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Strategic alliance with MWE China Law Offices (Shanghai)

E-010-16

Clare Connor Ranalli
Attorney at Law
cranalli@mwe.com
+1 312 984 3365

January 15, 2016

VIA OVERNIGHT

Courtney Avery
Illinois Health Facilities and Services Review Board
525 West Jefferson, 2nd Floor
Springfield, Illinois 62761

RECEIVED

JAN 19 2016

HEALTH FACILITIES
SERVICES REVIEW BOARD

Re: Heartland Regional Medical Center Certificate of Exemption (COE) application
requesting approval for Discontinuation of Open Heart Service

Dear Ms. Avery:

Enclosed please find a COE application as referenced above, along with the applicable filing fee.
Thank you, as always, for your consideration.

Very truly yours,


Clare Connor Ranalli

cc: Mike Constantino
Kolbe Sheridan, Heartland
Doug Wolford, CHS

DM_US 69366328-1.092662.0016

ORIGINAL

E-010-16

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**RECEIVED****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

JAN 19 2016

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Heartland Regional Medical Center		
Street Address: 3333 West Deyoung Street		
City and Zip Code: Marion 62959		
County: Williamson	Health Service Area: 5	Health Planning Area: F-06

HEALTH FACILITIES &
SERVICES REVIEW BOARD**Applicant/Co-Applicant Identification****[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name: Marion Hospital Corporation d/b/a Heartland Regional Medical Center
Address: 3333 West Deyoung Street
Name of Registered Agent: Illinois Corporation Service C
Name of Chief Executive Officer: James X. Flynn
CEO Address: 3333 West Deyoung Street, Marion, IL 62959
Telephone Number: (618) 998-7021

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input checked="" 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: Clare Connor Ranalli
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

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

Name: Not Applicable
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name: Community Health Systems, Inc.
Address: 4000 N. Meridian Blvd., Franklin, TN 37067
Name of Registered Agent: Leonard Sachs, Esq.
Name of Chief Executive Officer: Wayne Smith
CEO Address: 4000 N. Meridian Blvd., Franklin, TN 37067
Telephone Number: 615-465-7000

Type of Ownership of Applicant/Co-Applicant

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

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

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Title: Partner
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Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

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

Name: Not Applicable
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Post Permit Contact

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

Name: James X. Flynn, c/o Clare Connor Ranalli
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cranalli@mwe.com
Fax Number: (312) 277-2964

Site Ownership

[Provide this information for each applicable site.]

Exact Legal Name of Site Owner: Marion Hospital Corporation
Address of Site Owner: 4000 Meridian Blvd., Franklin, TN 37607
Street Address or Legal Description of Site: 3333 West Deyoung Street, Marion, IL 62959
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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: Marion Hospital Corporation
Address: 3333 West Deyoung Street, Marion, IL 62959
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

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

Flood Plain Requirements**(Not Applicable – No Construction)**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (<http://www.hfsrb.illinois.gov>).

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

Historic Resources Preservation Act Requirements**(Not Applicable)**

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification:

- Substantive
 Non-substantive

2. Narrative Description

Provide in the space below, 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.

The applicant/hospital proposes to discontinue its Open Heart Program. The discontinuation will occur on February 28, 2016, or sooner, upon issuance of a permit by the Illinois Health Facilities and Services Review Board.

This project does not include the construction, demolition, or modernization of any existing buildings, and there are no project costs.

This is a substantive project because it proposes the discontinuation of a designated category of service.

Project Costs and Sources of Funds

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 equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	-0-	-0-	-0-
Site Survey and Soil Investigation	-0-	-0-	-0-
Site Preparation	-0-	-0-	-0-
Off Site Work	-0-	-0-	-0-
New Construction Contracts	-0-	-0-	-0-
Modernization Contracts	-0-	-0-	-0-
Contingencies	-0-	-0-	-0-
Architectural/Engineering Fees	-0-	-0-	-0-
Consulting and Other Fees	-0-	-0-	-0-
Movable or Other Equipment (not in construction contracts)	-0-	-0-	-0-
Bond Issuance Expense (project related)	-0-	-0-	-0-
Net Interest Expense During Construction (project related)	-0-	-0-	-0-
Fair Market Value of Leased Space or Equipment	-0-	-0-	-0-
Other Costs To Be Capitalized	-0-	-0-	-0-
Acquisition of Building or Other Property (excluding land)	-0-	-0-	-0-
TOTAL USES OF FUNDS	-0-	-0-	-0-
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	-0-	-0-	-0-
Pledges	-0-	-0-	-0-
Gifts and Bequests	-0-	-0-	-0-
Bond Issues (project related)	-0-	-0-	-0-
Mortgages	-0-	-0-	-0-
Leases (fair market value)	-0-	-0-	-0-
Governmental Appropriations	-0-	-0-	-0-
Grants	-0-	-0-	-0-
Other Funds and Sources	-0-	-0-	-0-
TOTAL SOURCES OF FUNDS	-0-	-0-	-0-

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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	

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

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

Estimated start-up costs and operating deficit cost is \$ **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): September 30, 2015

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

Not Applicable – No Costs

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

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

Provide in the following format, the department/area **DGSF** or the building/area **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 department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical			N / A				
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 following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are 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: Heartland Regional Medical Center			CITY: Marion		
REPORTING PERIOD DATES: CY14		From: 01/01/2014 to 12/31/2014:			
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	68	3,518	10,969	N/A	68
Obstetrics	12			N/A	12
Pediatrics	0	945	1,918	N/A	0
Intensive Care	18	658	2,542	N/A	18
Comprehensive Physical Rehabilitation	0			N/A	0
Acute/Chronic Mental Illness	0			N/A	0
Neonatal Intensive Care	0			N/A	0
General Long Term Care	0			N/A	0
Specialized Long Term Care	0			N/A	0
Long Term Acute Care	0			N/A	0
Other ((identify))	0			N/A	0
TOTALS:	98	4,879	15,429	N/A	98

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 manager 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 the behalf of Marion Hospital Corporation d/b/a Heartland Regional Medical 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 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.

James X. Flynn
SIGNATURE

James X. Flynn
PRINTED NAME

President and CEO, Heartland Regional Medical Center
PRINTED TITLE

BENJAMIN WEUS
SIGNATURE

BENJAMIN WEUS
PRINTED NAME

Chief Financial Officer, Heartland Regional Medical Center
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of January, 2016

Notarization:
Subscribed and sworn to before me
this 14th day of January, 2016

Rebecca J. Arnold
Signature of Notary

Rebecca J. Arnold
Signature of Notary



*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 manager 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 the behalf of Community Health System, 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.

SIGNATURE

Rachel A. Seifert

PRINTED NAME

Executive Vice President, Secretary and General Counsel

PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 13th day of January, 2016

Signature of Notary

Seal

*Insert EXACT legal name of the applicant



My Comm. Expires
May 22, 2017

SIGNATURE

Martin Schweinhart

PRINTED NAME

Executive Vice President

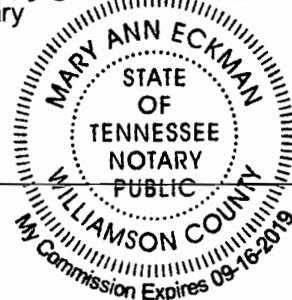
PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 8th day of January, 2016

Signature of Notary

Seal



My Commission Expires 09-16-2019

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, 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 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

XI. Safety Net Impact Statement

(See Attachment 40)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information**(See Attachment 41)**Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of **Attachment 44**.

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

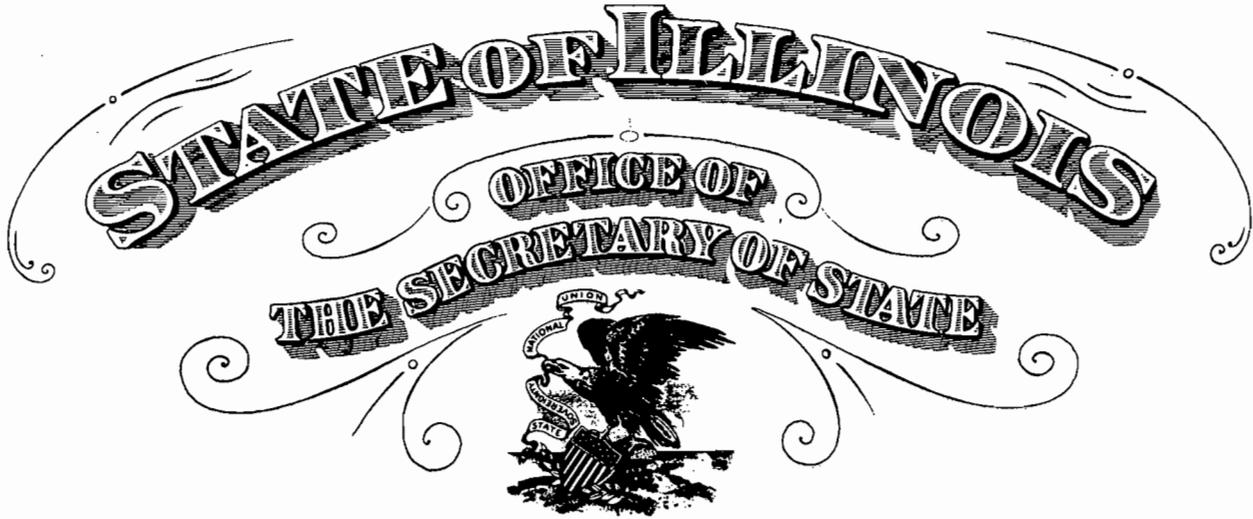
APPEND DOCUMENTATION AS **ATTACHMENT-41**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	16
2	Site Ownership	19
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	20
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	22
5	Flood Plain Requirements	
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7	Project and Sources of Funds Itemization	
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10	Discontinuation	23
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
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15	Project Service Utilization	
16	Unfinished or Shell Space	
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19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	Selected Organ Transplantation	
29	Kidney Transplantation	
30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
32	Community-Based Residential Rehabilitation Center	
33	Long Term Acute Care Hospital	
34	Clinical Service Areas Other than Categories of Service	
35	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
36	Availability of Funds	
37	Financial Waiver	
38	Financial Viability	
39	Economic Feasibility	
40	Safety Net Impact Statement	25
41	Charity Care Information	27

Marion Hospital Corporation d/b/a Heartland Regional Medical Center and Community Health Systems, Inc. are co-applicants.

See attached Certificates of Good Standing.



To all to whom these Presents Shall Come, Greeting:

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

MARION HOSPITAL CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 12, 1996, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

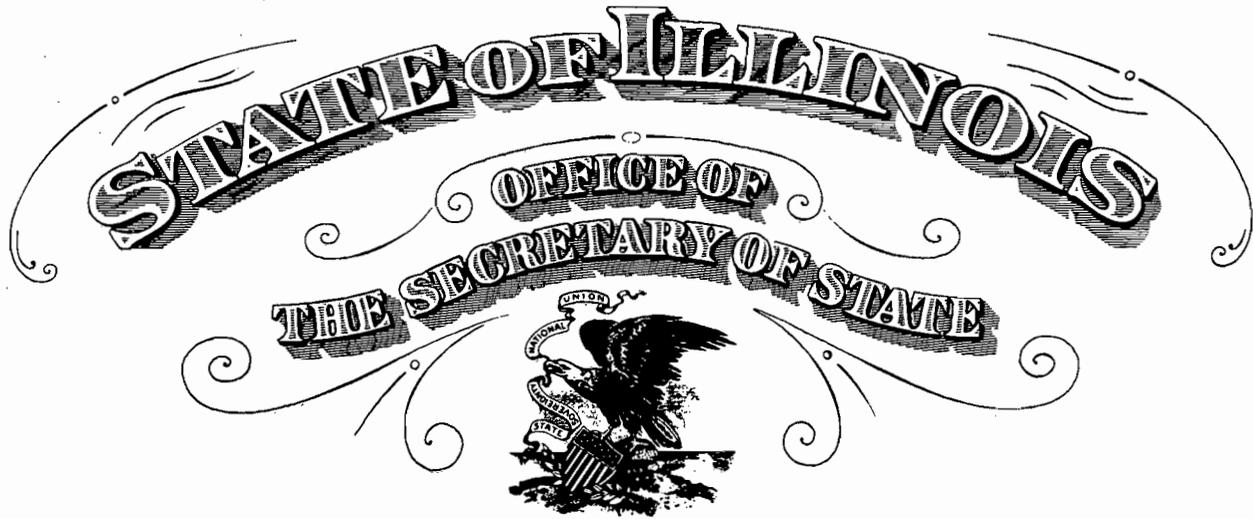
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 15TH day of JANUARY A.D. 2016 .



Authentication #: 1601501514 verifiable until 01/15/2017
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

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

COMMUNITY HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 31, 2006, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED 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 15TH day of JANUARY A.D. 2016 .



Jesse White

SECRETARY OF STATE

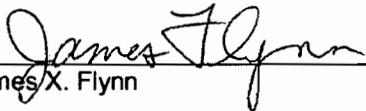
Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Certification of Need

Dear Ms. Avery:

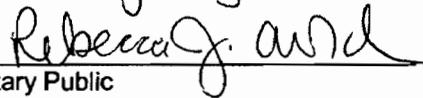
Marion Hospital Corporation hereby certifies that it is the owner of the site on which Heartland Regional Medical Center is located.

Sincerely,

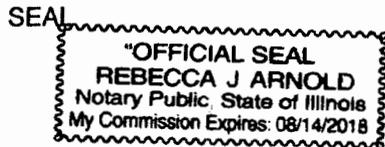


James X. Flynn

Subscribed and sworn to before me this
15th day of January, 2016.



Notary Public



Hospital licensee is Marion Hospital Corporation (100% ownership) d/b/a Heartland Regional Medical Center.

See attached certificate of good standing.



To all to whom these Presents Shall Come, Greeting:

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

MARION HOSPITAL CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 12, 1996, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



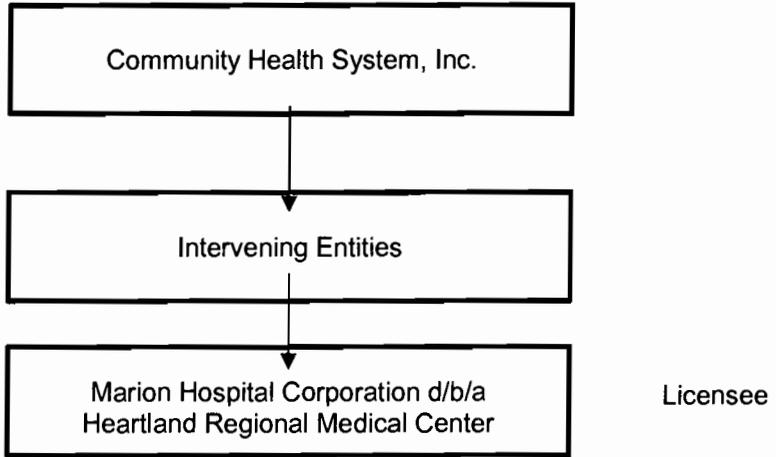
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 15TH day of JANUARY A.D. 2016 .

Jesse White

SECRETARY OF STATE

HRMC ORGANIZATIONAL CHART

Organization Chart



ATTACHMENT 10

Discontinuation

General Information Requirements

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

Heartland Regional Medical Center is proposing to discontinue its Open Heart Program. It notified HFSRB of its temporary discontinuation on March 2, 2015.

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

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

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

The discontinuation will occur in February 2016, or earlier, upon receipt of COE from the HFSRB.

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

The physical space for the program will be used for orthopedic and other surgical cases.

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.*

All medical records will be maintained at Heartland Regional Medical Center in accordance with its standard health information policies, and in accordance with all applicable legal and regulatory authorities.

6. *For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB of 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 60 days following the date of discontinuation.*

Not applicable.

Reasons for Discontinuation

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See Criterion 110.130(b) for examples.

Inability to procure and maintain adequate physician and ancillary staff to support an Open Heart Program and lack of volume/need due to the increased use and efficacy of less invasive procedures to treat heart disease.

Impact on Access

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

No impact is expected. The service is available at Memorial Hospital in Carbondale, just 13 miles away. Volume at Heartland declined to the point the service was temporarily discontinued in March of 2015, with no apparent impact.

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

ATTACHMENT 10

Not applicable per technical assistance.

3. *Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.*

Not applicable.

ATTACHMENT 40

Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

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

None known or expected.
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.*

None.
3. *How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by applicant.*

No impact. Due to low volume, discontinuation will not overwhelm any other provider. In fact, it may have a positive impact by increasing volume at area providers who offer this service and decreasing competition for staff.

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

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

See chart below.
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.*

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

Heartland Regional Medical Center believes that given the low volume within its Open Heart Program there will be no impact on Safety Net Services when it discontinues.

ATTACHMENT 40

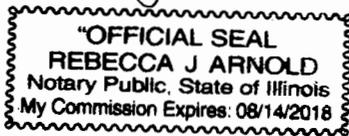
Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	FY2014	FY2013	FY2012
Inpatient	30	86	79
Outpatient	77	266	238
Total	107	352	317
Charity (cost in dollars)			
Inpatient	\$201,504	\$400,960	\$510,616
Outpatient	\$53,431	\$172,519	\$224,418
Total	\$254,935	\$573,479	\$735,035
MEDICAID			
Medicaid (# of patients)	FY2014	FY2013	FY2012
Inpatient	1,570	1,326	1,195
Outpatient	16,570	12,815	13,251
Total			
Medicaid (revenue)			
Inpatient	\$17,361,683	\$13,262,360	\$12,450,125
Outpatient	\$2,471,589	\$1,473,583	\$1,467,983
Total	\$19,833,272	\$14,735,943	\$13,928,108

James X. Flynn
 James X. Flynn, Chief Executive Officer
 Heartland Regional Medical Center

Subscribed and sworn to before me this
 14th day of January, 2016.

Rebecca J Arnold
 Notary Public

SEAL



ATTACHMENT 41

Charity Care Information

Charity Care Information MUST be furnished for ALL projects.

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

See chart below.

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

See chart below. Please note that this chart reflects charity care provided by Heartland Regional Medical Center only and not co-applicant Community Health Systems, Inc. which would necessarily include other facilities that are neither involved in nor relevant to this project.

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

Not applicable.

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

The following is Community Health Systems, Inc. Illinois Hospital Information.

CHARITY CARE			
	FY2014	FY2013	FY2012
Net Patient Revenue	\$112,935,504	\$106,200,639	\$100,947,781
Amount of Charity Care	\$2,082,805	\$4,636,051	\$5,454,403
Cost of Charity Care	\$254,935	\$573,479	\$735,035
Ratio of Costs to Charges (RCC)	12.23%	12.37%	13.48%