

12-073

**Constantino, Mike**

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**From:** maryjane.yothment@hklaw.com on behalf of Clare.Ranalli@hklaw.com  
**Sent:** Tuesday, August 07, 2012 12:44 PM  
**To:** Constantino, Mike  
**Subject:** MetroSouth Medical Center  
**Attachments:** Certification Pages.PDF

Per our discussion.

**Clare Connor Ranalli | Holland & Knight**  
Partner  
131 South Dearborn Street, 30th Floor | Chicago IL 60603  
Phone 312.578.6567 | Fax 312.578.6666  
[clare.ranalli@hklaw.com](mailto:clare.ranalli@hklaw.com) | [www.hklaw.com](http://www.hklaw.com)

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# Holland & Knight

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Clare Connor Ranalli  
(312) 578-6567  
clare.ranalli@hklaw.com

August 7, 2012

Via UPS

Mike Constantino  
Supervisor - Project Review  
Health Facilities & Service Review Board  
525 W. Jefferson St., 2nd Floor  
Springfield, IL 62761

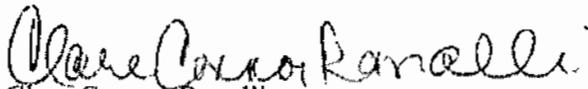
Re: MetroSouth Medical Center  
Application to Establish AMI Category of Service

Dear Mr. Constantino:

Per our conversation, enclosed are the Certification pages to the above Application for MetroSouth Medical Center.

Please feel free to call me with any questions.

HOLLAND & KNIGHT LLP

  
Clare Connor Ranalli

CCR:mjy  
Enclosures

cc: James Rayome  
Enrique Beckmann, M.D.

**CERTIFICATION**

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

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

This Application for Permit is filed on behalf of Blue Island Hospital Company, LLC dba MetroSouth Medical Ctr. \* 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.

Martin G. Schweinhart  
SIGNATURE

Rachel A. Seifert  
SIGNATURE

Martin G. Schweinhart  
PRINTED NAME

Rachel A. Seifert  
PRINTED NAME

President  
PRINTED TITLE

Executive Vice President and Secretary  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 6<sup>th</sup> day of August, 2012

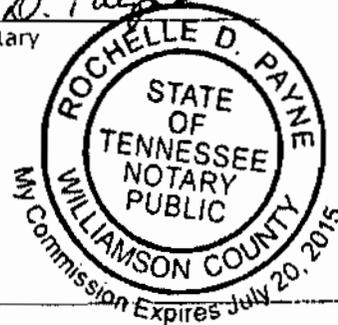
Notarization:  
Subscribed and sworn to before me  
this 6<sup>th</sup> day of August 2012

Mary Ann Eckman  
Signature of Notary

Rochelle D. Payne  
Signature of Notary

Seal

Seal



\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

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

This Application for Permit is filed on behalf of Community Health Systems, Inc. \*  
 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.

Martin G. Schweinhart  
 SIGNATURE

Rachel A. Seifert  
 SIGNATURE

Martin G. Schweinhart  
 PRINTED NAME  
Senior Vice  
President - Operations  
 PRINTED TITLE

Rachel A. Seifert  
 PRINTED NAME  
Executive Vice President and Secretary  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 03 day of August, 2012

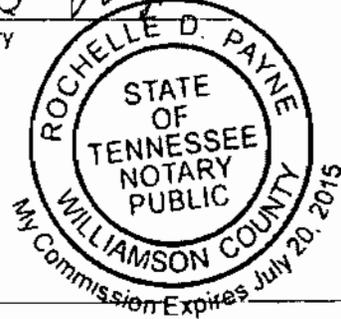
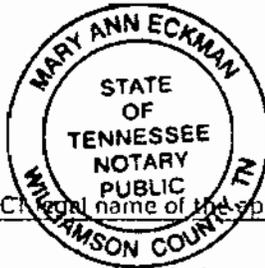
Notarization:  
 Subscribed and sworn to before me  
 this 04 day of August 2012

Mary Ann Eckman  
 Signature of Notary

Rochelle D. Payne  
 Signature of Notary

Seal

Seal



\* Insert EXACT legal name of the applicant