



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 FAX: (217) 785-4111

January 2, 2014

EMAIL
CERTIFIED MAIL
RETURN RECEIPT REQUESTED

David B. Weiss, President
Transitional Care Center of Naperville LLC
1630 Des Peres Road #310
Saint Louis, MO 63131

Re: Project 13-038- Transitional Care of Naperville

Dear Mr. Weiss:

We are in receipt of the supplemental material provided to the State Board in response to the Intent to Deny. We need the following information:

1. Lockport NP Partners, LLC needs to be a co-applicant. Please provide Page 2 of the application with Lockport NP Partners, LLC as the co-applicant. See 77 IAC **Section 1130.220 Necessary Parties to the Application for Permit or Exemption**
2. A certificate of good standing for Lockport NP Partners, LLC.
3. Financial Ratios for Lockport NP Partners, LLC for the prior 3 years.
4. Audited Financial Statements for the prior 3 years for Lockport NP Partners, LLC.
5. A revised Appendix A reflecting the amount of the loan indicated in the supplemental information that was received on December 11, 2013. Appendix A must include a revised amount for the mortgage and an increase in the cash portion of the source of funds.
6. A letter from a financial institution that states upon "approval of the Illinois Health Facilities and Services Review Board a loan in the amount of \$17,250,000 will be made."

Should you have questions or concerns please contact me at 217.785.1557 or at mike.constantino@illinois.gov

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Constantino".

Mike Constantino

Attached

- Page 2 of the application for permit
- Appendix A
- Financial Ratios
- Certification Page

Facility/Project Identification

Facility Name:		
Street Address:		
City and Zip Code:		
County:	Health Service Area:	Health Planning Area:

Applicant /Co-Applicant Identification

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

Exact Legal Name:
Address:
Name of Registered Agent:
Name of Chief Executive Officer:
CEO Address:
Telephone Number:

Type of Ownership (Applicant/Co-Applicants)

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

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

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

Additional Contact

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

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

APPENDIX A

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
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			

Financial Viability – Lockport NP Partners, LP

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-28, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

CERTIFICATION - Lockport NP Partners, LP

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

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

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

SIGNATURE

SIGNATURE

PRINTED NAME

PRINTED NAME

PRINTED TITLE

PRINTED TITLE

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

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

Signature of Notary

Signature of Notary

Seal

Seal

*Insert EXACT legal name of the applicant