

# FOLEY & ASSOCIATES, INC.

Charles H. Foley, MHSA  
cfoley@foleyandassociates.com

John P. Kniery  
jkniery@foleyandassociates.com

HAND DELIVERED

July 16, 2014

**RECEIVED**

JUL 16 2014

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

Health Facilities and Services Review Board  
Attn: Michael Constantino  
Supervisor, Project Review Section  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

**RE: E-016-14 additional information requested**

Dear Mr. Constantino:

In accordance with your request, enclosed herein are the payor rates, Applicant page, copy of the signed certification page, and the Delaware Certificate of Good Standing for US HealthVest, LLC.

The original signature page is being forwarded to us via FedEx overnight delivery and we will hand deliver it once we receive it.

We trust that this is sufficient information to deem this application complete.

Should you have any questions please contact us.

Sincerely,

  
Charles H. Foley, MHSA

Enclosures

Cc: Richard A. Kresch  
Martina Sze  
Mark J. Silberman



Office: 217/544-1551

Health Care Consulting  
133 South Fourth Street, Suite 200 • Springfield, IL 62701  
foley@foleyandassociates.com

Fax: 217/544-3615

## Kathy Harris

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**From:** Martina Sze [msze@ushealthvest.com]  
**Sent:** Wednesday, July 16, 2014 12:13 PM  
**To:** Kathy Harris  
**Cc:** Richard Kresch; Silberman, Mark J.; John Kniery; Charles Foley  
**Subject:** Re: US HealthVest LLC app & cert pages

Payor rates  
Medicaid - \$750  
Medicare- \$720  
Other- \$750

On Jul 16, 2014, at 12:00 PM, "Kathy Harris" <[kharris@foleyandassociates.com](mailto:kharris@foleyandassociates.com)> wrote:

> Dr. Kresch,  
>  
> Please sign the attached Certification page and send via e-mail back to me. Please FedEx  
overnight the original to Foley & Associates.  
>  
> Thank you,  
>  
> Kathy Harris  
>  
> Foley & Associates, Inc.  
> 133 South Fourth Street, Suite 200  
> Springfield, Illinois 62701  
> 217.544.1551 - Office  
> 217.544.3615 - Facsimile  
> [foley@foleyandassociates.com](mailto:foley@foleyandassociates.com)<<mailto:foley.associates@sbcglobal.net>>  
> CONFIDENTIALITY NOTICE  
> This transmission and the attachments accompanying it contain confidential information  
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protect it or obtain damages for unauthorized disclosure copying, distribution, publication  
or use.  
>  
>  
>  
> From: Kathy Harris  
> Sent: Wednesday, July 16, 2014 10:57 AM  
> To: 'Martina Sze'; 'Silberman, Mark J.'  
> Cc: John Kniery; Charles Foley  
> Subject: US HealthVest LLC app & cert pages  
>  
> Attached is the Applicant page and the Certification page for US HealthVest,LLC. Please  
verify that all information is correct on the applicant page. Please have the signature page

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR EXEMPTION FOR THE  
CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY**

**15. INFORMATION FOR EXISTING FACILITY**

Current Facility Name Maryville Behavioral Health Hospital  
Address 555 Wilson Lane  
City Des Plaines Zip Code 60016 County Cook  
Name of current licensed entity for the facility Maryville Academy  
Does the current licensee: own this facility  OR lease this facility \_\_\_\_\_ (if leased, check if sublease )  
Type of ownership of the current licensed entity (check one of the following:)  
 Sole Proprietorship  
 Not-for-Profit Corporation  For Profit Corporation  Partnership  Governmental  
 Limited Liability Company  Other, specify \_\_\_\_\_  
Illinois State Senator for the district where the facility is located: Sen. Dan Kotowski (D)  
State Senate District Number 27<sup>th</sup> Mailing address of the State Senator: M118 Capitol Building, Springfield, IL 62706  
  
Illinois State Representative for the district where the facility is located: Rep. Martin J. Moylan (D)  
State Representative District Number #55 Mailing address of the State Representative 242-W Stratton Office Building, Springfield, IL 62706

16. **OUTSTANDING PERMITS.** Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes  No . If yes, refer to Section 1130.520(f), and indicate the projects by Project # N/A

17. **NAME OF APPLICANT** (complete this information for each co-applicant and insert after this page).  
Exact Legal Name of Applicant US HealthVest, LLC  
Address 32 E. 57<sup>th</sup> Street, 17<sup>th</sup> Floor  
City, State & Zip Code New York, New York 10022  
Type of ownership of the current licensed entity (check one of the following:)  
 Sole Proprietorship  
 Not-for-Profit Corporation  For Profit Corporation  Partnership  Governmental  
 Limited Liability Company  Other, specify \_\_\_\_\_

18. **NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.**

Exact Legal Name of Entity to be Licensed 2014 Health, LLC  
Address 32 E. 57<sup>th</sup> Street, 17<sup>th</sup> Floor  
City, State & Zip Code New York, New York 10022  
Type of ownership of the current licensed entity (check one of the following:)  
 Sole Proprietorship  
 Not-for-Profit Corporation  For Profit Corporation  Partnership  Governmental  
 Limited Liability Company  Other, specify \_\_\_\_\_

19. **BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY**

Exact Legal Name of Entity That Will Own the Site 2014 Health, LLC  
Address 32 E. 57<sup>th</sup> Street, 17<sup>th</sup> Floor  
City, State & Zip Code New York, New York 10022  
Type of ownership of the current licensed entity (check one of the following:)  
 Sole Proprietorship  
 Not-for-Profit Corporation  For Profit Corporation  Partnership  Governmental  
 Limited Liability Company  Other, specify \_\_\_\_\_

16. **PRIMARY CONTACT PERSON.** Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

Name: Martina Sze, Senior Vice President, Finance

Address: 32 E. 57<sup>th</sup> Street, 17<sup>th</sup> Floor

City, State & Zip Code: New York, NY 10022

Telephone (212) 243-5565 Ext. \_\_\_\_\_

17. **ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: John P. Kniery, Foley and Associates, Inc.

Address: 133 South Fourth Street, Suite 200

City, State & Zip Code: Springfield, Illinois 62701

Telephone (217) 544-1551 Ext. \_\_\_\_\_

17. **ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: Mark J. Silberman, Duane Morris LLP

Address: 190 South LaSalle Street, Suite 3700

City, State & Zip Code: Chicago, Illinois 60603-3433

Telephone (312) 499-6713 Ext. \_\_\_\_\_

18. **CERTIFICATION**

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the number of beds within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

**US HealthVest, LLC**

Signature of Authorized Officer



Typed or Printed Name of Authorized Officer

RICHARD A. KRESCH

Title of Authorized Officer:

MANAGER

Address:

32 EAST 57<sup>th</sup> STREET, 17<sup>th</sup> FLOOR

City, State & Zip Code:

NEW YORK, NY 10022

Telephone

(212) 243-5565

Date:

JULY 16, 2014

**NOTE:** complete a separate signature page for each co-applicant and insert following this page.

# Delaware

PAGE 1

## The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "U S HEALTHVEST, LLC" 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 SIXTEENTH DAY OF JULY, A.D. 2014.

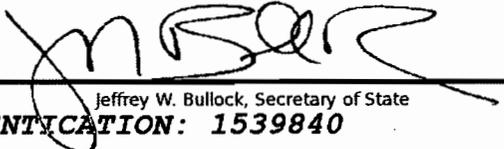
AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "U S HEALTHVEST, LLC" WAS FORMED ON THE NINTH DAY OF OCTOBER, A.D. 2012.

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

5225011 8300

140960467



  
Jeffrey W. Bullock, Secretary of State  
AUTHENTICATION: 1539840

DATE: 07-16-14