

ORIGINAL

NOTE: Being used in lieu of exemption application until one is available

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

E-002-17

Facility/Project Identification

Facility Name: Galesburg Cottage Hospital – Discontinue LTC Beds			
Street Address: 695 N. Kellogg Street			
City and Zip Code: Galesburg, IL 61401			
County: Knox	Health Service Area	2	Health Planning Area: C-03

Applicant /Co-Applicant Identification

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

RECEIVED

Exact Legal Name: Galesburg Hospital Corporation		JAN 23 2017
Address: 695 N. Kellogg St., Galesburg, IL 61401		
Name of Registered Agent: Illinois Service Corporation		
Name of Chief Executive Officer: Barry Schneider		HEALTH FACILITIES & SERVICES REVIEW BOARD
CEO Address: 695 N. Kellogg St., Galesburg, IL 61401		
Telephone Number: 309-345-4567		

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
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: NONE
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: Galesburg Cottage Hospital – Discontinue LTC Beds			
Street Address: 695 N. Kellogg Street			
City and Zip Code: Galesburg, IL 61401			
County: Knox	Health Service Area	2	Health Planning Area: C-03

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

Exact Legal Name: Quorum Health Corporation
Address: 1573 Mallory Lane, Brentwood, TN 37027
Name of Registered Agent: Illinois Service Corporation
Name of Chief Executive Officer: Tom Miller
CEO Address: 1573 Mallory Lane, Brentwood, TN 37027
Telephone Number: 615-221-3500

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**.

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Fax Number: (312) 277-2964

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

Name: NONE
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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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: Barry Schneider
Title: CEO
Company Name: Galesburg Cottage Hospital
Address: 695 N. Kellogg Street
Telephone Number: 309-345-4567
E-mail Address: Barry_Schneider@QuorumHealth.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Galesburg Hospital Corporation
Address of Site Owner: 695 N. Kellogg St., Galesburg, IL 61401
Street Address or Legal Description of Site: 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: Galesburg Hospital Corporation d/b/a Galesburg Cottage Hospital
Address: 695 N. Kellogg St., Galesburg, IL 61401
<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.

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Flood Plain Requirements Not Applicable

[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

N/A – Exemption to Discontinue Category of Service

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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.

Galesburg Cottage Hospital is seeking approval to discontinue its 34 bed hospital licensed long term care unit. It intends to permanently discontinue the service upon the Illinois Health Facilities and Planning Board's issuance of an exemption allowing it to do so.

This project is non-substantive under the Board's rules and is subject to an exemption under the current authorizing statute.

Galesburg Cottage Hospital will notify its state senator and representative within thirty (30) days of the issuance of an exemption to discontinue the long term care service.

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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			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)	N	/	A
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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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 Yes 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 \$ N/A .

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): Within thirty (30) days From Exemption Approval

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not Applicable**

- 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.

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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.

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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: Galesburg Cottage Hospital		CITY: Galesburg			
REPORTING PERIOD DATES: From: 01/01/2015 to 12/31/2015:					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	87	1,378	6,541	0	87
Obstetrics	10	431	991	0	10
Pediatrics	18	11	42		18*
Intensive Care	12	416	1,713	0	12
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	12	160	2,506		12
Neonatal Intensive Care					
General Long Term Care	34	315	4,171	-34	0
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	173	2,711	15,964	-34	139

*The hospital recently notified HFSRB and IDPH of its intent to reallocate 4 of its 87 medical surgical beds to AMI beds. The process is not yet complete through IDPH, and the beds identified are for the reporting period of CY 2015.

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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 Galesburg Hospital Corporation d/b/a Galesburg Cottage Hospital 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.

Barry Schneider
SIGNATURE

Barry Schneider
PRINTED NAME

CEO
PRINTED TITLE

Millie Smith
SIGNATURE

Millie Smith
PRINTED NAME

Interim CFO
PRINTED TITLE

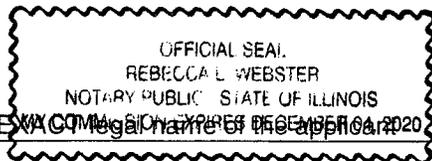
Notarization:
Subscribed and sworn to before me
this 9th day of January, 2017

Notarization:
Subscribed and sworn to before me
this 9th day of January, 2017

Rebecca L. Webster
Signature of Notary

Rebecca L. Webster
Signature of Notary

Seal



*Insert EWA Company Name of the Applicant

Seal



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- 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 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 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

Thomas D. Miller
PRINTED NAME

President and CEO
PRINTED TITLE

SIGNATURE

R. Harold McCard, Jr.
PRINTED NAME

Senior Vice President and General Counsel
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of January 2017

Notarization:
Subscribed and sworn to before me
this 9th day of January 2017

Signature of Notary

Seal

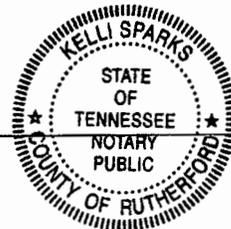


*Insert EXACT legal name of the applicant

MY COMMISSION EXPIRES:
OCTOBER 21, 2018

Signature of Notary

Seal



MY COMMISSION EXPIRES:
OCTOBER 21, 2018

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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.

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XI. 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.
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 43.

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.

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XII. 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.
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.

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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	16-18
2	Site Ownership	19-23
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	24-25
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	26
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	27-28
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
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	
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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	29-30
41	Charity Care Information	31

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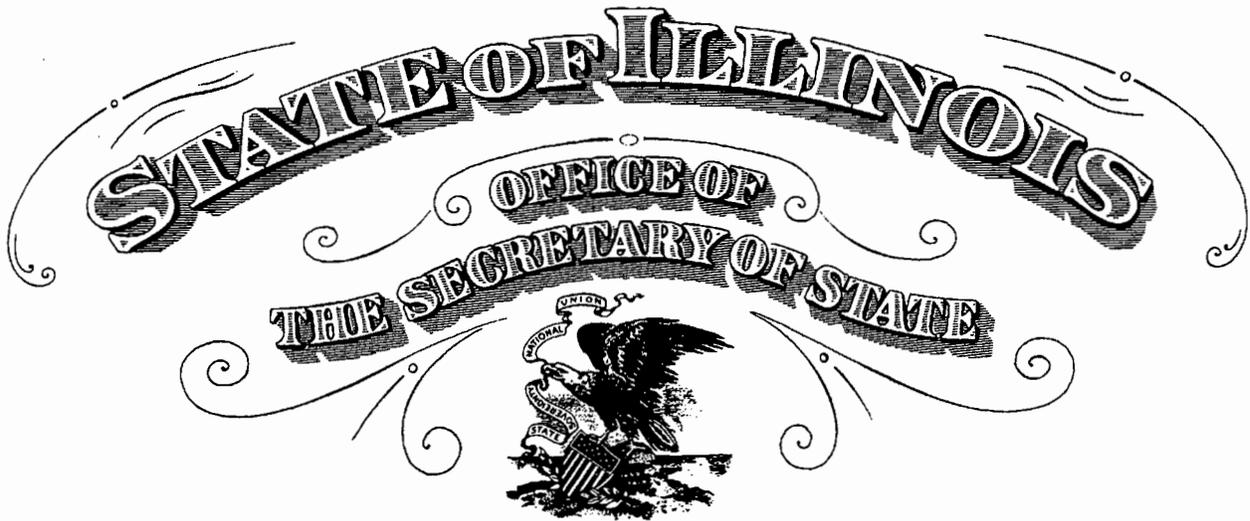
Ownership of Applicant

See attached Certificates of Good Standing for Galesburg Hospital Corporation and Quorum Health Corporation.

ORIGINAL

File Number

6337-215-3



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

GALESBURG HOSPITAL CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON FEBRUARY 27, 2004, 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 21ST day of NOVEMBER A.D. 2016 .

Jesse White

SECRETARY OF STATE

Authentication #: 1632603108 verifiable until 11/21/2017
Authenticate at: <http://www.cyberdriveillinois.com>

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "QUORUM HEALTH CORPORATION" IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-FIRST DAY OF NOVEMBER, A.D. 2016.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

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



5792308 8300

SR# 20166737763

You may verify this certificate online at corp.delaware.gov/authver.shtml

A handwritten signature in black ink, appearing to read "JBULLOCK", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

Authentication: 203377184

Date: 11-21-16

Ownership of Site

Galesburg Cottage Hospital and its grounds and facilities are owned by Galesburg Hospital Corporation (see attached).

ORIGINAL

CITY COURTHOUSE
CHERRY ST.
GALESBURG, IL 61401

2015 REAL ESTATE TAX BILL

K129

B-025	BILL NUMBER 2015-024369	CLASS CODE 0060	TOWNSHIP CITY OF GALESBURG	TAX CODE 0036
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Payable to: Knox County Collector

Legal Description and Site Address:
GALES 2ND ADD E192' LOT 6, LOTS 4,5 & 7T
HRU 11 BLK 12 & N1/2 VAC ST LYG S & ADJ
LOT 6 & ALSO LOT 1 PROFESSIONAL PARK

834 N SEMINARY ST
GALESBURG, IL 61401

GALESBURG HOSPITAL CORPORATION
PROPERTY VALUATION SERVICES
METCALF AVE
LAND PARK KS 66223

PENALTY OF 1 1/2% PER MONTH EFFECTIVE
FIRST DAY FOLLOWING DUE DATE.
PENALTY NOT PRORATED.

GALESBURG HOSPITAL CORPORATION

	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Pension Soc/Sec	Library Amount	Difference Amount
	1.31850	\$45,834.09	1.32445	\$46,040.93	\$14,194.84	\$0.00	\$206.84
	0.96471	\$33,535.54	0.95001	\$33,024.53	\$18,291.92	\$0.00	\$-511.01
	0.61915	\$21,523.08	0.60345	\$20,977.31	\$351.45	\$0.00	\$-545.77
RESERVATION	0.00064	\$22.25	0.00065	\$22.60	\$0.00	\$0.00	\$0.35
	0.31426	\$10,924.40	0.31862	\$11,075.96	\$3,087.24	\$0.00	\$151.56
	0.15985	\$5,556.75	0.15741	\$5,471.93	\$696.30	\$0.00	\$-84.82
	4.59146	\$159,609.71	4.70178	\$163,444.69	\$12,731.04	\$0.00	\$3,834.98
	1.61346	\$56,087.58	1.78203	\$61,975.27	\$25,986.91	\$15,220.32	\$5,887.69

Totals 9.58203 \$333,093.40 9.83920 \$342,033.22 \$75,339.70 \$15,220.32 \$8,939.82

If your taxes are in escrow and your mortgage company is responsible for them, this bill is for your information only.

DUE DATE	09/07/2016
2ND INSTALLMENT	\$171,016.61
INTEREST	COST
AMOUNT PAID	

GA 8/10/16

2252015

1

2015-024369	BACK TAX	\$0.00
99-10-278-025	AMOUNT	\$171,016.61

RETURN THIS PORTION WITH PAYMENT

BILL NUMBER	2015-024369	BACK TAX	
PERMANENT INDEX NUMBER	99-10-278-025	AMOUNT	

Tax Bill Transmittal
Statement 1 of 1
 May 31, 2016
 Martin Guenther - Manag

Galesburg Cottage Hospital
 Attn: Millie Smith
 Interim CFO
 695 North Kellogg Street
 Galesburg, IL 61401
 309.345.4389

Property Valuation Servic
 14400 Metcalf Avenue
 Overland Park, KS 6622

Voice: 913.498.0790
 Fax: 913.239.2423
 Email:
 mguenther@propertyval

Community Health Systems
 Professional Services
 Corporation
 Galesburg Cottage Hospital (25677)
 190
 695 North Kellogg Street
 Galesburg, IL 61401

Assessor: Galesburg City and T
 Lien Date: January 1, 2015
 Tax Year: 2015

Jurisdiction
 Knox County/Galesburg City & Tw
Total Tax Rate

Taxes Payable To:			
Collector is, County Treasurer erry Street . 61401 se DO NOT Remit Payment to Property Valuation Services			
	Due	Delinquent	Amount
	Jun/21/2016	Jun/22/2016	342,033.22
1	Jun/21/2016	Jun/22/2016	171,016.61
2	Sep/07/2016	Sep/08/2016	171,016.61

The above tax rate may incorpora
 and/or non ad valorem fees or ch
 therefore, may differ from the tax
 attached tax bill.

Please Note:

Additional tax statements for ir
 already included on this approv
 approved at a later date.

Type	Assessment Ratio	Market Value	Jurisdiction	Taxable Value	Tax Amount
MOB RE Street	33.33%	10,429,730	Knox County/Gal	3,476,230	342,033.22 342,033.22

ORIGINAL

DAVIS, COUNTY TREASURER
UNTY COURTHOUSE
H CHERRY ST.
RG, IL 61401

KNOX COUNTY 2015 REAL ESTATE TAX BILL

PIN	BILL NUMBER	CLASS CODE	TOWNSHIP	TAX CODE
-281-023	2015-024391	0060	CITY OF GALESBURG	0036

payable to: Knox County Collector

Legal Description and Site Address:

GALES 2ND ADDN EX N 40' LT 9 ALL BLK 13
ALSO S 1/2 VAC ST ADJ LT 1 AKA TR D

LESBURG HOSPITAL CORPORATION
) PROPERTY VALUATION SERVICES
100 METCALF AVE
ERLAND PARK KS 66223

695 N KELLOGG ST
GALESBURG, IL 61401

PENALTY OF 1 1/2% PER MONTH EFFECTIVE
FIRST DAY FOLLOWING DUE DATE.
PENALTY NOT PRORATED.

GALESBURG HOSPITAL CORPORATION

	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Pension Soc/Sec	Library Amount	Difference Amount
IRE	1.31850	\$36,353.42	1.32445	\$36,517.47	\$11,258.66	\$0.00	\$164.05
18	0.96471	\$26,598.79	0.95001	\$26,193.49	\$14,508.29	\$0.00	\$-405.30
ATER CONSERVATION	0.00064	\$17.85	0.00085	\$17.92	\$0.00	\$0.00	\$0.27
IST	0.31426	\$8,864.71	0.31862	\$8,784.93	\$2,448.65	\$0.00	\$120.22
99	0.15985	\$4,407.35	0.15741	\$4,340.08	\$552.26	\$0.00	\$-67.27
205	4.59148	126,594.82	4.70178	129,636.54	\$10,097.65	\$0.00	\$3,041.72
	1.01348	\$44,486.00	1.78283	\$49,155.83	\$20,611.58	\$12,072.03	\$4,669.83

Totals	9.58203	\$264,193.82	9.83920	\$271,284.46	\$59,755.85	\$12,072.03	\$7,090.64
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6/21/2016	
35,642.23	

If your taxes are in escrow and your mortgage company is responsible for them, this bill is for your information only.

DUE DATE	09/07/2016
2ND INSTALLMENT	\$135,642.23
INTEREST	COST
AMOUNT PAID	

PAID
JUN 09 2016

2252015
QA
6-8-16

1

URN THIS PORTION WITH PAYMENT

2015-024391	BACK TAX	\$0.00
	AMOUNT	

RETURN THIS PORTION WITH PAYM

BILL NUMBER	2015-024391	BACK TAX
PERMANENT		AMOUNT

Tax Bill Transmittal
Statement 1 of 1
 May 31, 2016
 Martin Guenther - Mayor

Galesburg Cottage Hospital
 Attn: Millie Smith
 Interim CFO
 695 North Kellogg Street
 Galesburg, IL 61401

Property Valuation Services
 14400 Metcalf Avenue
 Overland Park, KS 66204

Voice: 913.498.0790
 Fax: 913.239.2423
 Email: mguenther@propertytax.com

309.345.4389

Community Health Systems
 Professional Services
 Corporation
 Galesburg Cottage Hospital (25677)
 190
 695 North Kellogg Street
 Galesburg, IL 61401

Assessor: Galesburg City and County
 Lien Date: January 1, 2015
 Tax Year: 2015

Jurisdiction
 Knox County/Galesburg City & County
Total Tax Rate

Payments Payable To:			
County Collector Travis, County Treasurer Cherry Street Galesburg, IL 61401 Please DO NOT Remit Payment to Property Valuation Services			
	Due	Delinquent	Amount
Assessment	Jun/21/2016	Jun/22/2016	271,284.46
Item 1	Jun/21/2016	Jun/22/2016	135,642.23
Item 2	Sep/07/2016	Sep/08/2016	135,642.23

The above tax rate may incorporate and/or non ad valorem fees or charges, therefore, may differ from the total amount shown on the attached tax bill.

Please Note:

Additional tax statements for property already included on this appraisal approved at a later date.

Type	Assessment Ratio	Market Value	Jurisdiction	Taxable Value	Tax Amount
91 Street Hospital RE	33.33%	8,272,370	Knox County/Gal	2,757,180	271,284.46 271,284.46

Operating Identity/Licensee

See attached Certificate of Good Standing for Galesburg Hospital Corporation.

ORIGINAL

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Illinois Department of PUBLIC HEALTH
HF110805



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
6/30/2017	General Hospital	0005330

Effective: 07/01/2016

Galesburg Cottage Hospital
695 North Kellogg Street
Galesburg, IL 61402

The face of this license has a colored background. Printed by Authority of the State of Illinois • PD, #4012320 10M 3/12

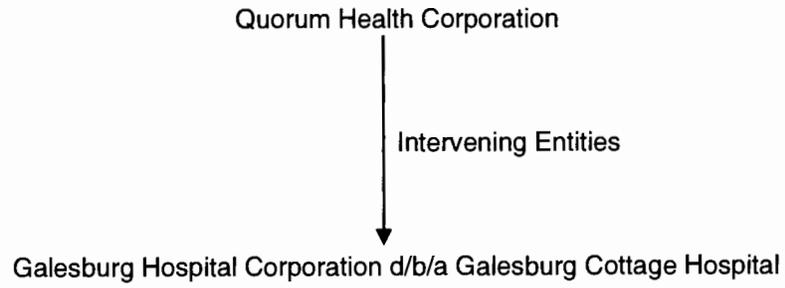
Exp. Date 6/30/2017
Lic Number 0005330

Date Printed 5/3/2016

Galesburg Cottage Hospital
695 North Kellogg Street
Galesburg, IL 61402

FEE RECEIPT NO.

Organizational Relationships



Discontinuation

GENERAL INFORMATION REQUIREMENTS

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

Hospital Licensed Long Term Care – 34 bed unit

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

None.

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

Upon or within 30 days from issuance of an exemption.

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

It is anticipated that the space will eventually be used for medical surgical beds. There will be no increase in medical surgical beds.

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.

The medical records for the long term care service will be maintained by Galesburg Cottage Hospital in compliance with state and federal law.

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.

N/A

REASONS FOR DISCONTINUATION

The service has been operating at significantly less than capacity and there are ample long term care facilities (six within the service area) available to care for the average in house census of eight residents in 2016 seen at Galesburg Cottage Hospital. From 2010-2015 the utilization of the long term care unit has decreased steadily.

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.

See response to reason for discontinuation. There are six long term care facilities in the service area with capacity to provide services to patients who were served by Galesburg Cottage Hospital.

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.

N/A per technical assistance, since the discontinuation of a category of service is now subject to an exemption.

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.

N/A per technical assistance.

Safety Net

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.*

Galesburg believes that the abundant supply of long term care beds in the Planning Area and Health Service Area are sufficient to ensure that this project will not have a material impact on essential safety net services in the community.

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.*

Given the available long term care beds in the service area, this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

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.*

Unknown, although area providers have expressed a willingness to provide care to patients, and there is no reason to believe the discontinuation of the service will impact safety net services in the community.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	FY2013	FY2014	FY2015
Inpatient	12	0	0
Outpatient	76	7	9
Total	88	7	9
Charity (cost in dollars)			
Inpatient	65,769	0	0
Outpatient	55,405	33,540	61,902
Total	121,174	33,540	61,902
MEDICAID			
Medicaid (# of patients)	FY2013	FY2014	FY2015
Inpatient	443	458	463
Outpatient	13,830	15,245	17,078
Total	14,273	15,703	17,541
Medicaid (revenue)			
Inpatient	10,153,414	10,419,290	7,757,195
Outpatient	324,486	(235,439)	3,721,794
Total	10,477,900	10,183,851	11,478,989

Barry Schneider
CEO, Galesburg Cottage Hospital

Subscribed and sworn to before me this
___ day of _____, 2016

Notary Public

**Charity Care
Galesburg Cottage Hospital**

CHARITY CARE			
	Year 2013	Year 2014	Year 2015
Net Patient Revenue	10,477,900	10,183,851	11,478,989
Amount of Charity Care (charges)	899,024	35,163	68,930
Cost of Charity Care	121,174	33,540	61,902