

**ORIGINAL** E-017-19

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

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

**RECEIVED**

**Facility/Project Identification**

Facility Name:	Galesburg Cottage Hospital		
Street Address:	695 North Kellogg Street		
City and Zip Code:	Galesburg, IL 61404		
County:	Knox	Health Service Area	II
		Health Planning Area:	C-09

APR 29 2019

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

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

Exact Legal Name:	Galesburg Hospital Corporation d/b/a Galesburg Cottage Hospital		
Street Address:	695 North Kellogg Street		
City and Zip Code:	Galesburg, IL 61404		
Name of Registered Agent:	CT Corporation System		
Registered Agent Street Address:	208 South LaSalle St. Suite 814		
Registered Agent City and Zip Code:	Chicago, IL 60604		
Name of Chief Executive Officer:	James X. Flynn		
CEO Street Address:	695 North Kellogg Street		
CEO City and Zip Code:	Galesburg, IL 61404		
CEO Telephone Number:	309/343-8131		

**Type of Ownership of Applicants**

<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 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**

Facility Name:	Galesburg Cottage Hospital		
Street Address:	695 North Kellogg Street		
City and Zip Code:	Galesburg, IL 61404		
County:	Knox	Health Service Area	II Health Planning Area: C-03

**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**

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

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- o 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:	Patricia Ellison
Title:	Chief Financial Officer
Company Name:	Galesburg Cottage Hospital
Address:	695 North Kellogg Street Galesburg, IL 61404
Telephone Number:	309/343-8131
E-mail Address:	Patricia_Ellison@QuorumHealth.com
Fax Number:	

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:
Address of Site Owner:
Street Address or Legal Description of the Site:
<b>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.</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Operating Identity/Licensee**

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name:	Galesburg Hospital Corporation		
Address:	695 North Kellogg Street Galesburg, IL 61404		
<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
X	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"><li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li><li>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.</li><li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li></ul>			
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

### **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.

The applicants propose to discontinue Galesburg Cottage Hospital's obstetrics category of service. The hospital is approved to operate ten obstetrics beds. In addition, the hospital will be discontinuing one C-Section room and its newborn nursery, which has ten Level II bassinette stations.

### 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 . 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.

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**Anticipated exemption completion date** (refer to Part 1130.570): within 30 days following approval of this COE application

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

Are the following submittals up to date as applicable:

Cancer Registry

XAPORS

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 being deemed Incomplete.**

**CERTIFICATION**

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of Galesburg 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.

James Flynn  
SIGNATURE

JAMES FLYNN  
PRINTED NAME

CEO  
PRINTED TITLE

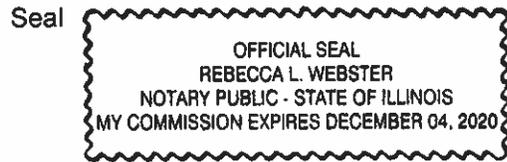
Patricia Ellison  
SIGNATURE

Patricia Ellison  
PRINTED NAME

CFO  
PRINTED TITLE

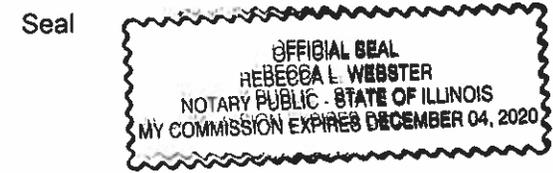
Notarization:  
Subscribed and sworn to before me  
this 23rd day of April

Rebecca L. Webster  
Signature of Notary



Notarization:  
Subscribed and sworn to before me  
this 23rd day of April

Rebecca L. Webster  
Signature of Notary



\*Insert the EXACT legal name of the applicant

**CERTIFICATION**

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- 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  
Alfred Lumsdaine  
 PRINTED NAME  
EVP & Chief Financial Officer  
 PRINTED TITLE

*[Signature]*  
 SIGNATURE  
Marty Smith  
 PRINTED NAME  
EVP & COO  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 24<sup>th</sup> day of April  
*[Signature]*  
 Signature of Notary

Notarization:  
 Subscribed and sworn to before me  
 this 24 day of April  
*[Signature]*  
 Signature of Notary

Seal  


Seal  


\*Insert the EXACT legal name of the applicant

## SECTION II. DISCONTINUATION

### Type of Discontinuation

- Discontinuation of an Existing Health Care Facility
- 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 3980/5.4]:**

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)	Year 2015	Year 2016	Year 2017
Inpatient	0	2	1
Outpatient	9	30	30
<b>Total</b>	<b>9</b>	<b>32</b>	<b>31</b>
Charity (cost in dollars)			
Inpatient	0	47,319	5,237
Outpatient	61,902	262,434	33,687
<b>Total</b>	<b>61,902</b>	<b>309,753</b>	<b>38,924</b>
MEDICAID			
Medicaid (# of patients)	Year 2015	Year 2016	Year 2017
Inpatient	463	472	481
Outpatient	17,078	17,079	16,880
<b>Total</b>	<b>17,541</b>	<b>17,551</b>	<b>17,361</b>
Medicaid (revenue)			

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
DISCONTINUATION APPLICATION FOR EXEMPTION- 08/2018 Edition

	Inpatient	7,757,195	6,632,368	8,736,792
	Outpatient	3,721,794	8,018	1,966,312
	<b>Total</b>	<b>11,478,989</b>	<b>6,640,386</b>	<b>10,703,104</b>

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**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.**

<b>CHARITY CARE</b>			
	<b>Year 2016</b>	<b>Year 2017</b>	<b>Year 2018</b>
<b>Net Patient Revenue</b>	<b>76,041,819</b>	<b>75,800,250</b>	<b>67,670,428</b>
<b>Amount of Charity Care (charges)</b>	<b>258,239</b>	<b>279,934</b>	<b>283,989</b>
<b>Cost of Charity Care</b>	<b>35,630</b>	<b>36,125</b>	<b>32,584</b>

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



**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 16TH day of APRIL A.D. 2019 .***



*Jesse White*

# 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

## Registered 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

## Tax Information

Last Annual Report Filed: 2018

Tax Due: \$ 0

Annual Tax Assessment: \$250000

Total Authorized Shares: 1300000000

## Filing 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 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



# Galesburg Cottage Hospital

695 North Kellogg Street • Galesburg, Illinois 61401 • Telephone: 309-343-8131

April 19, 2019

Illinois Health Facilities and  
Services Review Board  
525 West Jefferson Street  
Springfield, IL 62761

To Whom It May Concern:

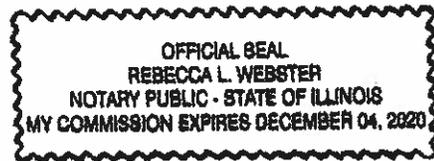
I hereby attest that the site of Galesburg Cottage Hospital, that being 695 N. Kellogg Street in Galesburg, Illinois, is owned by Galesburg Hospital Corporation.

Sincerely,

James X. Flynn  
Chief Executive Officer

Notarized: Rebecca L. Webster  
Notary Public

State of Illinois  
County of Knox  
April 19, 2019





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***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 16TH day of APRIL A.D. 2019 .***



Authentication #: 1910802074 verifiable until 04/16/2020  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

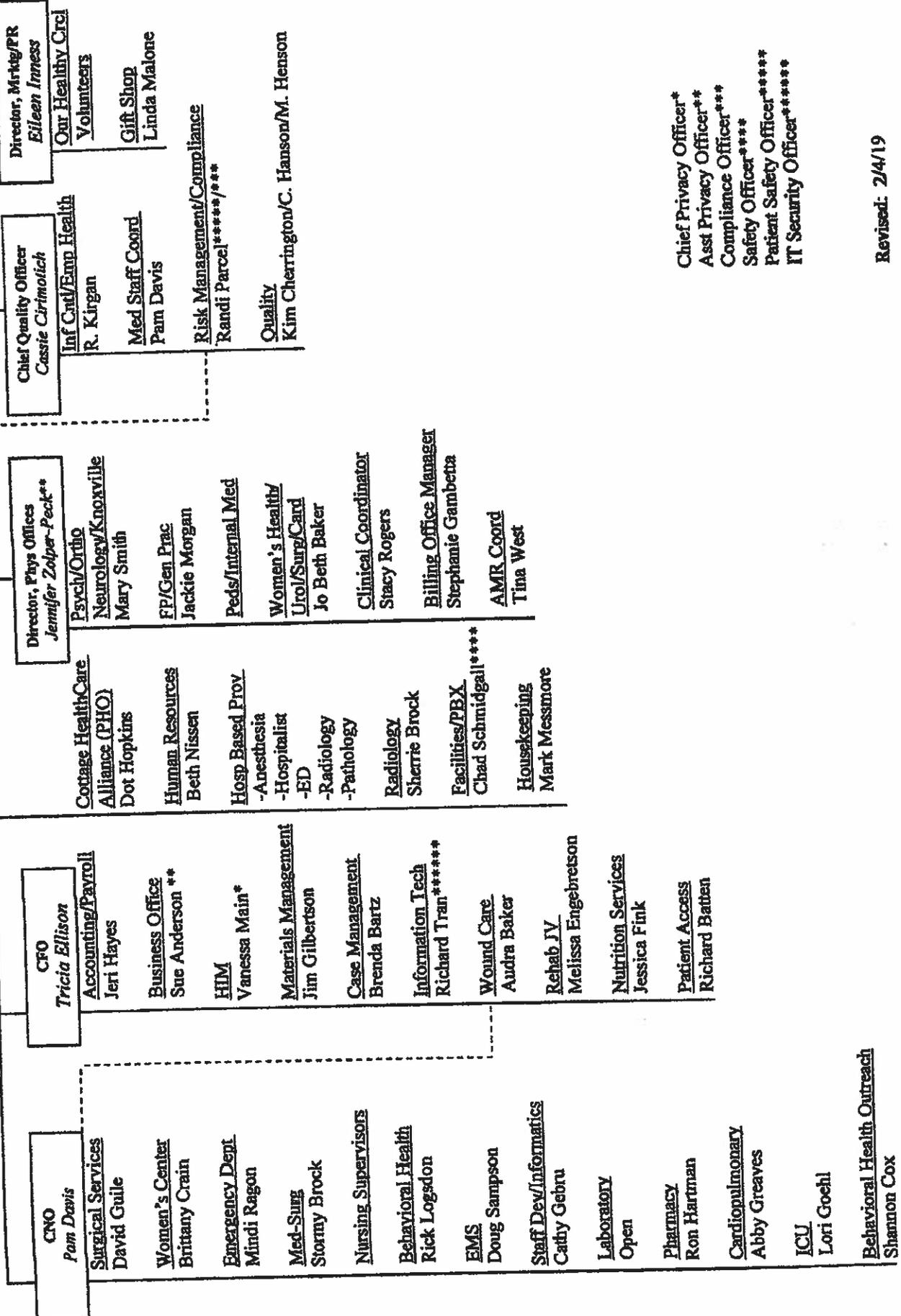
SECRETARY OF STATE ATTACHMENT 3

**GCH ORGANIZATION STRUCTURE**

**BOARD OF TRUSTEES**  
Mark Blackburn, Chairman

**Quorum Health Corporation**

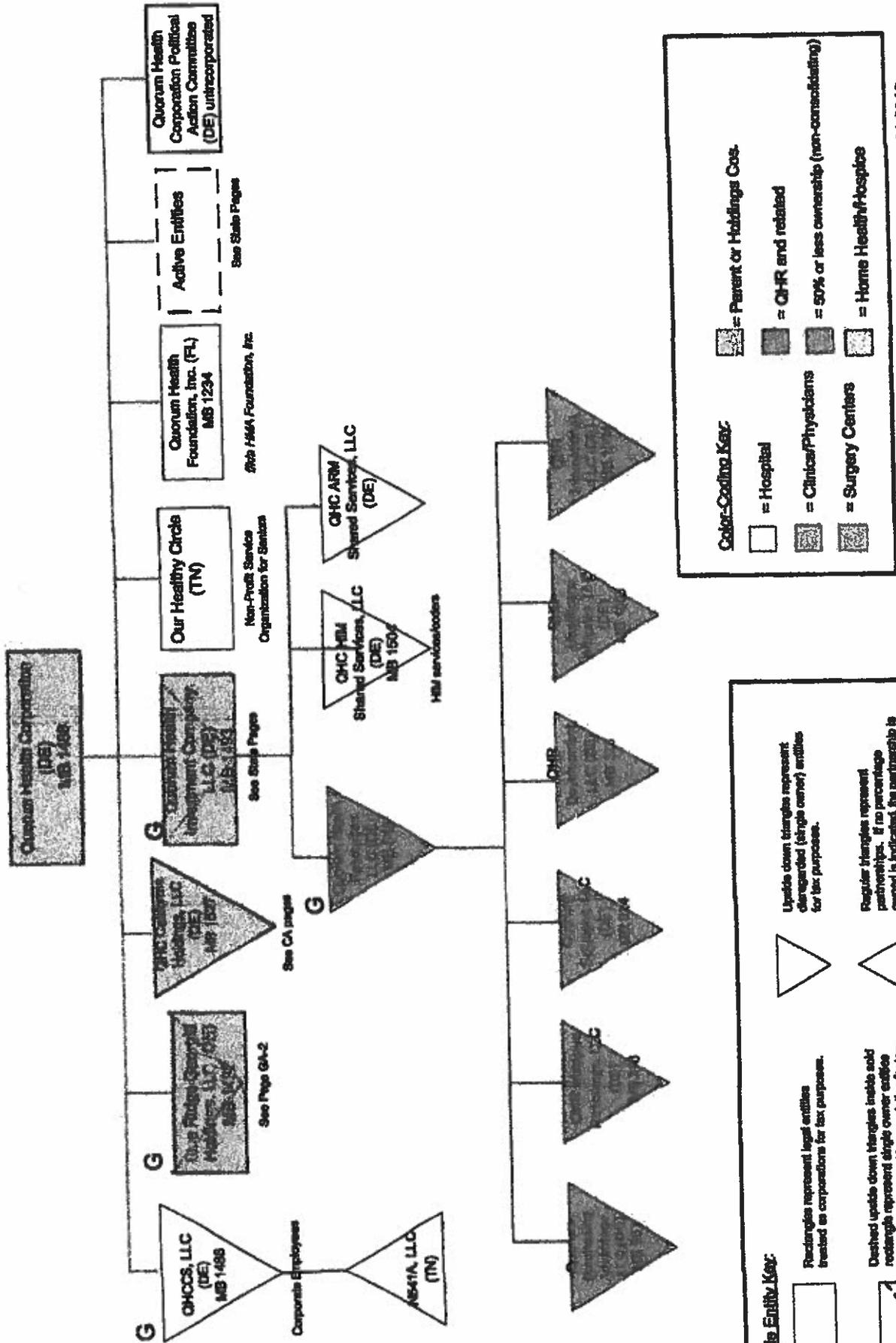
**CEO**  
James Flynn



Chief Privacy Officer\*  
Asst Privacy Officer\*\*  
Compliance Officer\*\*\*  
Safety Officer\*\*\*\*  
Patient Safety Officer\*\*\*\*\*  
IT Security Officer\*\*\*\*\*

Revised: 2/4/19

# Quorum Health Corporation



**Color-Coding Key:**

- [White Box] = Hospital
- [Light Gray Box] = Parent or Holdings Cos.
- [Dark Gray Box] = CH-R and related
- [Medium Gray Box] = Clinical/Physicians
- [Dark Gray Box] = 50% or less ownership (non-consolidating)
- [White Box] = Surgery Centers
- [Dark Gray Box] = Home Health/Hospice

**Taxable Entity Key:**

- [White Triangle] = Regularly represent legal entities treated as corporations for tax purposes.
- [Light Gray Triangle] = Upside down triangles represent disregarded (single center) entities for tax purposes.
- [Dark Gray Triangle] = Dashed upside down triangles include sold redangle represent single center entities electing to be a taxable association for tax purposes.
- [White Triangle] = Regular triangles represent partnerships. If no percentage control is indicated, the partnership is disregarded for tax purposes.

## DISCONTINUATION

1. This Certificate of Exemption ("COE") application addresses the discontinuation of the applicant hospital's obstetrics category of service, which includes 10 authorized beds.
2. The following clinical areas/services, each of which is associated with obstetrics care, will be discontinued:
  - one C-Section room
  - ten Level II nursery stations/bassinets
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. No final plans have been made for the re-use of the space to be vacated as a result of the discontinuation. Equipment will be used in other areas of the hospital, dispersed among other Quorum Health hospitals, sold, or discarded.
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 Register-Mail on April 15, 2019. Proof of publication is attached.

**Business Notices**

**Galesburg Cottage Hospital**  
695 N. Kellogg Street, Galesburg, IL  
is discontinuing its obstetrics service on  
Thursday, May 2, 2019. Current OB  
patients are being notified now of their  
care transition options. We will work with  
all of our fellow health care providers in the  
community, including St. Mary's, St.  
Francis and Unity Point to help patients  
establish care. Our Cottage OB Clinician  
will be working with current patients  
expected to deliver their baby after May 2,  
2019 to assist in their care transition. Our  
emergency department will continue to  
treat patients experiencing a medical  
emergency - obstetric-related or  
otherwise.

## REASONS FOR DISCONTINUATION

The primary reasons for proposing the discontinuation of the hospital's obstetrics program are the loss of an obstetrician from the medical staff low utilization.

The hospital currently has, in recent years, had two obstetricians on its Medical Staff. One of those obstetricians ceased practicing in the community, effective April 23, 2019, leaving the hospital with only one obstetrician practicing at the hospital. With only 349 babies being delivered at the hospital in 2018, an anticipation that the loss of an obstetrician from the Medical Staff will result in a reduction in the number of babies delivered at the hospital, and another, more active obstetrics program being available in the community, the discontinuation of the program will result in the elimination of an unnecessary duplication of service, without adversely impacting access for area residents.

## IMPACT ON ACCESS

The discontinuation of obstetrics services at Galesburg Cottage Hospital will not have an appreciable adverse effect on accessibility to the service. The other hospital in Galesburg, OSF St. Mary's Medical Center ("St. Mary's"), provides obstetrics services, and conversations have taken place between the leadership of the two hospitals relating to the impending discontinuation.

Attached is a copy of the letter sent to the President of St. Mary's, in order to comply with the requirements of Section 1110.290.c. St. Mary's is the only other provider of obstetrics services in the HFSRB-defined geographic service area. Should St. Mary's provide a formal response to the attached letter, it will be forwarded to HFSRB staff.

April 12, 2019

**VIA CERTIFIED MAIL  
RETURN RECEIPT REQUESTED**

Ms. Jennifer Juris  
President  
OSF St. Mary Medical Center  
3333 North Seminary Street  
Galesburg, IL 61401

RE: Galesburg Cottage Hospital  
Proposed Discontinuation of Obstetrics  
Category of Service

Dear Jennifer:

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.

Galesburg Cottage Hospital will suspend its obstetrics category of service on April \_\_, 2019, and anticipates the formal discontinuation of that service to occur within thirty days following the Illinois Health Facilities and Services Review Board's ("IHFSRB's") approval of the hospital's Certificate of Exemption application to discontinue the category of service. It is anticipated that application will be filed by the end of this month.

During the 24-month period ending December 31, 2018, a total of 815 patients were admitted to the hospital's obstetrics unit, and 1,824 patient days of care were provided. \_\_\_ babies were born at the hospital 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,

James Flynn  
CEO

ATTACHMENT 7

From: "Crosser, Roxanna" <[Roxanna.Crosser@osfhealthcare.org](mailto:Roxanna.Crosser@osfhealthcare.org)>  
Date: April 19, 2019 at 3:47:22 PM CDT  
To: "Flynn, James X" <[Jim.Flynn@QuorumHealth.com](mailto:Jim.Flynn@QuorumHealth.com)>, "Junis, Jennifer A." <[Jennifer.A.Junis@osfhealthcare.org](mailto:Jennifer.A.Junis@osfhealthcare.org)>  
Subject: [EXTERNAL] RE: Letters to St. Mary's Leadership

WARNING: This email came from outside of CHS's email system. DO NOT CLICK LINKS or ATTACHMENTS in this email unless you recognize the sender.

I did get my letter. I also know that Patty Luker received hers also.

Rox

From: Flynn, James X (<mailto:Jim.Flynn@QuorumHealth.com>)  
Sent: Friday, April 19, 2019 3:39 PM  
To: Crosser, Roxanna <[Roxanna.Crosser@osfhealthcare.org](mailto:Roxanna.Crosser@osfhealthcare.org)>; Junis, Jennifer A. <[Jennifer.A.Junis@osfhealthcare.org](mailto:Jennifer.A.Junis@osfhealthcare.org)>  
Subject: [EXTERNAL] FW: Letters to St. Mary's Leadership

CAUTION: This email originated from outside of the OSF HealthCare network. Do not click links or open attachments unless you recognize the sender and know the content is safe. If you have any questions about the legitimacy of this email, please call the OSF Service Center at (800) 673-5721.

Hi Rox and Jennifer,

Can you please confirm receipt of the letters? This is required as part of the COE. Thank you and have a great weekend.

| James Flynn, Chief Executive Officer | Galesburg Cottage Hospital | 695 N. Kellogg St. Galesburg, IL 61401 | Office: (309) 345-4567 | Fax: (309) 343-2393 | Cell: (309) 335-5725 | [Jim.Flynn@QuorumHealth.com](mailto:Jim.Flynn@QuorumHealth.com)

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

HF 115879

# Illinois Department of PUBLIC HEALTH

## 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 <b>6/30/2019</b>	CATEGORY <b>General Hospital</b>	LIC. NUMBER <b>0005330</b>
<b>Effective: 07/01/2018</b>		

**Galesburg Cottage Hospital**  
695 North Kellogg Street  
Galesburg, IL 61402

28

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. 448240 5M 5/18

Exp. Date 6/30/2019  
Lic Number 0005330

Date Printed 5/15/2018

Galesburg Cottage Hospital  
695 North Kellogg Street  
Galesburg, IL 61402

FEE RECEIPT NO.



May 30, 2017

Jim X. Flynn  
CEO  
Galesburg Cottage Hospital  
695 North Kallogg Street  
Galesburg, IL 61401

Joint Commission ID #: 7348  
Program: Hospital Accreditation  
Accreditation Activity: 60-day Evidence of  
Standards Compliance  
Accreditation Activity Completed: 05/30/2017

Dear Mr. Flynn:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospitals**

This accreditation cycle is effective beginning March 17, 2017 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS  
Chief Operating Officer

Division of Accreditation and Certification Operations

ATTACHMENT 8



# Galesburg Cottage Hospital

695 North Kellogg Street • Galesburg, Illinois 61401 • Telephone: 309-343-8131

April 19, 2019

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

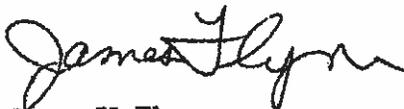
Dear Ms. Avery:

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:

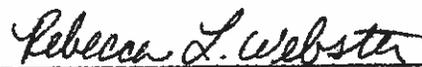
1. Quorum Health Corporation has not had any adverse actions against any Illinois facility owned, operated, and/or controlled by the applicant during the three (3) year period prior to the filing of this application, and
2. Quorum Health Corporation authorizes the State Board and Agency access to information 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 at (309) 345-4567.

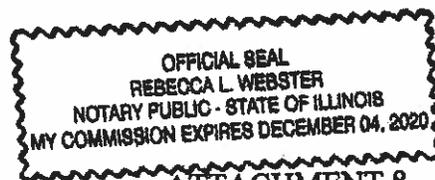
Sincerely,



James X. Flynn  
Chief Executive Officer

Notarized:   
Notary Public

State of Illinois  
County of Knox  
April 19, 2019



ATTACHMENT 8

## SAFETY NET IMPACT STATEMENT

The proposed discontinuation of obstetrics services at Galesburg Cottage Hospital will not, in the opinion of the applicants, have any material impact on access to essential safety net services in the community. Further, the applicants do not anticipate that the proposed discontinuation will have any material impact on other safety net providers.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant Identification including Certificate of Good Standing	15
2	Site Ownership	17
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	18
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	19
5	Discontinuation General Information Requirements	21
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9	Safety Net Impact Statement	31
10	Charity Care Information	14

# Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

**RECEIVED**

APR 29 2019

**HEALTH FACILITIES &  
SERVICES REVIEW BOARD**

**by FedEx**

April 26, 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 Galesburg Cottage Hospital in Galesburg.

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