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HEALTH FACILITIES & SERVICES REVIEW BOARD

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: Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center
Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
County: McLean Health Service Area: 4 Health Planning Area: 113

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

Exact Legal Name: Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center
Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 South LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago 60604
Name of President: Kenneth R. Schoenig, M.D.
President Street Address: 1302 Franklin Avenue, Suite 1000
Manager City and Zip Code: Normal 61701
Manager Telephone Number: (309) 268-3400

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Juan Morado, Jr. and Mark J. Silberman
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4967 and (312) 212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number: (312) 767-9192

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

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City and Zip Code: Normal 61761
County: McLean Health Service Area: 4 Health Planning Area: 113

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

Exact Legal Name: Surgical Care Affiliates, LLC
Street Address: 569 Brookwood Village, Suite 901
City and Zip Code: Birmingham 35209
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 South LaSalle St., Suite 814
Registered Agent City and Zip Code: Chicago 60604
Name of CEO: Winborne Macphail
CEO Street Address: 569 Brookwood Village, Suite 901
CEO City and Zip Code: Birmingham 35209
CEO Telephone Number: (205) 545-2605

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
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County: McLean Health Service Area: 4 Health Planning Area: 113

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

Exact Legal Name: Kenneth Schoenig, M.D.
Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
Name of Registered Agent: N/A
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer: N/A
CEO Street Address:
CEO City and Zip Code:
CEO Telephone Number:

Type of Ownership of Applicants

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

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Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
County: McLean Health Service Area: 4 Health Planning Area: 113

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

Exact Legal Name: Robert Clark, M.D.
Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
Name of Registered Agent: N/A
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer: N/A
CEO Street Address:
CEO City and Zip Code:
CEO Telephone Number:

Type of Ownership of Applicants

☐ Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
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City and Zip Code: Normal 61761
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Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Vijaya Misra, M.D.
Street Address: 1302 Franklin Avenue, Suite 1000
City and Zip Code: Normal 61761
Name of Registered Agent: N/A
Registered Agent Street Address:
Registered Agent City and Zip Code:
Name of Chief Executive Officer: N/A
CEO Street Address:
CEO City and Zip Code:
CEO Telephone Number:

Type of Ownership of Applicants

☐ Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
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City and Zip Code: Normal 61761
County: McLean Health Service Area: 4 Health Planning Area: 113

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

Exact Legal Name: Physicians Endoscopy, L.L.C.
Street Address: 2500 York Road, Suite 300
City and Zip Code: Jamison 18929
Name of Registered Agent: The Corporation Trust Company
Registered Agent Street Address: Corporation Trust Center, 1209 Orange Street
Registered Agent City and Zip Code: Wilmington, DE 19801
Name of Chief Executive Officer: Winborne Macphail
CEO Street Address: 569 Brookwood Village, Suite 901
CEO City and Zip Code: Birmingham 35209
CEO Telephone Number: (205) 545-2605

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
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Post Permit Contact [Person to receive all correspondence after permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Michelle Remsen
Title: Director of Operations
Company Name: SCA Health
Address: One N. Wacker Drive, Suite 425, Chicago, IL 60606
Telephone Number: 630-405-3804
E-mail Address: michelle.remsen@scasurgery.com
Fax Number: N/A

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: The Carle Foundation
Address of Site Owner: 611 W Park St., Urbana, IL 61801
Street Address or Legal Description of the Site: 1111 Superior Street, Suite 204, Melrose Park, IL 60160 **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: Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center
Address: 1302 Franklin Avenue, Suite 1000, Normal, IL 61761

☐	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 organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

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

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

Flood Plain Requirements [Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org. This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**. **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

Prairieland Outpatient Diagnostic Center d/b/a Digestive Disease Endoscopy Center, an ambulatory surgical treatment center ("ASTC"), seeks to discontinue its facility at 1302 Franklin Avenue, Suite 1000, in Normal, Illinois 61761. The facility is approved for three (3) Procedure Rooms at the current location.

The discontinuation of this facility is being proposed due to the inability to reach agreement on a lease extension with the facility's landlord.

This project is classified as substantive, in that it involves a discontinuation of a health care facility per 77 Ill. Admin. Code. 1110.20(b).

There will be no cost associated with discontinuing operations at this location.

Project Costs and Sources of Funds – NOT APPLICABLE

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: **Not Applicable**
Fair Market Value: **Not Applicable**

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 **Not applicable.**

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): Upon approval of the Board to discontinue facility or by June 1, 2025.

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?

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

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

Cost Space Requirements – NOT APPLICABLE

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

Not Reviewable Space [i.e., non-clinical]: *means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center		**CITY: Normal**			
REPORTING PERIOD DATES:		**From: January 2022**			**To: December 2022**
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 (Gastro-Intestinal)	3	4,689	4,689	-	-
TOTALS:	3	4,689	4,689	-	-

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 Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center 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	SIGNATURE
Kenneth R Schwerig	
PRINTED NAME	PRINTED NAME
Physician / Board member	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 9th day of April 2025	Notarization: Subscribed and sworn to before me this 9th day of April 2025
Holly Beth Halliday	Holly Beth Halliday
Signature of Notary	Signature of Notary
Seal HOLLY BETH HALLIDAY Official Seal Notary Public - State of Illinois My Commission Expires Sep 9, 2025	Seal HOLLY BETH HALLIDAY Official Seal Notary Public - State of Illinois My Commission Expires Sep 9, 2025

*Insert the EXACT legal name of the applicant

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- 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 Surgical Care Affiliates, 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

Ladd W. Mark

PRINTED NAME

General Counsel, VP, and Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of April 2025

Signature of Notary

Seal

REANNA MONTGOMERY
My Commission Expires
June 3, 2025

SIGNATURE

Wes Fain

PRINTED NAME

Deputy General Counsel, VP, Asst. Sec.

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of April 2025

Signature of Notary

Seal

REANNA MONTGOMERY
My Commission Expires
June 3, 2025

*Insert the exact legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Ladd W. Mark

PRINTED NAME

Secretary and VP

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of April 2025

Signature of Notary

Seal

REANNA MONTGOMERY
My Commission Expires
June 3, 2025

SIGNATURE

Wes Fain

PRINTED NAME

VP

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of April 2025

Signature of Notary

Seal

REANNA MONTGOMERY
My Commission Expires
June 3, 2025

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of Kenneth Schoenig, M.D. 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	SIGNATURE
Kenneth R Schoenig	
PRINTED NAME	PRINTED NAME
Physician/Board Member	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 9th day of April 2025	Notarization: Subscribed and sworn to before me this 9th day of April 2025
Holly Beth Halliday	Holly Beth Halliday
Signature of Notary	Signature of Notary
Seal: HOLLY BETH HALLIDAY Official Seal Notary Public - State of Illinois My Commission Expires Sep 9, 2025	Seal: HOLLY BETH HALLIDAY Official Seal Notary Public - State of Illinois My Commission Expires Sep 9, 2025

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of Robert Clark, M.D. 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

Robert Clark
PRINTED NAME

Physician
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of April 2025

Holly Beth Halliday
Signature of Notary

Seal

HOLLY BETH HALLIDAY
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 9, 2025

*Insert the EXACT legal name of the applicant

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of April 2025

Holly Beth Halliday
Signature of Notary

Seal

HOLLY BETH HALLIDAY
Official Seal
Notary Public - State of Illinois
My Commission Expires Sep 9, 2025

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 ~~Vijay Misra~~ Vijay Laxmi Misra, MD, M.D. 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	SIGNATURE
V. MISRA	
PRINTED NAME	PRINTED NAME
PHYSICIAN	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 15th day of April, 2025	Notarization: Subscribed and sworn to before me this _____ day of _____
Elena Manzo	
Signature of Notary	Signature of Notary
Seal	Seal

Official Seal
ELENA MANZO
Notary Public, State of Illinois
Commission No. 597111
My Commission Expires March 14, 2028

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notices listed in Item 7 below MUST be submitted with this Application for Discontinuation https://www.ilga.gov/legislation/ilcs/documents/002039600K8.7.htm**

Criterion 1110.290 – 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 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. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**
8. 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.

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 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility 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 the **geographic service area**.

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

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1. Identify **ALL** 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.

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)**

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS – NOT APPLICABLE

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

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

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

Variance

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

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

SECTION IX. 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 the cash and equivalents must be retained in the balance sheet asset accounts 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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, ***including the impact on racial and health care disparities 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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 37.

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

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

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	29-32
2	Site Ownership	33
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	34-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36
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	37-60
11	Background of the Applicant	61-64
12	Purpose of the Project	65
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
Financial and Economic Feasibility:		
34	Availability of Funds	n/a
35	Financial Waiver	n/a
36	Financial Viability	n/a
37	Economic Feasibility	n/a
38	Safety Net Impact Statement	66-67
39	Charity Care Information	68
40	Flood Plain Information	n/a

ATTACHMENT 1
Type of Ownership of Applicant

Included with this attachment are:

1. The Certificate of Good Standing for the Applicant, Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center.

2. The Certificate of Good Standing for Surgical Care Affiliates, LLC

3. The Certificate of Good Standing for Physicians Endoscopy, L.L.C.

ATTACHMENT 1
Certificate of Good Standing
Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

File Number 0071854-8

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

PRAIRIELAND OUTPATIENT DIAGNOSTIC CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 16, 2002, 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* 21ST *day of* FEBRUARY *A.D.* 2025 .

Authentication #: 2505203468 verifiable until 02/21/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Surgical Care Affiliates, LLC

File Number 0226541-9

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

SURGICAL CARE AFFILIATES, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JULY 09, 2007, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS 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* 19TH *day of* MAY *A.D.* 2024 .

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

Authentication #: 2414000392 verifiable until 05/19/2025
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Physicians Endoscopy, L.L.C.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "PHYSICIANS ENDOSCOPY, L.L.C." IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-SECOND DAY OF MAY, A.D. 2024.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

2954776 8300

SR# 20242352535

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 203533753

Date: 05-22-24

ATTACHMENT 2
Site Ownership

The current owner of the building is The Carle Foundation. A copy of the most recently available McLean County property tax bill (2020) is enclosed as evidence of control over the site.

McLEAN COUNTY ILLINOIS REAL ESTATE TAX BILL
TAX YEAR 2020 PAYABLE 2021

REBECCA C. McNEIL
McLEAN COUNTY TREASURER/COLLECTOR
P.O. BOX 2400
115 E. WASHINGTON, RM M101
BLOOMINGTON, ILLINOIS 61702-2400
Ph (309) 888-5180 Fax (309) 888-5176
Office Hours: 8AM - 4:30PM, Mon. - Fri.
www.mcleancountyil.gov

Township: NORMAL
Tax Code: 3001
Prop Use Code: 8060

Legal Description
LEASEHOLD PARCEL IN ADVOCATE BROMENN MEDICAL OFFICE BUILDING 14-33-254-033

Site Address
1302 FRANKLIN AVE
NORMAL, IL 61761

14-33-254-037

THE CARLE FOUNDATION
611 W PARK ST
URBANA, IL 61801-2512

DUPLICATE

Pay by E-Check, Credit Card or Visa Debit Card at www.mcleancountyil.gov/tax or call 1-877-647-7238. Fee applies: E-Check $2.00 / Credit/Debit Card $1.50+2.25%

Taxing Body		Current Rate	Current Tax	Prior Rate	Prior Tax	Difference
MCLEAN COUNTY		0.75744	$1,208.44	0.75342	$868.16	340.28
MCLEAN COUNTY	PENSION	0.15842	$249.55	0.16187	$186.30	63.25
NORMAL TOWNSHIP		0.21714	$346.43	0.21814	$251.35	95.08
NORMAL TOWNSHIP	PENSION	0.01510	$24.09	0.01498	$17.27	6.82
TOWN OF NORMAL		0.05943	$94.81	0.18005	$207.47	-112.66
TOWN OF NORMAL	PENSION	0.96856	$1,542.06	0.85258	$982.42	559.64
NORMAL TWP ROAD DIST		0.07848	$125.21	0.09006	$103.78	21.43
B-N WATER RECLAMATION DISTRICT		0.16558	$264.17	0.16578	$191.03	73.14
B-N WATER RECLAMATION DISTRICT	PENSION	0.02121	$33.84	0.02257	$26.00	7.84
BLM-NRM AIRPORT AUTH		0.13581	$216.68	0.13358	$153.92	62.76
BLM-NRM AIRPORT AUTH	PENSION	0.00958	$15.44	0.01008	$11.63	3.81
CUSD 5 NORMAL		5.45139	$8,697.20	5.15835	$5,943.92	2753.28
CUSD 5 NORMAL	PENSION	0.19565	$312.14	0.19706	$227.07	85.07
NORMAL PUBLIC LIBRARY		0.43367	$691.88	0.43648	$502.95	188.93
HEARTLAND COMM COLLEGE 540		0.57762	$921.54	0.58179	$670.39	251.15
Totals		9.24119	$14,743.48	8.97660	$10,343.66	$4,399.82

Owner Name: THE CARLE FOUNDATION

PENALTIES

PENALTY PER MONTH ADDED AFTER EACH INSTALLMENT DUE DATE.
ADDITIONAL $10 ADDED AFTER DELINQUENT NOTICE IS MAILED

If postmarked after 10/03, contact office. Additional Interest & Penalties apply.

Certified funds required for payments tendered within 30 days of the NOVEMBER 16, 2021 tax sale.

EAV BASE	0
EAV INCREASED	0
EAV FREEZE BASE	0
EAV EQUALIZED VALUE	478,670
TOTAL ACRES	0.00
LAND VALUE	0
+ BUILDING VALUE	159,541
+ HOME IMPROVEMENT	0
= ASSESSED VALUE	159,541
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	159,541
- HOMESTEAD EXEMPT	0
- SENIOR EXEMPT	0
- DISABLED VET EXEMPT	0
- NET HOMESTEAD	0
- DISABLED PER EXEMPT	0
- NET VET HOMESTEAD	0
+ FARM LAND	0
+ FARM BUILDING	0
= NET TAXABLE VAL	159,541
TAX RATE	9.24119
= CURRENT TAX	$14,743.48
- DISCOUNT	
PRIOR SALE FOR?	NO
= TOTAL TAX DUE	$14,743.48
TOTAL TAX PAID	$14,743.48
= TOTAL TAX DUE	$0.00

McLean County Real Estate Tax Bill

PLEASE MAIL TO PAYMENT PROCESSING CENTER:
MCLEAN COUNTY COLLECTOR
P.O. BOX 843637
KANSAS CITY, MO 64184-3637

2

THE CARLE FOUNDATION
611 W PARK ST
URBANA, IL 61801-2512

DUPLICATE

TAX YEAR 2020 PAYABLE 2021

Parcel Number 14-33-254-037
Second Installment Due Date 09/16/2021
Prior Sale For? NO
Total Due 2nd Install Paid on 09/03/2021 $0.00

IF POSTMARKED AFTER	TAX	PENALTY	PLEASE PAY
09/16/2021	7,371.74	110.58	7,482.32
10/03/2021	7,371.74	Contact Office	Contact Office

2

McLean County Real Estate Tax Bill

PLEASE MAIL TO PAYMENT PROCESSING CENTER:
MCLEAN COUNTY COLLECTOR
P.O. BOX 843637
KANSAS CITY, MO 64184-3637

1

THE CARLE FOUNDATION
611 W PARK ST
URBANA, IL 61801-2512

DUPLICATE

TAX YEAR 2020 PAYABLE 2021

Parcel Number 14-33-254-037
First Installment Due Date 06/16/2021
Prior Sale For? NO
Total Due 1st Install Paid on 06/22/2021 $0.00

IF POSTMARKED AFTER	TAX	PENALTY	PLEASE PAY
06/16/2021	7,371.74	110.58	7,482.32
07/16/2021	7,371.74	221.15	7,592.89
08/16/2021	7,371.74	331.73	7,703.47
09/16/2021	7,371.74	442.30	7,814.04
10/03/2021	7,371.74	Contact Office	Contact Office

1

ATTACHMENT 3
Operating Entity/Licensee

Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, is licensed by the Illinois Department of Public Health. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

ATTACHMENT 3
Operating Entity
Certificate of Good Standing – Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

File Number 0071854-8

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

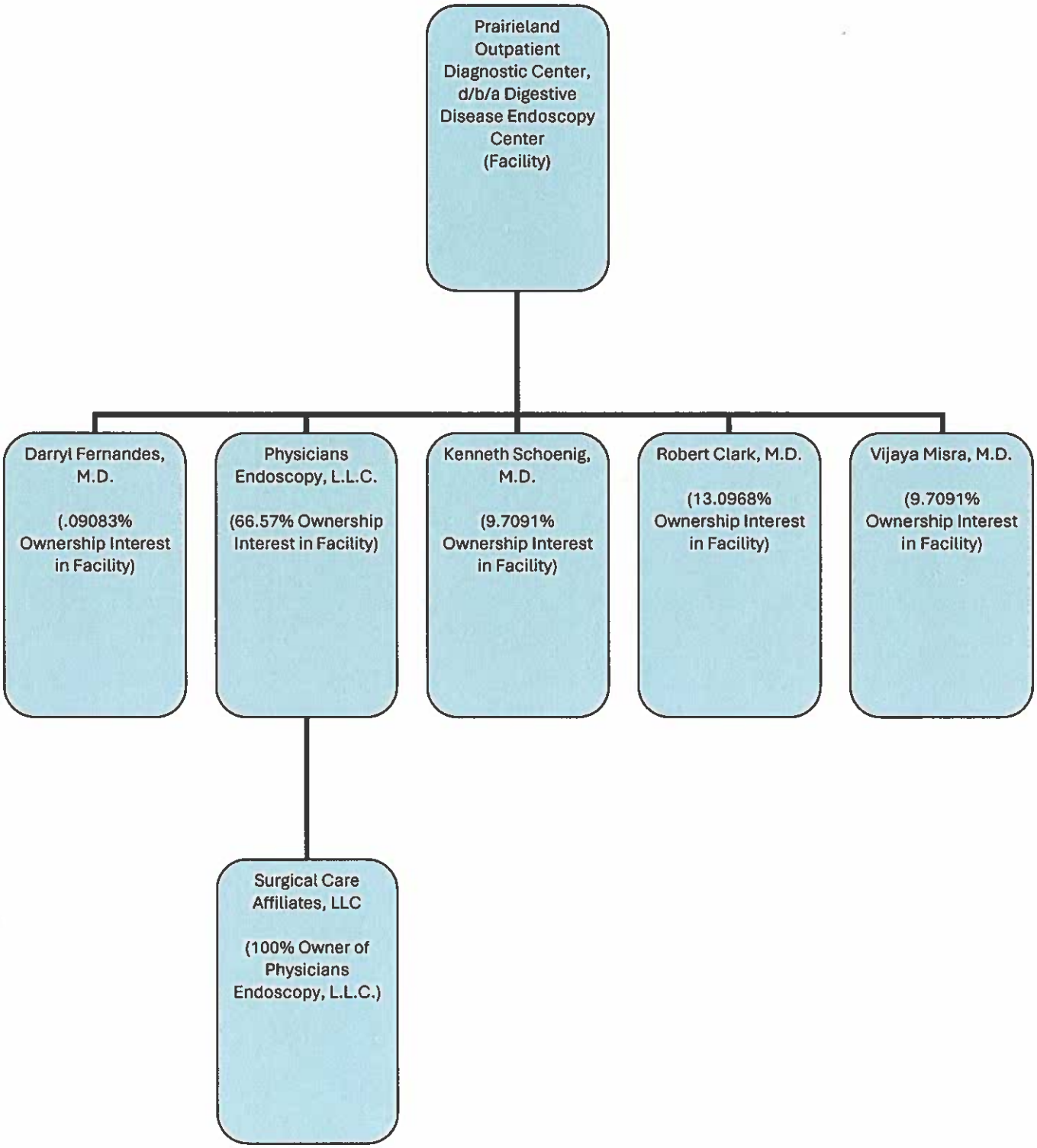
PRAIRIELAND OUTPATIENT DIAGNOSTIC CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 16, 2002, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* FEBRUARY *A.D.* 2025 .

Authentication #: 2505203468 verifiable until 02/21/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 4
Organizational Chart



ATTACHMENT 10
Discontinuation

General:

1. **Categories of service and the number of beds, if any that are to be discontinued.**

   The facility is approved for three (3) procedure rooms at the ASTC that will be discontinued.

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

   Gastrointestinal procedures are the only category of service currently offered at the facility and upon approval of this application will be discontinued.

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

   The Applicant proposes to permanently discontinue the service upon approval of the Board or by June 1, 2025.

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

   The anticipated use of the physical plant has not been determined as the licensee does not own the structure. Certain usable medical equipment will be transferred to other facilities if this discontinuation is approved.

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.**

   The medical records will be maintained Carle Health System and other locations based on where the current physician owners will continue their practice. Ultimately, all records will be maintained in accordance with applicable state law requirements.

6. **Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.**

   Included in Attachment 10 is a copy of the Notice provided to the local media that would routinely be notified about the facility's events.

7. **For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.**

   Included in Attachment 10 are copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services.

8. **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.**

   Included in Attachment 10 is a certification from the Applicant that all required data will be submitted no later than 90 days following the date of discontinuation.

ATTACHMENT 10
Discontinuation

Reasons For Discontinuation

The reason for discontinuation of the facility is a result of the Applicant being unable to reach a reasonable agreement with the owner/landlord of the property for a continuation of the lease. As a result, the continued operation at the facility was not economically feasible and continuation of operations under the lease terms proposed by the building owner would impair the facility's financial viability. There were no issues related to demand for service, staff or compliance with licensing or certification requirements.

Impact of Access

1. **Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.**

   The discontinuation will not have an adverse effect upon access of care for residents of the facility's market area. There are other facilities in the Applicant's Service Area providing similar services and the facility itself is on the campus of a health system with a full-service acute care hospital.

   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 the geographic service area.

   Included in Attachment 10 are copies of the notification letter and request for an impact statement sent to area facilities within the geographic service area and maps indicating the distance and drive times to the facilities.

ATTACHMENT 10
Discontinuation
Media Notice

The Applicants will publish the notice below in the Pantagraph, a local newspaper that routinely notifies the public about facility events. The notice below is scheduled to be published a single time in the classified ad section of the newspaper on March 31, 2025. The Pantagraph has a print circulation of 16,930, and an online presence. The Pantagraph is a newspaper of general circulation throughout McLean County and surrounding areas, and is a newspaper as defined by 715 ILCS 5/5.

"**Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center** has filed a Certificate of Need application with the Illinois Health Facilities and Services Review Board ("HFSRB") to discontinue their ambulatory surgical treatment center located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 in the second quarter of 2025. After submission of the application to discontinue the facility to the HFSRB, the application for the proposed discontinuation may be found on the HFSRB website at https://www2.illinois.gov/sites/hfsrb/Pages/default.aspx. If you are or have been a patient at **Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center**, and have questions about accessing your medical records, please call (309) 268-3400."

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Benesch

Juan Morado, Jr
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

February 18, 2025

VIA USPS

Hon. Sharon Chung
State Representative, District 91
216 North Center Street
Bloomington, IL 61701

Re: Notice of Intent to Discontinue Prairieland Outpatient Diagnostic Center, LLC dba Digestive Disease Endoscopy Center

Dear Representative Chung,

This letter is to notify you that Prairieland Outpatient Diagnositc Center, LLC dba Digestive Disease Endoscopy Center, located at 1302 Franklin Avenue, Suite 1000 Normal, Illinois 61761 is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to seek approval of the Facility's proposed discontinuation of services. The discontinuation is anticipated to occur after approval is obtained from the HFSRB, and most likely in the second quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location. The facility is located on the campus of Carle BroMenn Medical Center where similar services are also available.

Pursuant to the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, in whose district the facility is located, the Mayor of Normal, the Director of the Department of Public Health and the Director of the Department of Healthcare and Family Services.

If you should have any questions or need any additional information regarding the proposed discontinuation, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Benesch

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

February 18, 2025

VIA USPS

Hon. David Koehler
State Senator, District 46
400 NE. Jefferson Suite, 200
Peoria, IL 61603

Re: Notice of Intent to Discontinue Prairieland Outpatient Diagnostic Center, LLC dba Digestive Disease Endoscopy Center

Dear Representative Koehler,

This letter is to notify you that Prairieland Outpatient Diagnositc Center, LLC dba Digestive Disease Endoscopy Center, located at 1302 Franklin Avenue, Suite 1000 Normal, Illinois 61761 is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to seek approval of the Facility's proposed discontinuation of services. The discontinuation is anticipated to occur after approval is obtained from the HFSRB, and most likely in the second quarter of 2025.

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If you should have any questions or need any additional information regarding the proposed discontinuation, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Benesch

Juan Morado, Jr
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

February 18, 2025

VIA USPS

Hon. Chris Koos
Town of Normal Mayor
11 Uptown Circle
Normal, Illinois 61761

Re: Notice of Intent to Discontinue Prairieland Outpatient Diagnostic Center, LLC dba Digestive Disease Endoscopy Center

Dear Mayor Koos,

This letter is to notify you that Prairieland Outpatient Diagnositc Center, LLC dba Digestive Disease Endoscopy Center, located at 1302 Franklin Avenue, Suite 1000 Normal, Illinois 61761 is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to seek approval of the Facility's proposed discontinuation of services. The discontinuation is anticipated to occur after approval is obtained from the HFSRB, and most likely in the second quarter of 2025.

We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location. The facility is located on the campus of Carle BroMenn Medical Center where similar services are also available.

Pursuant to the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, in whose district the facility is located, the Mayor of Normal, the Director of the Department of Public Health and the Director of the Department of Healthcare and Family Services.

If you should have any questions or need any additional information regarding the proposed discontinuation, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Benesch

Juan Morado, Jr
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

February 18, 2025

VIA USPS

Hon. Elizabeth M. Whitehorn
Director
Illinois Department of Health and Family Services
201 South Grand Avenue, East
Springfield, Illinois 62763

Re: Notice of Intent to Discontinue Prairieland Outpatient Diagnostic Center, LLC dba Digestive Disease Endoscopy Center

Dear Director Whitehorn,

This letter is to notify you that Prairieland Outpatient Diagnositc Center, LLC dba Digestive Disease Endoscopy Center, located at 1302 Franklin Avenue, Suite 1000 Normal, Illinois 61761 is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to seek approval of the Facility's proposed discontinuation of services. The discontinuation is anticipated to occur after approval is obtained from the HFSRB, and most likely in the second quarter of 2025.

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Pursuant to the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, in whose district the facility is located, the Mayor of Normal, the Director of the Department of Public Health and the Director of the Department of Healthcare and Family Services.

If you should have any questions or need any additional information regarding the proposed discontinuation, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 10
Discontinuation
Notices to Elected Officials and Agency Heads

Benesch

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

February 18, 2025

VIA USPS

Hon. Sameer Vohra, M.D.
Director
Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 62761

Re: Notice of Intent to Discontinue Prairieland Outpatient Diagnostic Center, LLC dba Digestive Disease Endoscopy Center

Dear Director Vohra,

This letter is to notify you that Prairieland Outpatient Diagnositc Center, LLC dba Digestive Disease Endoscopy Center, located at 1302 Franklin Avenue, Suite 1000 Normal, Illinois 61761 is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") to seek approval of the Facility's proposed discontinuation of services. The discontinuation is anticipated to occur after approval is obtained from the HFSRB, and most likely in the second quarter of 2025.

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Pursuant to the Health Facilities Planning Act, we are providing this notice to our State Representative, State Senator, in whose district the facility is located, the Mayor of Normal, the Director of the Department of Public Health and the Director of the Department of Healthcare and Family Services.

If you should have any questions or need any additional information regarding the proposed discontinuation, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

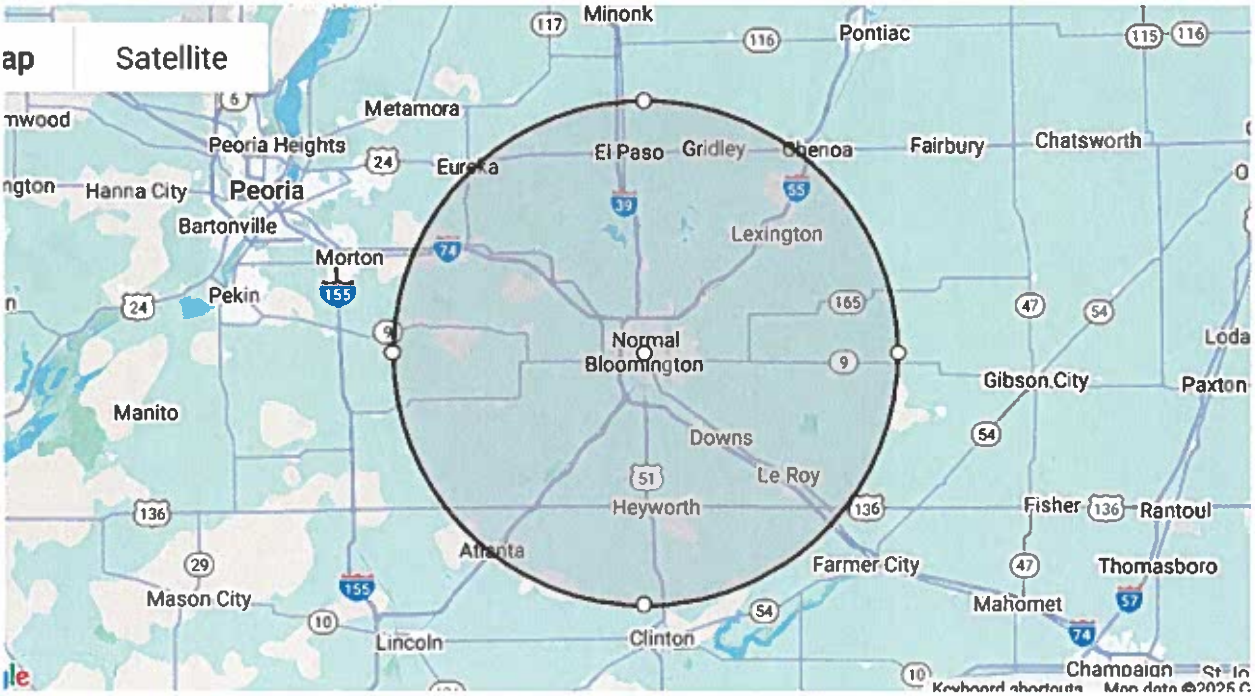
BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 10
Discontinuation
Notice to Area Facilities

The following notification letters were sent to area facilities within the geographic service area ("GSA") as determined by the distance and drive times to the facilities. Also listed on the following pages in accordance with 77 Illinois Admin Code Section 1110.235(c)(1)(A) are the facilities located in the GSA. Also listed are all of the zip codes that are located within a 21-mile radius of the existing site of the ASTC. We have included a map of the multi-directional travel radii of the proposed ASTC site below.

21 Mile Radius from 1302 Franklin Avenue, Suite 1000, Normal, IL 61761



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

Facility Name	Facility Address
Bloomington Normal Healthcare Surgery Center	2100 Fort Jesse Road Normal, IL 61761
Central Illinois Gastroenterology, LLC	2200 Jacobssen Drive, Suite A Normal, IL 61761
Ireland Grove Center for Surgery	3801 Ireland Grove Rd. Bloomington, IL 61704
Bloomington Eye Institute, LLC	1008 North Center St. Bloomington, IL 61701
Eastland Medical Plaza Surgicenter	1505 Eastland Drive Bloomington, IL 61701
The Center for Orthopedic Medicine, LLC	2502 E. East Empire St. Bloomington, IL 61704
OSF St. Joseph Medical Center	2200 East Washington Bloomington, IL 61704

ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
Bloomington Normal Healthcare Surgery Center
2100 Fort Jesse Road
Normal, IL 61761

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

To Whom It May Concern:

This letter is to notify you that Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 ("Facility") is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the Facility's planned discontinuation of all services. The discontinuation will occur upon approval of the Facility's discontinuation application submitted to HFSRB. It is anticipated that the facility will cease operations in the second quarter of 2025.

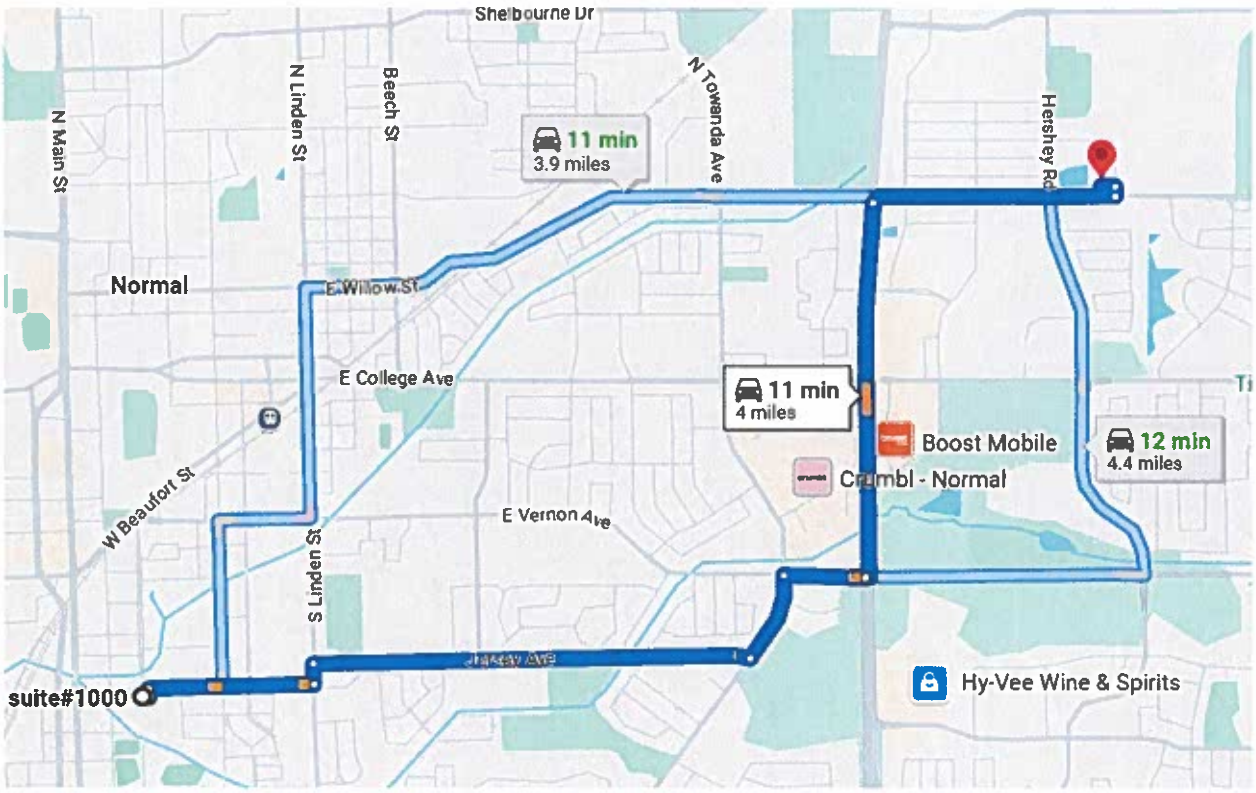
We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as there are other facilities providing similar services within the health service area.

Pursuant to the Health Facilities Planning Act, we are providing this notice. Please respond in writing if you anticipate an adverse impact of this proposed discontinuation on your facility.

Sincerely,

Kenneth Schoenig, M.D.
President

ATTACHMENT 10
Discontinuation
Notice to Area Facilities



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
Central Illinois Gastroenterology, LLC
2200 Jacobssen Dr., Suite A
Normal, IL 61761

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

To Whom It May Concern:

This letter is to notify you that Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 ("Facility") is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the Facility's planned discontinuation of all services. The discontinuation will occur upon approval of the Facility's discontinuation application submitted to HFSRB. It is anticipated that the facility will cease operations in the second quarter of 2025.

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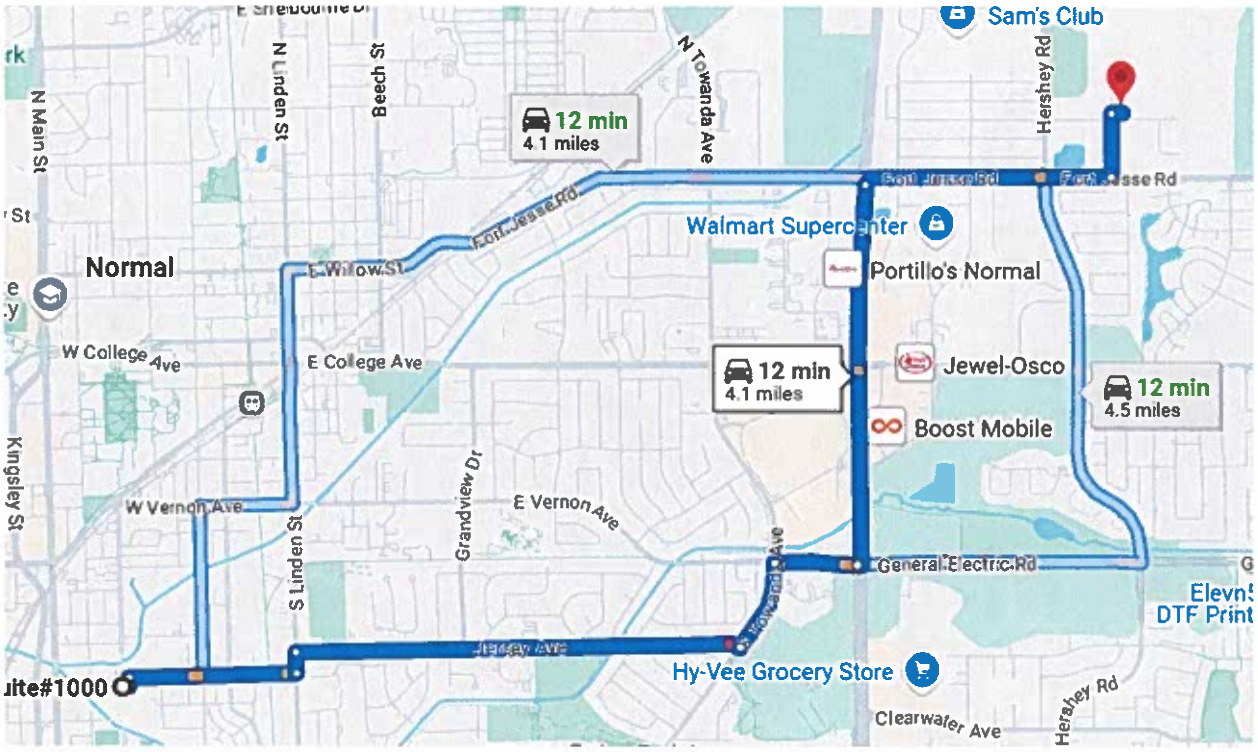
Sincerely,

Kenneth Schoenig, M.D.
President

ATTACHMENT 10
Discontinuation
Notice to Area Facilities



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
Ireland Grove Center for Surgery
3801 Ireland Grove Rd.
Bloomington, IL 61704

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

To Whom It May Concern:

This letter is to notify you that Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 ("Facility") is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the Facility's planned discontinuation of all services. The discontinuation will occur upon approval of the Facility's discontinuation application submitted to HFSRB. It is anticipated that the facility will cease operations in the second quarter of 2025.

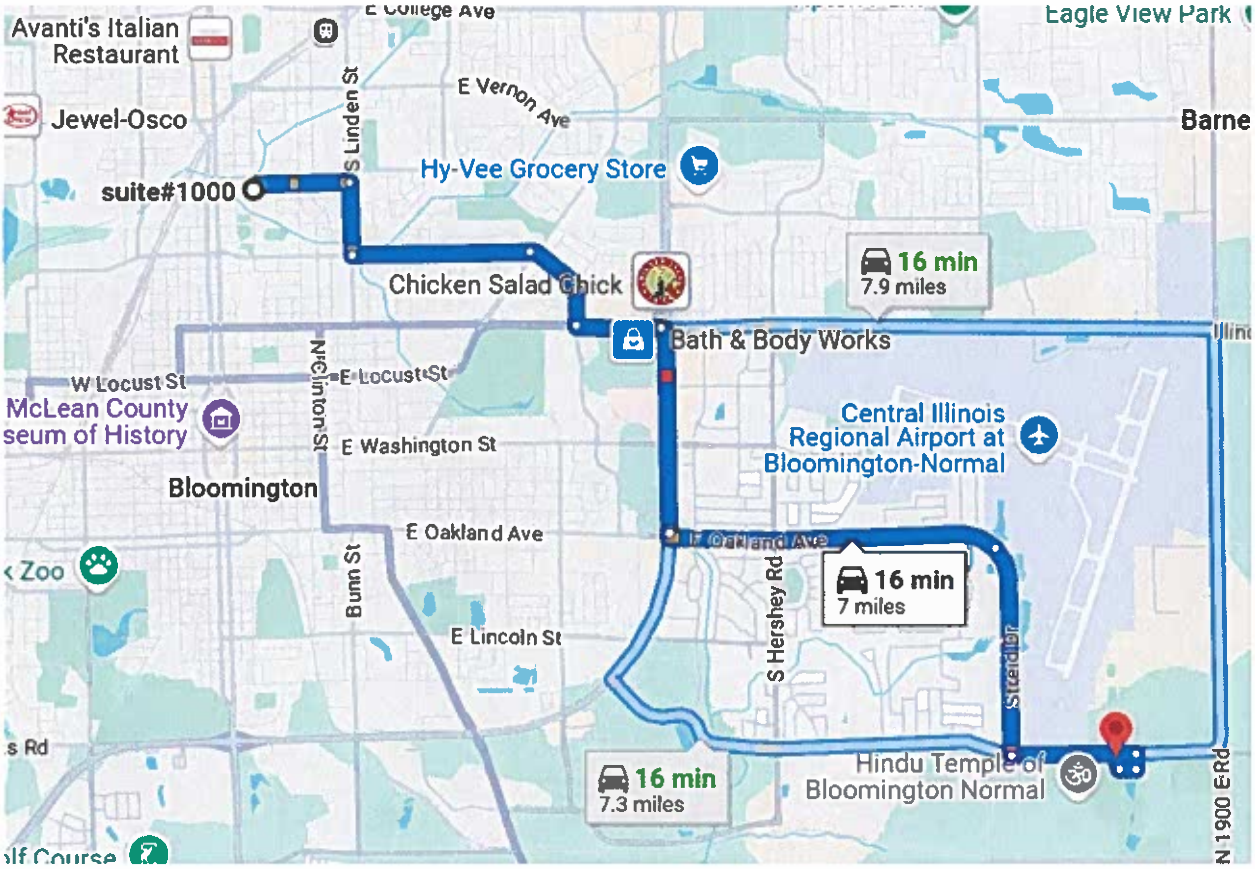
We are not aware of any adverse impact upon patient access and do not anticipate any such impact from the permanent discontinuation of the services at this location as there are other facilities providing similar services within the health service area.

Pursuant to the Health Facilities Planning Act, we are providing this notice. Please respond in writing if you anticipate an adverse impact of this proposed discontinuation on your facility.

Sincerely,

Kenneth Schoenig, M.D.
President

ATTACHMENT 10
Discontinuation
Notice to Area Facilities



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
Bloomington Eye Institute
1008 North Center St.
Bloomington, IL 61701

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

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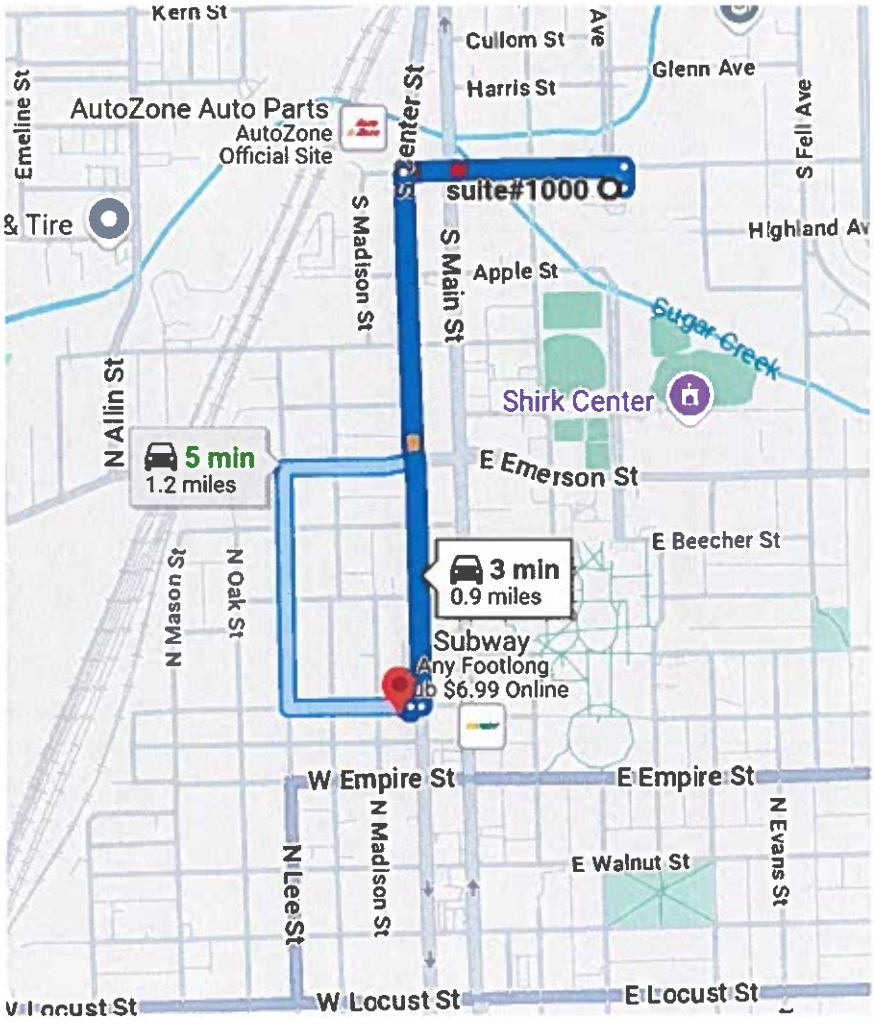

ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
Eastland Medical Plaza Surgicenter
1505 Eastland Drive
Bloomington, IL 61701

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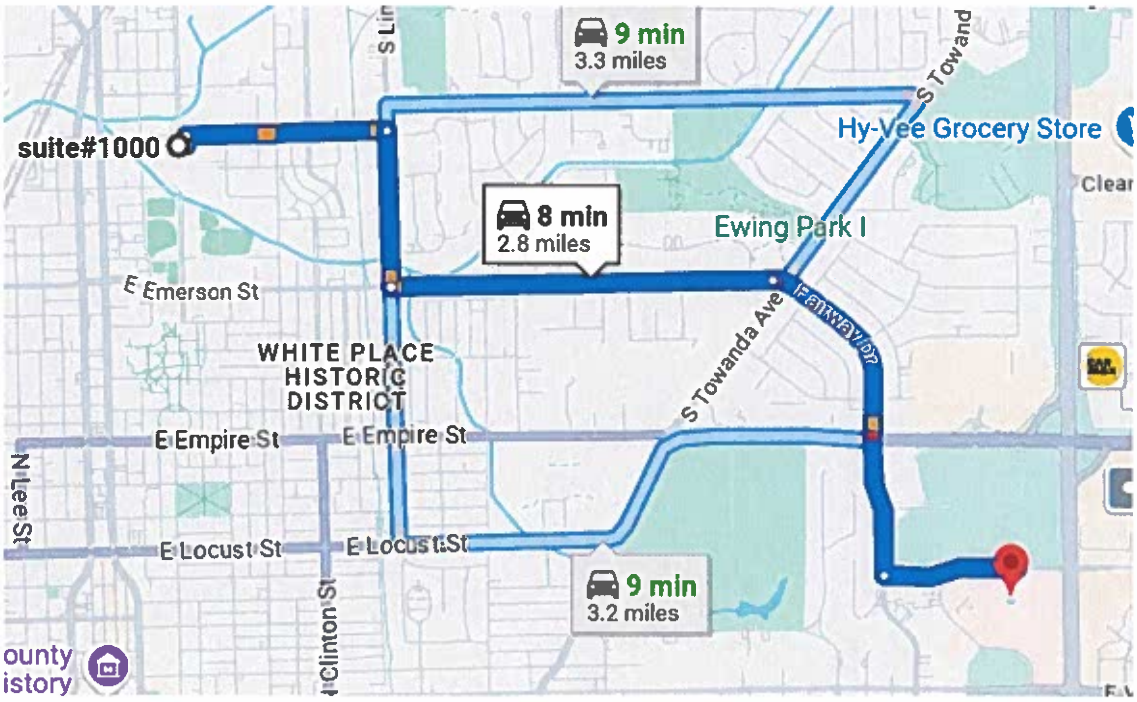
Notice to Area Facilities



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
The Center for Orthopedic Medicine, LLC
2502 E. East Empire St.
Bloomington, IL 61704

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

To Whom It May Concern:

This letter is to notify you that Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 ("Facility") is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the Facility's planned discontinuation of all services. The discontinuation will occur upon approval of the Facility's discontinuation application submitted to HFSRB. It is anticipated that the facility will cease operations in the second quarter of 2025.

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Kenneth Schoenig, M.D.
President

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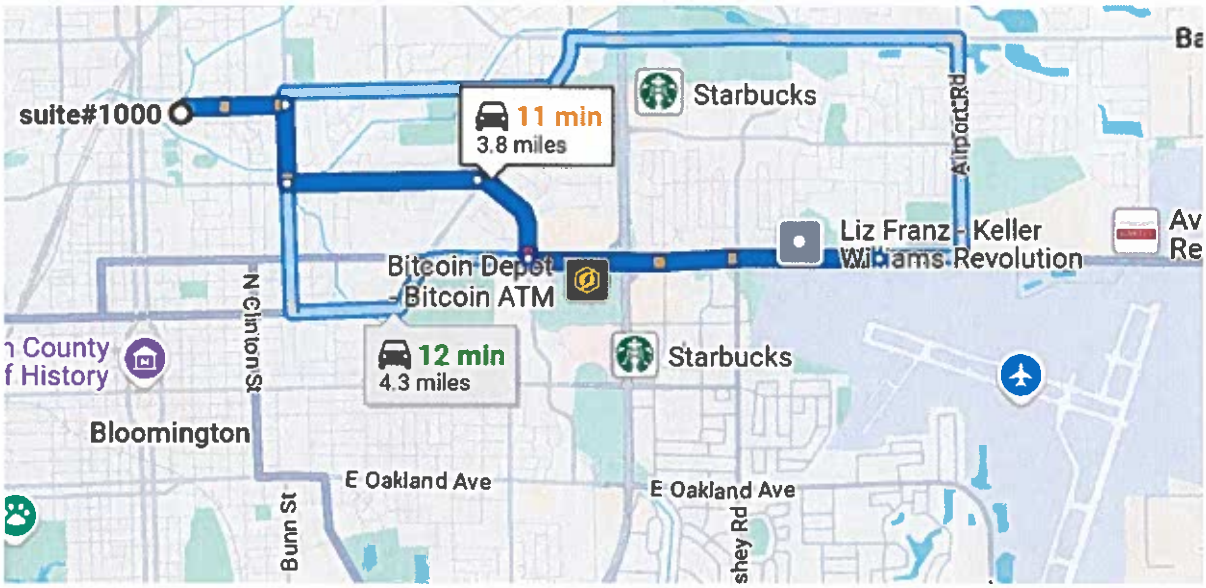
Discontinuation
Notice to Area Facilities



ATTACHMENT 10
Discontinuation
Notice to Area Facilities

DDEC | Digestive Disease Endoscopy Center

March 31, 2025

Administrator
OSF St. Joseph Medical Center
2200 East Washington
Bloomington, IL 61704

Re: Notice of Discontinuation of Ambulatory Surgical Treatment Center - Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center

To Whom It May Concern:

This letter is to notify you that Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center, located at 1302 Franklin Ave., Suite 1000, Normal, IL 61761 ("Facility") is filing an application with the Illinois Health Facilities and Services Review Board ("HFSRB") relating to the Facility's planned discontinuation of all services. The discontinuation will occur upon approval of the Facility's discontinuation application submitted to HFSRB. It is anticipated that the facility will cease operations in the second quarter of 2025.

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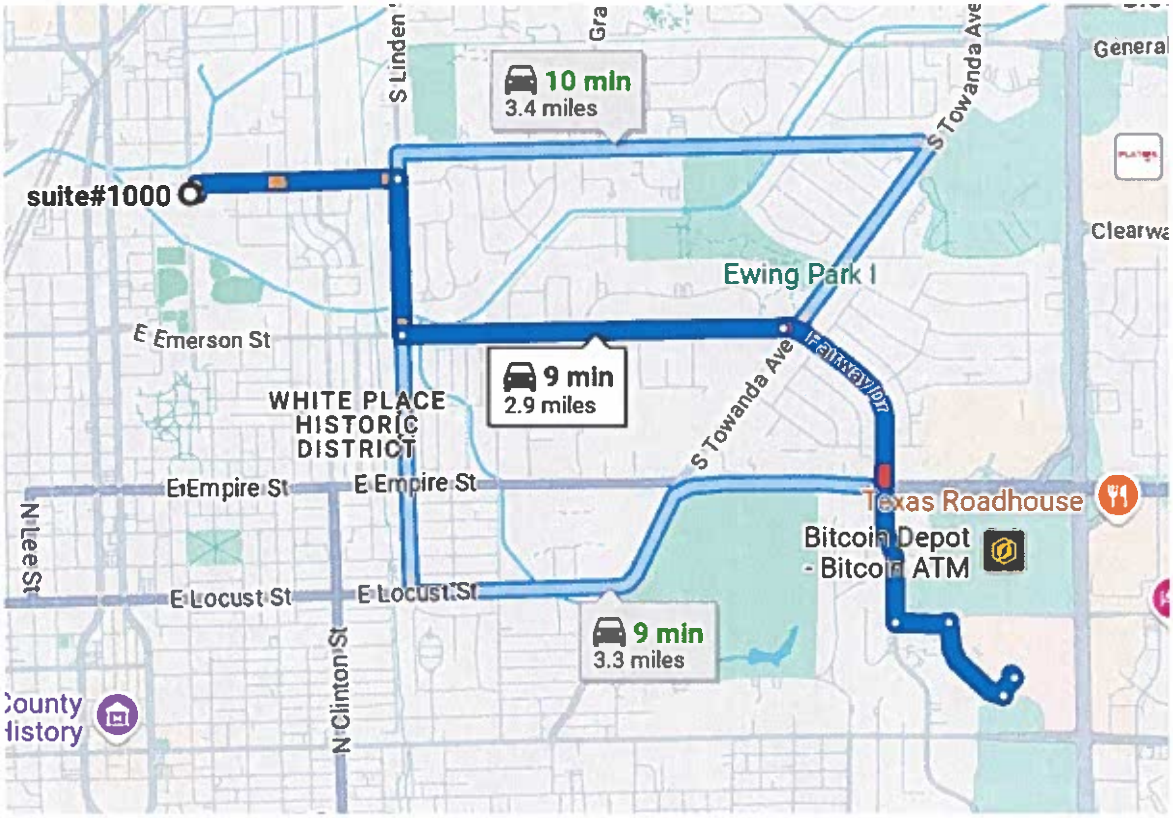
Kenneth Schoenig, M.D.
President

ATTACHMENT 10
Discontinuation
Notice to Area Facilities



ATTACHMENT 11
Background of the Applicants

The following information is provided to illustrate the qualifications, background, and character of the Applicants, and to assure the Review Board that the proposed discontinuation of services will provide a proper standard of health care services for the community.

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification, if applicable.

The Applicants have ownership in several other ASTCs in the state and have listed them all in their certification and authorization letter included in this attachment.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

The Applicant have ownership in several other ASTCs in the state and have listed them all in their certification and authorization letter included in this attachment.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

Pursuant to the certification executed with the submission of this application, the Applicants certify that there have been no adverse actions taken against any facility owned and/or operated by the Applicant during the three years prior to filing of the application.

b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.

Pursuant to the certification executed with the submission of this application, the Applicants certify that there have been no individuals cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding.

ATTACHMENT 11
Background of the Applicants

c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

Pursuant to the certification executed with the submission of this application, the Applicants certify that no person has been charged with fraudulent conduct or any act involving moral turpitude.

d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

Pursuant to the certification executed with the submission of this application, the Applicants certify that they do not have any unsatisfied judgments against him or her.

e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

Pursuant to the certification executed with the submission of this application, the Applicants certify that they do not have any Applicants who are in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.

The Applicants permit the 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.

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

a. Not Applicable.

ATTACHMENT 11
Background of the Applicants

March 31, 2025

John P. Kniery
Board Administrator
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification and Authorization- Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center

Dear Mr. Kniery,

As representative of Surgical Care Affiliates, LLC, Physicians Endoscopy, L.L.C., and Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center, I, Ladd Mark, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that, Surgical Care Affiliates, LLC has ownership interest in excess of 5% in the following Illinois healthcare facilities:

- Hawthorn Place Outpatient Surgery Center, L.P. d/b/a Hawthorn Surgery Center
- Joliet Surgery Center Limited Partnership d/b/a Amsurg Surgery Center
- Northwest Surgicare, Ltd., an Illinois Limited Partnership
- Advocate Condell Ambulatory Surgery Center, LLC d/b/a Advocate Surgery Center - Libertyville
- Southwest Surgery Center, LLC d/b/a Center for Minimally Invasive Surgery
- Midwest Center for Day Surgery, LLC
- Naperville Surgical Centre, LLC
- Advocate Southwest Ambulatory Surgery Center, L.L.C. d/b/a Tinley Woods Surgery Center
- LGH-A/Golf ASTC, L.L.C. d/b/a Golf surgical Center
- Rush Oak Brook Surgery Center, LLC
- Lindenhurst Surgery Center, LLC d/b/a Red Oaks Surgical Suites

Physicians Endoscopy Center, L.L.C. has an ownership interest in excess of 5% in Elgin Gastroenterology Endoscopy Center, L.L.C and Prairieland Outpatient Diagnostic Center, LLC d/b/a Digestive Disease Endoscopy Center.

Additionally, none of the health care facilities listed above have been cited for an adverse action in the past three (3) years. Further, Prairieland Outpatient Diagnostic Center, LLC has no interest in any other Illinois healthcare facilities.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

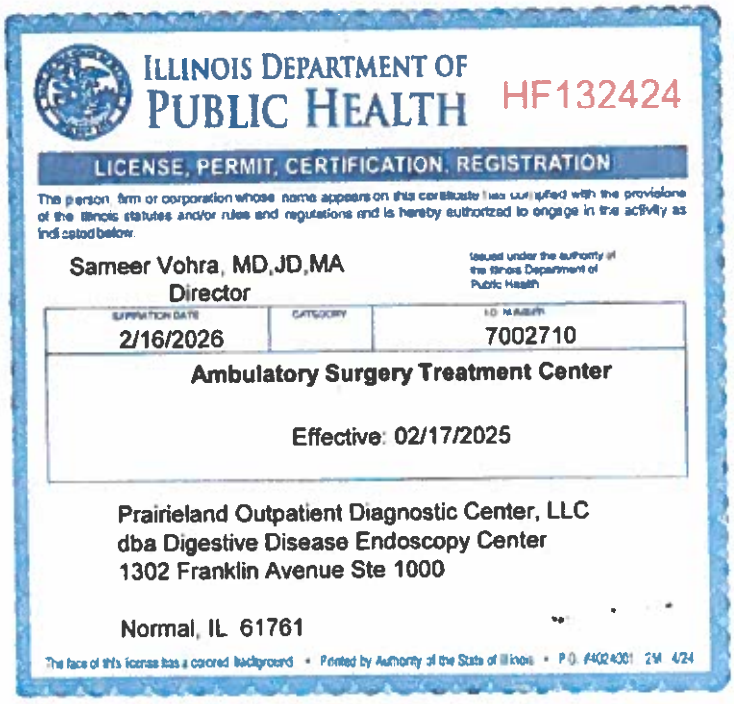
Sincerely,

Ladd Mark
General Counsel
Surgical Care Affiliates, LLC

4908-7956-5615.3

ATTACHMENT 11
Background of the Applicant
Facility License Information

Facility Name	Facility Address	Facility License Number
Golf Surgical Center	8901 Golf Road Des Plaines, IL 60016	7002231
Center for Minimally Invasive Surgery	19110 Darvin Drive, Suite A Mokena, IL 60448	7003201
Red Oaks Surgical Suites	1050 Red Oak Lane Lindenhurst, IL 60046	7003168
Naperville Surgical Centre	1263 Rickert Dr. Naperville, IL 60540	7003205
Hawthorn Surgery Center	240 Center Drive Vernon Hills, IL 60061	7003188
AmSurg Surgery Center	998 129th Infantry Drive Joliet, IL 60435	7003160
Advocate Condell Ambulatory Surgery Center	825 S. Milwaukee Ave, Libertyville, IL 60048	7003208
Midwest Center for Day Surgery	3811 Highland Avenue Downers Grove, IL 60515	7001076
Elgin Gastroenterology Endoscopy Center	745 Fletcher Dr. Suite 201 Elgin, IL 60123	7003015
Tinley Woods Surgery Center	18200 S. LaGrange Rd. Tinley Park, IL 60487	7002652



ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF132424

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.

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
2/16/2026		7002710

Ambulatory Surgery Treatment Center

Effective: 02/17/2025

Prairieland Outpatient Diagnostic Center, LLC
dba Digestive Disease Endoscopy Center
1302 Franklin Avenue Ste 1000

Normal, IL 61761

The face of this license has a colored background • Printed by Authority of the State of Illinois • P.O. #4024301 2M 4/24

ATTACHMENT 12
Purpose of Project

Reasons For Discontinuation

The reason for discontinuation of the facility is a result of the Applicant being unable to reach a reasonable agreement with the owner/landlord of the property for a continuation of the lease. As a result, the continued operation at the facility was not economically feasible and continuation of operations under the lease terms proposed by the building owner would impair the facility's financial viability. There were no issues related to demand for service, staff or compliance with licensing or certification requirements.

Impact of Access

Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.

The discontinuation will not have an adverse effect upon access of care for residents of the facility's market area. There are other facilities in the Applicant's Service Area providing similar services and the facility itself is on the campus of a health system with a full-service acute care hospital.

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 the geographic service area.

Included in Attachment 10 are copies of the notification letter and request for an impact statement sent to area facilities within the geographic service area and maps indicating the distance and drive times to the facilities.

ATTACHMENT 38
Safety Net Impact Statement

1. The project will not have a material impact, on essential safety net services in the community, *including the impact on racial and health care disparities in the community,* to the extent that it is feasible for an applicant to have such knowledge.

The Applicant facility will cease operations upon approval of this discontinuation application and there will be no adverse material impact on available safety net services due to the existence of licensed facilities providing similar services within the service area. Additionally, the discontinuation of its facility will not impact existing providers.

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.

The project should not have any impact on the ability of another provider or health care system to cross subsidize safety net services.

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

The discontinuation of the facility will not impact remaining safety net providers as other facilities providing similar services exist within the service area.

Attachment 38
Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2020**	**2021**	**2022**
Inpatient	-	-	-
Outpatient	0	0	0
Total	**0**	**0**	**0**
Charity (cost in dollars)			
Inpatient	-	-	-
Outpatient	$0	$0	$0
Total	**$0**	**$0**	**$0**
MEDICAID			
Medicaid (# of patients)	**2020**	**2021**	**2022**
Inpatient	-	-	-
Outpatient	6	2	5
Total	6	2	5
Medicaid (revenue)			
Inpatient	-	-	-
Outpatient	$1,273	$1,409	$22,958
Total	$1,273	$1,409	$22,958

Attachment 39
Charity Care Information

Prairieland Outpatient Diagnostic Center, d/b/a Digestive Disease Endoscopy Center			
	2020	2021	2022
Net Patient Revenue	**$4,326,527**	**$5,284,877**	**$13,644,431**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

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	29-32
2	Site Ownership	33
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	34-35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	36
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	37-60
11	Background of the Applicant	61-64
12	Purpose of the Project	65
13	Alternatives to the Project	n/a
14	Size of the Project	n/a
15	Project Service Utilization	n/a
16	Unfinished or Shell Space	n/a
17	Assurances for Unfinished/Shell Space	n/a
Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	n/a
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
31	Freestanding Emergency Center Medical Services	n/a
32	Birth Center	n/a
Financial and Economic Feasibility:		
34	Availability of Funds	n/a
35	Financial Waiver	n/a
36	Financial Viability	n/a
37	Economic Feasibility	n/a
38	Safety Net Impact Statement	66-67
39	Charity Care Information	68
40	Flood Plain Information	n/a