E-025-19

ORIGINAL

# ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
# DISCONTINUATION APPLICATION FOR EXEMPTION

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
JUN 20 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

### Facility/Project Identification

| | | | |
|---|---|---|---|
| Facility Name: | Heartland Regional Medical Center | | |
| Street Address: | 3333 N. Deyoung Street | | |
| City and Zip Code: | Marion, IL 62959 | | |
| County: Williamson | Health Service Area V | Health Planning Area: F-06 | |

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

| | |
|---|---|
| Exact Legal Name: | Marion Hospital Corporation |
| Street Address: | 1573 Mallory Lane, Suite 100 |
| City and Zip Code: | Brentwood, TN 37027 |
| Name of Registered Agent: | CT Corporation System |
| Registered Agent Street Address: | 208 South LaSalle Street, Suite 814 |
| Registered Agent City and Zip Code: | Chicago, IL 60604 |
| Name of Chief Executive Officer: | Robert Fish |
| CEO Street Address: | 1573 Mallory Lane, Suite 100 |
| CEO City and Zip Code: | Brentwood, TN 37027 |
| CEO Telephone Number: | 615/221-1400 |

### Type of Ownership of Applicants

- ☐ Non-profit Corporation
- X 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: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7101 |

# ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
# DISCONTINUATION APPLICATION FOR EXEMPTION

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

### Facility/Project Identification

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|---|---|---|---|---|---|
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| Street Address: | 3333 N. Deyoung Street | | | | |
| City and Zip Code: | Marion, IL 62959 | | | | |
| County: | Williamson | Health Service Area | V | Health Planning Area: | F-06 |

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

| | |
|---|---|
| Exact Legal Name: | Quorum Health Corporation |
| Street Address: | 1573 Mallory Lane Suite 100 |
| City and Zip Code: | Brentwood, TN 37027 |
| Name of Registered Agent: | The Corporation Trust Company |
| Registered Agent Street Address: | 1209 Orange Street |
| Registered Agent City and Zip Code: | Wilmington, DE 19801 |
| Name of Chief Executive Officer: | Robert Fish |
| CEO Street Address: | 1573 Mallory Lane Suite 100 |
| CEO City and Zip Code: | Brentwood, TN 37027 |
| CEO Telephone Number: | 615/221-1400 |

### Type of Ownership of Applicants

- ☐ Non-profit Corporation
- X For-profit Corporation
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- 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.

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### Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|---|---|
| Name: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7101 |

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

| | |
|---|---|
| Name: | none |
| Title: | |
| Company Name: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Fax Number: | |

**Post Exemption Contact**
[Person to receive all correspondence subsequent to exemption issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

| | |
|---|---|
| Name: | Melisa Adkins |
| Title: | CEO |
| Company Name: | Heartland Regional Medical Center |
| Address: | 3333 N. Deyoung Street Marion, IL 62959 |
| Telephone Number: | 618/998-7000 |
| E-mail Address: | melisa-adkins@quorumhealth.com |
| Fax Number: | 618/998-7087 |

**Site Ownership**
[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Quorum Health Corporation

Address of Site Owner: 1573 Mallory Lane Suite 100 Brentwood, TN 37027

Street Address or Legal Description of the Site: 3333 N. 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 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: Marion Hospital Corporation d/b/a Heartland Regional Medical Center

Address: 3333 N. Deyoung Street Marion, IL 62959

- ☐ Non-profit Corporation
- X 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 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.**

## 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.

Heartland Regional Medical Center proposes to discontinue its twelve-bed obstetrics category of service. In addition, the hospital will be discontinuing associated ancillary areas, including twelve Level I nursery stations, four Level II nursery stations, five labor-delivery-recovery rooms, and one C-section room. The twelve obstetrics beds will be used as medical/surgical beds, with that re-designation to be reflected in the hospital's 2019 IDPH *Annual Hospital Questionnaire*. Those beds are identified on the hospital's *Annual Bed Report* as rooms 251-262, each of which is a private room.

Because this application addresses the discontinuation of a HFSRB-designated category of service, the project is classified as being substantive.

## Project Status and Completion Schedules

**Outstanding Permits:** Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No _X_. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

_____

_____

_____

_____

_____

**Anticipated exemption completion date** (refer to Part 1130.570): _____

## State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

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

**Failure to be up to date with these requirements will result in the Application being deemed incomplete.**

## 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 __Marion Hospital Corporation____ 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

Melisa Adkins

PRINTED NAME

Chief Executive Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of June, 2019

Signature of Notary

Seal

OFFICIAL SEAL
REBECCA J ARNOLD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES AUG. 14, 2022

SIGNATURE

Gay Huff

PRINTED NAME

Chief Financial Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of June, 2019

Signature of Notary

Seal

OFFICIAL SEAL
REBECCA J ARNOLD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES AUG. 14, 2022

*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 __Quorum Health Corporation____.**

**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 |
| Marty Smith | Hal McCard |
| PRINTED NAME | PRINTED NAME |
| EVP & COO | SVP, General Counsel & Secretary |
| PRINTED TITLE | PRINTED TITLE |
| Notarization: Subscribed and sworn to before me this 12th day of June, 2019 | Notarization: Subscribed and sworn to before me this 12th day of June, 2019 |
| Rochelle D. Payne | Rochelle D. Payne |
| Signature of Notary | Signature of Notary |
| Seal | Seal |

ROCHELLE D. PAYNE TENNESSEE NOTARY PUBLIC COUNTY OF WILLIAMSON

ROCHELLE D. PAYNE TENNESSEE NOTARY PUBLIC My Comm Exp. September 22, 2019 COUNTY OF WILLIAMSON

## SECTION II. DISCONTINUATION

### Type of Discontinuation

☐ Discontinuation of an Existing Health Care Facility

X Discontinuation of a category of service

### Criterion 1130.525 and 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 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, provide 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.
7. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

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

**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 1110.130(b) for examples.

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

**IMPACT ON ACCESS**

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

2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

**APPEND DOCUMENTATION AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

## SECTION III. BACKGROUND

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

3. 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.**

4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, 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 is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

**APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.**

## SECTION IV. SAFETY NET IMPACT STATEMENT

**SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL PROJECTS TO DISCONTINUE A HEALTH CARE FACILITY OR CATEGORY OF SERVICE [20 ILCS 3960/5.4]:**

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 9.**

| Safety Net Information per PA 96-0031 | | | |
|---|---|---|---|
| **CHARITY CARE** | | | |
| **Charity (# of patients)** | 2016 | 2017 | 2018 |
| Inpatient | 15 | 3 | 75 |
| Outpatient | 78 | 54 | 278 |
| **Total** | **93** | **57** | **353** |
| **Charity (cost in dollars)** | | | |
| Inpatient | 528,716 | 341,580 | 50,948 |
| Outpatient | 778,631 | 881,431 | 21,754 |
| **Total** | **1,307,347** | **1,223,011** | **72,702** |
| **MEDICAID** | | | |
| **Medicaid (# of patients)** | 2016 | 2017 | 2018 |
| Inpatient | 1,264 | 1,241 | 1,031 |
| Outpatient | 15,882 | 15,126 | 13,068 |
| **Total** | 17,146 | 16,367 | 14,099 |
| **Medicaid (revenue)** | | | |
| Inpatient | 18,953,503 | 12,655,263 | 10,868,439 |
| Outpatient | 12,734 | 452,731 | 4,228,560 |
| **Total** | 18,966,237 | 13,107,994 | 15,096,999 |

## SECTION V. CHARITY CARE INFORMATION

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 10.**

| CHARITY CARE | | | |
|---|---|---|---|
| | **2016** | 2017 | 2018 |
| **Net Patient Revenue** | **106,229,985** | **107,493,477** | **125,956,140** |
| Amount of Charity Care (charges) | 564,225 | 75,908 | 373,741 |
| Cost of Charity Care | 1,307,347 | 1,223,011 | 72,702 |

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

*File Number* 5895-587-6

## *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* 9TH *day of* MAY *A.D.* 2019 .

Authentication #: 1912902680 verifiable until 05/09/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

# State Of Delaware

Entity Details

4/19/2019 9:38:50AM

File Number: 5792308

Incorporation Date / Formation Date: 7/27/2015

Entity Name: QUORUM HEALTH CORPORATION

Entity Kind: Corporation

Entity Type: General

Residency: Domestic

State: DELAWARE

Status: Good Standing

Status Date: 9/6/2017

**latered Agent Information**

Name: THE CORPORATION TRUST COMPANY

Address: CORPORATION TRUST CENTER 1209 ORANGE ST

City: WILMINGTON

Country:

State: DE

Postal Code: 19801

Phone: 302-658-7581

**: Information**

d AnnualReport Filed: 2018

Tax Due: $ 0

nual Tax Assessment: $250000

Total Authorized Shares: 1300000000

**ing History (Last 5 Filings)**

| Seq | Description | No of Pages | Filing Date mm/dd/yyyy | Filing Time | Effective Date mm/dd/yyyy |
|---|---|---|---|---|---|
| 1 | Change of Agent<BR>9000014 | 1 | 12/9/2016 | 12:51 PM | 12/9/2016 |
| 2 | Restated Stock | 7 | 4/28/2016 | 3:01 PM | 4/29/2016 |
| 3 | Stock Corporation | 4 | 7/27/2015 | 4:38 PM | 7/27/2015 |

ATTACHMENT 1

HEARTLAND REGIONAL MEDICAL CENTER
3333 West DeYoung - Marion, Illinois 62959
(618) 998-7000 • Fax (618) 998-7449

Illinois Health Facilities and
Services Review Board
Springfield, IL

To Whom It May Concern:

I hereby attest that the site of Heartland Regional Medical Center, that being 3333 N. DeYoung Street in Marion, Illinois, is owned by Marion Hospital Corporation.

Sincerely,

Melisa Adkins

Melisa Adkins
Chief Executive Officer

Notarized:

OFFICIAL SEAL
REBECCA J ARNOLD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES AUG. 14, 2022

Rebecca J Arnold
6-12-19

ATTACHMENT 2

*File Number* 5895-587-6

## *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.

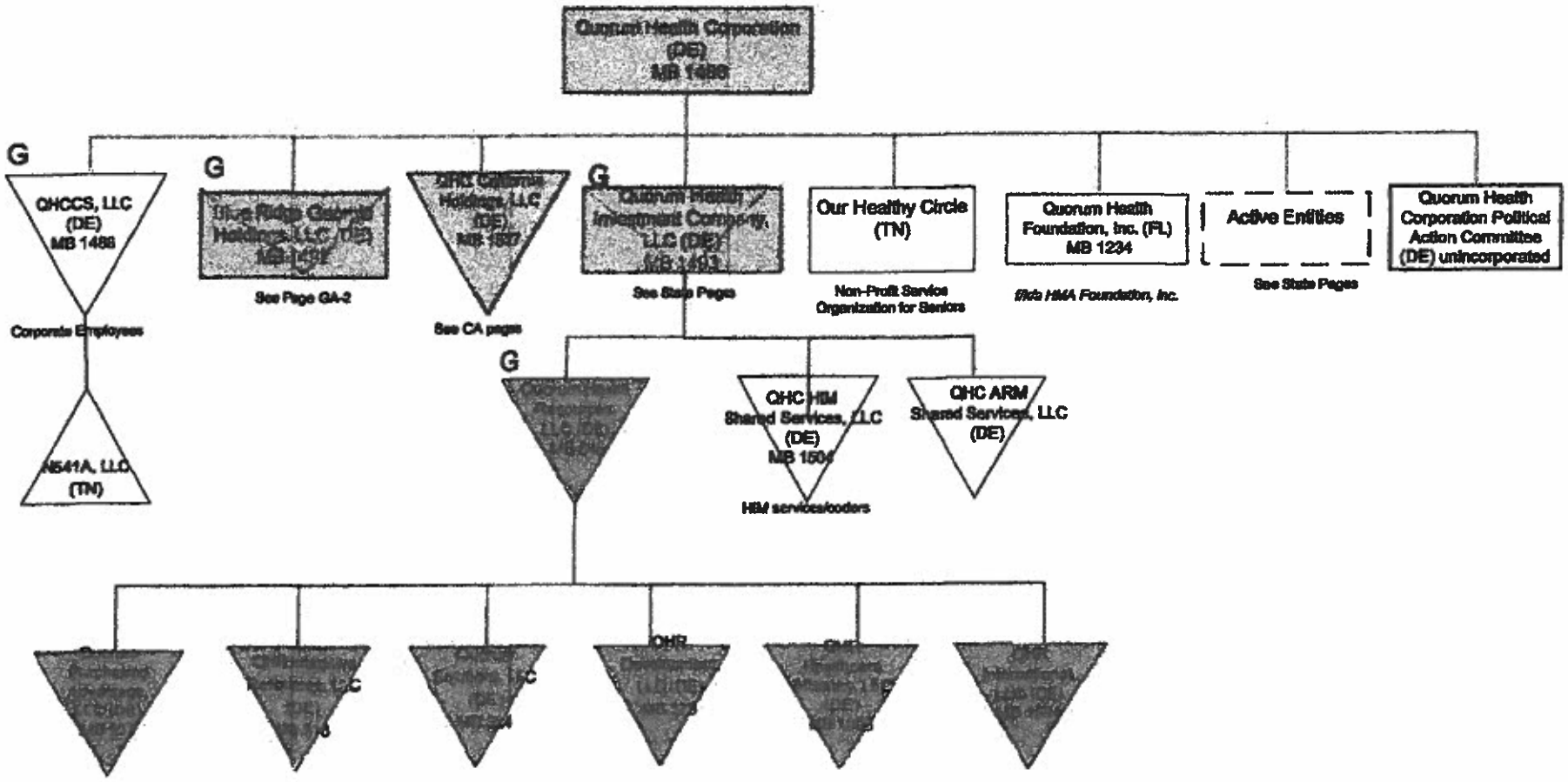
***In Testimony Whereof,*** *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* MAY *A.D.* 2019 .

Authentication #: 1912902680 verifiable until 05/09/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 3

# Quorum Health Corporation




**Taxable Entity Key:**

- Rectangles represent legal entities treated as corporations for tax purposes.
- Upside down triangles represent disregarded (single owner) entities for tax purposes.
- Dashed upside down triangles inside solid rectangle represent single owner entities electing to be a taxable association for tax purposes
- Regular triangles represent partnerships. If no percentage owned is indicated, the partnership is disregarded for tax purposes.

**Color-Coding Key:**

- = Hospital
- = Clinics/Physicians
- = Surgery Centers
- = Parent or Holdings Cos.
- = QHR and related
- = 50% or less ownership (non-consolidating)
- = Home Health/Hospice

3.31.2019
Page 1

ATTACHMENT 4

18

DISCONTINUATION

1. This Certificate of Exemption ("COE") application addresses the discontinuation of the applicant hospital's obstetrics category of service, which includes 12 authorized beds.

2. The following clinical areas/services, each of which is associated with obstetrics care, will also be discontinued:
    - five labor-delivery-recovery rooms ("LDRs")
    - twelve Level 1 nursery stations/bassinettes
    - four Level 2 nursery stations/bassinettes
    - one C-Section room

3. All of the clinical services identified in items 1 and 2, above, will be discontinued within 30 days following receipt of the request COE Permit. Discontinuation will occur via formal notification to the HFSRB.

4. The obstetrics unit includes twelve private patient rooms, designated rooms 251-262, and the support space typical to a postpartum unit. The twelve patient rooms/beds will be re-designated as Medical/Surgical rooms/beds, and the former postpartum unit will operate as an orthopedics unit, with the former nursery and the existing unit's support space serving as support and therapy space on the orthopedics unit. The LDRs will be converted into observation rooms, and the C-Section room will be used as a surgical suite.

   Equipment will be used in other areas of the hospital, as applicable, moved to other hospitals owned by applicant Quorum Health, sold, or discarded.

ATTACHMENT 5

Additionally, the obstetrical areas of the hospital have 35.0 FTEs. All employees have been offered other positions at the hospital.

5. The medical records of past patients will be retained by the hospital, consistent with licensure and accreditation requirements, as well as contemporary medical records retention practices.

6. This COE application is limited to the discontinuation of a category of service.

7. The required legal notice was published in the Benton Evening News on May 22, 2019. Proof of publication is attached.

ATTACHMENT 5

**Benton Evening News**

**Cease the operations of its obstetrics beds**

**Legal Notice**

5/22/2019

## Certificate of Publication

The **Benton Evening News** is a secular newspaper, has been continuously published weekly for more than fifty (50) weeks prior to the first publication of the attached notice, is published in the city of **Benton**, county of **Franklin**, State of Illinois, is of general circulation throughout that county and surrounding areas, and is a newspaper as defined by 715 ILCS 5/5.

This notice, a copy of which is attached, was published **One** times in **Benton Evening News**, namely one time per week for One successive weeks.

The first publication of the notice was made in the newspaper, dated and published on **5/22/2019** and the last publication was **5/22/2019**

The notice was also placed on a statewide public notice website as required by 715 ILCS 5/2.1.
In witness, Benton Evening News has signed this certificate by its registered agent.

Benton Evening News
By:

Registered Agent

| Publication Charge: |
| --- |
| $17.92 |

**Legal Text**

LEGAL NOTICE Heartland Regional Medical Center intends to cease the operations of its obstetrics beds following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur before July 31, 2019. The hospital intends to file the required Certificate of Exemption application with the IHFSRB by May 30, 2019; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hfsrb.illinois.gov.

ATTACHMENT 5

## REASONS FOR DISCONTINUATION

The proposed discontinuation is the result low and steadily decreasing utilization of the hospital's obstetrical unit, as identified in the table below. Over past five years, admissions have decreased from 945 to 603, and patient days have decreased from 1,918 to 1,571, resulting in the unit's average daily census dropping to 4.3 patients, and an average of only 1.65 babies being born per day.

| | Adm. | Patient Days |
|---|---|---|
| 2014 | 945 | 1,918 |
| 2015 | 880 | 1,971 |
| 2016 | 784 | 2,046 |
| 2017 | 681 | 1,640 |
| 2018 | 603 | 1,571 |

ATTACHMENT 6

## IMPACT ON ACCESS

The discontinuation of obstetrical services at Heartland Regional Medical Center ("HRMC) will not have an appreciable impact on accessibility to obstetrics services for area residents. Memorial Hospital of Carbondale is located only thirteen miles to the west of HRMC, and in 2017, it operated with an average daily census of 15.6 patients on its 28-bed obstetrics unit, resulting in a 56% occupancy rate.

Memorial Hospital of Carbondale is the only provider of obstetrics services other than HRMC located within the HFSRB-designated geographic service area, and a notification letter, consistent with the provisions of Section 1110.290.d, has been sent to that hospital. A response was received from Memorial Hospital of Carbondale on May 29, 2019, indicating no admission restrictions or limitations. Copies of the letters are attached.

ATTACHMENT 7

HEARTLAND REGIONAL MEDICAL CENTER
3333 West DeYoung - Marion, Illinois 62959
(618) 998-7000 • Fax (618) 998-7449

May 15, 2019

**VIA CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

Mr. Al Taylor
Vice President/Administrator
Memorial Hospital of Carbondale
405 West Jackson Street
Carbondale, IL 62902

RE: Heartland Regional Medical Center
Proposed Discontinuation of Obstetrics
Category of Service

Dear Mr. Taylor:

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

Heartland Regional Medical Center ("HRMC") intends to file a Certificate of Exemption ("COE") application within the next thirty days, seeking approval from the Illinois Health Facilities and Services Review Board (IHFSRB") to discontinue HRMC's 12-bed obstetrics category of service, and the formal discontinuation of that service will occur within thirty days following the IHFSRB's approval of that application.

During the 24-month period ending December 31, 2018, a total of 1,284 patients were admitted to the hospital's obstetrics unit, and 3,211 patient days of care were provided. 1,203 babies were born at HRMC during that period.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing obstetrical services to residents from our service area. Any impact statement received will be forwarded to the IHFSRB. If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

Melisa Adkins

Melisa Adkins
Chief Executive Officer

Attachment 7

SIH

received
5/29/19

SIH System Office

t 618.457.5200
f 618.529.0568

May 23, 2019

Ms. Melisa Adkins
Chief Executive Officer
Heartland Regional Medical Center
3333 West DeYoung
Marion, IL 62959

Re: Heartland Regional Medical Center
Proposed Discontinuation of Obstetrics Category of Service

Dear Ms. Adkins:

This letter is in response to your request that we provide an impact statement regarding your intention to discontinue your Obstetrics category of service.

In accordance with our mission, SIH-Memorial Hospital of Carbondale and our other hospitals never turn anyone away for needed healthcare services, regardless of their ability to pay.

SIH-Memorial Hospital of Carbondale has no admission restrictions or limitations that would preclude it from providing obstetrical services to residents from our region, and we are privileged to care for all expectant mothers who present to us in need of care.

Should you require any further information, please don't hesitate to contact me.

Sincerely,

Cathy Blythe
System Manager, Planning and Physician Recruitment
Southern Illinois Healthcare

cc: Courtney Avery, IHFSRB
Philip L. Schaefer
Al Taylor

ATTACHMENT 7

## BACKGROUND OF THE APPLICANT

The following Illinois hospitals are owned and operated by Quorum Health Corporation:

Crossroads Community Hospital
Mt. Vernon

Heartland Regional Medical Center
Marion

Union County Hospital
Anna

Galesburg Cottage Hospital
Galesburg

MetroSouth Medical Center
Blue Island

Vista Medical Center
Waukegan

Gateway Regional Medical Center
Granite City

Red Bud Regional Hospital
Red Bud

ATTACHMENT 8

**Illinois Department of PUBLIC HEALTH**

HF115878

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.

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

| EXPIRATION DATE | CATEGORY | I.D. NUMBER |
|---|---|---|
| 6/17/2019 | | 0005298 |

**General Hospital**

Effective: 06/18/2018

Marion Hospital Corporation
dba Heartland Regional Medical Center
3333 West De Young Street

Marion, IL 62959

The face of this license has a colored background. Printed by Authority of the State of Illinois • RD: [illegible]

ATTACHMENT 8

The Joint Commission

September 16, 2016

Re: # 7378
CCN: #140184
Program: Hospital
Accreditation Expiration Date: July 22, 2019

James X. Flynn
CEO
Heartland Regional Medical Center
3333 West DeYoung Street
Marion, Illinois 62959

Dear Mr. Flynn:

This letter confirms that your July 18, 2016 - July 21, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on September 02, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 22, 2016.

The Joint Commission is also recommending your organization for continued Medicare certification effective July 22, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Heartland Regional Medical Center
d/b/a Heartland Regional Medical Center
3333 West DeYoung Street, Marion, IL, 62959

Heartland Regional Urgent Care
2250 Reed Station Parkwary Suite 305, Carbondale, IL, 62901

Heartland Therapy and Lab Services
1009 Main Street, Marion, IL, 62959

Medical Office Building
3331 West DeYoung Street, Marion, IL, 62959

The Joint Commission

The HUB
d/b/a Aqua Therapy
917 West Main Street, Marion, IL, 62959

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 5 /Survey and Certification Staff

HEARTLAND REGIONAL MEDICAL CENTER
3333 West DeYoung - Marion, Illinois 62959
(618) 998-7000 • Fax (618) 998-7449

Ms. Courtney Avery
Illinois Health Facilities And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Quorum Health Corporation has not had any adverse actions against any Illinois facility owned, operated, and/or controlled by the applicant during the three (3) year period prior to the filing of this application, and
2. Quorum Health Corporation authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Melisa Adkins

Melisa Adkins
Chief Executive Officer

Date: 6-12-19

Notarized:

OFFICIAL SEAL
REBECCA J ARNOLD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES AUG. 14, 2022

Rebecca J. Arnold
6-12-19

ATTACHMENT 8

SAFETY NET IMPACT STATEMENT

While not designated by IHFS as being a "Safety Net Hospital," Heartland Regional Medical Center ("HRMC") is, and will continue to be a provider of safety net services to its community. The hospital primarily serves Marion and the surrounding communities and rural areas, which include a significant proportion of Medicaid recipients. During 2018, 26% of the patients admitted to HRMC were Medicaid recipients. Given that this proposal will not impact any non-obstetrical services provided by the hospital, and the low number (fewer than two per day) of patients admitted to the hospital's obstetrics unit in 2018; with another provider located in close proximity to the hospital, the proposed discontinuation will have minimal impact on accessibility to safety net services.

Two other hospitals are located in the HFSRB-designated geographic service area ("GSA"). However, and because of the low number of patients to be impacted by the proposed discontinuation, it is not believed that the proposed discontinuation will have a material effect on other hospitals' ability to provide safety net services.

ATTACHMENT 9

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 | 14 |
| 2 | Site Ownership | 16 |
| 3 | Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | 17 |
| 4 | Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc. | 18 |
| 5 | Discontinuation General Information Requirements | 19 |
| 6 | Reasons for Discontinuation | 22 |
| 7 | Impact on Access | 23 |
| 8 | Background of the Applicant | 26 |
| 9 | Safety Net Impact Statement | 31 |
| 10 | Charity Care Information | 12 |

**Axel & Associates, Inc.**

MANAGEMENT CONSULTANTS

**by FedEX**

June 19, 2019

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

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Exemption ("COE") application addressing the discontinuation of the obstetrics category of service at Heartland Regional Medical Center in marion.

The application is accompanied by a check, in the amount of $2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004