E-016-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

FEB 28 2017

HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Access Ambulatory Care Center for Excellence in Surgery Services
Street Address: 26 West Newell Road
City and Zip Code: Danville 61834
County: Vermilion Health Service Area 004 Health Planning Area:

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

Exact Legal Name: Vermilion County Surgery Center, LLC d/b/a Access Ambulatory Care Center for Excellence in Surgery Services
Street Address: 26 West Newell Road
City and Zip Code: Danville 61834
Name of Registered Agent: Kathleen Cronin
Registered Agent Street Address: 18927 Hickory Creek Drive Suite 300
Registered Agent City and Zip Code: Mokena 60448
Name of Chief Executive Officer: Jared Rogers, M.D.
CEO Street Address: 812 N. Logan Avenue
CEO City and Zip Code: Danville 61832
CEO Telephone Number: 217-443-2141

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Colleen Burns
Title: System Director, Strategic Planning & Business Development
Company Name: Presence Health
Address: 200 S. Wacker Dr., Chicago, IL 60606
Telephone Number: 312-308-3937
E-mail Address: Colleen.Burns@presencehealth.org
Fax Number:

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

Name: Clare Ranalli
Title: Counsel
Company Name: McDermott Will & Emery LLP
Address: 227 West Monroe Street, Chicago, IL 60606-5096
Telephone Number: 312-984-3365
E-mail Address: Cranalli@mwe.com
Fax Number: 312-984-7700

Post Exemption Permit Contact

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

Name: Jared C. Rogers, MD
Title: Regional President and CEO
Company Name: Presence United Samaritans Medical Center
Address: 812 North Logan, Danville, IL 61832
Telephone Number: 217-443-5201
E-mail Address: Jared.Rogers@presencehealth.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Vermilion County Surgery Center, LLC
Address of Site Owner: 26 West Newell Road, Danville, IL 61834
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Vermilion County Surgery Center, LLC d/b/a Access Ambulatory Care Center for Excellence in Surgery Services
Address: 26 West Newell Road, Danville, IL 60834
☐ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☒ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

Flood Plain Requirements *Not Applicable*

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements *Not Applicable*

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

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

Vermilion County Surgery Center, LLC (the "Applicant") seeks authority to discontinue in its entirety its existing ambulatory surgical treatment center (a 3 operating room multi-specialty surgery center) located at 26 Newell Road, Danville, IL 61834. Cessation of operations and closure expected to be end of March 2017 (contingent upon HFSRB approval) at which point sale of the property will be explored.

This project is considered substantive because it involves the discontinuation (closing) of an Ambulatory Surgical Treatment Center.

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _____

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

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

☐ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☐ Cancer Registry ***Not Applicable***
☐ APORS ***Not Applicable***
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

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

CERTIFICATION

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

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

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

SIGNATURE

Jared C Rogers MD
PRINTED NAME

Regional President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of February 2017

Signature of Notary

Seal

OFFICIAL SEAL
TERESA C GAFFNEY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/10/17

SIGNATURE

Charles R Hulett
PRINTED NAME

Reg. Growth & Strategy Office
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of February 2017

Signature of Notary

Seal

OFFICIAL SEAL
TERESA C GAFFNEY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/10/17

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

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

Type of Discontinuation

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

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

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

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY *Not Applicable*

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY *Not Applicable*

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 *Not Applicable*

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source"

as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

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

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

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

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

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

A table in the following format must be provided for all facilities as part of Attachment 1.

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

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

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	16-17
2	Site Ownership	18-19
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	20-22
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	23
5	Flood Plain Requirements	N/A
6	Historic Preservation Act Requirements	N/A
7	Project and Sources of Funds Itemization	N/A
8	Financial Commitment Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	24-26
11	Background of the Applicant	N/A
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
	Service Specific:	
14	Neonatal Intensive Care Services	N/A
15	Change of Ownership	N/A
	Financial and Economic Feasibility:	
16	Availability of Funds	N/A
17	Financial Waiver	N/A
18	Financial Viability	N/A
19	Economic Feasibility	N/A
20	Safety Net Impact Statement	27
21	Charity Care Information	28

ATTACHMENT - 1

ILLINOIS CERTIFICATE OF GOOD STANDING

See attached Certificate of Good Standing of Vermilion County Surgery Center, LLC

File Number 0374850-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

VERMILION COUNTY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 14, 2011, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* FEBRUARY *A.D.* 2017 .

Authentication #: 1703902046 verifiable until 02/08/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment - 1

ATTACHMENT - 2

SITE OWNERSHIP DOCUMENTATION

See attached 2015 Vermilion County Property Tax Statement

P.I.N Number	Tract Number	SUE STINE, County Treasurer / Tax Collector		Tax Code
18-17-100-007	NEWR0403A	2015 VERMILION COUNTY REAL ESTATE TAXES	3651 0060	NE014

Assessed Value	x Multiplier	= Eq. Val	- Exemptions	= Taxable Value	x Total Tax Rate	+ Drainage	- Enterprise Zone	= TOTAL TAX DUE
761,956	1.0000	761,956	0	761,956	10.24324	$0.00	$0.00	$78,048.98

Eq 77 Value 938

Exemptions

Interest — 1st Installment $39,024.49

Fair Market Value	Prior Sale	Owner Occupied	Freeze Amount	Senior Citizen	Disabled	Cost	2nd Installment
2,286,097							$39,024.49

Assessed To

VERMILION CO SURGERY CENTER LLC % PRESENCE HEAL
5747 DEMPSTER ST
MORTON GROVE IL 60053

Acreage 6.14

Property Description: E SDE N2 NE4 NW4 17 20 11 EX 4807 SQ FT SW CR

Property Address 26 W NEWELL

1st Installment Receipt

2014 Amount	Taxing District	Rate	2015 Amount	Pension	Amount Change	Library
806.84	Airport Authority	0.11031	840.51	86.48	33.67	0.00
918.77	Conservation District	0.12344	940.56	125.57	21.79	0.00
11,019.11	Vermilion County	1.48477	11,313.30	2,573.27	294.19	0.00
4,712.55	DACC 507	0.62345	4,750.41	0.00	37.86	0.00
0.00	Danville Sanitary	0.00000	0.00	0.00	0.00	0.00
1,580.98	Newell Township	0.20801	1,584.94	180.97	3.96	0.00
1,871.21	Newell Road & Bridge	0.25824	1,967.68	36.95	96.47	0.00
40,144.34	Bismarck/Henning Unit 1	5.35243	40,783.16	2,570.98	638.82	0.00
15,660.10	Danville City	2.08259	15,868.42	10,714.33	208.32	4,588.12
76,713.90	Totals	10.24324	78,048.98	16,288.55	1,335.08	4,588.12

2nd Installment Receipt

1st Installment Due
/15/2016

2nd Installment Due
09/12/2016

DO NOT FOLD OR STAPLE

2015 VERMILION COUNTY REAL ESTATE TAXES

P.I.N Number	Tract Number	Total Tax	2nd Installment Due	2nd Installment Amount
18-17-100-007	NEWR0403A	$78,048.98	09/12/2016	$39,024.49

Property Address 26 W NEWELL

Interest_____ Cost_____
Total_____

Assessed to VERMILION CO SURGERY CENTER LLC, % PRESENCE HEALTHCARE SEI
5747 DEMPSTER ST
MORTON GROVE IL 60053

2 ND INSTALLMENT DELINQUENT IF UNPAID AFTER

09/12/2016

Make Checks Payable to:
VERMILION COUNTY TREASURER

Return this coupon with your payment
Bring whole statement when paying in person.

18171000070000000780489800000003902449

DO NOT FOLD OR STAPLE

2015 VERMILION COUNTY REAL ESTATE TAXES

P.I.N Number	Tract Number	Total Tax	1st Installment Due	1st Installment Amount
18-17-100-007	NEWR0403A	$78,048.98	08/15/2016	$39,024.49

Property Address 26 W NEWELL

Interest_____ Cost_____
Total_____

Assessed to VERMILION CO SURGERY CENTER LLC, % PRESENCE HEALTHCARE SEI
5747 DEMPSTER ST
MORTON GROVE IL 60053

1 ST INSTALLMENT DELINQUENT IF UNPAID AFTER

08/15/2016

Make Checks Payable to:
VERMILION COUNTY TREASURER

Return this coupon with your payment
Bring whole statement when paying in person.

18171000070000000780489800000003902449

Attachment - 2

ATTACHMENT - 3

OPERATING IDENTITY/LICENSEE

See attached Certificate of Good Standing and license for Vermilion County Surgery Center, LLC d/b/a/ Access Ambulatory Care Center for Excellence in Surgery Services

HF111272

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
08/07/2017		7003175

Ambulatory Surgery Treatment Center

Effective: 08/08/2016

Vermilion County Surgery Center, LLC
26 West Newell Road
Danville, IL 61834

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

Attachment- 3

File Number 0374850-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

VERMILION COUNTY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 14, 2011, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* FEBRUARY *A.D.* 2017 .

Authentication #: 1703902046 verifiable until 02/08/2018
Authenticate at: http://www.cyberdriveillinois.com

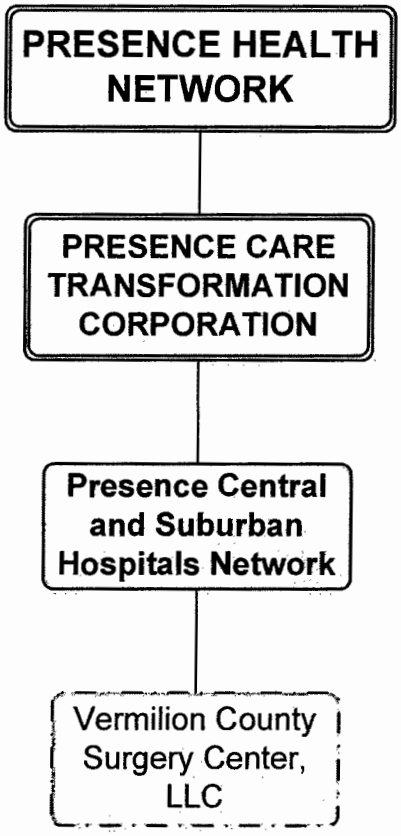
Jesse White

SECRETARY OF STATE

Attachment-3

ATTACHMENT – 4

ORGANIZATIONAL CHART



ATTACHMENT – 10

CRITERION 1110.130 – DISCONTINUATION

A. GENERAL INFORMATION REQUIREMENTS

1. **Identify the categories of service and the number of beds, if any that is to be discontinued.**

   The Applicant seeks authority form the Health Facilities and Services Review Board to discontinue in its entirety the existing three operating room ambulatory surgical treatment center located at 26 Newell Road, Danville, IL 61834. The facility is licensed for General Surgery, Plastics, Urology, ENT, Orthopedics, Ophthalmology, Pain Management, and GI.

2. **Identify all of the other clinical services that are to be discontinued.**

   No other clinical services will be discontinued as a result of this project.

3. **Provide the anticipated date of discontinuation for each identified service or for the entire facility.**

   Anticipated discontinuation of date: March 31, 2017, contingent upon HFSRB approval

4. **Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.**

   Attempts will be made to transfer any viable equipment possible to Presence Health for distribution to one of its hospital affiliates. All other assets, including the building and real property, will be made available for sale.

5. **Provide the anticipated disposition and location of all medical records pertaining to the service**

   Medical records will be retained by Presence Health in accordance with all laws and regulations.

6. **For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.**

   Presence Health will provide all questionnaires and data required by HFSRB or DPH through the date of discontinuation.

7. **Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.**

   The Applicant is providing notice of the closure in the Commercial-News in Danville, IL. Attached is a copy of the notice that ran in the online edition of the newspaper on Saturday, February 18, 2017 and Sunday, February 19, 2017 and in the print edition of the newspaper on Saturday, February 25, 2017 and Sunday, February 26, 2017.

B. REASONS FOR DISCONTINUATION

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

The Applicant is discontinuing services due to a lack of utilization resulting in ongoing financial losses at the facility. Currently the facility is utilized by interventional pain specialists and ophthalmologists only, and has lost over $1 million per year for the past two years.

Continuing to operate at this level of financial loss could threaten the future viability of Presence Health in the Danville market. 2016 Net Loss is expected to be approximately $1.2 million; the Net Loss from 2015 was $1.58 million.

C. IMPACT ON ACCESS

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

   Discontinuation of services at the facility will not have an adverse effect upon access to care for residents in the area. There is ample OR capacity in the service area. Other facilities in the service area and distance from the facility include:
   - Presence United Samaritans Medical Center: 5.1 miles, 11 min
   - Danville PolyClinic ASC: 5.3 miles, 12 min
   - Carle SurgiCenter: 2.8 miles, 6 min

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

   Not applicable; this is no longer required per recent statutory changes.

Attachment – 10

754 – 2/25, 26 2017

PUBLIC NOTICE
Vermilion County Surgery Center/ ACCESS Surgery Center Closure

Effective March 31, 2017, Vermilion County Surgery Center (also known as ACCESS Surgery Center) located at 26 West Newell Road, Danville, IL 61834 will discontinue service. ACCESS Surgery Center patients or their authorized representatives may obtain copies of patient records by contacting Presence United Samaritans Medical Center Health Information Management Department at 217-477-2992. Please contact your physician for information regarding the location of any procedure scheduled after the closing date.

Attachment - 10

ATTACHMENT – 20

SAFETY NET IMPACT STATEMENT

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.

The discontinuation of services at this facility will have no impact on access to care or essential safety net services.

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.

Presence United Samaritans Medical Center, which sees all patients regardless of payer status, is approximately 5 miles away from the facility and can provide any needed care to those patients who would have sought outpatient surgical services from the facility.

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.

Given the type of services provided and the low levels of charity care at the facility, the discontinuation of the facility will have a negligible impact on the remaining safety net providers in the community.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2014**	**2015**	**2016**
Inpatient	0	0	0
Outpatient	0	5	2
Total	**0**	**3**	**2**
Charity (cost in dollars)	**$0**	**$2,001**	**$989**
Inpatient	0	0	0
Outpatient	$0	$2,001	$989
Total	**$0**	**$2,001**	**$989**
MEDICAID			
Medicaid (# of patients)	**2014**	**2015**	**2016**
Inpatient	0	0	0
Outpatient	0	0	0
Total	$0	$0	$0
Medicaid (revenue)			
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0

ATTACHMENT – 21

CHARITY CARE INFORMATION

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue	**2014**	**2015**	**2016**
Amount of Charity Care (charges)	$0	$6,422	$3,555
Cost of Charity Care	$0	$2,001	$989

Attachment - 21