

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

**RECEIVED**

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

**DEC 30 2016**

**This Section must be completed for all projects.**

**HEALTH FACILITIES &  
SERVICES REVIEW BOARD**

**Facility/Project Identification**

Facility Name: Hammond-Henry Hospital – Discontinuation of the Obstetrics Services		
Street Address: 600 North College Avenue		
City and Zip Code: Geneseo Illinois 61254		
County: Henry County	Health Service Area: 10	Health Planning Area: C-05

**Applicant /Co-Applicant Identification**

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

Exact Legal Name: Henry Hospital District
Address: 600 North College Avenue
Name of Registered Agent: Kathy Tank
Name of Chief Executive Officer: Jeffrey Lingerfelt
CEO Address: 600 North College Avenue, Geneseo, Illinois 61254
Telephone Number: 309-944-9100

**Type of Ownership of Applicant/Co-Applicant**

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

☐ Corporations and limited liability companies must provide an Illinois certificate of good standing.  
☐ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

**Primary Contact**

**[Person to receive ALL correspondence or inquiries]**

Name: Laura Domino
Title: Vice President of Patient Care Services
Company Name: Hammond-Henry Hospital
Address: 600 North College Avenue
Telephone Number: 309-944-9101
E-mail Address: lauradomino@hammondhenry.com
Fax Number: 309-944-9299

**Additional Contact**

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

Name: Lisa DeKezel
Title: Quality Risk Manager
Company Name: Hammond-Henry Hospital
Address: 600 North College Avenue
Telephone Number: 309-944-2341
E-mail Address: lisadekezel@hammondhenry.com
Fax Number: 309-944-9299



**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: Jeff Lingerfelt
Title: CEO
Company Name: Hammond-Henry Hospital
Address: 600 North College Avenue Geneseo, Illinois
Telephone Number: 309-944-9100
E-mail Address: jefflingerfelt@hammondhenry.com
Fax Number: 309-944-9299

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Henry Hospital District
Address of Site Owner: 600 North College Avenue Geneseo, Illinois
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 <u>ATTACHMENT-2</u> , 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: Henry Hospital District	
Address: 600 North College Avenue, Geneseo, Illinois 61254	
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Partnership <input type="checkbox"/> Governmental <input type="checkbox"/> Sole Proprietorship
<input checked="" type="checkbox"/> Other	
<ul style="list-style-type: none"> <li>○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>○ 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>○ <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>	
APPEND DOCUMENTATION AS <u>ATTACHMENT-3</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

**Organizational Relationships**

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

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



**Flood Plain Requirements NOT APPLICABLE**

[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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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**

[Refer to application instructions.]

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

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

**DESCRIPTION OF PROJECT****1. Project Classification**

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

Part 1110 Classification:

☒ Substantive

☐ Non-substantive



## 2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Hammond-Henry Hospital (the "Hospital") currently operates an obstetrics service consisting of three (3) Labor, Delivery, Recovery and Post-Partum (LDRP) rooms (three beds total) at 600 North College Avenue, Geneseo, Illinois 61254. The Hospital is proposing to discontinue all obstetrical services and re-assign the three LDRP beds (and associated space) to Medical/Surgical services.

Obstetrics patients who present at the Hospital and require obstetrical services will be triaged, treated and transferred from the Emergency Room to the nearest facility that offers obstetrical services at the level required by the patient.

The total bed capacity of the Hospital will not change as a result of the Project. The hospital is currently licensed for 23 Critical Access Hospital beds, 23 beds are staffed and certified as follows: three (3) as Obstetric, four (4) as Intensive Care, and sixteen (16) as Medical/Surgical. As indicated, the three (3) Obstetric beds will be re-designated for Medical/Surgical beds, maintaining a total of twenty-three (23) licensed Critical Access Hospital beds.

There are no construction or modernization costs associated with this Project.

Assuming approval of this certificate of exemption application by the Health Facilities Services Review Board, the obstetrics service line will be discontinued no later than April 30, 2017, which will allow sufficient time to complete or transition the care of current patients, to conduct community education in relation to the discontinuation of the obstetrics service and the availability of alternative providers, and to conduct internal hospital training on the treatment, triage, and transfer of obstetrics patients who present to the emergency department.

### Project Costs and Sources of Funds NOT APPLICABLE – NO PROJECT COSTS

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 NOT APPLICABLE – NO PROJECT COSTS**

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)			
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)			
<b>TOTAL USES OF FUNDS</b>			
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			
<b>TOTAL SOURCES OF FUNDS</b>			
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			



**Related Project Costs NOT APPLICABLE – NO PROJECT COSTS**

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price:	\$ <u>0.00</u>	
Fair Market Value:	\$ <u>0.00</u>	

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 \$ \_\_\_\_\_.

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>	
Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>Upon approval by the HFSRB</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS <u>ATTACHMENT-8</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

**State Agency Submittals**

Are the following submittals up to date as applicable:
<input checked="" type="checkbox"/> Cancer Registry
<input checked="" type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> All reports regarding outstanding permits
<b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b>



**Cost Space Requirements NOT APPLICABLE – NO PROJECT COSTS**

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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							



**Facility Bed Capacity and Utilization**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed incomplete.

FACILITY NAME: Hammond-Henry Hospital			CITY: Geneseo, Illinois		
REPORTING PERIOD DATES: From: June 1, 2015 to: May 31, 2016					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	16			+3	19
Obstetrics	3			-3	0
Pediatrics	-				-
Intensive Care	4			-	4
Comprehensive Physical Rehabilitation	-				-
Acute/Chronic Mental Illness	-				-
Neonatal Intensive Care	-				-
General Long Term Care	38				38
Specialized Long Term Care	-				-
Long Term Acute Care	-				-
Other ((identify))					-
TOTALS:	61				61

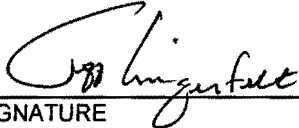


**CERTIFICATION**

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) 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 manger 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 for Permit is filed on the behalf of Henry Hospital District dba Hammond-Henry 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.

  
SIGNATURE

Jeff Lingerfelt  
PRINTED NAME

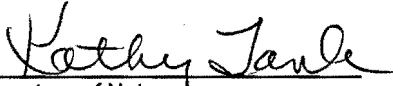
Chief Executive Officer  
PRINTED TITLE

  
SIGNATURE

Laura Domino  
PRINTED NAME

V.P. of Patient Care Services  
PRINTED TITLE

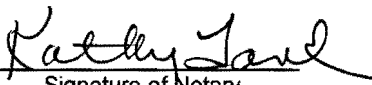
Notarization:  
Subscribed and sworn to before me  
this 22<sup>nd</sup> day of December, 2016

  
Signature of Notary

Seal

\*Insert EXACT legal name of the applicant  
Notary Public, State of Illinois  
My Commission Expires 02-21-2018

Notarization:  
Subscribed and sworn to before me  
this 22<sup>nd</sup> day of December, 2016

  
Signature of Notary

Seal

"OFFICIAL SEAL"  
KATHY TANK  
Notary Public, State of Illinois  
My Commission Expires 02-21-2018



**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.



### SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

#### Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

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, 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 the information has been 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-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.**

##### PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

**NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.**

**APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.**



**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 40.

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

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

**XII. Charity Care Information - Not Applicable**



**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 41.**

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

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



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

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16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
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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	
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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	
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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT**

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

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: Hammond-Henry Hospital – Discontinuation of the Obstetrics Services		
Street Address: 600 North College Avenue		
City and Zip Code: Geneseo Illinois 61254		
County: Henry County	Health Service Area 10	Health Planning Area: C-05

**Applicant /Co-Applicant Identification**

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

Exact Legal Name: Henry Hospital District	
Address: 600 North College Avenue	
Name of Registered Agent: Kathy Tank	
Name of Chief Executive Officer: Jeffrey Lingerfelt	
CEO Address: 600 North College Avenue, Geneseo, Illinois 61254	
Telephone Number: 309-944-9100	

**Type of Ownership of Applicant/Co-Applicant**

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.





**To all to whom these presents shall come, Greeting:**

Whereas, there has been filed in the Office of the Secretary of State on the 11th day of September A.D. 1950 under and in accordance with the provisions of "An Act providing for the creation and operation of Hospital Districts" approved July 15 1949 in force July 15 1949 a copy of the Order of Vera M. Binks County Judge of Henry County, Illinois pending the results of the election in a certain proceeding for the organization of the Henry Hospital District and

Whereas, said Order was entered and is dated the 26th day of April A.D. 1950 and is certified to be a true and correct copy by the County Clerk of Henry County, Illinois and

Whereas, it is found by said Order that those voting in favor of the establishment of the Henry Hospital District were 1,762 and those voting in the negative and against such proposition were 709 and that the affirmative of said proposition received a majority of 1,053 and said Order determines the said Henry Hospital District to be established

Now, Therefore, I, EDWARD J. BARRETT, Secretary of State of the State of Illinois, by virtue of the power and authority vested in me by law do hereby issue this Certificate of Incorporation to said Henry Hospital District



In Testimony Whereof, I hereto set my hand and the Great Seal of the State of Illinois Done at the Capitol in the City of Springfield this the 11th day of September A.D. nineteen hundred and fifty and of the Independence of the United States the one hundred and seventy-fifth

*Edward J. Barrett*  
 SECRETARY OF STATE

Attachment 1

Applicant Identification



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

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Henry Hospital District
Address of Site Owner: 600 North College Avenue Geneseo, Illinois
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 <u>ATTACHMENT-2</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The attachment is proof of site ownership by Henry Hospital District.  
Attachment 2, Exhibit 1 – Henry County Tax Bill  
Attachment 2, Exhibit 2 – Deed



**TIM WELLS**  
**HENRY COUNTY COLLECTOR**  
**307 W. CENTER STREET**  
**CAMBRIDGE, IL 61238**

**REAL ESTATE TAX BILL**  
**(2015 PAYABLE 2016)**

FIRST DUE DATE 06/13/2016	SECOND DUE DATE 09/06/2016
FIRST INSTALLMENT \$24,216.44	SECOND INSTALLMENT \$24,216.44
PRIOR TAX SOLD NO	FORFEITED NO

**HENRY COUNTY**  
**REAL ESTATE TAX BILL**



LOCATION: 600 N COLLEGE AVE  
 GENESEO IL 61254  
 LEGAL DESC: LT 10 & S275 LT 9 FORDS SUB & VAC ELK ST  
 & LTS 10 & 11 BLK 3 PARK VILLA SUB & LT  
 S 1 THRU 8 BLK 6 STOUGHS ADD CITY OF GEN  
 ESEO

PERMANENT PARCEL NUMBER	
08-16-326-016	
PROPERTY CLASS	9060
ACRES	7.26
FAIR CASH VALUE (NON-FARM)	1,869,150

NAME:  
 HOSPITAL HENRY DISTRICT  
 600 N COLLEGE AVE  
 GENESEO IL 61254

FORMULATION FOR TAX CALCULATIONS	
LAND ASMT	4,997
BUILDING ASMT	617,990
HOME IMP/VET EXEMPTION	0
STATE MULTIPLIER	1.0000
STATE EQUALIZED VALUE	622,987
OWNER OCCUPIED EXEMPTION	0
SENIOR CITIZEN EXEMPTION	0
SENIOR ASSESSMENT FREEZE	0
DISABLED VET HOMESTEAD	0
DISABLED PERSON EXEMPTION	0
RETURNING VET EXEMPTION	0
VET/FRAT EXEMPTIONS	0
FARM LAND ASMT	0
FARM BUILDING ASMT	0
NET TAXABLE VALUE	622,987
TAX RATE / PER \$100 EAV	7.7743
ENTERPRISE ZONE ABATEMENT	\$0.00
TOTAL REAL ESTATE TAX	\$48,432.88
DRAINAGE	\$0.00
TOTAL AMOUNT DUE	\$48,432.88

TAX CODE	HENRY COUNTY		TOWNSHIP		
080001	ITEMIZED STATEMENT		GENESEO		
TAXING BODY	PRIOR YEAR RATE	PRIOR YEAR TAX	CURRENT RATE	CURRENT TAX	PENSION AMOUNT
HENRY COUNTY	0.9198	\$5,730.22	0.9567	\$5,960.14	\$1,689.55
GENESEO SCHOOL UNIT #228	4.1414	\$25,800.38	4.1916	\$26,113.12	\$1,386.17
GENESEO TOWNSHIP	0.0625	\$389.37	0.0577	\$359.46	\$0.00
BLACKHAWK COLLEGE #503	0.5485	\$3,417.08	0.5492	\$3,421.44	\$63.54
GENESEO FIRE DISTRICT	0.2911	\$1,813.52	0.3011	\$1,875.81	\$0.00
GENESEO ROAD DISTRICT	0.2463	\$1,534.42	0.2431	\$1,514.48	\$0.00
CITY OF GENESEO	0.5509	\$3,432.04	0.5729	\$3,569.09	\$2,032.19
GENESEO PARK DISTRICT	0.4950	\$3,083.79	0.5033	\$3,135.49	\$196.86
GENESEO LIBRARY	0.1988	\$1,238.50	0.1952	\$1,216.07	\$114.63
HAMMOND HENRY HOSPITAL	0.2061	\$1,283.98	0.2035	\$1,267.78	\$1,267.78
TOTAL	7.6604	\$47,723.30	7.7743	\$48,432.88	\$6,750.72

TAX DISTRICT PENSION AND SOCIAL SECURITY TAX AMOUNTS ARE INCLUDED IN ABOVE CURRENT TAX

**PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION**



WARRANTY DEED.

THIS INDENTURE WITNESSETH, That the Grantor, THE CITY OF GENESEO, a municipal corporation, situated in the County of Henry and State of Illinois, for and in consideration of ONE DOLLAR in hand paid, CONVEY and WARRANT to HENRY HOSPITAL DISTRICT, a municipal corporation situated in Henry and Rock Island Counties, Illinois, with its principal office in the City of Geneseo, County of Henry and State of Illinois, the following described real estate, to-wit:

Lot Eleven (11) of Block Three (3) of the Park Villa addition to the said City of Geneseo, saving and excepting from the said grant the South one hundred feet (100 ft.) of said lot and the North thirty (30 ft.) feet thereof, and the East twenty four feet six inches (24 ft. 6 in.) thereof, the last two of the excepted tracts being public streets, and further excepting therefrom the following:

- A. All poles, wires, and outside transformers belonging to the Municipal Utilities of the said City, which property the City shall retain; and
- B. All street right-of-ways and public streets presently existing on said premises, which shall be retained by the City, said street right-of-ways and public streets, if any, at variance to the exceptions in the above description being the result of the previous widening of said streets;

situated in the County of Henry, in the State of Illinois, hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

The said premises are conveyed to the said grantee in order that they may be used for Hospital purposes.

Dated this 25<sup>th</sup> day of March A.D. 1952.

CITY OF GENESEO

By: A. W. Wellstein (SEAL)  
Mayor.

Attest: Myrtle J. Bessant (SEAL)  
City Clerk

State of Illinois, } ss.  
County of Henry, }

I, the undersigned, a Notary Public in and for the said County and State aforesaid, do hereby certify that A. W. Wellstein, as Mayor of the City of Geneseo, Illinois, and Myrtle J. Bessant, City Clerk of said City, personally known to me to be such officers, and in their capacity as such officers, and personally known to me to be the same persons whose names are subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that they signed, sealed and delivered the said instrument as their free and voluntary act, and the free and voluntary act of said City, for the uses and purposes therein set forth, including the release, and waiver of the right of Homestead.

Given under my hand and seal, this 25<sup>th</sup> day of March, A.D. 1952.

Edward J. Jones  
Notary Public.

Attachment 2

Exhibit 2



State of Illinois, ss:  
County of Henry,

Filed for record May 6, 1965 at 3:45 o'clock P. M. and recorded in-  
Book \_\_\_\_\_, page \_\_\_\_\_, as Document No. 65R1614

JOHN W. KENWARD Recorder of Deeds  
By Lucille Neumann Deputy.

WARRANTY DEED, Statutory Form

This Indenture Witnesseth, That the Grantor ,

BERTHA HAECHERL, a widow,  
of Geneseo, County of Henry and State of Illinois,  
for and in consideration of Thirteen Thousand and no/100-----  
DOLLARS in hand paid, CONVEYS and WARRANTS to

HENRY HOSPITAL DISTRICT, a municipal corporation,  
of Geneseo, in the County of Henry and State of Illinois  
the following described real estate, to-wit:



Lot 5 of Block 6 of O. J. Stough's  
Addition to the Town, now City, of  
Geneseo; subject to general taxes  
for the year 1965;



*Part of 5 pages*

situated in the County of Henry in the State of Illinois, hereby releasing and waiving all rights  
under and by virtue of the Homestead Exemption Laws of the State of Illinois.

Dated this 4th day of May, A. D. 19 65.



Bertha Haecherl (SEAL)  
Bertha Haecherl  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (SEAL)

State of Illinois, } ss.  
County of Henry, }

I, O. H. Chamberlain, the undersigned, a Notary  
Public in and for the said County and State aforesaid, do hereby  
certify that

BERTHA HAECHERL, a widow,

personally known to me to be the person whose name  
is subscribed to the foregoing instrument, appeared before  
me this day in person and acknowledged that she signed.  
sealed and delivered the said instrument as her free and  
voluntary act, for the uses and purposes therein set forth includ-  
ing the release, and waiver of the right of Homestead.

Given under my hand and official seal, this 4th

day of May, A. D. 1965.

My Commission Expires

O. H. Chamberlain, Notary Public.

Attachment 2

Exhibit 2



Filed for record August 27-1959 at 3 o'clock P. M. and recorded in  
Book 623, page 371, as Document No. 254865

Robert J. Harberg Recorder of Deeds  
By Mildred Scammon Deputy.

WARRANTY DEED, Statutory Form

This Indenture Witnesseth, That the Grantor s, HARRY W. VOSS, a bachelor,

of the City of Geneseo County of Henry and State of Illinois

for and in consideration of Seven Thousand (\$7,000.00)-----

DOLLARS in hand paid, CONVEY and WARRANT to

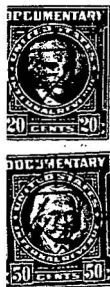
HENRY HOSPITAL DISTRICT, a municipal corporation situated in  
Henry and Rock Island Counties, Illinois, with its principal office in the  
~~in~~ City of Geneseo in the County of Henry and State of Illinois

the following described real estate, to-wit:

All of Lot 10 in Block 3 of Park Villa Addition to the Town, now  
City, of Geneseo, situated in the County of Henry and State of Illinois,  
except the West 208 feet of said Lot 10, and also except the East 24½  
feet of said Lot 10, heretofore dedicated to the City of Geneseo for  
street purposes.

AND

All of the South 100 feet of Lot 11 of said Block 3, except the West  
158 feet of said South 100 feet, and also except the East 24½ feet of  
said South 100 feet, heretofore dedicated to the City of Geneseo  
for street purposes,



situated in the County of Henry in the State of Illinois, hereby releasing and waiving all rights  
under and by virtue of the Homestead Exemption Laws of the State of Illinois, subject to  
all tax liens thereon.

Dated this 15th day of August A. D. 19 59.

Harry W. Voss (SEAL)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (SEAL)

State of Illinois, }  
County of Henry, } ss.

I, Joseph L. Shaw, the undersigned, a Notary  
Public in and for the said County and State aforesaid, do hereby  
certify that

HARRY W. VOSS, a bachelor,

personally known to me to be the person whose name  
is subscribed to the foregoing instrument, appeared before  
me this day in person and acknowledged that he signed.  
sealed and delivered the said instrument as his free and  
voluntary act, for the uses and purposes therein set forth includ-  
ing the release, and waiver of the right of Homestead.

Given under my hand and official seal, this 15th  
day of August A. D. 19 59.

My Commission Expires

Joseph L. Shaw  
Notary Public.

Attachment 2  
Exhibit 2



State of Illinois, ss:  
County of Henry,

Filed for record Oct 3 1967 at 2:05 o'clock P M. and recorded in  
Book \_\_\_\_\_, page \_\_\_\_\_, as Document No. 67R3958

JOHN W. KENWARD Recorder of Deeds

By Russell Neumann Deputy.

**WARRANTY DEED, Statutory Form**

**This Indenture Witnesseth**, That the Grantors MARVIN R. JOHNSON and MARION M. JOHNSON, his wife,

of Geneseo County of Henry and State of Illinois

for and in consideration of SIXTEEN THOUSAND (\$16,000.00)-----

DOLLARS in hand paid, CONVEY and WARRANT to

HENRY HOSPITAL DISTRICT, a municipal corporation

of Geneseo in the County of Henry and State of Illinois

the following described real estate, to-wit:



Lot Six (6) in Block Six (6) in Stough's Addition  
to the City of Geneseo



situated in the County of Henry in the State of Illinois, hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

Subject to the taxes for the year 1967.

Dated this 25th day of September, A. D. 1967

Marvin R. Johnson (SEAL)  
Marvin R. Johnson  
Marion M. Johnson (SEAL)  
Marion Johnson  
\_\_\_\_\_  
(SEAL)

State of Illinois, } ss.  
County of Henry, }

I, Mabel W. Brown, the undersigned, a Notary Public in and for the said County and State aforesaid, do hereby certify that Marvin R. Johnson and Marion Johnson, his wife,

personally known to me to be the persons whose names are subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that they signed, sealed and delivered the said instrument as their free and voluntary act, for the uses and purposes therein set forth including the release, and waiver of the right of Homestead.

Given under my hand and official seal, this 25th day of September, A. D. 1967

My Commission Expires  
January 11, 1970

Mabel W. Brown  
Notary Public.

Attachment 2  
Exhibit 2



**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****Operating Identity/Licensee**

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

Exact Legal Name: Henry Hospital District

Address: 600 North College Avenue, Geneseo, Illinois 61254

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**





**To all to whom these Presents Shall Come, Greeting:**

Whereas, there has been filed in the Office of the Secretary of State on the 11th day of September A.D. 1950 under and in accordance with the provisions of "An Act providing for the creation and operation of Hospital Districts"

approved July 15 1949 in force July 15 1949  
a copy of the Order of Vera M. Binks County Judge  
of Henry County, Illinois finding the results of the  
election in a certain proceeding for the organization of the Henry  
Hospital District, and

Whereas said Order was entered and is dated the 26th day  
of April A.D. 1950 and is certified to be a true and correct  
copy by the County Clerk of Henry County, Illinois and

Whereas it is found by said Order that those voting in favor of  
the establishment of the Henry Hospital District  
were 1,752 and those voting in the negative and against such  
proposition were 709 and that the affirmatives of said proposition  
received a majority of 1,053 and said Order determines the said  
Henry Hospital District to be established.

Now Therefore I, EDWARD J. BARRETT, Secretary of State of the  
State of Illinois, by virtue of the power and authority vested in me by law  
do hereby issue this Certificate of Incorporation to said Henry  
Hospital District.



In Testimony Whereof, I hereto set my hand and  
the Great Seal of the State of Illinois Done at the Capitol  
in the City of Springfield this the 11th  
day of September A.D. nineteen  
hundred and fifty and of the  
Independence of the United States the one hundred and  
seventy-fifth.

*Edward J. Barrett*  
SECRETARY OF STATE

Attachment 3

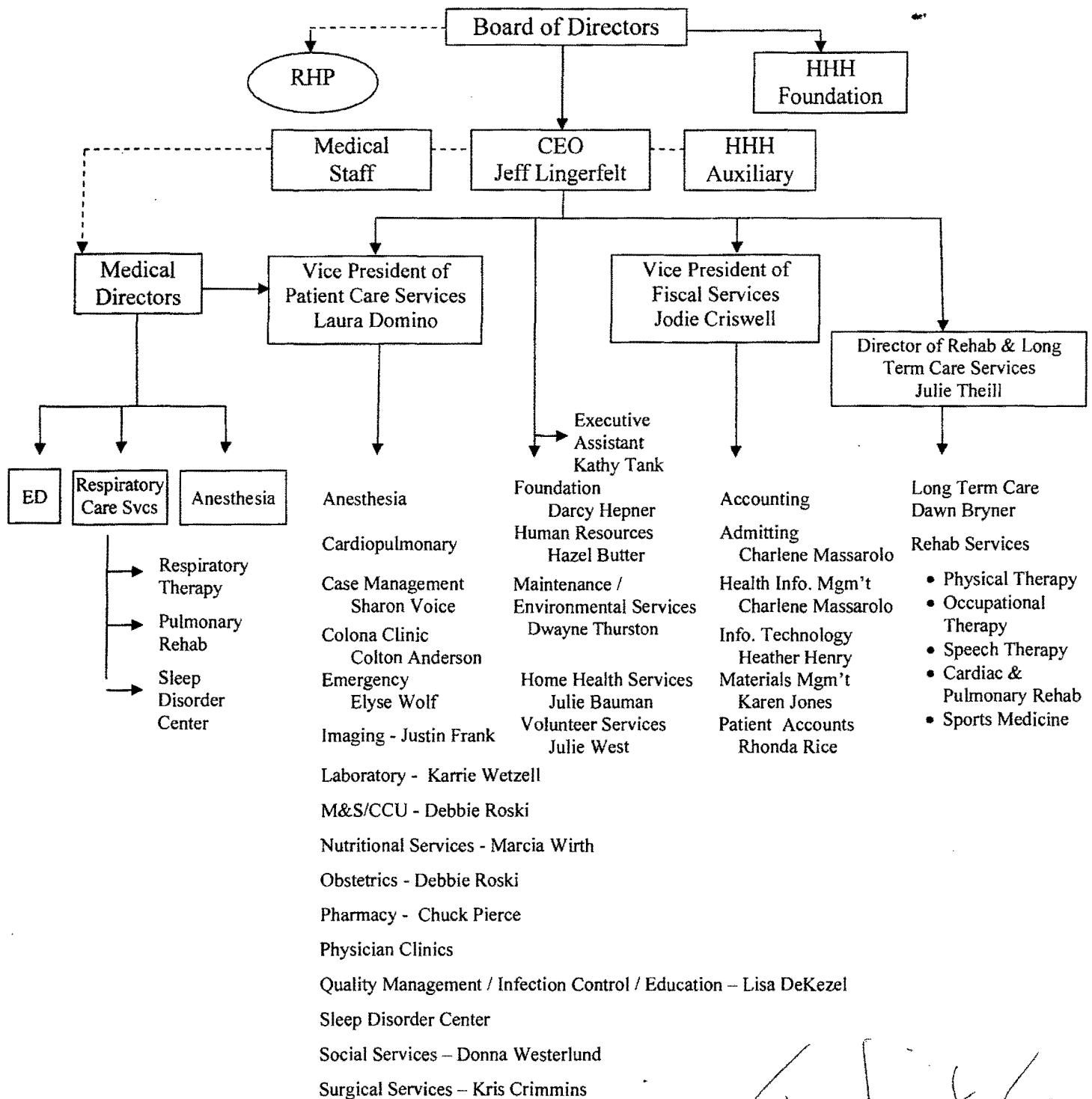


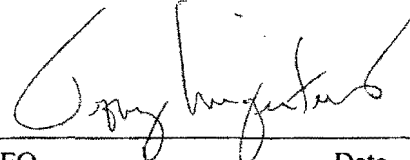
**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****Organizational Relationships**

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.



# Hammond-Henry Hospital Organizational Chart



 8-11-16  
 CEO Date



**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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.**

By the notarized signatures of the Certificate pages of this application, the authorized representatives of Hammond-Henry Hospital attest that the site shown on Attachment 5, as identified as the most recent FEMA Flood Insurance Rate Map complies with the Flood Plain Rule and requirements stated under Illinois Executive Order #2005-5, "Construction Activities in the Special Flood Hazard Area." Hammond-Henry Hospital is not located in a flood plain. The project complies with requirements of Illinois Executive Order #2005-5

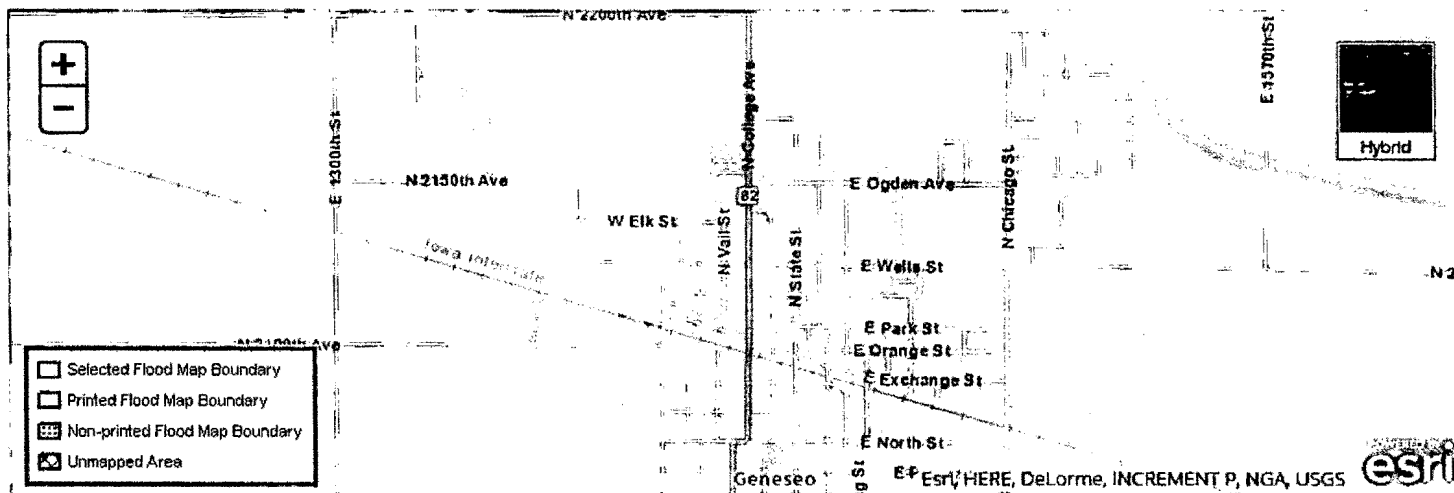



**Enter an address, place, or coordinates:** 

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### Locator Map



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 Official website of the Department of Homeland Security

28



**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.**

The discontinuation of the obstetrical services does not involve the demolition of any structure, or construction of new building or modernization of existing building.



**Section II. DISCONTINUATION****1110.130 Discontinuation of Authorized Obstetric Inpatient Beds****General Information Requirements**

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

The Hospital proposes to discontinue its entire obstetrics service line, consisting of three licensed Obstetrics (LDRP) beds.

- 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.***

The obstetrics service will be discontinued on or about April 30, 2017, assuming approval of the certificate of exemption by the Health Facilities and Services Review Board. A time frame of four (4) months has been identified as the appropriate period of time necessary to inform the current patients of the discontinuation and to permit them to make alternative arrangements for obstetrical services as they may choose. This time period also will be utilized to appropriately communicate with and educate the community, and to have OSF, the Regional Perinatal Level III Center, train and prepare the Hammond-Henry Hospital Emergency Department for OB emergency and triage services.

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

The Hospital expects to re-deploy the former obstetrics beds/space for medical/surgical category patients. The three (3) Obstetric LDRP beds are located on the third floor of the facility, as are the Hospital's other twenty (20) utilized beds. Staffing and utilization, accordingly for all twenty-three (23) staffed and utilized beds will be located on the same floor. The total bed capacity of the Hospital will not change. There are no construction or modernization costs associated with the discontinuation of the obstetrics service or the re-purposing of those beds for medical/surgical patients.

Appropriate equipment as directed by OSF St. Francis Perinatal Level III Center will be maintained as required in the emergency department for OB emergencies. All other OB equipment will be removed from service after closing of OB services.



5. ***Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.***

All medical records pertaining to obstetrical services will continue to be maintained at the Hospital, as part of its electronic health records system. The Hospital complies with all applicable federal and state laws to assure proper storage, retention and destruction of health system medical records. Obstetrical health records are retained for ten (10) years from the last date of service or until the minor reaches twenty-three (23) years of age.

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.***

Not Applicable

## **REASONS FOR DISCONTINUATION**

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

1. The Hospital has determined that maintenance of its obstetrics service under changing market conditions and under stricter regulatory obligations will require us to make significant additional investments of our scarce financial and other resources in obstetrics. In particular, we have been unable to retain or recruit OB/GYN physicians to the community. Recruitment of physicians in this specialty to a Level I service with fewer than 250 deliveries per year would require subsidies beyond the means of the Hospital. Those resources can otherwise be used to alleviate medical/surgical capacity issues and to expand services that will serve a broader segment of the community, including services for our senior population and strengthening our surgical and orthopedic services. Declining volume of Obstetric providers has caused unrealistic scheduling of providers and placing specific timeframes for Obstetric emergency expectations in jeopardy.

Across the state, most Critical Access Hospitals have discontinued offering obstetrical services in order to focus on more pressing community healthcare needs.

The principal reasons for discontinuation are the following:

1. The Hospital currently must rely on four (4) family practice physicians, three of which are located in Kewanee (30 miles from the hospital) and one provider in Geneseo to cover deliveries. The four providers performing OB services also serve as the Emergency Department providers. Documented evidence has been shown to demonstrate numerous times the physicians are serving in both capacities. Declining volume of providers challenged us to meet Illinois Provider Trust scheduling expectations requiring one provider for delivery and one provider available for the care of the baby. Meeting specific timeframes for emergency procedures has been in jeopardy. Scheduling difficulties, inability to recruit and retain providers and the



financial burden of a high Medicaid population has lead to Hammond-Henry Hospital making a difficult decision of closing the Obstetric services.

2. As a Level I facility, HHH does not have a neonatal intensive care unit or a neonatologist on staff. Surveys of the community indicate that the availability of these services is a significant factor in the choice of a hospital for delivery, and community members increasingly are requiring these resources as a minimum standard for an obstetrics facility. It is unrealistic and not achievable to become a Level II facility.
3. In the most recent year, approximately 75 percent of the normal newborn deliveries originating in the Hospital's primary service area occurred at facilities other than the Hospital. Approximately 55 percent of the normal newborn deliveries originating in the Hospital's secondary service area occurred at facilities other than the Hospital. The Hospital provided 37 percent of the deliveries this past year for the primary and secondary service areas. This is indicative of the weak demand for the obstetrics service at the Hospital, as well as the reasonable availability of alternative providers.
4. High peak census on the medical/surgical floor has created back flow into the Emergency Department, often extending the patient stay in the ED until a medical/surgical bed is available or resulting in transfer to another facility. The re-designation of the three obstetrics beds to medical/surgical use is expected to significantly reduce these occurrences.

#### 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.***

Obstetrical services will continue to be available to all patients within the Hammond-Henry Hospital primary and secondary service areas.

The primary service area includes Geneseo, Annawan, Atkinson, Cambridge, and Mineral. The secondary market includes Colona, Erie, Kewanee and Hillsdale.

Seventy (70) percent of the obstetric patients that come to Hammond-Henry Hospital come from the secondary service area. These patients after closure of the OB service line will be served at Cottage Hospital in Galesburg, Illinois and OSF Hospital in Peoria, Illinois. Cottage Hospital (Level II) is located 35 miles from Kewanee and OSF (Level III) is located 48 miles from Kewanee.

Twenty five (25) percent of the obstetric patients come to Hammond-Henry Hospital from the primary service area. These patients will be served at Genesis Medical Center – Illini (Level II) in Silvis, Illinois, 16 miles from Geneseo; Genesis Medical Center (Level II) in Davenport, Iowa, 28 miles from Geneseo; and UnityPoint Hospital (Level II) in Moline, Illinois, 23 miles from Geneseo. Many of our expectant mothers in the primary market are already proactively choosing to deliver at the hospital that provide higher level of care.

Obstetrical services will continue to be available to all patients residing within 45 minutes' travel time of the Hospital. The following hospitals provide obstetrical care within that radius:



- a. Genesis Health, Silvis, IL (23 minutes from Hammond-Henry Hospital)
- b. Trinity Hospital (Unity Point), Moline, IL (25 Minutes)
- c. Trinity Hospital (Unity Point), Bettendorf, IA (31 minutes)
- d. Genesis Health, Davenport, IA (34 minutes)
- e. Cottage Hospital, Galesburg, IL (47 minutes)\*
- f. OSF St. Elizabeth Medical Center, Ottawa, IL (71 minutes)\*
- g. OSF St. Francis Medical Center, Peoria, IL (80 minutes)\*

\* Located within 45 minutes of a segment of the residents who live within 45 minutes of the Hospital.

(See Maps - Attachment 10, Exhibit 1 & 2)

The Hospital has existing transfer agreements with OSF Saint Francis Medical Center in Peoria (the Regional Perinatal Level III Center), UnityPoint Health in Moline, and Genesis Medical Center – Davenport & Illini Campuses (see Attachment 10, Exhibit 3, 4 & 5)

- 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.**

Written impact statements were not required, per conversation with Mike Constantino.

The Hospital represents that it has had verbal discussions with the CEOs of UnityPoint and Genesis Medical Center regarding the impact of the discontinuation of obstetrical services at the Hospital. Verbal agreement was obtained that these organizations can meet the community's obstetrical care needs.

OSF Perinatal Center is aware of our intent to close obstetrical services and have begun strategies to meet the needs of the secondary market at OSF St. Luke Medical Center in Kewanee.

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

Not applicable.

Attachment 10  
Discontinuation



# Google Map Developers

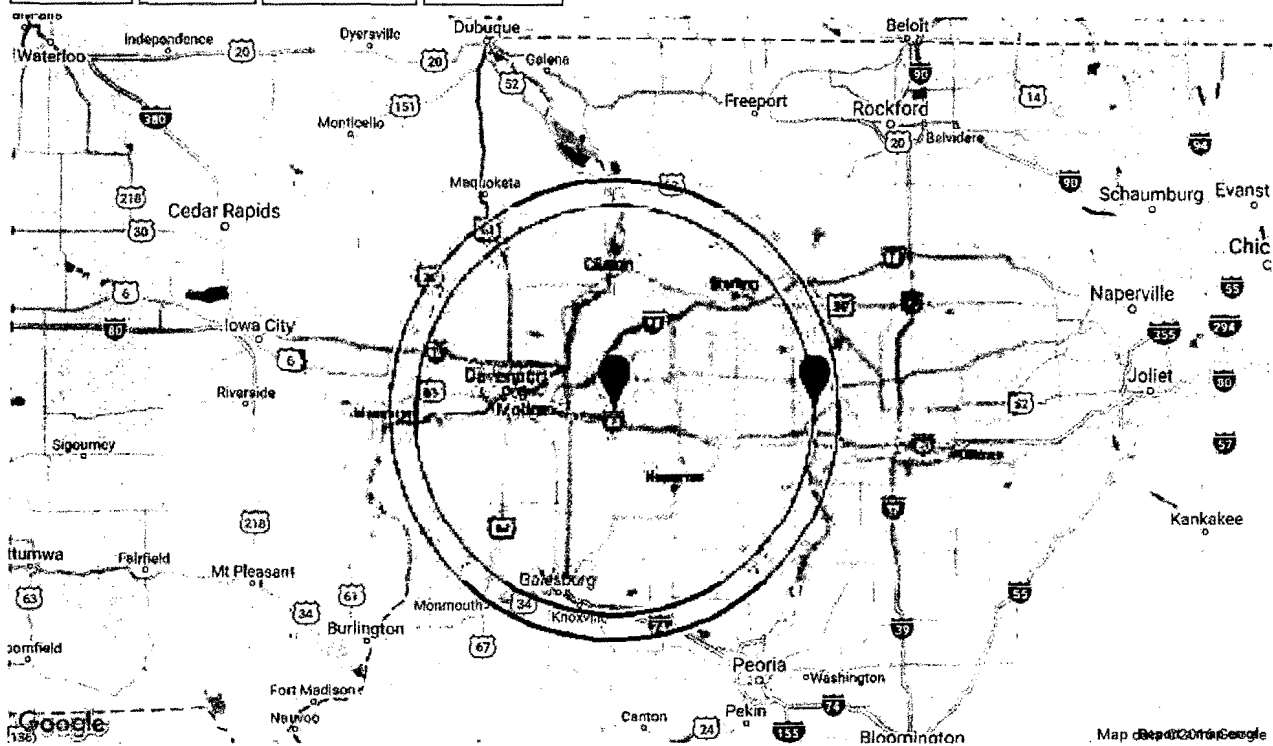
not associated with google maps

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## Draw a circle - Create a circle on a google map using a point and a radius.

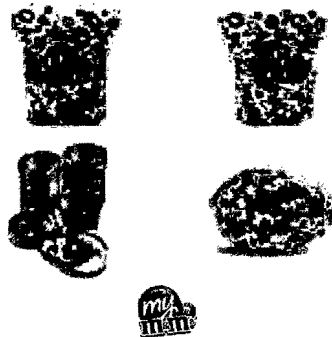
Use this tool to draw a circle by entering its radius along with an address. You can also click a point on the map to place a circle at that spot. You can adjust the placement of the circle by dragging it to a different location. You can also change the radius by either dragging the marker on the outside of the circle or by entering the radius in the field below and clicking edit circle. After drawing the circles you can come back to the map or send someone else to it by copying the link listed below. I hope that you find this radius tool useful. If you have any suggestions on how to make it better please **let me know**

Address:  Radius:   Circle:  Border:  Only Show Border ☒



Return to this radius map here, just save this link

<https://www.mapdevelopers.com/draw-circle-tool.php?circles=%5B%5B72420.3%2C41.4596126%2C-90.1576584%2C%22%23AAAAAA%22%2C%22%23000000%22%2C0%5D%2C%5B64373.6%2C41.4596126%2C-90.1576584%2C%22%23AAAAAA%22%2C%22%23000000%22%2C0%5D%5D>



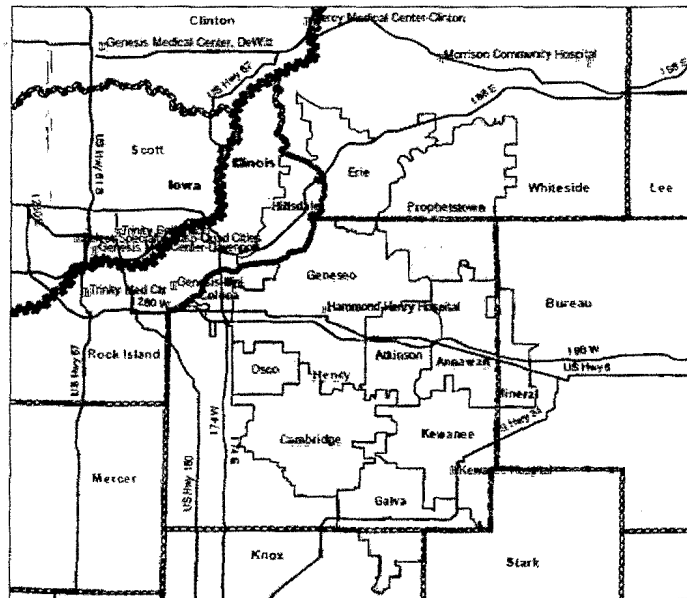


# Service Area Definition

Hammond-Henry Hospital - Geneseo, IL

- ☐ Primary Service Area (PSA)
- ☐ Secondary Service Area (SSA)
- ☐ Tertiary Service Area (TSA)

County	ZIP Code	Post Office Name
Henry	61254	Geneseo
Henry	61238	Cambridge
Henry	61235	Atkinson
Henry	61234	Annawan
Bureau	61344	Mineral
<b>Total PSA</b>		
Henry	61443	Kewanee
Whiteside	61250	Erie
Henry	61241	Colona
Rock Island	61257	Hillsdale
<b>Total SSA</b>		
Henry	61274	Osco
Whiteside	61277	Prophetstown
Henry	61434	Galva
<b>Total TSA</b>		
Other ZIP Codes		
<b>Total Discharges</b>		



Source: HealthTechS3, September 2016; Truven Health; COMPdata



**TRANSFER AGREEMENT**  
**between**  
**HAMMOND-HENRY HOSPITAL**  
**and**  
**OSF HEALTHCARE SYSTEM,**  
**OSF SAINT FRANCIS MEDICAL CENTER**  
**and CHILDREN'S HOSPITAL OF ILLINOIS**

THIS TRANSFER AGREEMENT ("Agreement") is effective as of January 1, 2015, by and between Hammond-Henry Hospital, located and doing business in Geneseo, Illinois (hereinafter referred to as "**Transferring Hospital**") and OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, having its Corporate Office in Peoria, Illinois, owner and operator of OSF Saint Francis Medical Center and Children's Hospital of Illinois, located and doing business in Peoria, Illinois ("**Receiving Facility**").

**RECITALS:**

A. The Transferring Hospital and the Receiving Facility desire to assure continuity of care and treatment appropriate to the needs of the patients to be transferred hereunder, including but not limited to the needs of pediatric patients.

B. The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals set forth above and incorporated by reference herein, the parties hereto agree as follows:

**I. PATIENT TRANSFER DUTIES AND RESPONSIBILITIES.**

**1.1 Receiving Facility Responsibilities.**

- a. In accordance with the policies and procedures of the Transferring Hospital and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Hospital to the Receiving Facility as long as the Receiving Facility has bed availability, staff availability, and is able to provide the services requested by the Transferring Hospital, and pursuant to any other necessary criteria established by the Receiving Facility. Receiving Facility shall designate a person to coordinate with Transferring Hospital in order to establish acceptable and efficient transfer guidelines. If Receiving Facility is unable to accept a referred patient



because of bed unavailability or for any other reason, Receiving Facility will take reasonable steps to assist Transferring Hospital in arranging for admission of the patient to another facility capable of providing the appropriate level of care.

1.2 Transferring Hospital Responsibilities. Transferring Hospital shall request transfers of patients to Receiving Facility pursuant to the criteria set forth in Section 1.1. Further, Transferring Hospital shall:

- a. Be responsible for obtaining any consent(s) required by law for the transfer of patient from Transferring Hospital to Receiving Facility, and provide a copy of any such consent to Receiving Facility.
- b. Provide Receiving Facility's contact information to the guardian of the patient.
- c. Notify Receiving Facility as far in advance as possible of the impending transfer.
- d. In the event a patient has personal effects with him or her at the time of transfer, provide a list to Receiving Facility with appropriate documentation of such personal effects.
- e. Affect the transfer to Receiving Facility through qualified personnel and appropriate transfer equipment and transportation (in accordance with patient acuity level), including the use of necessary and medically appropriate life support measures. Receiving Facility's responsibility for the patient's care shall begin when the patient arrives at the Receiving Facility. Notwithstanding anything to the contrary set forth above, in the event the patient is transferred by Receiving Facility's Air Ambulance program, Receiving Facility's responsibility shall begin when the patient leaves Transferring Hospital's Emergency Department.
- f. Transfer, and supplement as necessary, all relevant medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue the patient's treatment without interruption and to provide identifying and other information, including contact information for referring physician, name of physician(s) at Receiving Facility contacted with regard to the patient (and to whom the patient is to be transferred), medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical and lab findings, history of the illness or injury, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring



Hospital, medications administered, known allergies, nursing, dietary information, ambulation status and pertinent administrative, third party billing and social information.

1.3 Joint Responsibilities.

- a. Receiving Facility and Transferring Hospital agree to exercise best efforts to provide for prompt admission of the patient, subject to the transfer criteria set forth in Section 1.1.
- b. Receiving Facility and Transferring Hospital shall comply with all EMTALA requirements with respect to all transfers, if applicable.
- c. With respect to the transfer of pediatric patients, the Receiving Facility and Transferring Hospital agree to each designate a representative, identified in Exhibit A attached hereto, who shall meet periodically, as needed, to review the pediatric patient transfer process, to develop and review policies and procedures in order to improve this transfer process (including efficiency, clinical care and patient safety), and to develop and review specific quality improvement measures as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome. The parties agree to reasonably cooperate with each other to oversee performance improvement and patient safety applicable to the activities under the Transfer Agreement to the extent permissible under applicable laws.

- 1.4 Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with a handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.

- 1.5 Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional or advertising material.

- 1.6 Standards. The parties shall provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of The Joint Commission, the Department of Health



and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Facility or Transferring Hospital. The parties shall perform their duties under this Agreement in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.

- 1.7 Exclusion/Debarment. By entering into this Agreement, the parties hereby certify that they have not been debarred, suspended, or excluded from participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare and Tricare. In addition, each party agrees that it will notify the other party immediately if it subsequently becomes debarred, suspended or excluded or proposed for debarment, suspension or exclusion from participation in any state or federal healthcare program.
- 1.8 Confidentiality. Receiving Facility and Transferring Hospital specifically acknowledge that certain material, which will come into the parties' possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties may be damaging to the other party. Each party agrees to hold all such material concerning the other party in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be required by law and to comply with the Health Insurance Portability and Accountability Act.
- 1.9 Access to Books and Records. Both parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each party will allow the other party reasonable access to such records for audit purposes and also the right to make photocopies of such records (at requesting party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.
- 1.10 Non-Exclusivity. This Agreement does not establish an exclusive arrangement between the parties, and both the Transferring Facility and the Receiving Hospital are permitted to enter into similar agreements with other entities. In addition, Transferring Facility's patients shall not be restricted in any way in their choice of emergency care providers.
- 1.11 Referrals. The parties specifically acknowledge and agree that the performance by the parties of their obligations hereunder in no way obligates and is in no way contingent upon, the admission, recommendation, referral, or any other form of arrangement between the parties for utilization by patients or others of any item or service offered by either party or any other entities with which the parties might be affiliated.



## II. FINANCIAL ARRANGEMENTS.

- 2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by Transferring Hospital or Receiving Facility. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Hospital nor the Receiving Facility shall have any liability to the other for billing, collection or other financial matters relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there shall be no compensation or anything of value, directly or indirectly, paid between the parties.
- 2.2 Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least Two Million Dollars (\$2,000,000.00) per occurrence and Four Million Dollars (\$4,000,000.00) annual aggregate to insure each party and its respective Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

## III. TERM AND TERMINATION.

- 3.1 Term. The promises and obligations contained herein shall commence as of the Effective Date, for a term of one (1) year therefrom, and thereafter shall automatically renew for successive periods of one (1) year, subject, however, to termination under Section 3.2 herein.
- 3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:
- a. Written agreement by both parties to terminate this Agreement.
  - b. In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by the non-breaching party, the non-breaching party may terminate this Agreement immediately upon written notice.
  - c. In the event either party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.



- d. Debarment, suspension or exclusion of either party, as set forth in Section 1.7.

3.3 Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

#### IV. MISCELLANEOUS.

- 4.1 Entire Agreement. This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Facility and Transferring Hospital shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.
- 4.2 Changes or Modifications. No change or modification of this Agreement shall be valid unless the same shall be in writing and signed by Receiving Facility and Transferring Hospital. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the person or party against whom charged.
- 4.3 Governing Law. This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Facility or Transferring Hospital arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.
- 4.4 Relationship of the Parties. The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:



Transferring Hospital:

CEO  
Hammond-Henry Hospital  
600 North Collage Avenue  
Geneseo, IL 61254

Receiving Facility:

President/CEO  
OSF Saint Francis Medical Center  
530 N.E. Glen Oak Avenue  
Peoria, IL 61637

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

- 4.5 Limitation of Liability: Rights of Third Parties. It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent or wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law. This Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or against a third party.
- 4.6 Severability. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.
- 4.7 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof.
- 4.8 Interpretation. This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same. Unless the context of this Agreement otherwise clearly requires, references to the plural include the singular and the singular, the plural. The words "hereof," "herein," "hereunder" and similar terms in this Agreement refer to this Agreement as a whole and not to any particular provision of this Agreement. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.

[Signature page follows]

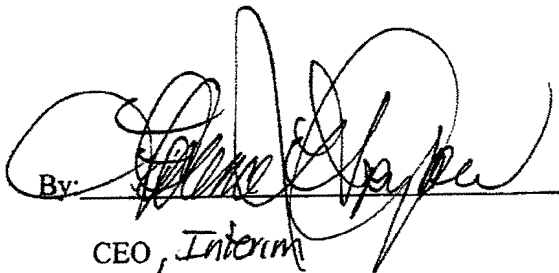


Transfer Agreement  
Hammond-Henry Hospital  
OSF HealthCare System,  
OSF Saint Francis Medical Center  
Page 8

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

TRANSFERRING HOSPITAL:

Hammond-Henry Hospital

By:   
CEO, Interim

Dated: 7/16/2015

RECEIVING FACILITY:

OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, owner and operator of OSF Saint Francis Medical Center and Children's Hospital of Illinois

By:   
Keith Steffen  
President & CEO

Dated: 7/16/15



## EXHIBIT A

### Pediatric Patient Representatives

#### Transferring Hospital:

Laura Domino  
Vice President of Patient Care  
Services  
Hammond-Henry Hospital  
600 N College Ave  
Geneseo, IL 61254  
p 309-944-9101  
c 309-944-7795  
lauradomino@hammondhenry.com

#### Receiving Facility:

Carolyn Henricks RN  
Pediatric Quality Coordinator  
Emergency Department/Clinical Decision Unit  
OSF Saint Francis Medical Center  
530 NE Glen Oak Avenue | Peoria, IL | 61637  
p 309.624.8466/ c 309.635.3695/  
f 309.624.8470  
Carolyn.Henricks@osfhealthcare.org



**TRANSFER AGREEMENT**  
**Between**  
**HAMMOND HENRY HOSPITAL**  
**TRINITY MEDICAL CENTER**

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, by and between Trinity Medical Center, an Illinois not-for-profit corporation (hereinafter referred to as "Receiving Hospital") and Hammond Henry Hospital (hereinafter referred to as "Transferring Facility").

**RECITALS:**

A. The Transferring Facility and the Receiving Hospital desire, by means of this Agreement, to assist physicians in the treatment of patients.

B. The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the parties hereto agree as follows:

**I. DUTIES AND RESPONSIBILITIES.**

1.1 Joint Responsibilities. In accordance with the policies and procedures of the Transferring Facility and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Facility to the Receiving Hospital as long as the Receiving Hospital has bed availability, staff availability, is able to provide the services requested by the Transferring Facility, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Receiving Hospital. In such cases, the Receiving Hospital and the Transferring Facility agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the parties shall comply with all EMTALA requirements with respect to such transfers. Receiving Hospital and Transferring Facility shall meet periodically to review the transfer process, of policies and procedures in order to improve the process, including efficiency, clinical care and patient safety.

1.2 Receiving Hospital. The Receiving Hospital shall accept patients in need of transfer from the Transferring Facility pursuant to the criteria set forth



in Section 1.1. Further, Receiving Hospital shall designate a person to coordinate with Transferring Facility in order to establish acceptable and efficient transfer guidelines.

1.3 Transferring Facility. Transferring Facility shall request transfers of patients to Receiving Hospital pursuant to the criteria set forth in Section 1.1. Further, Transferring Facility shall:

- a. Have responsibility for obtaining the patient's informed consent for the potential transfer to Receiving Hospital, if the patient is competent. If the patient is not competent, the consent of the legal guardian, agent with power of attorney for health care, or surrogate decision maker of the patient shall be obtained.
- b. Notify Receiving Hospital as far in advance as possible of the impending transfer.
- c. Transfer to Receiving Hospital the personal effects, including money and valuables, and information related thereto. Personal effects will be listed and sent with appropriate documentation at the time of the patient transfer.
- d. Affect the transfer to Receiving Hospital through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures. Receiving Hospital's responsibility for the patient's care shall begin when the patient arrives at the Receiving Hospital. Notwithstanding anything to the contrary set forth above, in the event the patient is transferred by Receiving Hospital's Life Flight program, Receiving Hospital's responsibility shall begin when the patient leaves Transferring Hospital's Emergency Department.
- e. Transfer, and supplement as necessary, all relevant medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue the patient's treatment without interruption and to provide identifying and other information, including contact information for referring physician, name of physician(s) at Receiving Hospital contacted with regard to the patient (and to whom the patient is to be transferred), medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical and lab findings, history of the illness or injury, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring Facility, medications administered, known allergies, nursing, dietary information,



ambulation status and pertinent administrative, third party billing and social information.

- 1.4 Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with an handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.
- 1.5 Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional or advertising material.
- 1.6 Standards. Receiving Hospital shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of The Joint Commission, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Hospital. Receiving Hospital shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.
- 1.7 Exclusion/Debarment. Both parties certify that they have not been debarred, suspended, or excluded from participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare and Tricare. In addition, each party agrees that it will notify the other party immediately if it subsequently becomes debarred, suspended or excluded or proposed for debarment, suspension or exclusion from participation in any state or federal healthcare program.
- 1.8 Confidentiality. Receiving Hospital agrees to maintain confidentiality. Receiving Hospital acknowledges that certain material, which will come into its possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties may be damaging to Transferring Facility. Receiving Hospital agrees to hold all such material in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be



required by law and to comply with the Health Insurance Portability and Accountability Act.

- 1.9 Access to Books and Records. Both parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each party will allow the other party reasonable access to such records for audit purposes and also the right to make photocopies of such records (at requesting party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.
- 1.10 Non-Exclusivity. This Agreement does not establish an exclusive arrangement between the parties, and both the Transferring Facility and the Receiving Hospital may enter into similar agreements with other hospitals. In addition, Transferring Facility's patients are not restricted in any way in their choice of emergency care providers.
- 1.11 Regulatory Compliance. The parties hereto agree that nothing contained in this Agreement shall require either party to refer patients to the other party for emergency care services or to purchase goods and services. Neither party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with Medicare and Medicaid programs.

## II. FINANCIAL ARRANGEMENTS.

- 2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by Transferring Facility or Receiving Hospital. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Facility nor the Receiving Hospital shall have any liability to the other for billing, collection or other financial matters relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the parties.
- 2.2 Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars (\$1,000,000.00) per occurrence and Three Million Dollars (\$3,000,000.00) annual aggregate to insure such party and its Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in



connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

### III. TERM AND TERMINATION.

- 3.1 Term and Automatic Renewal. The promises and obligations contained herein shall commence as of September 1, 2013 for a term of one (1) year therefrom and shall automatically renew pursuant to like terms unless one party shall give the other party a notice of intent not to renew thirty (30) days prior to the expiration of the initial term, or the then-existing term, subject, however, to termination under Section 3.2 herein.
- 3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:
- a. Written agreement by both parties to terminate this Agreement.
  - b. In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by either party, such other party may terminate this Agreement immediately with written notice of such termination to the breaching party.
  - c. In the event either party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.
  - d. Debarment, suspension or exclusion, as set forth in Section 1.7.
- 3.3 Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

### IV. MISCELLANEOUS.

- 4.1 This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Hospital and Transferring Facility shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.
- 4.2 This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit



of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Hospital or Transferring Facility arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.

- 4.3 The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Receiving Hospital:

Richard Seidler  
Chief Executive Officer  
Trinity Regional Health System  
2701-17th Street  
Rock Island, IL 61021

Transferring Facility:

Hammond Henry Hospital  
Chief Executive Officer  
600 N. College Ave,  
Geneseo, IL 61256

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

- 4.4 It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or against a third party. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.
- 4.5 This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or



conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same.

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

RECEIVING HOSPITAL:

Trinity Medical Center

By: \_\_\_\_\_

Richard A Seidler  
President & CEO

Dated: \_\_\_\_\_

8/26/13

TRANSFERRING FACILITY:

Hammond Henry Hospital

By: \_\_\_\_\_

Brenda S. Allen

Dated: \_\_\_\_\_

8-16-13



## PATIENT TRANSFER IN AGREEMENT

This Patient Transfer In Agreement (the "Agreement") is made and entered effective this 1st day of June, 2016 by and between GENESIS HEALTH SYSTEM d/b/a GENESIS MEDICAL CENTER, DAVENPORT ("Genesis") and HAMMOND HENRY HOSPITAL ("Transferring Facility") (hereinafter individually "Party" or collectively "Parties").

In accordance with the terms set forth below, Genesis agrees to admit patients received from Transferring Facility.

- I. Procedures. In order to facilitate timely transfer of patients and promote continuity of care and treatment appropriate to the needs of the patients, Genesis and Transferring Facility agree:
  - a. Transfers shall take place upon the recommendation of an attending physician or advanced registered nurse practitioner who is a member of the medical staff or maintains appropriate privileges at Genesis and certifies that the transfer is medically appropriate;
  - b. Arrangements shall be made with a physician member of the Genesis Medical Staff to accept the patient before the patient is transferred;
  - c. The patient shall be admitted and cared for by Genesis in accordance with the policies, rules and regulations of Genesis and its medical staff;
  - d. Genesis reserves the right to decline a transfer, in accordance with applicable laws, when there are inadequate resources (capacity, space, staffing, level of care), or the presence of the patient in the facility would be dangerous to other patients;
  - e. Transferring Facility shall:
    1. Arrange for appropriate transportation of the patient;
    2. Transfer the personal effects, money and valuable information relating to the same and be responsible therefore until signed for by a representative of Genesis;
    3. Obtain required consents or certifications from the Attending Physician or ARNP; and
    4. Arrange for a copy of the patient's medical record, including lab work and x-rays from Transferring Facility to be delivered to Genesis with the patient.



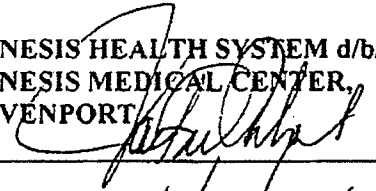
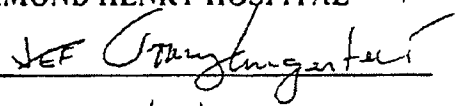
- II. Insurance. Genesis and Transferring Facility shall each carry professional and general liability insurance in minimum limits of \$1,000,000 per occurrence and \$3,000,000 aggregate or provide for self-insurance with the same limits and each shall, if requested by the other, promptly submit adequate proof of the existence of such coverage.
- III. Term and Termination. This Agreement shall be effective as of the date first written above and remain in effect for an initial term of one (1) year. Thereafter, this Agreement shall automatically renew for successive one (1) year terms until terminated in accordance with the provisions herein (individually and collectively, the initial term and each renewal term shall be referred to as the "term" or "Term"). Either Party may terminate this Agreement at anytime by providing the other Party with at least thirty (30) days advance written notice. In addition, either Party may terminate this Agreement immediately if the other Party: (1) becomes ineligible for reimbursement from a federal health care program; or (2) has any license or registration in the State in which it is located revoked, suspended, or not renewed; or (3) fails to carry the requisite insurance coverage as provided for herein.
- IV. Compliance With Laws.
- a. Each Party shall comply with all applicable Federal and State laws prohibiting discrimination against persons on account of race, sex, color, age, religion, national origin, disability, ability to pay or any other protected class.
  - b. Each Party certifies that it and its employees and agents are not excluded, debarred, or suspended from or otherwise ineligible to participate in any Federal and State health care program, including Medicare and Medicaid programs.
  - c. Nothing in this Agreement shall be construed as an offer or payment by one Party to the other Party (or any affiliate of the other Party) of any remuneration for patient referrals, or for recommending or arranging for the purchase, lease or order of any item of service for which payment may be made in whole or in part by Medicare or Medicaid. Any payments made by and between the Parties is intended to represent the fair market value of the supplies and/or services to be rendered by the respective Party hereunder and are not in any way related to or dependent upon referrals by and between Facility and Hospital. Furthermore, it is the stated intent of both parties that nothing contained in this Agreement is or shall be construed as an endorsement for any act of either Party.
  - d. Each Party shall comply with all relevant Federal, State and local laws as well as with any applicable rules, regulations and standards promulgated by The Joint Commission and the Medicare and Medicaid programs.
- V. Choice of Law. This Agreement shall be governed and construed in accordance with the State of Iowa. The county in which Genesis is located shall be the sole, proper venue for



any litigation proceedings between the Parties which arises out of or in connection with any right, duty or obligation under this Agreement.

- VI. Non-exclusivity. Nothing in this Agreement shall be construed as limiting the right of either Party to affiliate or contract with any other hospital or nursing facility on either a limited or general basis while this Agreement is in effect.
- VII. Amendments. This Agreement may only be amended, modified, waived or discharged by the written consent of both Parties.
- VIII. Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be a waiver of any subsequent breach of the same or other provision hereof.
- IX. Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.
- X. Entire Agreement. This Agreement constitutes the entire Agreement of the parties with respect to the subject matter hereof, and all prior and contemporaneous understandings, agreements and representations, whether oral or written, with respect to such matters are superseded.
- XI. Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be an original, but all of which shall be deemed to constitute one instrument.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the date first written above.

GENESIS HEALTH SYSTEM d/b/a GENESIS MEDICAL CENTER, DAVENPORT	TRANSFERRING FACILITY HAMMOND HENRY HOSPITAL
By 	By 
Date: 6/21/2016	Date: 6/17/16
Print Name: Jackie Lohalt	Print Name: JEFFREY LINGERFELT
Title: VP Patient Services/CNE	Title: CEO
Address: 1227 East Rusholme Street Davenport, IA 52803 Phone: 563-421-6519	Address: 600 N. College Avenue Geneseo, IL 61254 Phone: 309-944-9102



### SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

#### Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

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.

Name and Location of Facility	Illinois License Identification Number	Accreditation Agency & Number
Hammond-Henry Hospital	0000893	DNV-GL 179406-2015-
Home Health Services of Hammond-Henry Hosp	1003292	Accreditation Commission for Health Care

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.

By the notarized signatures on the Certification pages of this application the authorized representatives of Hammond-Henry Hospital attest that there have been no adverse actions during the three years prior to filing this application against any facility owned and/or operated by Hammond-Henry Hospital by any regulatory agency which would affect its ability to operate a license entity.

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.**

By the notarized signatures on the Certification pages of this application the authorized representatives of Hammond-Henry Hospital hereby authorize the Health Facilities and Services Review Board and the Illinois Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

4. If, during a given calendar year, an applicant submits more than one application for permit, 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 the information has been 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.

##### **Exception for Filing Multiple Certificates of Need in One Year**

Not Applicable. This is the first certificate of need filed by Hammond-Henry Hospital in 2016.





**Illinois Department of  
PUBLIC HEALTH**

HF110765

**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	ID NUMBER
6/30/2017		0000893
<b>Critical Access Hospital</b>		
<b>Effective: 07/01/2016</b>		

**Hammond-Henry Hospital**  
**600 N. College Avenue**  
**Geneseo, IL 61254**

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# CERTIFICATE OF ACCREDITATION

Certificate No.:  
179406-2015-AHC-USA-NIAHO

Initial date:  
5/20/2015

Valid until:  
5/20/2018

This is to certify that:

## **Hammond Henry Hospital**

600 N. College Ave., Geneseo, IL 61254

has been found to comply with the requirements of the:

## **NIAHO® Hospital Accreditation Program**

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:  
DNV GL - Healthcare  
Katy, TX

  
Patrick Morine  
Chief Executive Officer







**Illinois Department of  
PUBLIC HEALTH**

HF110151

**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	ID NUMBER
3/31/2017		1003292

**Home Health Agency**

\*\*\*\*\* Skilled Nursing \*\*\*\* Speech Therapy \*\*\*\*\*  
\*\*\*\*\* Physical Therapy \*\*\* Occupational Therapy \*\*\*\*\*  
\*\*\*\*\* Medical Social Services \*\*\* Home Health Aides \*\*\*\*\*

Home Hlth Svcs of Hammond Henry Hosp  
600 N. College Avenue  
Geneseo, IL 61254

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**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.**

The discontinuation of obstetrics services at Hammond-Henry Hospital will not impact other area providers as there is availability of Obstetric beds in the Level II and Level III facilities that already serve Stark and Henry County. Obstetric emergencies will be cared for at Hammond-Henry Hospital emergency department services. Appropriate education, equipment and competency will be provided to the Emergency Department and Emergency Medical Services for OB treatment, triage and transfer. Hammond Henry Hospital has patient transfer agreements with UnityPoint Health in Moline, Genesis Medical Center Davenport Campus and Illini Campus, and OSF St. Francis Medical Center in Peoria.

**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.**

Hammond-Henry Hospital has no knowledge regarding cross subsidization of 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 the applicant.**

The discontinuation of the obstetric services will have no impact on other area safety net providers in our community.

Hammond-Henry Hospital has an established history of providing safety net services to its community. In FY2016, Hammond-Henry provided nearly \$5,436,075. (Community Benefits Data Report 2015- Attachment 40, Exhibit 1)

At Hammond-Henry our community involvement and mission are both priorities for the organization and its leadership team. Hammond-Henry's board of directors and our leadership team are devoted to community advocacy and community health initiatives. Hammond-Henry's Strategic Plan has several pillars and one is "Community" – It is a strategy of Hammond-Henry Hospital to seek innovative solutions to community needs through community, school, and business teams and bring the community and HHH together through volunteerism and support in the spirit of improving the overall quality of life for residents in our service area. A monthly report is provided to the board of directors of Hammond-Henry's community involvement. Members ranging at the executive level, managers, education department, and many of our staff are committed to community health initiatives and events.

**Hammond-Henry provides the following support to the area communities:**

**Sponsors**

- a. HHH Community Health Fair
- b. Community Health Screening at discounted rate(2x/ year – blood chemical profiles, free screenings- colorectal cancer, blood pressure checks, bone density, & body composition)
- c. Monthly Women' & Men's Health Series – (a variety of health topics are presented)
- d. Relay for Life, Junior Achievement Bowl-a-thon, Heart Walk, Senior Expo
- e. 4 – Community Blood Drives
- f. Local race events – Heart Walk, Maple City 4, Jingle Run, Bark in the Park

**Support Group & Other Meetings**

- a. Cancer survivors
- b. Cardiac Rehab
- c. Alzheimer's
- d. Living with Loss
- e. Geneseo Ministerial Assoc.



**Nurse Educators / Dietary Manager**

- a. CPR/AED training
- b. First Aid classes Present health topics at school or other organizations (*nutritional programs, hand washing, backpack awareness, diabetes, skin cancer awareness, stroke awareness, etc*)

**Volunteer Program**

307 –Active Volunteers –Total hours volunteers to benefit HHH–17,936(Attachment 40, Exhibit 2)

**Miscellaneous**

- a. Teddy Bear Clinic – (1<sup>st</sup> graders experience a tour of the hospital & providing mock demonstrations and their teddy bears receive a cast or stitches. This experience helps children to have less anxiety of the hospital)
- b. Free2Play program – for area schools
- c. Baseline concussion Testing
- d. Provide flu vaccinations for all employees & volunteers
- e. E-newsletter is published bi-monthly with updates of hospital events, health news, and services.
- f. Website provides a health news search library
- g. Face book homepage – announces events, health news and services

**Behavioral HealthCare and Access**

- a. Contracted services with UnityPoint Robert Young Center (tele-psychiatry emergency department)
- b. Contracted services with Bridgeway
- c. Full time Social Service access

**Summary**

The discontinuation of the Level I obstetric service line at Hammond-Henry Hospital will not impact the safety net services as Obstetric Level II services are offered within less than 35 miles from within the primary and secondary market. Hammond-Henry Hospital is committed to meeting the community's needs and expectations as a safety net provider now and into the future.

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year 2014	Year 2015	Year 2016
Inpatient			
Outpatient			
<b>Total</b>	<b>116</b>	<b>63</b>	<b>240</b>
Charity (cost in dollars)			
Inpatient			
Outpatient			
<b>Total</b>	<b>278,000</b>	<b>153,000</b>	<b>65,000</b>



MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient	199	252	202
Outpatient	2,313	2,347	2,838
<b>Total</b>	<b>2,512</b>	<b>2,599</b>	<b>3,040</b>
Medicaid (revenue)			
Inpatient	2,191,088	2,939,451	2,690,094
Outpatient	4,777,025	5,663,407	6,112,911
<b>Total</b>	<b>5,968,113</b>	<b>8,602,858</b>	<b>8,803,005</b>

Attachment 40

Exhibit 1 - Community Data Report

Exhibit 2 – Volunteer &amp; Auxiliary Services Report



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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
COMMUNITY BENEFITS DATA REPORT - 2015**

In accordance with the Illinois Health Facilities Planning Act [20 ILCS 3960/], this is a formal request for full, complete and accurate information as stated herein. Failure to respond within the required time frame may result in fines and sanctions as mandated by the Act.

This report must be completed and submitted by August 5, 2016.  
No Exceptions or Extensions will be allowed.

Facility Information	
Hospital Name	Hammond Henry Hospital
Hospital Address	600 N. College Avenue
Hospital City	Geneseo
Contact Person	Kathy Tank
Telephone	309-944-9102
Email	kathytank@hammondhenry.com

Indicate the Starting and Ending Dates of Your Reporting Period (mm/dd/yyyy)

Starting [Help] 06/01/2015

Ending [Help] 05/31/2016

**Community Benefits:**

Report the amounts (rounded to nearest dollar) spent on any community benefit programs offered by your facility.

**Community Benefit Definitions**

Community Benefits	Amount
a. Language Assistant Services	752
b. Government Sponsored Indigent Health Care	4,162,116
c. Donations	12,501
d. Volunteer Services	0
i. Employee Volunteer Services	7,479
ii. Non-Employee Volunteer Services	147,972
e. Education	3,191
f. Government Sponsored Program Services	0
g. Research	0
h. Subsidized Health Services	0
i. Bad Debts	1,091,764
j. Other Community Benefits (please explain below)	10,300

If you have any comments or explanations, please enter them in the space below.

Hospital's website provides a health news search library. Promote a free women's & men's health series and a Free2Play program. Health screening is provided to the public at a discounted rate, plus free colorectal screenings.

Continue to the next page to submit your report.

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Attachment 40



**Hammond-Henry Hospital  
2015 Volunteer Services and Auxiliary  
Activity Report**

In-house volunteers	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
Adult	239	247	240	239	238	248	225	223	197	188
Junior Volunteers	68	63	58	52	55	51	63	65	62	56
<b>Total</b>	<b>307</b>	<b>310</b>	<b>298</b>	<b>291</b>	<b>293</b>	<b>299</b>	<b>288</b>	<b>288</b>	<b>259</b>	<b>244</b>

**New adult volunteers trained in 2015 - 27**

Auxiliary Members	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
Active	143	152	132	143	152	144	143	127	135	126
Associate	20	24	14	19	22	27	20	15	19	14
Sustaining	18	21	10	20	20	10	11	12	15	14
Life	101	99	93	92	87	78	65	71	63	51
<b>Total</b>	<b>282</b>	<b>296</b>	<b>249</b>	<b>274</b>	<b>281</b>	<b>259</b>	<b>239</b>	<b>225</b>	<b>232</b>	<b>205</b>

**Total hours**

**17,936 hours volunteered to benefit HHH**

(reported as of 12-31-2015)

	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
<b>Total hours</b>	<b>17,936</b>	<b>17,921</b>	<b>18,032</b>	<b>18,594</b>	<b>18,378</b>	<b>17,185</b>	<b>17,235</b>	<b>16,591</b>	<b>16,497</b>	<b>16,052</b>

**Economic Impact - Total Value of volunteer time\* \$413,784 (8.6 FTE's)**

(\*as reported by Independent Sector & Bureau of Labor statistics)

**Volunteer shifts assigned to specific departments each month**

Surgery	22 shifts/ 18 volunteers
HIM	9 shifts/ 2 volunteers
Long Term Care - Activities	20 shifts/14 volunteers
LTC summer youth volunteers **	see below
Human resources	5 shifts/ 1 volunteer
Home Health	2 shifts/ 1 volunteer
Housekeeping	8 shifts / 1 volunteer

**Total assigned to specific departments: 66 shifts/ 37 volunteers**

**Volunteers assigned to general areas (serving several departments) each month**

in-house couriers	45 shifts/38 volunteers
out-of-house couriers	49 shifts/ 14 volunteers
shuttle drivers	45 shifts/ 35 volunteers
gift shop	68 shifts/48 volunteers
gift shop flowers	5 shifts/ 8 volunteers
specialty physicians clinics (CVM)	21 shifts/15 volunteers
information desk - front	45 shifts/21 volunteers
information desk - east	<u>45 shifts/23 volunteers</u>

**Total assigned to general areas: 323 shifts/202 volunteers**

**Monthly total of 389 volunteer shifts filled each month with 239 volunteers.**



Teen volunteers (summer -- 9 weeks)

46 assigned to LTC Activities 432 shifts/ 46 volunteers

10 assigned to other depts. 90 shifts/10 volunteers

Total number of teens during the summer: 522 shifts/56 volunteers

#### Notes about volunteer services in 2015

- Fifteen teen (high school) volunteers assist in LTC activities on Saturday mornings. An additional teen volunteer from the Life Skills class at GHS comes on Tuesdays and Thursday afternoons.
- Volunteer couriers to Colona Clinic continue M-F with pick-ups at 11 am and 7 pm. They bring lab work, mail supplies and this year added the Colona Clinic deposit paperwork.
- Six volunteers are knitting prostheses for cancer rehab patients
- One AmeriCorps volunteer: 300 hours (10 weeks in the summer) and assisted with the Junior Volunteer Program.
- Twenty 5<sup>th</sup> grade girls participated in a science program for young women (2/2015) sponsored by the University of Illinois Extension Service, learning about science-related careers in a hospital. Hands-on experiences were held in lab, emergency, surgery, imaging and physical therapy departments.
- Gift Shop total sales in 2015: \$57,586  
(in 2014: \$55,537; 2013: \$57,643; 2012: \$51,793; in 2011: \$57,481)

#### Items purchased by Auxiliary volunteers in 2015

Bladder scanner	\$ 11,525
Wheelchairs (4)	\$ 1,600
Cancer rehab materials	\$ 500
Breast cancer awareness materials	\$ 208
Pelvic floor model	\$ 188
Scholarships	<u>\$ 14,000</u>
Total	\$28,021

\*\*\* Purchase of the other items in the 2015 pledge were postponed until 2016.



**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 41.

CHARITY CARE			
	Year 2014	Year 2015	Year 2016
<b>Net Patient Revenue</b>	<b>32,947,320</b>	<b>34,934,382</b>	<b>36,158,343</b>
Amount of Charity Care (charges)	277,975	152,744	65,216
Cost of Charity Care	125,433	65,069	27,130