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October 27, 2015

VIA EMAIL AND FEDEX

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

Re: **Opposition to Project 15-044, Transformative Care**

Dear Ms. Avery:

On behalf of various facilities that will be negatively impacted, I am submitting for consideration by the Illinois Health Facilities and Services Review Board ("HFSRB" or "Board") these comments **in opposition** to Project 15-044 (the "Project") which proposes a new 98 bed long term care facility in McHenry County.

No Need for Beds in HSA 8

Health Service Area 8 ("HSA 8") has 8724 beds with a projected bed need of 8015 in 2018. There is an excess of 836 beds in the Health Service Area, although McHenry County which is within the HSA does have a projected need for beds by 2018. This is the sole basis for the applicants' project, but it is wholly unsupported due to the fact that the project's *30 minute service area* includes facilities in primarily Lake County, and significant excess capacity exists in the service area. The applicant ignores the overall health service area excess beds and the excess capacity in its proposed 30 minute service area and erroneously relies on the McHenry County alleged need, because that is the only straw to rely on to possibly support the proposed facility. While the applicant relies on a stated need for beds in McHenry County this alleged need is belied by the fact that:

- **8 out of 11** of the facilities **within the 30 minute service area of the proposed new facility have unutilized capacity** that could meet any growing need for services in the service area; and

- the purported need in McHenry County is irrelevant to the applicants' proposed service area and is based on general long term care need, but the proposed facility will serve only patients requiring short term rehabilitation, who will be primarily Medicare Part A patients further bolstering the lack of need as the Medicare Part

A patient population within the service area has actually **declined** from 2013 to 2014.

Moreover, the applicants ignore the maldistribution of services throughout the Health Service Area, which is evidenced by the number of facilities that are within the 30 minute service area of the proposed facility that are not at target utilization. The application glosses over many key factors which indicate this facility is unnecessary to provide access to quality care.

Some of the necessary information that is missing or incorrect includes:

- A realistic assessment of the impact the Project will have on existing facilities including:
  - The impact on occupancy rates;
  - The effect on available staffing;
  - The impact of payer mix;
  - The duplication of services created by this Project;
- An accurate assessment of the area providers who service the Medicaid population;
- Necessary information regarding the provision of Medicaid and charity care.

Existing Facilities /Negative Impact on Medicaid Service

The applicants state outright within the application that they will serve short stay rehabilitative need patients and patients referred from the Hospital, all of which would be primarily Medicare Part A. Indeed, their application is based upon historical referrals of mostly Medicare Part A patients (2,490 – all of which are currently being referred to existing area providers) and anticipated patient days (32,193). This would suggest an ALOS of 13 days, if all patient referrals materialized. This short LOS is typical for a rehab focused LTC facility, and due to this shorter LOS, these facilities require a great deal of patient admission volume to keep the facility at capacity. The volume for the proposed facility will all come from existing Part A Medicare volume within the service area. In other words, the proposed facility will cannibalize the lucrative Part A Medicare patients from existing facilities. While the applicants may argue there will be growth in this patient cohort, this argument is not supported by the last 3 years historical volume. In fact, the Medicare patient population in the service area declined in 2014 from 2013 levels. This "skimming" of Medicare Part A patients will dramatically impact the other area facilities bottom lines (see attached). The existing facilities rely heavily on reimbursement for Medicare Part A patients to support capital improvements and to provide quality care to all patients, both Medicare and Medicaid. A diversion/loss of this revenue may result in fewer Medicaid beds being available or even the closure of some of these facilities, which are barely operating at a sustainable profit margin now. In sum, the proposed project's skimming 65% of the Medicare patient referrals from existing facilities that have capacity will be devastating to area providers and Medicaid recipients, who will lose access to quality care. The applicants' project, which proposes no Medicaid beds based on its service model, will decimate the other

existing area facilities, which do offer Medicaid beds, ability to provide care, invest capital, recruit staff and serve the **entire** population, not just the Medicare population with higher reimbursement rates. While the applicants may state growth will allow them to provide their service without negative impact, this argument fails because:

- There are quality facilities within 10 minutes from the site of the proposed new facility below target occupancy which primarily serve short term rehabilitative needs patients, as well as private pay and Medicaid patients;

- The trend toward reimbursement is for shorter stays due to mandates from ACOs and managed care companies resulting in shorter lengths of stays which will more than offset any alleged growth in the service area;

- The State's own projections show a decreased need for beds in 2018 versus the need for more beds in the service area as proposed by the applicants;

- The recent three year available information shows no growth in the Medicare patient population at area facilities;

- The trend with respect to shorter length of stays is also to provide and pay for only OP care, which in this case is in home therapy and related services for patients requiring short term rehab. It is more efficient, less costly and gets the patient home more quickly which in many circumstances is a safer environment. Building a new facility when there is already excess capacity in this environment is nonsensical.

Given these factors, adding more capacity for this type of service is wholly unwarranted and contrary to the purposes of the Planning Act.

Staffing

Staffing facilities with quality staff is a constant struggle due to the lack of available professionals. The Application fails to address the effect that recruitment of staff from existing long term care facilities and area hospitals in the community will have on those facilities.

Given the State-wide shortage of professional nursing staff, including RNs, LPNs and CNAs, and also physical, speech and occupational therapists, all of whom will be required for this facility we are concerned that the establishment of this Project would have on existing staffing levels.

Applicant Confusion/Should Symphony Post Acute Care Network be a Co-Applicant?

The referral letters within the application indicate Symphony Acute Care Network is the applicant. It is not, nor is it a co-applicant. The physician referral letters state they are providing referrals on behalf of "Symphony". In addition, Symphony facilities are referred to in the

"Background" section of the application The application states "Through Symphony Post Acute Care Network, the project is related to other nursing homes", and there is reference to Symphony throughout the application as a provider that will somehow be involved in the operations of the proposed facility. If this is the case, why is Symphony not a co-applicant and/or its relationship to the project not addressed specifically?

Need Over Maldistribution

The applicants repetitive reference to need in McHenry County are designed to distract from the actual stated over bedding in HSA 8 and underutilization of facilities within the applicants' proposed service area. In fact McHenry County is irrelevant to the project, as the service area includes facilities in Lake, McHenry and even Cook County. The applicants ignore the negative impact this facility will have on existing facilities and the duplication of service that will result if the project is approved. The Application laments the average number of skilled nursing beds per person within McHenry County, but McHenry County is irrelevant to the project. The underutilization of facilities in the area of the proposed project supports the State's findings, and shows no need in that area and that approval of this project will further an exacerbation of maldistribution of services within the HSA.

Conclusion

Given the HFSRB goal of orderly and economic development to provide access to care without unduly burdening existing providers with capacity, we respectfully request the Board first consider the potential for better utilization and expansion of the existing facilities in the service area and better distribution overall within the HSA by denying this application. We also urge the Board to consider the impact the proposed facility, dedicated to serving lucrative reimbursement Part A Medicare patients, will have on area facilities that already serve this population, and also serve a significant number of Medicaid patients. These facilities rely heavily on the higher reimbursed Medicare Part A patient population to subsidize losses sustained in serving Medicaid patients so as to allow them to be able to continue to serve these residents.

See attached for further discussion of application deficiencies.

Sincerely,

Clare Connor Ranalli

Clare Connor Ranalli

cc: Mike Constantino

Re: Transformative Health of McHenry Certificate of Need Application Review
Project 15-044

General Issues, Non-Compliant Referral Letter and Staffing Information

1. Throughout the CON Application, Symphony Post Acute Care Network is mentioned several times. Its facilities are used in the "Background" section and it is referred to as "the facility" in the physician referral letters. Nonetheless, there is insufficient information provided regarding the nature of this entity and its relationship to the project or the applicants.

2. The equipment cost for a 98 bed new facility is stated to be under $900,000.00 which seems low.

3. The applicants fail to address the Alden Huntley facility already approved, but yet to be constructed.

4. The applicants erroneously claim only 65% of the beds in the service area are Medicaid beds. They erroneously exclude Wauconda and Lexington (see attached). With these beds added in 85% of beds have Medicaid capacity.

5. The applicants list some "related" facilities in the organization section but fail to mention these facilities Medicaid patients/revenue or Medicare star ratings.

Criterion 1125.540, Part 1: Document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years. Documentation of the referrals shall include: resident/patient origin by zip code; name and specialty of referring physician or identification of another referral source; and name and location of the recipient LTC facility. (p. 119)

In response to this question, the Applicants provided 11 letters from Centegra hospital and local physicians) saying that they would refer to the new facility. There was no mention of the specific cases that were referred historically and where they were referred, whether the referrals were for general long term care or rehabilitative long term care, or zip code origin of the referrals. In addition, the Centegra Huntley referral letters completely ignore the yet to be constructed Alden Huntley LTC facility. As a result it is difficult to ascertain where the historical referrals were seen in the service area, obfuscating the negative impact this project will have on area providers. Although the applicants cite HIPAA concerns for a lack of information, it does not appear they even attempted to satisfy this requirement.

Criterion 1125.590, Part 1: For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. (p. 187)

In response to this question, the Applicants simply state that nursing is the only category of service applicable. Obviously this is not the case, particularly since this proposed a rehabilitative focused LTC facility. There is no mention of physical, speech or occupational therapists, LPNs, CNAs or social workers. Nor is there a mention to how the applicant will find and employ these individuals in a way that will not poach from other providers of service, whether LTC or hospital facilities. This section is not at all responsive to the criterion, and fails to in any way show that needs were considered or that proper staffing may be achieved.

Criterion 1125.320, Part 6: Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate. (p. 60)

The Applicants fail to provide any quantifiable goals for the new project. This is curious because the project is allegedly to provide care in a way that it does not exist, despite a facility located within 7 minutes of the proposed project site that offers the exact service the applicants state will be "transformative".

Criterion 1125.330, Part 1: Alternative options must include a joint venture or similar arrangement. (p. 76)

The Applicants fail to provide an option that involves a joint venture or similar arrangement. Although they intimate that the chosen project plan satisfies the joint venture requirement, the regulations clearly state that the alternative options must include a choice of this nature.

Criterion 1125.330, Part 1: Alternative options must include a larger project. (p. 82)

Amongst the alternative options provided by the Applicants was a larger project. Although the Applicants provided a section for "Financial Benefits," they failed to provide sufficient detail and did not discuss long and short term benefits, as required by the regulations.

Summary of General Long-Term Nursing Care Beds and Need by Planning Area				
Health Service Area 8				
PLANNING AREA	EXISTING BEDS	PROJECTED BEDS NEEDED - 2018	ADDITIONAL BEDS NEEDED	EXCESS BEDS
Kane County	3064	2705	0	359
Lake County	4663	4186	0	477
McHenry County	997	1124	127	0
HSA 8 TOTALS	8724	8015	127	836

ServiceArea 2012

FACILITY NAME	LICENSED BEDS	OCCUPANCY PERCENTAGE	AVG. MEDICARE PATIENTS PER DAY	AVG. MEDICAID PATIENTS PER DAY	NET INCOME	MEDICARE REVENUE - (A)
Alden Terrace of McHenry Rehab	316	64.15%	23.68	167.24	$ (1,732,544)	$ 3,672,850
Crossroads Care Center Woodstock	115	72.68%	19.42	59.44	$ (206,365)	$ 3,012,400
Crystal Pines Rehab & HCC	114	**93.87%**	23.25	61.48	$ 319,048	$ 3,606,975
Fair Oaks Health Care Center	51	79.46%	10.83	5.76	$ (343,247)	$ 1,680,025
Heartstone Manor	75	39.73%	10.67	20.18	$ 322,210	$ 1,654,950
Springs at Crystal Lake	97	64.43%	41.08	-	$ 1,119,515	$ 6,372,025
Valley Hi Nursing Home	128	**94.54%**	32.11	64.93	$ (79,750) **(B)**	$ 4,981,425
Wauconda Healthcare and Rehab	135	84.67%	33.12	48.60	$ 270,400	$ 5,137,825
Hillcrest Retirement Village	144	**92.53%**	21.01	99.28	$ (168,049)	$ 3,259,750
Lexington of Lake Zurich	203	**92.60%**	44.22	130.20	$ (1,332,584)	$ 6,859,925
Prairieview Nursing Unit	20	***NO INFORMATION AVAILABLE***				
	1,398	**77.87%**	**259.39**	**657.11**	**(1,831,366.00)**	**40,238,150.00**

ServiceArea 2013

FACILITY NAME	LICENSED BEDS	OCCUPANCY PERCENTAGE	AVG. MEDICARE PATIENTS PER DAY	AVG. MEDICAID PATIENTS PER DAY	NET INCOME	MEDICARE REVENUE - (A)
Alden Terrace of McHenry Rehab	316	58.52%	12.64	154.45	$ (2,442,316)	$ 1,960,780
Crossroads Care Center Woodstock	115	82.14%	24.75	60.21	$ 517,085	$ 3,839,344
Crystal Pines Rehab & HCC	114	88.53%	24.32	64.38	$ 361,108	$ 3,772,640
Fair Oaks Health Care Center	51	82.02%	17.33	5.65	$ 59,767	$ 2,688,975
Heartstone Manor	75	65.46%	20.09	18.54	$ (366,509)	$ 3,116,461
Springs at Crystal Lake	97	58.54%	44.66	-	$ 602,670	$ 6,928,350
Valley Hi Nursing Home	128	**94.50%**	28.44	57.34	$ (234,195) **(B)**	$ 4,411,755
Wauconda Healthcare and Rehab	135	80.29%	31.05	45.82	$ 134,306	$ 4,816,950
Hillcrest Retirement Village	144	87.50%	20.96	93.12	$ (139,658)	$ 3,252,100
Lexington of Lake Zurich	203	**90.61%**	42.25	132.18	$ (18,591)	$ 6,554,350
Prairieview Nursing Unit	20	***NO INFORMATION AVAILABLE***				
	1,398	**78.81%**	**266.51**	**631.68**	**(1,526,333.00)**	**41,341,705.00**

ServiceArea 2014

FACILITY	LICENSED	OCCUPANCY	AVG. MEDICARE	AVG. MEDICAID		MEDICARE

NAME	BEDS	PERCENTAGE	PATIENTS PER DAY	PATIENTS PER DAY	NET INCOME	REVENUE (A)
Alden Terrace of McHenry Rehab	316	38.60%	11.72	86.60	$ (1,992,712)	$ 1,817,300
Crossroads Care Center Woodstock	115	81.69%	21.21	61.46	$ 1,321,809	$ 3,289,500
Crystal Pines Rehab & HCC	114	85.23%	24.70	61.39	$ 378,057	$ 3,830,950
Fair Oaks Health Care Center	51	85.16%	20.21	5.00	$ 314,602	$ 3,134,800
Heartstone Manor	75	65.60%	12.20	23.20	$ (120,085)	$ 1,892,525
Springs at Crystal Lake	97	63.75%	52.38	-	$ 461,826	$ 8,125,575
Valley Hi Nursing Home	128	**95.82%**	25.13	47.81	$ (8,884) **(B)**	$ 3,898,525
Wauconda Healthcare and Rehab	135	70.34%	28.68	44.79	$ (1,039,788)	$ 4,448,900
Hillcrest Retirement Village	144	84.19%	20.99	87.06	$ 33,344	$ 3,256,350
Lexington of Lake Zurich	203	**91.92%**	44.50	125.25	$ 1,232,688	$ 6,903,275
Prairieview Nursing Unit	20	***NO INFORMATION AVAILABLE***				$ -
	1,398	**76.23%**	**261.71**	**542.55**	**580,857.00**	**40,597,700.00**

NOTE: Above information obtained from the State of Illinois Medicaid Cost Reprts.

(A) - Based on Average Daily Medicare Rate of $425.00.

(B) - After adjusting for non-facility related income.

Based on the above tables if the applicant achieves their 90% utilization rate

Number of beds	98.00
	X .90
90% occupancy	**88.20**
	X 365 Days
Total Days	**32,193**
Average Medicare Rate Per Day	X $425.00
	$ 13,682,025

Percentage of All Medicare Revenue **33.70%**

Total all facilities Average Medicare Days	**261.71**	**D35**
Total Average Medicare Days Anticipated By Applicant	**88.20**	**B46**
Total Percentage of All Medicare Days Available in Market Area	**33.70%**	

Nursing Homes in Illinois

Who Regulates Nursing Homes?
A Listing of Illinois Nursing Homes
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Centers for Medicare and Medicaid Services Nursing Home Database
Quarterly Reports of Nursing Home Violation
Illinois Law on Advance Directives
Nursing Homes with No Certification Deficiencies
Nursing Home Care Act
Illinois Health Care Worker Registry
Centers for Medicare and Medicaid Services Nursing Home Quality Initiative

Facility Information

WAUCONDA HEALTHCARE AND REHAB

176 THOMAS COURT
WAUCONDA IL 60084

ADMINISTRATOR: CHERYL HAHN
TELEPHONE: 847-526-5551

Licensee ID	:0044859
Facility ID	:6009435
Skilled beds	:135
Intermediate beds	:0
Icf-dd beds	:0
Shelter Care beds	:0
Community Living beds	:0
Under 22 beds	:0
Medicare beds	:56
Medicare/Medicaid beds	:79
Medicaid beds	:0
Fax	:847-526-7549
County	:Lake
Medicare Certification Number	:14-5887
Medicare Skilled Certification Number	:
Medicaid ICF/DD Certification Number	:
Medicaid DD Certification Number	:
Medicaid Swing Bed Certification Number	:

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Facility Information

LEXINGTON OF LAKE ZURICH

900 SOUTH RAND ROAD
LAKE ZURICH IL 60047

ADMINISTRATOR: PAULINE CONSTANTINO
TELEPHONE: 847-726-1200

Licensee ID	:0039768
Facility ID	:6014138
Skilled beds	:203
Intermediate beds	:0
Icf-dd beds	:0
Shelter Care beds	:0
Community Living beds	:0
Under 22 beds	:0
Medicare beds	:46
Medicare/Medicaid beds	:157
Medicaid beds	:0
Fax	:847-726-1265
County	:Lake
Medicare Certification Number	:14-5816
Medicare Skilled Certification Number	:
Medicaid ICF/DD Certification Number	:
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Facility Name & ID Number Wauconda Healthcare & Rehab # 0044859 Report Period Beginning: 1-Jan-2014 Ending: 31-Dec-2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	135	Skilled (SNF)	135	49,275	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		593	10,468	11,061	8
9	SNF/PED					9
10	ICF	16,347	7,133	118	23,598	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,347	7,726	10,586	34,659	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.34%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Seetion B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1st May 2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1st May 2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 9,190

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31st Dec 2014 Fiscal Year: 31st Dec 2014

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lexington of Lake Zurich # 0039768 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			16,243	16,243	8
9	SNF/PED					9
10	ICF	45,715	6,150		51,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,715	6,150	16,243	68,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.92%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/20/94

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 203 and days of care provided 11,896

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

* All facilities other than governmental must report on the accrual basis.