manatt

Attachment: Comment on Additional Information and Provider Impact

Date: March 29, 2022

To: Debra Savage, Chairperson

Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Project #20-044 Quincy Medical Group Hospital, Quincy

Dear Ms. Savage,

Manatt Health (Manatt), was engaged by Blessing Health System (Blessing) to perform an independent review of the comments and analyses submitted by, or on the behalf of, the Quincy Medical Group Hospital, Inc. (QMGH), in regards to its Certificate of Need (CON) application to build an acute care hospital at the Quincy Mall. The review focused on (1) the alleged validity and reasonableness of the revised Analysis and Forecasts of Utilization submitted by Mr. Ralph Weber on February 22, 2022 (the "Weber Letter"), and (2) the proposed new hospital's potential to impact negatively access to essential safety net services to the Quincy, Illinois, community.

Manatt's review of the record can be summarized as follows:

1. The claims and projections made by QMGH, in the Weber Letter, are not accurate and appear to be a contrived attempt to justify a result desired by QMGH.
2. Opening a new inpatient facility in Quincy significantly risks causing a material negative economic impact to Blessing and weaken its ability to provide essential safety net services to the local community.

About Manatt

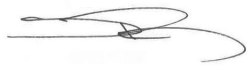
Manatt, Phelps & Phillips LLP is a multidisciplinary, integrated national professional services firm known for quality and an extraordinary commitment to clients. We approach client needs holistically, achieving business objectives through a suite of blended legal and consulting offerings.

Manatt's healthcare practice, Manatt Health, is composed of a diverse team of more than 160 health care professionals, including lawyers, MBAs, financial experts, technology experts, reimbursement experts and former government officials. Our culture supports collaboration and teamwork, both within our own organization and with our clients. We serve federal, state and local governments and agencies and our clients include a wide range of stakeholders, including state and federal policymakers and agencies; payers; health care providers and systems; foundations; associations; pharmaceutical, biotech and device companies; and product and service suppliers.

Sincerely,

Stephen D. Libowsky

Stephen Libowsky
Partner



Joseph Ray
Managing Director

Paul Berrini
Senior Manager

The Weber Letter Is Wrong and Contrived.

The claims and projections made in the Weber Letter are simply wrong. The Weber Letter attempts to question three items: (a) the alleged differences in utilization data when comparing Blessing's 2020 HFSRB Facility Profile and 2020 Medicare Cost Report (MCR), (b) the alleged projected demand for inpatient services within the QMGH proposed service area, and (c) whether Blessing could or had a need to expand inpatient capacity in 2021. The Weber Letter's attempts to sully Blessing are objectively wrong and misrepresent the data to try to justify its arguments.

a. Blessing's 2020 HFSRB Facility Profile Med/Surg totals are accurate and should only be compared to Blessing's 2020 MCR data when properly accounting for inpatient acute mental illness days.

- The Weber letter observed that Blessing's HFSRB facility profiles and MCRs, despite core differences in reporting methodology which are addressed below, had historically been comparable for assessing overall trends for medical/surgical volume at the hospital and that in 2020 this was no longer the case as the MCR displayed a significant increase in utilization not recorded on the HFSRB facility profile. Without any examination, the Weber letter goes on to present this difference as an attempt to invalidate Blessing's utilization totals and a reason to select data solely to favor QMGH's projected inpatient utilization within the proposed service area to justify the need for additional medical surgical inpatient beds. This is simply wrong.

  Blessing, as of January 3, 2021, was approved by the Centers for Medicare & Medicaid Services (CMS) *(see exhibits 1 and 2 in appendix)* to include inpatient acute mental illness (AMI) days in the MCR's line item for adult and pediatric inpatient and observation totals beginning with the 2020 fiscal reporting period. AMI days had been separated out as a distinct line item in years prior. This approved change in reporting method created a significant increase in the adult and pediatric inpatient and observation total reported to CMS in Blessing's 2020 MCR. Therefore, to compare accurately Blessing's MCR total to years prior, the AMI days (= 8,671) during that period (10/1/2019 – 9/30/2020) must be subtracted out from the 2020 total (= 53,796) which results in 44,805 patient days. Taking this total and comparing it to Blessing's 2020 HFSRB facility profile as had been done in prior years results in exactly the opposite of what the Weber Letter contends as seen below:

	HFSRB Facility Profile	Medicare Cost Report
2020 reported totals without adjusting for inclusion of AMI days in 2020 MCR total	44,943	53,476
AMI days recorded at Blessing During 2020 MCR cost reporting period that were seperately and distinctly reported prior to the 2020 reporting period	*Adjustment not required*	8,671
2020 totals after adjusting for AMI days	44,943	44,805

Source: HFSRB Facility Profile Data; Blessing 2020 Medicare Cost Report; Blessing internal data

- The HFSRB and MCR methodologies are different. MCRs do not separate out medical/surgical volume as a distinct service category as is done by the HFSRB. This results in the inclusion of pediatric, obstetric, and acute mental illness volumes (per CMS approval as described above) in the adult and pediatric inpatient and observation totals line item of the MCR and not in the HFSRB.

- The reporting periods are also different – HFSRB is based on calendar year, and MCRs are on a fiscal year (October 1 – September 30) *(see exhibit 3 in appendix).*

The Weber Letter fails to account accurately the facts and the differences between MCR and HFSRB to attempt to show something that does not exist.

b. The methods used by The Weber Letter do not address the forecasting issues described in Guidehouse's response to QMGH CON Application dated 3/31/2021 and do not follow generally accepted forecasting principles and assumptions to project market inpatient volumes.

- The Weber Letter 's "analysis" attempts to use only the recent history of inpatient volumes for a single provider (Blessing) instead of using the generally accepted methodology and evaluating the inpatient utilization trends of and within the **total** proposed service area. The Weber Letter ignores or attempts to work around the following facts:
  - Inpatient utilization rates for medical/surgical and obstetrics services declined at an average annual rate of 5.7% in the proposed Quincy service area between the 2018 -2020 fiscal year periods (10/1 – 9/30) (see exhibit 4 in appendix);
  - Inpatient utilization rates within the Quincy service area are already high when compared to the Illinois State and National Averages and have declined within the proposed service area between the 2018-2020 fiscal year periods as was described in the Guidehouse response and displayed in the table below:

	Proposed Service Area IP Market Volume (Actuals)			Illinois State Average	National Average
	FY 18	FY 19	FY 20	(2018)*	(2018)*
Service Area Inpatient Utilization Rate (Discharges per 1,000)	152.7	146.8	137.4	107	105

  - The population within the proposed service area is projected to experience a modest decline of -1.5% in the next 5 years putting additional downward pressure on inpatient utilization (see exhibit 5 in appendix);
  - When using generally accepted forecasting methodology, and including the actual above facts, there is no need for additional medical/surgical inpatient beds in the proposed service area as demonstrated in the (1) Truven/IBM Watson and (2) constant use rate forecasts following these accepted methodologies as prepared by Guidehouse (see exhibit 6 in appendix).

The Weber Letter's "forecast" fails to use the actual data available, does not use generally accepted forecasting methods, and is simply an attempt to mislead this Board.

c. Blessing appropriately followed Illinois' CON guidelines as described in section 5, subsection (c) of the Illinois Health Facilities Planning Act in using the "20 bed rule" and had justifiable need, with the second application of the rule occurring during the height of the COVID pandemic.

CON Guidelines:

(20 ILCS 3960/5) (from Ch. 111 1/2, par. 1155)

(Section scheduled to be repealed on December 31, 2029)

Sec. 5. Construction, modification, or establishment of health care facilities or acquisition of major medical equipment; permits or exemptions. No person shall construct, modify or establish a health care facility or acquire major medical equipment without first obtaining a permit or exemption from the State Board. The State Board shall not delegate to the staff of the State Board or any other person or entity the authority to grant permits or exemptions whenever the staff or other person or entity would be required to exercise any discretion affecting the decision to grant a permit or exemption. The State Board may, by rule, delegate authority to the Chairman to grant permits or exemptions when applications meet all of the State Board's review criteria and are unopposed.

A permit or exemption shall be obtained prior to the acquisition of major medical equipment or to the construction or modification of a health care facility which:

(c) changes the bed capacity of a health care facility by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than 20 beds or more than 10% of total bed capacity as defined by the State Board, whichever is less, over a 2-year period.

Reporting on inpatient capacity constraints in Quincy during COVID pandemic:

Headline from ABC 7 News KHQA Quincy Dated November 11, 2020

Blessing Hospital reaching low bed capacity due to COVID-19 surge

by Sarah Rosenthal | Wednesday, November 11th 2020

https://khqa.com/news/local/blessing-hospital-is-reaching-a-low-bed-capacity-due-to-covid-19-surge

Headline from NBC News WGEM Dated December 16, 2021

COVID cases spiking once again, Blessing bed availability dwindling

By Charity Bell
Published: Dec. 16, 2021 at 11:03 PM CST

QUINCY (WGEM) - Once again, COVID-19 cases are spiking in the Tri-States, and local hospitals are bearing the brunt of it.
https://www.wgem.com/2021/12/17/covid-cases-spiking-once-again-blessing-bed-availability-dwindling/

Other than simply stating an alleged violation where none occurred, The Weber Letter presents no facts or evidence that Blessing misused the 20-bed rule in any way, and there are no such facts or evidence.

Opening a new inpatient facility in Quincy risks causing a significant negative economic impact to Blessing and the local community.

a. Opening a new inpatient facility in Quincy will almost certainly destroy Blessing's status as a Sole Community Hospital, thereby removing an average of $6.9 million in annual Sole Community Hospital Medicare reimbursements to Blessing (see Exhibit 7) even before accounting for any potential loss of volume.

b. Introducing duplicative services will dilute utilization and associated reimbursements needed to cover Blessing's costs to deliver care and will certainly put pressure on Blessing's ability to invest in, provide and sustainably subsidize clinical services with high community need. For example:

   - QMGH is proposing to introduce duplicative inpatient services (e.g., medical/surgical and Obstetric) into a proposed market area with a flat to declining inpatient utilization rate for those services.

   - These duplicative inpatient services will result in QMGH saturating the inpatient market and thereby dilute inpatient utilization at Blessing resulting in an immediate and rapid decline in inpatient revenue. Even under a conservative scenario, assuming (a) Blessing's average blended per diem reimbursement (all payer classes) during the 2021 fiscal period (10/1/2020 – 9/30/21), (b) QMGH operating at only 25% capacity, and (c) only 25% of that activity migrating out of Blessing, the result would produce a $2 million dollar impact and rapidly scale up from there as described in the below table:

Revenue per day		$ 3,734		
Capacity		25%	50%	75%
QMG Patient Days		2,246	4,492	6,738
% Utlization Pulled from Blessing @	75%	1,685	3,369	5,054
	50%	1,123	2,246	3,369
	25%	562	1,123	1,685
Lost revenue to Blessing	75%	$ 6,289,923	$ 12,579,846	$ 18,869,769
	50%	$ 4,193,282	$ 8,386,564	$ 12,579,846
	25%	$ 2,096,641	$ 4,193,282	$ 6,289,923

Source: Blessing Financial Data

- Concurrent with this revenue loss will be the increased demand for specialized clinical personnel and support staff as QMGH competes with Blessing for clinical talent putting additional upward pressure on Blessing's employment, recruitment, and operating costs. This would be occurring when Blessing's costs have risen significantly in recent years as shown in the table below.

Blessing Hospital Operating Expenses					
				Annual Cost Growth (%)	
Line Items Specific to Employed Personnel and Supplies	**Actual 2019**	**Actual 2020**	**Actual 2021**	**2019-2020**	**2020-2021**
Salaries & Wages	142,233,683	148,834,912	168,503,219	4.64%	13.21%
Benefits	45,241,285	47,508,890	53,707,876	5.01%	13.05%
General Supplies	59,168,258	63,772,932	85,028,014	7.78%	33.33%
Purchased Services	23,134,477	28,113,092	28,547,825	21.52%	1.55%
General & Admin Exp	52,200,186	63,792,595	89,859,878	22.21%	40.86%
Total Operating Expense					
Total Operating Exp	403,015,763	440,848,155	524,912,972	9.39%	19.07%
Source: Blessing Financial Data					

In combination, these factors produce an environment significantly risking Blessing's financial health and ability to invest sustainably in its Mission as Quincy's only not-for-profit hospital providing a safety net and dedicated commitment to serving residents of the proposed service regardless of their ability to pay.

Exhibit 1

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YOUR SMART HEALTHCARE CONSULTANTS

November 27, 2019

Michael Potjeau
Principal Program Representative
Centers for Medicare and Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue
Suite 600
Chicago, IL 60601-5519
312-353-2908

Transmitted via FedEx

RE: Blessing Hospital (CCN: 14-0015) Request to Change Status of Inpatient Psychiatric Unit (CCN: 14-S015) from Excluded from the Inpatient Prospective Payment System to Not Excluded

Dear Mr. Potjeau,

I am writing on behalf of our client, Blessing Hospital (CCN: 14-0015) which is a short-term acute care hospital located at 1001 Broadway Street, Quincy, Illinois 62301. Blessing Hospital currently operates an IPPS-excluded psychiatric unit (CCN: 14-S015). Effective January 1, 2020, Blessing Hospital would like to change the status of its IPPS-excluded psychiatric unit to not excluded.

Per the requirements at 42 CFR 412.25(c)(2), a hospital may change the status of an excluded unit from excluded to not excluded at any time during its cost reporting period. However, the hospital must provide notice to the CMS Reginal Office and Medicare Administrative Contractor at least 30 days prior to the data of the change. 42 CFR 412.25(c)(2) provides:

The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

Pursuant to the regulation, please accept this correspondence as timely notice of Blessing Hospital's request to change the status of its psychiatric unit from excluded to

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not excluded. Please not that a copy of this correspondence has also been provided to National Government Services, Inc., the provider's Medicare Administrative Contractor; Illinois Department of Healthcare and Family Services, the administrator of the Illinois Medicaid Program, and Illinois Department of Pubic Health. Blessing Hospital will file the requisite Form CMS-855A for terminating the subprovider CCN 14-S015.

Thank you for your assistance with this matter. If you require additional information with respect to this request, please do not hesitate to give me a call.

Sincerely,

Ryan Yokley
Vice President
Advis
708-478-7030
ryokley@advis.com

c.c.

John Stoll
National Government Services, Inc.
J6-Part A Provider Audit & Reimbursement

Illinois Department of Healthcare and Family Services
Provider Participation Unit

Karen Senger, RN, BSN
Illinois Department of Public Health
Division of Health Care Facilities and Programs

Exhibit 2

National Government Services

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MEDICARE

www.NGSMedicare.com

Provider Enrollment Part A, PO Box 6474, Indianapolis, IN 46206-6474

January 3, 2020

BLESSING HOSPITAL
Attention: VALERIE M FORD
19065 HICKORY CREEK DR, STE 115
MOKENA, IL 60448-8684

Case Number: ESIG19357592237

Dear BLESSING HOSPITAL:

We are pleased to inform you that your change of information request is approved. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

Provider\Supplier Name:	BLESSING HOSPITAL
Primary Practice location:	19065 HICKORY CREEK DR, STE 115 MOKENA, IL 60448-8684
National Provider Identifier (NPI):	1578617684
Provider Transaction Access Number (PTAN):	14S015
Specialty:	Hospital - General
Medicare Termination Date:	01/01/2020
Changed Information:	Section 4: Deleted Blessing Hospital practice location-end date 01/01/2020 Section 13: Added Andrea Graham and Valerie Ford as contacts
Medicare Year-End Cost Report date:	09/30

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to 42 CFR §424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

National Government Services

MEDICARE

www.NGSMedicare.com

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS) at www.cms.hhs.gov/MedicareProviderSupEnroll.

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at www.NGSMedicare.com or the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/home/medicare.asp.

If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit the additional information with the reconsideration request that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration request must be signed and dated by the physician, non-physician practitioner or any responsible authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

If you have any questions, please contact our office at 855-834-5596 between the hours of 8:00 AM and 4:00 PM.

National Government Services

MEDICARE

www.NGSMedicare.com

Sincerely,

Monica Soriano
Provider Enrollment Representative
National Government Services, Inc.

PECOS Web—your ticket to fast, secure, online enrollment https://pecos.cms.hhs.gov

Exhibit 3

Health Financial Systems | BLESSING HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0015	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 12/30/2020 1:42 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 12/30/2020 Time: 1:42 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

Encryption Information

ECR: Date: 12/30/2020 Time: 1:42 pm
fsUl.qLU5Jnq2znf3jmwnGH:7HiCN0
kDHBc0zYBJVO5LPwIQZ0ZOsHvZbTLT
oXWS1P62g10L68qi

PI: Date: 12/30/2020 Time: 1:42 pm
H78eCICj:DtxD.SnZbYoW0B2z9pr10
ZlTDO011.evwwiDGSPU6eT8Jy99Z34
jyLb0J161v052CD0

(Signed) TIMOTHY MOORE
Officer or Administrator of Provider(s)

CFO/VP-FINANCE
Title

12/30/2020 01:40:50 PM (PT)
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,133,684	-261,452	0	0	1.00
2.00	Subprovider - IPF	0	62,849	-20		0	2.00
3.00	Subprovider - IRF	0	103,120	-370		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	37,094	-20,616		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		17,231		0	10.00
200.00	Total	0	-930,621	-265,227	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Exhibit 4

Proposed Service Inpatient Market Volume (Actuals)

Proposed Service Area Inpatient Market Volume- Recent History (Actuals)

	FY18 Discharges	FY19 Discharges	FY20 Discharges
Total Inpatient Market Discharges	**11,079**	**10,577**	**9,814**
Med/Surg	8,190	7,586	6,981
OB/Newborns	1,663	1,689	1,595
Other	1,226	1,302	1,238
Normal Newborns	440	442	420
Total without Normal Newborns	10,639	10,135	9,394
Service Area Total Population	**69,691**	**69,025**	**68,394**
Service Area Inpatient Utilization Rate	152.7	146.8	137.4

Demographic data from Claritas, Inpatient Volume from Blessing Health

Exhibit 5

Proposed Service Area and Population Projections

Proposed service area and 2020 population totals
From Guidehouse QMGH CON Evaluation Report 3/31/2021

ZIP	City	2020 Population	County	State
62343	Hull	624	Pike County	IL
62360	Payson	1,648	Adams County	IL
62345	Kinderhook	364	Pike County	IL
62365	Plainville	596	Adams County	IL
62312	Barry	2,097	Pike County	IL
62301	Quincy	32,070	Adams County	IL
62305	Quincy	18,160	Adams County	IL
62376	Ursa	1,277	Adams County	IL
62351	Mendon	1,723	Adams County	IL
62379	Warsaw	1,918	Hancock County	IL
62348	Lima	-	Adams County	IL
62347	Liberty	2,321	Adams County	IL
62338	Fowler	1,328	Adams County	IL
62359	Paloma	178	Adams County	IL
62325	Coatsburg	465	Adams County	IL
62320	Camp Point	2,180	Adams County	IL
62349	Loraine	607	Adams County	IL
62339	Golden	838	Adams County	IL
Service Area Total		**68,394**		

Demographic Data provided by Claritas

Population Projections
From Guidehouse QMGH CON Evaluation Report 3/31/2021

Proposed Service Area Population Projections

Service Area Population by Age Cohort	2020	2025	5 Year Growth No.	5 Year Growth Percent	5 Year Growth CAGR
Age 0-17	15,322	15,092	*(230)*	*-1.5%*	*-0.3%*
Age 18-44	21,530	21,167	*(363)*	*-1.7%*	*-0.3%*
Age 45-64	17,301	15,797	*(1,504)*	*-8.7%*	*-1.8%*
Age 65-84	11,833	13,025	*1,192*	*10.1%*	*1.9%*
Age 85+	2,408	2,453	*45*	*1.9%*	*0.4%*
Service Area Total	**68,394**	**67,534**	***(860)***	***-1.3%***	***-0.3%***
Female Age 15-44	11,938	11,756	*(182)*	*-1.5%*	*-0.3%*

Demographic projections provide by Claritas

Exhibit 6

Projected Market Utilization using Generally Accepted Forecasting Principles and Assumptions

Scenario 1: Truven/IBM Watson Market Forecast – Inpatient Bed Need Forecast
From Guidehouse QMGH CON Evaluation Report 3/31/2021

	FY18	FY19	FY20	Truven Market Expert Projections				
	Days	Days	Days	FY21 Projected	FY22 Projected	FY23 Projected	FY24 Projected	FY25 Projected
Total Inpatient Market Days	**48,311**	**44,591**	**44,640**	**43,669**	**43,432**	**43,196**	**42,961**	**42,729**
Med/Surg	36,075	32,354	32,286	32,149	32,012	31,876	31,741	31,606
OB/Newborns	4,373	3,963	4,168	4,103	4,038	3,975	3,913	3,851
Other	7,013	7,443	7,455	7,418	7,381	7,344	7,308	7,271
Normal Newborns	**850**	**831**	**731**	720	708	697	686	675
Total without Normal Newborns	47,461	43,760	43,909	42,950	42,723	42,498	42,275	42,053
ADC Withouth Normal Newborns	130.03	119.89	120.30	117.67	117.05	116.43	115.82	115.21
Bed Need at 80% Capacity	162.54	149.86	150.37	147.09	146.31	145.54	144.78	144.02

Scenario 2: FY19 Constant Use Rate Forecast – Inpatient Bed Need Forecast
From Guidehouse QMGH CON Evaluation Report 3/31/2021

	FY18	FY19	FY20	Constant Use Rate Projections				
	Days	Days	Days	FY21 Projected	FY22 Projected	FY23 Projected	FY24 Projected	FY25 Projected
Total Inpatient Market Days	**48,311**	**44,591**	**44,640**	**43,250**	**43,141**	**43,032**	**42,923**	**42,815**
Med/Surg	36,075	32,354	32,286	31,977	31,896	31,816	31,735	31,655
OB/Newborns	4,373	3,963	4,168	3,917	3,907	3,897	3,887	3,877
Other	7,013	7,443	7,455	7,356	7,338	7,319	7,301	7,282
Normal Newborns	**850**	**831**	**731**	821	819	817	815	813
Total without Normal Newborns	47,461	43,760	43,909	42,429	42,322	42,215	42,108	42,002
ADC Withouth Normal Newborns	130.03	119.89	120.30	116.24	115.95	115.66	115.36	115.07
Bed Need	162.54	149.86	150.37	145.3	144.9	144.6	144.2	143.8

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January 6, 2021

Mr. Timothy A. Moore
Vice President Finance
& Chief Accounting Officer
Blessing Health System
P.O. Box 7005
Quincy, Illinois 62305-7005

Dear Tim:

As a follow-up to our conversation regarding the impact of Blessing Hospital's Sole Community Hospital (SCH) status due to the construction of an acute care hospital within the city of Quincy, Illinois, or surrounding service area, my concern is that Blessing Hospital could potentially lose the Medicare designation as a SCH once another acute care hospital facility is operational.

Criteria and Duration of SCH Designation

Criteria for SCH designation is outlined in 42 C.F.R. – Public Health, §412.92, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, Special treatment: Sole community hospitals (see Attachment 1). CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in §412.64) in which the hospital is located between 25 and 35 miles from other like hospitals and no more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area. This is likely the criteria by which Blessing Hospital originally qualified for designation as a SCH.

As to the duration of classification as a SCH, §412.92 states that "an approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the Medicare Administrative Contractor (MAC) if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification," and goes on to state that "a sole community hospital must report the following to the MAC within 30 days of the event" such as "the opening of a new hospital in its service area."

Summary of Benefits

The following is a short summary of the benefits by inpatient, outpatient, other, and 340B drug pricing program provided as part of the SCH designation:

- Inpatient – SCH status provides certain payment enhancements and protections to Blessing Hospital. For inpatient services, SCH's receive the higher of payments under (1) the Inpatient Prospective Payment System (IPPS) or (2) an updated hospital-specific rate, which are payments based on their costs in a base year (1982, 1987, 1996, or 2006) updated to the current year and adjusted for changes in their case mix.

- Outpatient – Since 2006, SCHs also receive an additional adjustment set at 7.1 percent above the Outpatient Prospective Payment System (OPPS) rate for outpatient services. Less impactful, there is also an increase in hospital outpatient lab tests (SCH's receive 62 percent fee schedule rather than 60 percent fee schedule).

- Other – Additionally, SCH's can qualify for adjustments due to decreases in inpatient volume.

- 340B Drug Pricing Program – There is a lower qualification threshold to participate in the 340B Drug Pricing Program (340B) as a SCH. As a SCH, Blessing Hospital can qualify for the 340B program with an 8 percent Disproportionate Share Hospital (DSH) add-on percentage, rather than the 11.75 percent DSH add-on needed to qualify. The drawback of the lower qualifying threshold is there are some drugs, such as orphan drugs used heavily in oncology services, that are not covered under 340B if Blessing Hospital only qualifies as an SCH.

Quantification of Benefits

- Inpatient – The inpatient operating payment increase due to SCH designation for Blessing Hospital would have been approximately $5.2 million for the 2019 cost reporting period and is approximately $4.0 million for the 2020 cost reporting period (see Attachment 2).

- Outpatient – The outpatient benefit is the additional adjustment set at 7.1 percent above the OPPS rate for outpatient services. The outpatient operating payment increase would have been approximately $2.3 million for the 2019 cost reporting period and is approximately $2.3 million for the 2020 cost reporting period (see Attachment 2).

- Outpatient Lab Fee Schedule and Other – Given that it is less material in benefit, I did not look at or try to quantify any benefit derived from an increase in payments for hospital outpatient lab tests. 42 CFR 412.92(e) provides an opportunity for SCH's experiencing significant declines in volume with the opportunity to receive additional reimbursement. A significant decline in volume is defined as greater than a 5 percent decrease in discharges from one cost reporting year to the next. The SCH must also prove that the volume decline is due to circumstances beyond the SCH's control. The additional payment amount that can be requested is the difference between Medicare inpatient operating costs and actual Medicare inpatient payments received for the year that the decrease in volume was experienced. While Blessing Hospital did not experience a decrease in volume greater than 5 percent in either the 2019 or 2020 cost reporting period, should it experience a decrease in volume greater than 5 percent in the future, the opportunity to recoup the difference between Medicare inpatient operating costs and Medicare inpatient payments would be taken away if Blessing Hospital did not retain its SCH designation.

- 340B Drug Pricing Program – Based on Blessing Hospital's 2019 Medicare cost report, it does not appear that Blessing Hospital would qualify for the 340B Drug Pricing Program under the lower qualification threshold for an SCH, as Blessing Hospital only had a 7.7 percent DSH add-on percentage on the 2019 cost report. However, for the 2020 cost reporting period Blessing Hospital's DSH add-on percentage is 12.6 percent, meaning that Blessing Hospital would now qualify for the 340B program regardless of its SCH designation.

Based on the items quantified above, the benefits of Blessing Hospital's SCH designation averaged approximately $6.9 million per year for the 2019 and 2020 cost reporting periods. Clearly, the loss of SCH designation for Blessing Hospital would be significant, both in the decrease of direct payments as well as the other protections and provision this designation provides.

Please let me know if you would like to discuss these matters further at your convenience.

Sincerely,

Frederick K. Helfrich, CPA
Partner

FKH:clr
Attachments
KN/81059

Oct 1, 2020

412.92 Special treatment: Sole community hospitals.

(a) Criteria for classification as a sole community hospital. CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in §412.64) and meets one of the following conditions:
(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the MAC certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(4) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria specified in paragraphs (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.

(b) Classification procedures—
(1) Request for classification as sole community hospital.
(i) The hospital must make its request to its MAC.
(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the MAC and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(iv) The MAC reviews the request and send the request, with its recommendation, to CMS.

(v) CMS reviews the request and the MAC's recommendation and forward its approval or disapproval to the MAC.

(2) Effective dates of classification.
(i) For applications received on or before September 30, 2018, sole community hospital status is effective 30 days after the date of CMS' written notification of approval, except as provided in paragraph (b)(2)(v) of this section. For applications received on or after October 1, 2018, sole community hospital status is effective as of the date the MAC receives the complete application, except as provided in paragraph (b)(2)(v) of this section.
(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses a CMS denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital's application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital's application for sole community hospital status was received on or after October 1, 1983 and on or before September 30, 2018, the effective date is 30 days after the date of CMS' original written notification of denial.

(C) If the hospital's application for sole community hospital status was received on or after October 1, 2018, the effective date is the date the MAC receives the complete application.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the CMS regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) For applications received on or before September 30, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification. For applications received on or after October 1, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after the date the MAC receives the complete application.

(v) If a hospital that is classified as an MDH under § 412.108 applies for classification as a sole community hospital because its status under the MDH program expires with the expiration of the MDH program, and that hospital's sole community hospital status is approved, the effective date of approval of sole community hospital status is the day following the expiration date of the MDH program if the hospital—

(A) Applies for classification as a sole community hospital prior to 30 days before the expiration of the MDH program; and

(B) Requests that sole community hospital status be effective with the expiration of the MDH program.

(3) Duration of classification.
(i) An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the MAC if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.
(ii) A sole community hospital must report the following to the MAC within 30 days of the event:

(A) The opening of a new hospital in its service area.

(B) The opening of a new road between itself and a like provider within 35 miles.

(C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.

(D) Its geographic classification changes.

(E) Any changes to the driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

(iii) A sole community hospital must report to the MAC if it becomes aware of any change that would affect its classification as a sole community hospital beyond the events listed in paragraph (b)(3)(ii) of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

(iv) A sole community hospital must report to the MAC any factor or information that could have affected its initial classification as a sole community hospital.

(A) If CMS determines that a sole community hospital has failed to comply with the requirement of paragraph ((b)(3)(iv) of this section, CMS may cancel the hospital's classification as a sole community hospital effective with the date the hospital failed to meet the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(B) Effective on or after October 1, 2012, if a hospital reports to CMS any factor or information that could have affected its initial determination and CMS determines that the hospital should not have qualified for sole community hospital status, CMS will cancel the sole community hospital status effective 30 days from the date of the determination.

(4) Cancellation of classification.
(i) A hospital may at any time request cancellation of its classification as a sole community hospital, and be paid at rates determined under subparts D and E of this part, as appropriate.
(ii) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(iii) If a hospital requests that its sole community hospital classification be cancelled, it may not be reclassified as a sole community hospital unless it meets the following conditions:

(A) At least one full year has passed since the effective date of its cancellation.

(B) The hospital meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(5) Automatic classification as a sole community hospital. A hospital that has been granted an exemption from the hospital cost limits before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, is automatically classified as a sole community hospital unless that classification has been cancelled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.
(c) Terminology. As used in this section—
(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.

(3) The term *service area* means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital. If the most recent cost reporting period ending before the hospital applies for classification as a sole community hospital is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(d) Determining prospective payment rates for inpatient operating costs for sole community hospitals—
(1) General rule. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
(i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.

(ii) The hospital-specific rate as determined under §412.73.

(iii) The hospital-specific rate as determined under §412.75.

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under §412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).

(v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under §412.78.

(2) Transition of FY 1996 hospital-specific rate. The MAC calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:
(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate as determined under §412.77.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 50 percent of the hospital-specific rate as determined under §412.77.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate as determined under §412.77.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(3) Adjustment to payments. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.
(e) Additional payments to sole community hospitals experiencing a significant volume decrease.
(1) For cost reporting periods beginning on or after October 1, 1983, the MAC provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the MAC must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement—

(i) Submit to the MAC documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) Effective for cost reporting periods beginning before October 1, 2017, the MAC determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105). Effective for cost reporting periods beginning on or after October 1, 2017, the MAC determines a lump sum adjustment amount equal to the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105) multiplied by the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs.

(i) In determining the adjustment amount, the MAC considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The MAC makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The MAC determination is subject to review under subpart R of part 405 of this chapter.

50 FR 12741, Mar. 29, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 51 FR 34793, Sept. 30, 1986; 52 FR 30367, Aug. 14, 1987; 52 FR 33057, Sept. 1, 1987; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 36070, Sept. 4, 1990; 56 FR 25487, June 4, 1991; 57 FR 39823, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 65 FR 47107, Aug. 1, 2000; 66 FR 32193, June 13, 2001; 66 FR 39932, Aug. 1, 2001; 66 FR 39933, Aug. 1, 2001; 67 FR 50111, Aug. 1, 2002; 70 FR 47485, Aug. 12, 2005; 71 FR 48138, Aug. 18, 2006; 73 FR 48755, Aug. 19, 2008; 77 FR 53674, Aug. 31, 2012; 82 FR 38511, Aug. 14, 2017; 83 FR 41702, Aug. 17, 2018; 85 FR 59021, Sept. 18, 2020

Blessing Hospital
Quantification of Medicare SCH Payment Benefit

	FY 2020	FY 2019
Worksheet E, Part A, line 48	61,996,456	63,179,845
Worksheet E, Part A, line 47	57,971,792	57,958,176
SCH benefit	4,024,664	5,221,669
Worksheet E, Part B, line 3	34,635,115	34,520,524
SCH add-on %	7.1%	7.1%
SCH benefit	2,296,072	2,288,475
	6,320,736	7,510,144