Dr. C. Torosian, Dr. D. Morawski, Dr. E. Bartel, Dr. J. Petrucci, Dr. J. Sostak, Dr. K. Ketterling, Dr. T. Atkins, Dr. T. Petsche and Dr. V. Mehta. Each own a ten percent (10%) interest. These same physicians will hold the same interest in the new licensee FVO Administrative Services, S.C. d/b/a Fox Valley Orthopaedic Institute. This is a merger of one entity into another and there is no cash being exchanged. The FMV of the facility is $6,000,000.00.

APPLICABLE REVIEW CRITERIA – 1130.520(b)(2)

All CON projects for which permits have been issued to the Hospital have been completed/obligated or will be prior to the change of ownership of the physical plant.

There will be no change to community benefit or cost savings as a result of the transaction. The purpose of the transaction is to eliminate an unnecessarily complicated corporate structure and to streamline operations for the shareholders.

The quality improvement program and the manner of selection of the licensee's governing body will not change as a result of the transaction.

A written response describing the transaction will be made available to the public.

There will be no decrease or material changes in services as a result of the transaction for a period of twenty-four (24) months after the transaction.

Barry Mathews, CEO

Subscribed and sworn to before me
This 30th day of May, 2017

Notary Public

"OFFICIAL SEAL"
ANDREW A MCCULLOUGH
Notary Public, State of Illinois
My Commission Expires 8/29/2020

CHARITY CARE INFORMATION

Fox Valley Orthopaedic Institute CHARITY CARE			
	2016	**2015**	**2014**
Net Patient Revenue	**$2,471,097**	**$1,492,644**	**$537,287**
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

NOTE: A 20% discount is provided to some patients based on ability to pay. Some surgeons do individual charity care (free) cases, but this is not tracked by the facility.

Reference Numbers Facility Id 7002165
Health Service Area 008 Planning Service Area 089
Fox Valley Orthopaedic Institute
2525 Kaneville Road
Geneva, IL 60134

Administrator
Deborah Lee Crook, RN, CASC

Date Complete
3/10/2016

Contact Person
Deborah Lee Crook, RN CASC

Telephone
630-513-2635

Registered Agent
Fox Valley Orthopaedic Associa

Property Owner
Kaneville Road Joint Vent

Legal Owner(s)
Dr. C. Popp
Dr. C. Torosian
Dr. D. Morawski
Dr. E. Bartel
Dr. J. Pertrucci
Dr. J. Sostak
Dr. K. Ketterling
Dr. T. Atkins
Dr. T. Petsche
Dr. V. Metha

Number of Operating Rooms	4
Procedure Rooms	0
Exam Rooms	0
Number of Recovery Stations Stage 1	7
Number of Recovery Stations Stage 2	7

Type of Ownership
Corporation (RA required)

HOSPITAL TRANSFER RELATIONSHIPS

HOSPITAL NAME	NUMBER OF PATIENTS
Delnor Community Hospital	3
	0
	0
	0
	0

STAFFING PATTERNS

PERSONNEL	FULL-TIME EQUIVALENTS
Administrator	1.00
Physicians	0.00
Nurse Anesthetists	0.00
Director of Nurses	0.00
Registered Nurses	10.60
Certified Aides	0.00
Other Health Profs.	5.39
Other Non-Health Profs	3.55
TOTAL	20.54

DAYS AND HOURS OF OPERATION

Monday	10
Tuesday	10
Wednesday	10
Thursday	10
Friday	10
Saturday	0
Sunday	0

NUMBER OF PATIENTS BY AGE GROUP

AGE	MALE	FEMALE	TOTAL
0-14 years	40	54	94
15-44 years	437	319	756
45-64 years	749	819	1,568
65-74 years	281	339	620
75+ years	148	207	355
TOTAL	1,655	1,738	3,393

NUMBER OF PATIENTS BY PRIMARY PAYMENT SOURCE

PAYMENT SOURCE	MALE	FEMALE	TOTAL
Medicaid	0	0	0
Medicare	336	447	783
Other Public	0	0	0
Insurance	1,187	1,206	2,393
Private Pay	126	74	200
Charity Care	6	11	17
TOTAL	1,655	1,738	3,393

NET REVENUE BY PAYOR SOURCE FOR FISCAL YEAR

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense	Charity Care Expense as % of Total Net Revenue
11.8%	0.0%	0.0%	70.0%	18.3%	100.0%		
881,923	0	0	5,242,782	1,369,779	7,494,484	24,186	0%

Source:Ambulatory Surgical Treatment Center Questionnaire for 2015, Illinois Department of Public Health, Health Systems Development

OPERATING ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	TOTAL SURGERIES	SURGERY TIME (HOURS)	SURGERY PREP AND CLEAN-UP TIME (HOURS)	TOTAL SURGERY TIME (HOURS)	AVERAGE CASE TIME (HOURS)
Cardiovascular	0	0.00	0.00	0.00	0.00
Dermatology	0	0.00	0.00	0.00	0.00
Gastroenterology	0	0.00	0.00	0.00	0.00
General	0	0.00	0.00	0.00	0.00
Laser Eye	0	0.00	0.00	0.00	0.00
Neurological	0	0.00	0.00	0.00	0.00
OB/Gynecology	0	0.00	0.00	0.00	0.00
Ophthalmology	0	0.00	0.00	0.00	0.00
Oral/Maxillofacial	0	0.00	0.00	0.00	0.00
Orthopedic	2024	2,236.00	1,170.00	3406.00	1.68
Otolaryngology	0	0.00	0.00	0.00	0.00
Pain Management	1026	194.00	197.50	391.50	0.38
Plastic	0	0.00	0.00	0.00	0.00
Podiatry	343	348.00	189.55	537.55	1.57
Thoracic	0	0.00	0.00	0.00	0.00
Urology	0	0.00	0.00	0.00	0.00
TOTAL	3393	2,778.00	1,557.05	4335.05	1.28

PROCEDURE ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	PROCEDURE ROOMS	TOTAL SURGERIES	SURGERY TIME (HOURS)	PREP AND CLEAN-UP TIME (HOURS)	TOTAL SURGERY TIME (HOURS)	AVERAGE CASE TIME (HOURS)
Cardiac Catheteriza	0	0	0	0	0	0.00
Gastro-Intestinal	0	0	0	0	0	0.00
Laser Eye	0	0	0	0	0	0.00
Pain Management	0	0	0	0	0	0.00
TOTALS	0	0	0	0	0	0.00

Leading Locations of Patient Residence

Zip Code	City	County	Patients
		Kane	2735
		De Kalb	177
		Du Page	123
		Mchenry	123
		Kendall	89
		Cook	78
		Lake	15
		Boone	4
		Charlotte	4
		La Salle	3
		Lee	3
		Ogle	3
		Vermilion	3
		Whiteside	3
		Maricopa	2
		Walworth	2
		Hamilton	2
		Grundy	2
		El Paso	1
		Larimer	1
		Stephenson	1
		Polk	1
		Orange	1
		Oldham	1