

12-087

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

OCT 1 7 2012

This Section must be completed for all projects.

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name: Western Diversey Surgical Center			
Street Address: 2744 N. Western Avenue			
City and Zip Code: Chicago, IL 60647			
County: Cook	Health Service Area	6	Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Renlin Xia	
Address: 3412 W. Fullerton Avenue, Chicago, IL 60647	
Name of Registered Agent: Renlin Xia	
Name of Chief Executive Officer: Renlin Xia	
CEO Address: 2744 N. Western Avenue, Chicago, IL 60647	
Telephone Number: 773-216-1460	

Type of Ownership of Applicant/Co-Applicant

- | | |
|--|--|
| <input type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship |
- Other
INDIVIDUAL
- 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.

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 during the review period]

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460
E-mail Address: awmscd@sbcglobal.net
Fax Number:

Additional Contact

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

Name: Ira Rogal
Title: Consultant
Company Name: Shea, Paige & Rogal, Inc.
Address: 547 S. LaGrange Road, LaGrange, IL 60525
Telephone Number: 708-482-4820
E-mail Address: iar4@aol.com
Fax Number: 708-482-1091

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Western Diversey Surgical Center			
Street Address: 2744 N. Western Avenue			
City and Zip Code: Chicago, IL 60647			
County: Cook	Health Service Area	6	Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: American Women Medical Group, Ltd. d/b/a Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Name of Registered Agent: Renlin Xia
Name of Chief Executive Officer: Renlin Xia
CEO Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input checked="" type="checkbox"/> Other INDIVIDUAL	
<ul style="list-style-type: none"> 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. 	

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 during the review period]

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
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Telephone Number: 708-482-4820
E-mail Address: iar4@aol.com
Fax Number: 708-482-1091

Post Permit Contact

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

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number:
E-mail Address:
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Renlin Zia, M.D.
Address of Site Owner: 3412 W. Fullerton, Chicago, IL 60647
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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:
Address:
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> 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 co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (<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:

- Substantive
- Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- Part 1120 Not Applicable
- Category A Project
- Category B Project
- DHS or DVA Project

2. Narrative Description

Provide in the space below, 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.

NARRATIVE DESCRIPTION

The facility is a corporation currently owned 50% by the applicant, Renlin Xia, M.D., and 50% by another individual. Applicant is buying out the other owner and will own 100% of the stock of this ASTC after the transaction is completed.

It is a change of ownership and therefore is classified as non-substantive.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must 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	500,000		500,000
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	500,000		500,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	500,000		500,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	500,000		500,000
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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price:	\$ _____	
Fair Market Value:	\$ _____	
The project involves the establishment of a new facility or a new category of service		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 \$ _____ 0 _____.		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:
<input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>June 30, 2013</u>
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
<input checked="" type="checkbox"/> Project obligation 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

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

Facility Bed Capacity and Utilization

NOT APPLICABLE

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

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

Cost Space Requirements

NOT APPLICABLE

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

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

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

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of American Women's Medical Group, Ltd. * 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

[Signature]
 SIGNATURE

 PRINTED NAME

 PRINTED TITLE

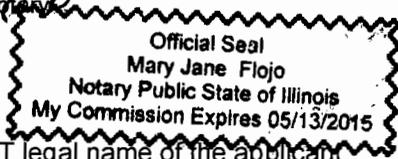
[Signature]
 SIGNATURE

 JAN BARTON
 PRINTED NAME

 President
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 10 day of October 2012

Notarization:
 Subscribed and sworn to before me
 this 4 day of Oct, 2012

[Signature]
 Signature of Notary
 Seal

 *Insert EXACT legal name of the applicant

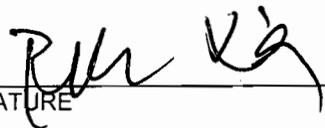
[Signature]
 Signature of Notary


CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of RENLIN XIA * 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.



 SIGNATURE

 RENLIN XIA
 PRINTED NAME

 PRINTED TITLE

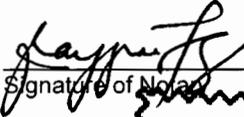
 SIGNATURE

 PRINTED NAME

 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 10 day of OCTOBER 2012

Notarization:
 Subscribed and sworn to before me
 this _____ day of _____



 Signature of Notary

 Signature of Notary

Seal

Seal



*Insert 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.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

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 the information has been 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.

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, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as 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 age and condition and 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 Agency 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 VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.

The sales contract is included in this attachment. Section 4 requires the Board's approval before closing.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered. **NONE**
2. Who the operating entity will be. **This will not change. It is American Women Medical Center Group d/b/a Western Diversey Surgical Center.**
3. The reason for the transaction. **A 50% owner desires to obtain control of the facility by buying out the other 50% owner.**
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction. **NONE**
5. A cost-benefit analysis for the proposed transaction. **This is a financial transaction between two owners of the corporation that operates the surgery center. The cost to Dr. Xia is \$500,000. His benefit is to obtain complete control over the operations of the surgery center and a return on his investment through profits from its operation. There is no cost to the corporation that operates the surgery center. It will benefit from management efficiencies gained by having a single owner.**

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction. **Admission policies are attached.**
2. The proposed admission policies for the facilities. **There will be no change in the policies.**
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive. **Attached is the required letter.**

C. Criterion 1110.240(d), Health Care System

NOT APPLICABLE.

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

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VIII. - 1120.120 - Availability of Funds

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:**

<u>\$500,000</u>	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
	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.
<u>\$500,000</u>	TOTAL FUNDS AVAILABLE	

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

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 43.

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

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 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

OWNERSHIP

CURRENT:

Renlin Xia	50%
Jan Barton	50%

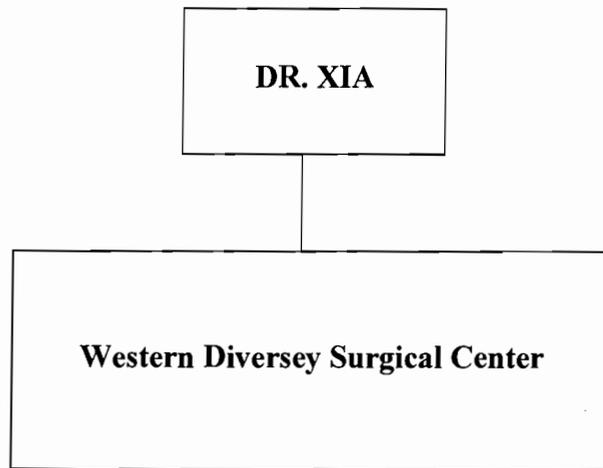
AFTER CHANGE OF OWNERSHIP:

Renlin Xia	100%
------------	------

ATTACHMENT 3

ORGANIZATIONAL RELATIONSHIPS

Co-applicant, Dr. Xia, now owns 50% of the stock of co-applicant, Western Diversey Surgical Center. After the completion of this transaction, he will own 100% of the stock of co-applicant, Western Diversey Surgical Center.



ATTACHMENT 4

FLOOD PLAIN REQUIREMENTS

This section of the application is inapplicable as the project does not involve construction.

ATTACHMENT 5

HISTORIC PRESERVATION REQUIREMENTS

This section of the application is inapplicable as the project does not involve construction.

ATTACHMENT 6

COST/SPACE REQUIREMENTS

Not applicable because there is no construction.

ATTACHMENT 9

BACKGROUND OF APPLICANT

1. The ASTC is the only health care facility owned or operated by the co-applicant, Western Diversey Surgical Center. The IDPH license follows this page. Co-applicant, Dr. Xia, also owns 100% of the stock of Fullerton Kimball Medical & Surgical Center.
2. Co-applicants certify that no adverse action has been taken against any facility owned or operated by it during the past three years.
3. Authorization permitting the Board and IDPH to access documents required follows this page.
4. Not applicable.

ATTACHMENT 11

AUTHORIZATION TO ACCESS DOCUMENTS

Co-applicant, Renlin Xia, M.D., authorizes the Illinois Health Facilities Services and Review Board and the Illinois Department of Public Health to access any documents necessary to verify the information submitted including, but not limited to, records of the Department of Public Health and other State agencies, the licensing and certification records of other states and the records of nationally recognized accreditation organizations.

Co-applicant certifies that no adverse action has been taken against any facility owned or operated by it during the three years prior to filing this application.

By: RM Xia
Signature

Renlin Xia, M.D.
Printed Name

Title

SECTION III – Project Purpose, Background and Alternatives – Information Requirements

PURPOSE OF THE 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.*

This is a change of ownership. The facility will remain open thus maintaining access to health care. The facility will recruit additional physicians to use the facility thereby improving access to health care in the immediate area.

2. *Define the planning area or market area, or other, per the applicant’s definition.*

The facility’s market area is Health Service 6. This will remain the same.

3. *Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project {see 1110.230(b) for examples of documentation}.*

None. This is a change of ownership.

4. *Cite the sources of the information provided as documentation.*

None.

5. *Detail how the project will address or improve the previously referenced issues, as well as the population’s health status and well-being.*

Not applicable. Change of ownership.

6. *Provide goals with quantified and measurable objections, with specific timeframes that relate to achieving the stated goals.*

Not applicable. Change of ownership.

ATTACHMENT 12

ALTERNATIVES TO THE PROJECT

Proposing a project of greater or lesser scope or cost.

This project is a change of ownership with one 50% shareholder purchasing all of the shares of the other 50% shareholder. Since all available shares are being purchased, no greater scope or cost is possible.

Purchasing fewer shares would be possible. The purchaser is paying \$10,000 for each 1% of the shares being purchased. If only 25% of the shares were purchased, the cost would be reduced by \$250,000, which would be a benefit to the purchaser. The purchaser would have the benefit of owning only 75% of the corporation owning the surgery center rather than 100%. It is uncertain whether the seller would agree to be a minority owner in the surgery center. The purchaser desires to obtain 100% ownership. That will give him complete control over operations including decisions relating to any future capital investment.

This alternative was rejected.

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.

This alternative does not relate to a purchase of stock in surgery center.

Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project.

This alternative does not relate to a purchase of stock in surgery center.

Do nothing.

Doing nothing would save the purchaser \$500,000. It would cost the buyer \$500,000. The buyer desires to obtain 100% ownership of the surgery center to obtain complete operational and financial control. Seller desires to sell. This alternative was rejected.

Purchase of additional 50% interest by Dr. Xia.

Dr. Xia seeks to obtain operational control and 100% financial control of the surgery center through this transaction. No other alternative achieves this result.

ATTACHMENT 13

CERTIFICATION OF ADMISSION POLICIES

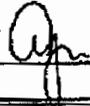
Applicant certifies that existing admission policies will not be changed. Applicant further certifies that the admission policies of the surgery center will not become more restrictive in the future.

ATTACHMENT 19

**Western Diversey Surgical Center
Policy Manual**

Section: Surgery

Subject: Admission of Patient

Page 1 of 1Approved By:  Effective Date: 3/10/04 Revised: _____**I. POLICY**

It is the policy of Western Diversey Surgical Center to provide a safe and anxiety free entry into our health care facility by preparing the patient prior to entering into the Operating Room.

II. PROCEDURES

- A. Upon admission to the pre-operative area, the patient will be prepared for surgery.
- B. The patient should arrive at the facility 30 minutes to one hour prior to his/her scheduled surgery. The patient is instructed on the upcoming sequence of events that will comprise his/her treatment.
- C. The patient will be interviewed to:
 1. Verify identity, with two forms of identification:
 - a. Name
 - b. Birth date
 2. Verify that the patient has followed the appropriate pre-operative instructions.
 3. Obtain a written consent.
 4. Obtain pain level, 1-10 and location.
 5. Complete the pre-admission interview and history form.
 6. Perform a physical assessment.
 7. Review the pre-operative testing data.
 8. Execute the standing and specific pre-operative orders from the physician.
- D. The Anesthesia Provider will interview and examine the patient, review diagnostic testing (lab, x-ray, etc.), document the patient interview sheet, and order the necessary medications.
- E. Any valuables brought by the patient will be secured for return after the surgery, or given to the responsible adult who accompanied the patient, if other than local anesthesia is to be used.
- F. No patient will undergo any surgical procedure if the patient does not meet a minimum level of risk, as judged by the Anesthesia Provider or surgeon.

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Stock Sale and Purchase Agreement

2744 North Western Avenue, Chicago, Illinois 60647

This Agreement is entered into on MARCH 20, 2008, by and between Renlin Xia M.D. ("Purchaser") and Jan Barton M.D. ("Seller") to purchase all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which leases the building and is currently doing business at 2744 North western Avenue, Chicago, Illinois 60647.

Recitals

WHEREAS, Seller and Purchaser are the sole and equal shareholders, each Party holding 50% of all of the Common Stock, in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647; and,

WHEREAS, American Women's Medical Group d/b/a Western Diversey Surgical Center is licensed by the Illinois Department of Public Health as an Ambulatory Surgical Treatment Center located at 2744 North Western Avenue, Chicago, Illinois 60647; and

WHEREAS, Seller is interested in selling all of the Seller's Stock Interests to the Purchaser and the Purchaser is interested in purchasing all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation; and,

WHEREAS, both Parties hereto acknowledge that such purchase, assignment and transfer of all of the Seller's Stock Interests to the Purchaser are subject to and conditioned upon receiving the approval for a Certificate of Exemption from the Illinois Health Facilities and Services Review Board; and, the approval from the US Department of Health and Human Services for authorized Medicaid and Medicare Services; and,

NOW, THEREFORE, for and in consideration of the mutual covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, it is agreed by and between the Parties as follows:

1. **Recitals.** The foregoing recitals are incorporated as an integral part of this Agreement.

2. **Stock Sale and Purchase.** The Parties hereto agree to sell and purchase the stock in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

2.1. Purchaser agrees to purchase and Seller agrees to sell, transfer and assign to Purchaser all of the Seller's Stock Interests in American Women's Medical Group d/b/a. Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

2.2. The Parties acknowledge and agree that the Seller is transferring all of his stock interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647 free and clear of all liens, liabilities, encumbrances and security interests of any kind; and, that this sole, transfer shall discharge and relieve the Seller of any amounts owed to the Purchaser.

2.3. Seller agrees to reasonably cooperate with Purchaser in all matters related to obtaining the necessary approvals and authorizations from the Illinois Health Facilities and Service and Services Review Board for the Ambulatory Surgical Treatment Center license.

3. **Purchase Price.** The Purchase Price for all of Seller's Stock Interests shall be \$500,000.00 US Dollars. At such time as the Illinois Health Facilities and Services Review Board approves a Certificate of Exemption regarding this sale; Purchaser shall make an initial payment of \$100,000.00 US Dollars which shall be paid to the seller with the remainder payable in equal/annual installments of \$100,000.00 US dollars to the Seller or as otherwise agreed to by the Parties in writing.

No interest or other dividend shall accrue on any outstanding balance due to the Seller. Purchaser shall be entitled to a credit for all amounts paid to the Purchaser by the Seller. These payments to the Seller shall continue to be made to the Seller, or his estate, until they are paid. Once Seller agrees to enter into this Agreement, the Seller may not terminate this Agreement; however, Seller shall retain its rights to specific performance for any amounts not paid within the time period provided.

4. **Time and Place of Closing.** Closing shall take place after the Parties obtain an approval of a Certificate of Exemption from the Illinois Health Facilities Planning Board; and, the approval from the US Department of Health and Human Services for authorized Medicaid and Medicare Services. Once such approvals are obtained the Parties shall agree on the day, time and location for the closing to take place.

5. **Document Delivery.** At closing the Seller shall deliver to the Purchaser the stock certificates representing all of Seller's Stock in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation located at 2744 North Western Avenue, Chicago, Illinois 60647 and all other usual and customary documentation reasonably acceptable in form and substance to the Purchaser and his counsel evidencing the transfer, conveyance and delivery of the stock interests to the Purchaser.

6. **Seller's Representations.** Seller hereby represents and warrants to the Purchaser: i) that he has all rights and title to all of the Seller's Stock Interests that he is transferring to the Purchaser; ii) that the Seller's Stock Interests are free and clear of all known liens, liabilities, encumbrances and security interests of any kind; iii) that he has the right, power and legal capacity to execute this Agreement and any other documents and instruments needed to be executed and delivered in connection with the transactions contemplated by this Agreement and to consummate the transactions contemplated herein; iv) that this Agreement and the Sale Documents will be duly and validly executed and delivered to the Purchaser which constitute legal, valid and binding obligations of the Seller which are enforceable against Seller in accordance with their respective terms; and, v) that no representation or warranty given by him in this Agreement or in any certificate or other document furnished or to be furnished pursuant hereto, does not, nor will not, contain any untrue statement of material facts or omits or will omit to state material facts necessary to make the statements contained therein not misleading.

7. **Purchaser's Representations.** Purchaser hereby represents and warrants to the Seller: i) that he has the right, power and legal capacity to execute this Agreement and any other documents and instruments needed to be executed and delivered in connection with the transactions contemplated by this Agreement and to consummate the transactions contemplated herein; ii) that the Purchaser is financially able to satisfy the payment of the purchase price for all of the Seller's Stock Interests in a complete and timely manner without delay; iii) that this Agreement and the Purchase Documents will be duly and validly executed and delivered to the Seller which constitute legal, valid

and binding obligations of the Purchaser which are enforceable against the Purchaser in accordance with their respective terms; and, iv) that no representation or warranty given by him in this Agreement or in any certificate or other document furnished or to be furnished pursuant hereto, does not nor will not contain any untrue statement of material facts or omits or will omit to state material facts necessary to make the statements contained therein not misleading.

8. **Default by a Party** In the event either Party shall fail to fulfill or satisfy any obligations, terms or conditions set forth in this Agreement the other Party shall be entitled to pursue all remedies available at law or in equity to the extent of sums due but no refund or return of any kind for payments made to Seller by Purchaser or any of Purchaser's entities that may have been made at any time can be required in any way whatsoever. All remedies shall be limited to requests for specific performance of obligations under the contract.

9. **Seller's Closing Documents**. On or before the closing on this Agreement the Seller shall deliver or cause to be delivered to the Purchaser all stock certificates with assignment/transfer instruments evidencing the irrevocable transfer to the Purchaser of all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

10. **Purchaser's Closing Documents**. On or before the closing on this Agreement the Purchaser shall deliver or cause to be delivered to the Seller the current amount due on the Purchase Price and such other documents, certificates and instruments as may be reasonably requested by the Seller or his counsel in accordance with the terms of the Agreement.

11. **Indemnification**. Purchaser agrees to indemnify, defend and hold Seller, including their heirs, representatives, successors and assigns, harmless from and against any and all liabilities, demands, claims, actions or causes of action from any source whatsoever which could result in the imposition of losses, fines, penalties, damages, costs and expenses including, but not limited to, legal and professional services expenses and costs in defending or prosecuting the matters in which a Party herein may suffer, incur or become subject to or arise from and/or as a result of any acts, failures to act or omissions by the other Party hereto relating to any misrepresentation, warranty, covenant, undertaking or failures to perform when and as required or any act of negligence, willful misconduct or violation of law. Seller shall no

such obligation to indemnify, defend and hold Purchaser, including their heirs, representatives, successors, and assigns, harmless from and against any and all liabilities, demands, claims, actions, or causes of action from any source whatsoever which could result in the imposition of losses, fines, penalties, damages, costs and expenses including, but not limited to, legal and professional services expenses and costs in defending or prosecuting the matters in which a Party herein may suffer, incur or become subject to or arise from and/or as a result of any acts, failures to act or omissions by the other Party hereto relating to any misrepresentation, warranty, covenant, undertaking or failures to perform when and as required or any act of negligence, willful misconduct or violation of law.

12. **Further Cooperation.** From time to time, without further consideration, the Parties shall execute such further documents, and perform such further acts, as may be reasonably necessary to transfer and convey all of the Seller's Stock Interests in all of the entities set out above in this Agreement and to otherwise comply with the terms of this Agreement and to consummate the transactions contemplated in the Agreement. The Parties acknowledge that it will take the Purchaser a significant time period to apply for and complete the process of receiving all the necessary governmental approvals.

13. **Expenses.** Purchaser hereto shall bear all fees and expenses incurred by each Party in connection with, relating to or arising out of the negotiation, preparation, execution, delivery and performance of this Agreement and the consummation of the transaction contemplated herein, including, without limitation, attorneys, accountants' and other professional fees, expenses or costs.

14. **Notices.** All notices and other communications under this Agreement must be in writing and shall be deemed given only if delivered when received personally or by their duly authorized representative, telecopied or electronically (with confirmation), mailed by registered or certified mail (return receipt requested) or delivered by a nationally recognized overnight express courier (with confirmation) to the Parties at the following addresses (or at such other address for a party as shall be specified by like notice):

To Seller:

Jan Barton M.D
2744 North Western Avenue
Chicago, Illinois 60647

To Purchaser:

Renlin Xia Shaw, M.D.
3412 W. Fullerton
Chicago, Illinois 60647

16. **Amendment.** This Agreement constitutes the entire understanding and agreement between the Parties and supersedes any prior agreements, oral or written. No modification of this Agreement shall be valid, binding and enforceable unless made in writing and signed by the Parties.

17. **Non-Waiver.** The failure in any one or more instances of a Party to insist upon performance of any of the terms, covenants or conditions of this Agreement, to exercise any right or privilege in this Agreement conferred, or the waiver by said Party of any breach of any of the terms, covenants or conditions of this Agreement, shall not be construed as a subsequent waiver of any such terms, covenants, conditions, rights or privileges, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred. No waiver shall be effective unless it is in writing and signed by an authorized representative of the waiving Party.

18. **Severability.** If any provision of this Agreement is judicially determined to be invalid or unenforceable as written, then such provision, if possible, may be modified and reformed to the degree necessary to render it valid and enforceable. Further, any such invalidity or unenforceability of any provision shall have no effect on the remainder of this Agreement which shall remain in full force and effect.

19. **Execution.** This Agreement may be executed and delivered by exchange of facsimile copies showing the signatures of all parties, and such signatures need not be affixed to the same copy. The facsimile copies showing the signatures of the parties will constitute originally signed copies of the same agreement.

20. **Governing Law.** This Agreement is governed in all respects, including validity, construction, interpretation and effect by the Laws of the State of Illinois. The Parties consent to the jurisdiction of the Circuit Court of Cook County, Illinois for the resolution of any disputes in connection with this Agreement.

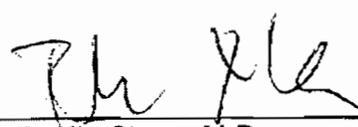
IN WITNESS WHEREOF, the parties have executed this Agreement on the date first above written.

SELLER:

PURCHASER:



Jan Barton, M.D.



Renlin Xia Shaw, M.D.

September _____, 2012

Illinois Health Facilities & Services Review Board
Springfield, Illinois

To Whom It May Concern:

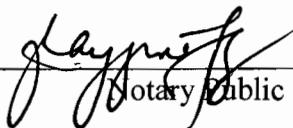
I have the cash and liquid assets that can be converted to cash within thirty days available to me in order to pay the \$500,000 cost required to be paid as part of this application for change of ownership.

The contract requires \$100,000 to be paid at closing and \$100,000 each year for four years.

Sincerely,


Renlin Xia, M.D.

SUBSCRIBED AND SWORN TO
before me this 10th day of
OCTOBER, 20 12



Notary Public



FINANCIAL VIABILITY

Funding is being provided by an individual, Dr. Renlin Xia. Dr. Xia does not have financial statements and cannot provide meaningful financial ratios.

ATTACHMENT 41

PROJECTED OPERATINS COSTS

FIRST YEAR OF OPERATION

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Salaries	\$434,994
Benefits	86,999
Supplies	<u>249,094</u>
Total:	\$771,087
Procedures	1,870
Operating cost per patient day	\$ 412

ATTACHMENT 42

**TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS
FIRST YEAR OF OPERATION**

Depreciation and Amortization	\$39,070
Interest	-0-
Total:	\$39,070
Patient Days	1,870
Capital Cost per Patient Day	\$ 20

SAFETY NET IMPACT STATEMENT

Not applicable. This is not a substantive project.

ATTACHMENT 43

CHARITY CARE

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year 2009	Year 2010	Year 2011
Net Patient Revenue	1,840,567	1,532,094	1,155,592
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

ATTACHMENT 44

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	1-19
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	20
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	21
5	Flood Plain Requirements	22
6	Historic Preservation Act Requirements	23
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	24
10	Discontinuation	
11	Background of the Applicant	25-27
12	Purpose of the Project	28
13	Alternatives to the Project	29
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	30-37
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	38
40	Financial Waiver	
41	Financial Viability	39
42	Economic Feasibility	40-41
43	Safety Net Impact Statement	42
44	Charity Care Information	43

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Western Diversey Surgical Center			
Street Address: 2744 N. Western Avenue			
City and Zip Code: Chicago, IL 60647			
County:	Cook	Health Service Area	6 Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Renlin Xia
Address: 3412 W. Fullerton Avenue, Chicago, IL 60647
Name of Registered Agent: Renlin Xia
Name of Chief Executive Officer: Renlin Xia
CEO Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input checked="" type="checkbox"/> Other INDIVIDUAL	
<ul style="list-style-type: none"> 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. 	

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 during the review period]

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460
E-mail Address: awmscd@sbcglobal.net
Fax Number:

Additional Contact

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

Name: Ira Rogal
Title: Consultant
Company Name: Shea, Paige & Rogal, Inc.
Address: 547 S. LaGrange Road, LaGrange, IL 60525
Telephone Number: 708-482-4820
E-mail Address: iar4@aol.com
Fax Number: 708-482-1091

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Western Diversey Surgical Center			
Street Address: 2744 N. Western Avenue			
City and Zip Code: Chicago, IL 60647			
County: Cook	Health Service Area	6	Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: American Women Medical Group, Ltd. d/b/a Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Name of Registered Agent: Renlin Xia
Name of Chief Executive Officer: Renlin Xia
CEO Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input checked="" type="checkbox"/> Other INDIVIDUAL	
<ul style="list-style-type: none"> 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. 	

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 during the review period]

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number: 773-216-1460
E-mail Address: awmscd@sbcglobal.net
Fax Number:

Additional Contact

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

Name: Ira Rogal
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Address: 547 S. LaGrange Road, LaGrange, IL 60525
Telephone Number: 708-482-4820
E-mail Address: iar4@aol.com
Fax Number: 708-482-1091

Post Permit Contact

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

Name: Renlin Xia
Title: President
Company Name: Western Diversey Surgical Center
Address: 2744 N. Western Avenue, Chicago, IL 60647
Telephone Number:
E-mail Address:
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Renlin Zia, M.D.
Address of Site Owner: 3412 W. Fullerton, Chicago, IL 60647
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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:
Address:
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none">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 co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (<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:

- Substantive
 Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- Part 1120 Not Applicable
 Category A Project
 Category B Project
 DHS or DVA Project

2. Narrative Description

Provide in the space below, 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.

NARRATIVE DESCRIPTION

The facility is a corporation currently owned 50% by the applicant, Renlin Xia, M.D., and 50% by another individual. Applicant is buying out the other owner and will own 100% of the stock of this ASTC after the transaction is completed.

It is a change of ownership and therefore is classified as non-substantive.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must 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	500,000		500,000
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	500,000		500,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	500,000		500,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	500,000		500,000
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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Purchase Price: \$ _____
Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 \$ _____ 0 _____.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>June 30, 2013</u>
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies <input checked="" type="checkbox"/> Project obligation 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

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

Facility Bed Capacity and Utilization

NOT APPLICABLE

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

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

Cost Space Requirements

NOT APPLICABLE

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

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

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

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of American Women's Medical Group, Ltd. * 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

[Signature]
SIGNATURE

PRINTED NAME

PRINTED TITLE

[Signature]
SIGNATURE

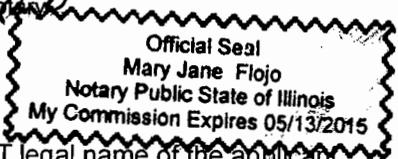
JAN BARTON
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of October 2012

[Signature]
Signature of Notary

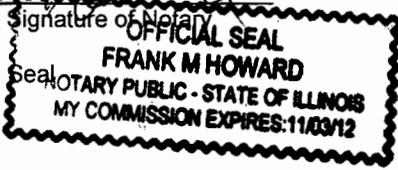
Seal



*Insert EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 4 day of Oct, 2012

[Signature]
Signature of Notary



CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of RENLIN XIA * 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 for permit 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 permit application fee required for this application is sent herewith or will be paid upon request.

REN XIA
SIGNATURE

SIGNATURE

RENLIN XIA
PRINTED NAME

PRINTED NAME

PRINTED TITLE

PRINTED TITLE

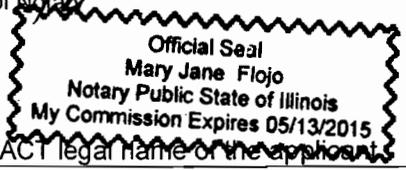
Notarization:
Subscribed and sworn to before me
this 10 day of OCTOBER 2012

Notarization:
Subscribed and sworn to before me
this ____ day of _____

Mary Jane Flojo
Signature of Notary

Signature of Notary

Seal



Seal

*Insert 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.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

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 the information has been 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.

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, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as 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 age and condition and 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 Agency 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 VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.

The sales contract is included in this attachment. Section 4 requires the Board's approval before closing.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered. **NONE**
2. Who the operating entity will be. **This will not change. It is American Women Medical Center Group d/b/a Western Diversey Surgical Center.**
3. The reason for the transaction. **A 50% owner desires to obtain control of the facility by buying out the other 50% owner.**
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction. **NONE**
5. A cost-benefit analysis for the proposed transaction. **This is a financial transaction between two owners of the corporation that operates the surgery center. The cost to Dr. Xia is \$500,000. His benefit is to obtain complete control over the operations of the surgery center and a return on his investment through profits from its operation. There is no cost to the corporation that operates the surgery center. It will benefit from management efficiencies gained by having a single owner.**

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction. **Admission policies are attached.**
2. The proposed admission policies for the facilities. **There will be no change in the policies.**
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive. **Attached is the required letter.**

C. Criterion 1110.240(d), Health Care System

NOT APPLICABLE.

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

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VIII. - 1120.120 - Availability of Funds

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:**

<u>\$500,000</u>	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
<u> </u>	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
<u> </u>	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
<u> </u>	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.
<u> </u>	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
<u> </u>	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
<u> </u>	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$500,000	TOTAL FUNDS AVAILABLE	

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for **ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS**:

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 43.

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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 44.

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

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

OWNERSHIP

CURRENT:

Renlin Xia	50%
Jan Barton	50%

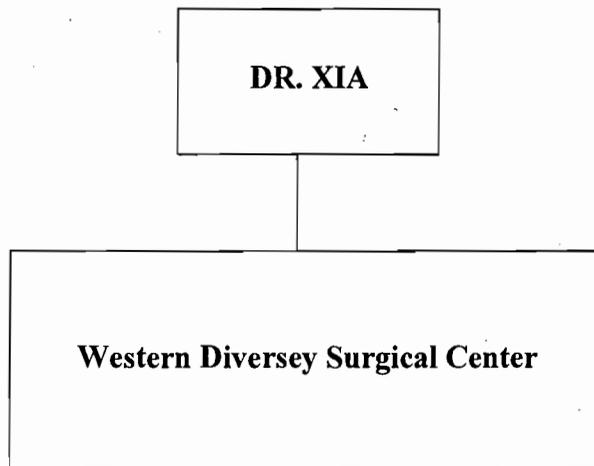
AFTER CHANGE OF OWNERSHIP:

Renlin Xia	100%
------------	------

ATTACHMENT 3

ORGANIZATIONAL RELATIONSHIPS

Co-applicant, Dr. Xia, now owns 50% of the stock of co-applicant, Western Diversey Surgical Center. After the completion of this transaction, he will own 100% of the stock of co-applicant, Western Diversey Surgical Center.



ATTACHMENT 4

FLOOD PLAIN REQUIREMENTS

This section of the application is inapplicable as the project does not involve construction.

ATTACHMENT 5

HISTORIC PRESERVATION REQUIREMENTS

This section of the application is inapplicable as the project does not involve construction.

ATTACHMENT 6

COST/SPACE REQUIREMENTS

Not applicable because there is no construction.

ATTACHMENT 9

BACKGROUND OF APPLICANT

1. The ASTC is the only health care facility owned or operated by the co-applicant, Western Diversey Surgical Center. The IDPH license follows this page. Co-applicant, Dr. Xia, also owns 100% of the stock of Fullerton Kimball Medical & Surgical Center.
2. Co-applicants certify that no adverse action has been taken against any facility owned or operated by it during the past three years.
3. Authorization permitting the Board and IDPH to access documents required follows this page.
4. Not applicable.

ATTACHMENT 11

AUTHORIZATION TO ACCESS DOCUMENTS

Co-applicant, Renlin Xia, M.D., authorizes the Illinois Health Facilities Services and Review Board and the Illinois Department of Public Health to access any documents necessary to verify the information submitted including, but not limited to, records of the Department of Public Health and other State agencies, the licensing and certification records of other states and the records of nationally recognized accreditation organizations.

Co-applicant certifies that no adverse action has been taken against any facility owned or operated by it during the three years prior to filing this application.

By: RM Xia
Signature

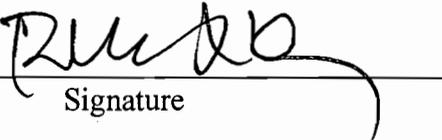
Renlin Xia, M.D.
Printed Name

Title

AUTHORIZATION TO ACCESS DOCUMENTS

Co-applicant, Western Diversey Surgical Center, authorizes the Illinois Health Facilities Services and Review Board and the Illinois Department of Public Health to access any documents necessary to verify the information submitted including, but not limited to, records of the Department of Public Health and other State agencies, the licensing and certification records of other states and the records of nationally recognized accreditation organizations.

Co-applicant certifies that no adverse action has been taken against any facility owned or operated by it during the three years prior to filing this application.

By: 
Signature

Renlin Xia, M.D.
Printed Name

Medical Director
Title

SECTION III – Project Purpose, Background and Alternatives – Information Requirements

PURPOSE OF THE 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.*

This is a change of ownership. The facility will remain open thus maintaining access to health care. The facility will recruit additional physicians to use the facility thereby improving access to health care in the immediate area.

2. *Define the planning area or market area, or other, per the applicant's definition.*

The facility's market area is Health Service 6. This will remain the same.

3. *Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project {see 1110.230(b) for examples of documentation}.*

None. This is a change of ownership.

4. *Cite the sources of the information provided as documentation.*

None.

5. *Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.*

Not applicable. Change of ownership.

6. *Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.*

Not applicable. Change of ownership.

ATTACHMENT 12

ALTERNATIVES TO THE PROJECT

Proposing a project of greater or lesser scope or cost.

This project is a change of ownership with one 50% shareholder purchasing all of the shares of the other 50% shareholder. Since all available shares are being purchased, no greater scope or cost is possible.

Purchasing fewer shares would be possible. The purchaser is paying \$10,000 for each 1% of the shares being purchased. If only 25% of the shares were purchased, the cost would be reduced by \$250,000, which would be a benefit to the purchaser. The purchaser would have the benefit of owning only 75% of the corporation owning the surgery center rather than 100%. It is uncertain whether the seller would agree to be a minority owner in the surgery center. The purchaser desires to obtain 100% ownership. That will give him complete control over operations including decisions relating to any future capital investment.

This alternative was rejected.

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.

This alternative does not relate to a purchase of stock in surgery center.

Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project.

This alternative does not relate to a purchase of stock in surgery center.

Do nothing.

Doing nothing would save the purchaser \$500,000. It would cost the buyer \$500,000. The buyer desires to obtain 100% ownership of the surgery center to obtain complete operational and financial control. Seller desires to sell. This alternative was rejected.

Purchase of additional 50% interest by Dr. Xia.

Dr. Xia seeks to obtain operational control and 100% financial control of the surgery center through this transaction. No other alternative achieves this result.

ATTACHMENT 13

CERTIFICATION OF ADMISSION POLICIES

Applicant certifies that existing admission policies will not be changed. Applicant further certifies that the admission policies of the surgery center will not become more restrictive in the future.

ATTACHMENT 19

**Western Diversey Surgical Center
Policy Manual**

Section: Surgery

Subject: Admission of Patient

Page 1 of 1Approved By: [Signature] Effective Date: 3/16/04 Revised: _____**I. POLICY**

It is the policy of Western Diversey Surgical Center to provide a safe and anxiety free entry into our health care facility by preparing the patient prior to entering into the Operating Room.

II. PROCEDURES

- A. Upon admission to the pre-operative area, the patient will be prepared for surgery.
- B. The patient should arrive at the facility 30 minutes to one hour prior to his/her scheduled surgery. The patient is instructed on the upcoming sequence of events that will comprise his/her treatment.
- C. The patient will be interviewed to:
 1. Verify identity, with two forms of identification:
 - a. Name
 - b. Birth date
 2. Verify that the patient has followed the appropriate pre-operative instructions.
 3. Obtain a written consent.
 4. Obtain pain level, 1-10 and location.
 5. Complete the pre-admission interview and history form.
 6. Perform a physical assessment.
 7. Review the pre-operative testing data.
 8. Execute the standing and specific pre-operative orders from the physician.
- D. The Anesthesia Provider will interview and examine the patient, review diagnostic testing (lab, x-ray, etc.), document the patient interview sheet, and order the necessary medications.
- E. Any valuables brought by the patient will be secured for return after the surgery, or given to the responsible adult who accompanied the patient, if other than local anesthesia is to be used.
- F. No patient will undergo any surgical procedure if the patient does not meet a minimum level of risk, as judged by the Anesthesia Provider or surgeon.

31

Stock Sale and Purchase Agreement

2744 North Western Avenue, Chicago, Illinois 60647

This Agreement is entered into on MARCH 20, 2008, by and between Renlin Xia M.D. ("Purchaser") and Jan Barton M.D. ("Seller") to purchase all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which leases the building and is currently doing business at 2744 North western Avenue, Chicago, Illinois 60647.

Recitals

WHEREAS, Seller and Purchaser are the sole and equal shareholders, each Party holding 50% of all of the Common Stock, in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647; and,

WHEREAS, American Women's Medical Group d/b/a Western Diversey Surgical Center is licensed by the Illinois Department of Public Health as an Ambulatory Surgical Treatment Center located at 2744 North Western Avenue, Chicago, Illinois 60647; and

WHEREAS, Seller is interested in selling all of the Seller's Stock Interests to the Purchaser and the Purchaser is interested in purchasing all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation; and,

WHEREAS, both Parties hereto acknowledge that such purchase, assignment and transfer of all of the Seller's Stock Interests to the Purchaser are subject to and conditioned upon receiving the approval for a Certificate of Exemption from the Illinois Health Facilities and Services Review Board; and, the approval from the US Department of Health and Human Services for authorized Medicaid and Medicare Services; and,

NOW, THEREFORE, for and in consideration of the mutual covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, it is agreed by and between the Parties as follows:

1. **Recitals.** The foregoing recitals are incorporated as an integral part of this Agreement.

2. **Stock Sale and Purchase.** The Parties hereto agree to sell and purchase the stock in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

2.1. Purchaser agrees to purchase and Seller agrees to sell, transfer and assign to Purchaser all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

2.2. The Parties acknowledge and agree that the Seller is transferring all of his stock interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647 free and clear of all liens, liabilities, encumbrances and security interests of any kind; and, that this sole, transfer shall discharge and relieve the Seller of any amounts owed to the Purchaser.

2.3. Seller agrees to reasonably cooperate with Purchaser in all matters related to obtaining the necessary approvals and authorizations from the Illinois Health Facilities and Service and Services Review Board for the Ambulatory Surgical Treatment Center license.

3. **Purchase Price.** The Purchase Price for all of Seller's Stock Interests shall be \$500,000.00 US Dollars. At such time as the Illinois Health Facilities and Services Review Board approves a Certificate of Exemption regarding this sale, Purchaser shall make an initial payment of \$100,000.00 US Dollars which shall be paid to the seller with the remainder payable in equal/annual installments of \$100,000.00 US dollars to the Seller or as otherwise agreed to by the Parties in writing.

No interest or other dividend shall accrue on any outstanding balance due to the Seller. Purchaser shall be entitled to a credit for all amounts paid to the Purchaser by the Seller. These payments to the Seller shall continue to be made to the Seller, or his estate, until they are paid. Once Seller agrees to enter into this Agreement, the Seller may not terminate this Agreement; however, Seller shall retain its rights to specific performance for any amounts not paid within the time period provided.

4. **Time and Place of Closing.** Closing shall take place after the Parties obtain an approval of a Certificate of Exemption from the Illinois Health Facilities Planning Board; and, the approval from the US Department of Health and Human Services for authorized Medicaid and Medicare Services. Once such approvals are obtained the Parties shall agree on the day, time and location for the closing to take place.

5. **Document Delivery.** At closing the Seller shall deliver to the Purchaser the stock certificates representing all of Seller's Stock in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation located at 2744 North Western Avenue, Chicago, Illinois 60647 and all other usual and customary documentation reasonably acceptable in form and substance to the Purchaser and his counsel evidencing the transfer, conveyance and delivery of the stock interests to the Purchaser.

6. **Seller's Representations.** Seller hereby represents and warrants to the Purchaser: i) that he has all rights and title to all of the Seller's Stock Interests that he is transferring to the Purchaser; ii) that the Seller's Stock Interests are free and clear of all known liens, liabilities, encumbrances and security interests of any kind; iii) that he has the right, power and legal capacity to execute this Agreement and any other documents and instruments needed to be executed and delivered in connection with the transactions contemplated by this Agreement and to consummate the transactions contemplated herein; iv) that this Agreement and the Sale Documents will be duly and validly executed and delivered to the Purchaser which constitute legal, valid and binding obligations of the Seller which are enforceable against Seller in accordance with their respective terms; and, v) that no representation or warranty given by him in this Agreement or in any certificate or other document furnished or to be furnished pursuant hereto, does not, nor will not, contain any untrue statement of material facts or omits or will omit to state material facts necessary to make the statements contained therein not misleading.

7. **Purchaser's Representations.** Purchaser hereby represents and warrants to the Seller: i) that he has the right, power and legal capacity to execute this Agreement and any other documents and instruments needed to be executed and delivered in connection with the transactions contemplated by this Agreement and to consummate the transactions contemplated herein; ii) that the Purchaser is financially able to satisfy the payment of the purchase price for all of the Seller's Stock Interests in a complete and timely manner without delay; iii) that this Agreement and the Purchase Documents will be duly and validly executed and delivered to the Seller which constitute legal, valid

and binding obligations of the Purchaser which are enforceable against the Purchaser in accordance with their respective terms; and, iv) that no representation or warranty given by him in this Agreement or in any certificate or other document furnished or to be furnished pursuant hereto, does not nor will not contain any untrue statement of material facts or omits or will omit to state material facts necessary to make the statements contained therein not misleading.

8. **Default by a Party** In the event either Party shall fail to fulfill or satisfy any obligations, terms or conditions set forth in this Agreement the other Party shall be entitled to pursue all remedies available at law or in equity to the extent of sums due but no refund or return of any kind for payments made to Seller by Purchaser or any of Purchaser's entities that may have been made at any time can be required in any way whatsoever. All remedies shall be limited to requests for specific performance of obligations under the contract.

9. **Seller's Closing Documents**. On or before the closing on this Agreement the Seller shall deliver or cause to be delivered to the Purchaser all stock certificates with assignment/transfer instruments evidencing the irrevocable transfer to the Purchaser of all of the Seller's Stock Interests in American Women's Medical Group d/b/a Western Diversey Surgical Center, an Illinois medical corporation which is currently doing business at 2744 North Western Avenue, Chicago, Illinois 60647.

10. **Purchaser's Closing Documents**. On or before the closing on this Agreement the Purchaser shall deliver or cause to be delivered to the Seller the current amount due on the Purchase Price and such other documents, certificates and instruments as may be reasonably requested by the Seller or his counsel in accordance with the terms of the Agreement.

11. **Indemnification**. Purchaser agrees to indemnify, defend and hold Seller, including their heirs, representatives, successors and assigns, harmless from and against any and all liabilities, demands, claims, actions or causes of action from any source whatsoever which could result in the imposition of losses, fines, penalties, damages, costs and expenses including, but not limited to, legal and professional services expenses and costs in defending or prosecuting the matters in which a Party herein may suffer, incur or become subject to or arise from and/or as a result of any acts, failures to act or omissions by the other Party hereto relating to any misrepresentation, warranty, covenant, undertaking or failures to perform when and as required or any act of negligence, willful misconduct or violation of law. Seller shall no

such obligation to indemnify, defend and hold Purchaser, including their heirs, representatives, successors, and assigns, harmless from and against any and all liabilities, demands, claims, actions, or causes of action from any source whatsoever which could result in the imposition of losses, fines, penalties, damages, costs and expenses including, but not limited to, legal and professional services expenses and costs in defending or prosecuting the matters in which a Party herein may suffer, incur or become subject to or arise from and/or as a result of any acts, failures to act or omissions by the other Party hereto relating to any misrepresentation, warranty, covenant, undertaking or failures to perform when and as required or any act of negligence, willful misconduct or violation of law.

12. **Further Cooperation.** From time to time, without further consideration, the Parties shall execute such further documents, and perform such further acts, as may be reasonably necessary to transfer and convey all of the Seller's Stock Interests in all of the entities set out above in this Agreement and to otherwise comply with the terms of this Agreement and to consummate the transactions contemplated in the Agreement. The Parties acknowledge that it will take the Purchaser a significant time period to apply for and complete the process of receiving all the necessary governmental approvals.

13. **Expenses.** Purchaser hereto shall bear all fees and expenses incurred by each Party in connection with, relating to or arising out of the negotiation, preparation, execution, delivery and performance of this Agreement and the consummation of the transaction contemplated herein, including, without limitation, attorneys, accountants' and other professional fees, expenses or costs.

14. **Notices.** All notices and other communications under this Agreement must be in writing and shall be deemed given only if delivered when received personally or by their duly authorized representative, telecopied or electronically (with confirmation), mailed by registered or certified mail (return receipt requested) or delivered by a nationally recognized overnight express courier (with confirmation) to the Parties at the following addresses (or at such other address for a party as shall be specified by like notice):

To Seller: Jan Barton M.D
2744 North Western Avenue
Chicago, Illinois 60647

To Purchaser: Renlin Xia Shaw, M.D.
3412 W. Fullerton
Chicago, Illinois 60647

16. **Amendment.** This Agreement constitutes the entire understanding and agreement between the Parties and supersedes any prior agreements, oral or written. No modification of this Agreement shall be valid, binding and enforceable unless made in writing and signed by the Parties.

17. **Non-Waiver.** The failure in any one or more instances of a Party to insist upon performance of any of the terms, covenants or conditions of this Agreement, to exercise any right or privilege in this Agreement conferred, or the waiver by said Party of any breach of any of the terms, covenants or conditions of this Agreement, shall not be construed as a subsequent waiver of any such terms, covenants, conditions, rights or privileges, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred. No waiver shall be effective unless it is in writing and signed by an authorized representative of the waiving Party.

18. **Severability.** If any provision of this Agreement is judicially determined to be invalid or unenforceable as written, then such provision, if possible, may be modified and reformed to the degree necessary to render it valid and enforceable. Further, any such invalidity or unenforceability of any provision shall have no effect on the remainder of this Agreement which shall remain in full force and effect.

19. **Execution.** This Agreement may be executed and delivered by exchange of facsimile copies showing the signatures of all parties, and such signatures need not be affixed to the same copy. The facsimile copies showing the signatures of the parties will constitute originally signed copies of the same agreement.

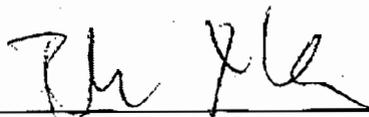
20. **Governing Law.** This Agreement is governed in all respects, including validity, construction, interpretation and effect by the Laws of the State of Illinois. The Parties consent to the jurisdiction of the Circuit Court of Cook County, Illinois for the resolution of any disputes in connection with this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date first above written.

SELLER:

PURCHASER:


Jan Barton, M.D.


Renlin Xia Shaw, M.D.

September _____, 2012

Illinois Health Facilities & Services Review Board
Springfield, Illinois

To Whom It May Concern:

I have the cash and liquid assets that can be converted to cash within thirty days available to me in order to pay the \$500,000 cost required to be paid as part of this application for change of ownership.

The contract requires \$100,000 to be paid at closing and \$100,000 each year for four years.

Sincerely,



Renlin Xia, M.D.

SUBSCRIBED AND SWORN TO

before me this 1st day of
OCTOBER, 20 12



Notary Public

FINANCIAL VIABILITY

Funding is being provided by an individual, Dr. Renlin Xia. Dr. Xia does not have financial statements and cannot provide meaningful financial ratios.

PROJECTED OPERATINS COSTS

FIRST YEAR OF OPERATION

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Salaries	\$434,994
Benefits	86,999
Supplies	<u>249,094</u>
Total:	\$771,087
Procedures	1,870
Operating cost per patient day	\$ 412

ATTACHMENT 42

**TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS
FIRST YEAR OF OPERATION**

Depreciation and Amortization	\$39,070
Interest	-0-
Total:	\$39,070
Patient Days	1,870
Capital Cost per Patient Day	\$ 20

SAFETY NET IMPACT STATEMENT

Not applicable. This is not a substantive project.

ATTACHMENT 43

CHARITY CARE

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year 2009	Year 2010	Year 2011
Net Patient Revenue	1,840,567	1,532,094	1,155,592
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

ATTACHMENT 44

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	1-19
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	20
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	21
5	Flood Plain Requirements	22
6	Historic Preservation Act Requirements	23
7	Project and Sources of Funds Itemization	
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10	Discontinuation	
11	Background of the Applicant	25-27
12	Purpose of the Project	28
13	Alternatives to the Project	29
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
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18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	30-37
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	38
40	Financial Waiver	
41	Financial Viability	39
42	Economic Feasibility	40-41
43	Safety Net Impact Statement	42
44	Charity Care Information	43