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April 4, 2022

**VIA EMAIL AND OVERNIGHT MAIL**

Ms. Debra Savage
Chair
Illinois Health Facilities and Services Review Board
("Board" or "HFSRB")
525 W. Jefferson St., Second Floor
Springfield, IL 62761

**Re: Quincy Medical Group ("QMG") Hospital ("QMG Hospital") Certificate of Need ("CON") Application (Project #20-044) (the "QMG Hospital Application")**

Dear Ms. Savage:

I am writing in my capacity as outside legal counsel to Blessing Health System based in Quincy, Illinois ("BHS"), which operates Blessing Hospital and other health care services and facilities (BHS and Blessing Hospital referred to collectively as "Blessing"). As you know, Blessing opposes the QMG Hospital Application.

The purpose of this correspondence is to set forth our view as to the legal standard that applies to the Board's review of the QMG Hospital Application. Applying that standard of review, we itemize key deficits in the application demonstrating the project is against public policy, detrimental to the existing safety net in the community, and inconsistent with the Illinois Health Facilities Planning Act[1] ("Act").

**At the core, we believe the QMG Hospital Application shrouds a cherry-picking hospital proposal in the disingenuous mantle of innovation, while simultaneously creating an unsupported and incorrect narrative that denigrates Blessing and ignores the negative impact the project would have on safety net services. Quite simply, it is an unabashed bid for an unnecessary, low Medicaid and low acuity boutique hospital that evidently will be controlled by a large for-profit physician group that is backed by one of the largest health care private equity firms in the United States[2].**

[1] 20 ILCS 3960.

[2] Please refer to my letters dated April 1, 2022, February 7, 2022 and September 13, 2021, each submitted to the Board as public comment in opposition to the QMG Hospital Application, which raise pressing questions we believe need to be addressed by the Board regarding recent acquisition of QMG by Duly Health and Care (formerly DuPage Medical Group) ("Duly/DMG"). Publicly available information indicates that Duly/DMG is owned in part and controlled by Ares Management, which is one of the largest health care private equity firms in the United States.

## I. Executive Summary

The Act is clear that the Board should assess a Certificate of Need ("CON") project to determine if it is: (1) in the public interest; (2) consistent with orderly and economic development of health care facilities that avoids unnecessary duplication of facilities; and (3) in accord with the Board's standards, criteria or plans. While the Board has discretion in applying this statutory standard, the Act indicates that the Board's conclusions must be evidence-based, and the Board, in reaching a decision regarding approval or disapproval of a project, must articulate the factual and legal basis for the decision.

The review standard set forth in the Act has been refined over time through statutory amendment. The current standard requires the Board to place emphasis on the effect of a project on the community as a whole. Moreover, the Board must evaluate and give special consideration to evidence regarding the impact of a CON project on the safety net in the community.

The Board, in reviewing a CON application for a new hospital, must critically assess information pertaining to the project. To meet the statutory requirement for an evidence-based conclusion, the Board must scrutinize and actively evaluate the merits of the applicants' representations and projections regarding key criteria such as need, cost, quality and capabilities.

As a result, the Board has an affirmative obligation not only to consider and analyze information presented by the applicants, but to give at least equal consideration to information from third parties that speaks to the credibility of the applicants' representations. Accordingly, while the Board has discretion to weigh the credibility of evidence presented by the applicants, it must assure a process that also allows evidence from third parties to be fully heard and considered. Nowhere is this responsibility more compelling than with the Board's review of information from provider members of a community's health care safety net.

**The Act imposes an explicit responsibility on the Board to evaluate a project's impact on the community generally, and on the health care safety net in particular, applying an evidence-based standard. We believe this requires the Board to: (1) use an application review process that allows the safety net's concerns regarding an application to be fully and effectively heard; and (2) give weight to the substance of the safety net's commentary regarding the merits of a new hospital CON application. And once this has occurred, the Board must demonstrate and sufficiently articulate the factual and legal basis for its decision on an application, to reach an evidence-based conclusion.**

## II. Board Analysis of QMG Hospital Application

***Applying the statutory standard to review of the QMG Hospital Application, we respectfully assert the Board has the following responsibilities under the Act:***

- **Undertake a critical analysis of the numerous incorrect representations in the application and supplemental materials related to current and future bed need.** Many of these are unsupported or flat out wrong. Blessing has provided countervailing detailed evidence rebutting many of these claims. Similarly, the Staff Report for this project reaches numerous conclusions that are contrary to the need claims of the applicants.

    - The applicants have inappropriately questioned the accuracy of Blessing's 2020 HFSRB Facility Profile Data related to inpatient utilization, based on their misunderstanding of how Blessing filed its 2020 Medicare Cost Report ("MCR")[3]. In February, the applicants, through consultation Ralph Weber, submitted a letter purporting to analyze and forecast inpatient utilization in the Quincy market ("Weber Letter"). Among many other inaccuracies, the Weber Letter incorrectly challenged Blessing's 2020 HFSRB Facility Profile Data. In response to the Weber Letter, Blessing retained national consulting firm Manatt to review the Weber Letter and pertinent Blessing and market data. Manatt produced a detailed written analysis, dated March 29, 2022 (the "Manatt Memo") (attached). A key finding in the Manatt Memo is that Blessing's 2020 HFSRB Facility Profile properly reflected its inpatient utilization for that year.[4] Accordingly, the 2020 HFSRB Facility Profile Data for Blessing is accurate and should continue to be relied upon by State Board Staff in bed need calculations.

    - The applicants stand alone in asserting that there is bed need in the planning area, contrary to generally accepted forecasting principles and to HFSRB analysis. The Manatt Memo confirmed previous findings by Guidehouse and by Blessing, using generally accepted forecasting principles, that there is no need for medical/surgical beds in the proposed service area. A key conclusion is that inpatient utilization rates for medical/surgical and obstetrics services declined at an annual average rate of 5.7% in the Quincy service area from 2018-2020[5]. In addition, Blessing calculates that, between now and 2029, emergency department ("ED") volume will decline by 5% and inpatient volume will decline by 1%[6]. All of this is consistent

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[3] This issue was initially raised by applicants' outside counsel at the May 26, 2021 HFSRB Meeting. Draft Transcript of Board Meeting ("May 2021 Board Meeting Transcript") at pp. 37-38.

[4] Manatt Memo at pp 2-3. What the Weber Letter failed to appreciate is that Blessing's 2020 Medicare Cost Report (MCR) for the first time included AMI days, in addition to adult and pediatric inpatient totals, in a single line-item entry. In previous years, AMI days were in a separate MCR line item. This change explained the perceived discrepancy between the 2020 HFSRB Profile Data and the 2020 MCR data. This MCR adjustment was made with CMS's advance consent.

[5] Manatt Memo at p. 3.

[6] Blessing Health System, "QMG Hospital Community Facts and Impact", April 2022 ("Blessing Presentation") at p. 8 (attached)

with the findings of the State Board Staff Report prepared for the May 4, 2021 HFSRB meeting ("Staff Report"), which determined there is no need for a new hospital.

- The applicants fail to acknowledge the gross underutilization of existing inpatient beds in the pertinent geographic area. Within a region that includes Illinois, Missouri and Iowa, there are currently 8 hospitals (including Blessing) and 4 ambulatory surgery centers[7]. All 8 hospitals in this region are substantially underutilized (average 46% utilization), and both hospitals in Hospital Planning Area ("HPA") E-05 are substantially underutilized (average 62% utilization).[8]

- The applicants disregard the glaring reality that the population in the proposed hospital's service area has been declining steadily, and will continue to decline. The population in Adams County declined by 2.5% from 2010 to 2019 according to the most recent census data.[9] And, the population within the Quincy service area is projected to decline by an additional 1.5% over the next 5 years.[10]

- The applicants represent, without reliable data, that patient outmigration supports the need for their proposed inpatient services.[11] In reality, the 2021 HFSRB Hospital Inventory shows net Illinois **inmigration** in Planning Area E-05 of 967 patients and over 4,800 bed days.[12] Nevertheless, the applicants rely primarily on anecdotes to advance their dubious claim that there is significant outmigration in the area that will be meaningfully addressed by a 28 bed hospital 1.9 miles down the road from the existing Sole Community Hospital.

- **Undertake a critical analysis of the numerous flawed representations in the application regarding Blessing's cost structure, pricing, quality, and operations**. Many representations of the applicants are unsupported or speculative and, as to Blessing, are false or misleading. Blessing has provided countervailing evidence rebutting these claims.

  - The applicants have no experience whatsoever running a hospital. Accordingly, their projections regarding the proposed hospital's cost structure, pricing, quality of care and operations lack credibility and are speculative at best.

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[7] Id. at p. 7.
[8] Id. at pp. 5-6.
[9] United States Census Bureau, "Quick Facts: Adams County, Illinois" (2021).
[10] Manatt Memo at p.3.
[11] May 2021 Board Meeting Transcript at pp. 110-115.
[12] HFSRB Inventory of Health Care Facilities and Services and Need Determinations (October 25, 2021) at P. A-39.

- The applicants tout their purported cost effectiveness, without acknowledging that it is both speculative and dependent on cherry picking low acuity and commercially insured business from the area's Sole Community Hospital. They position the proposed boutique hospital as a lower cost alternative to Blessing Hospital, without acknowledging that Blessing has provided and will continue to provide high acuity/high-cost services, charity care, community benefit, inpatient psychiatric care, trauma care and high Medicaid care.

- Despite applicants' assertions, Blessing's cost and charge structure is entirely appropriate for the level of care it provides. As detailed in the Guidehouse Analysis dated March 31, 2021, that was previously submitted to the Board by Blessing and is part of the public record, Blessing Hospital is within the market median (50th percentile) across comparable hospitals in the area. This same report notes that its ED rates are particularly reasonable.

- The applicants like to portray Blessing as a monopolist.[13] But let us be very clear: Blessing is the only entity in this part of rural Illinois that has borne responsibility as the lead safety net provider, and as a result it has earned a government – administered Sole Community Hospital designation. QMG does not complain about Blessing's historical "monopoly" in providing Medicaid or charity care services, or in providing unprofitable trauma, inpatient psychiatric or ICU services. QMG does not care about Blessing's need to cross-subsidize these safety net services, but instead only wants a piece of the profitable hospital business.

- Applicants make much of their imagined future high quality, as compared with Blessing Hospital's actual high-quality performance. In fact, they had the audacity to produce, in their application materials, charts comparing the proposed hospital's imagined quality to the actual performance of other existing high performing hospitals, including Blessing.[14] As of Fall 2020, Blessing Hospital has maintained a Leapfrog Hospital Grade of A. This A grade was most recently issued in November 2021[15]. Blessing Hospital has a 4-star quality rating from CMS, on a 5 star scale[16]. Blessing Hospital also was recognized in 2021-2022 by U.S. News and World Report with a "High Performing" rating for treatment of COPD, heart failure, colon cancer surgery, stroke, heart attack and kidney failure.

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[13] See Transcript of Public Hearing on QMG Hospital Application (March 18, 2022) at pp. 30-31; May 2021 Board Meeting Transcript at p. 41.
[14] QMG Supplemental Application Materials (July 26, 2021), Exhibit A, pp. 5-6.
[15] Of the approximately 2,900 hospitals nationally receiving a Leapfrog grade, only 32%, including Blessing Hospital, received an A grade.
[16] Of the hospitals in Illinois participating in the CMS Hospital Compare quality rating, only 47%, including Blessing Hospital, earned an overall rating of 4 stars or higher.

Suffice it to say that Blessing Hospital has demonstrated actual high quality service delivery, as contrasted with the proposed hospital's aspirations for high quality.

- The applicants inaccurately suggest that Blessing is not actively engaged in Value-based Care ("VBC") or innovation in the shift to telehealth, home-based care and ambulatory care. Nothing could be further from the truth. Blessing is a leader in innovation and in VBC, as detailed below.

- The applicants appear to suggest that the proposed hospital will admit only 4.5% of its ED patients and seeks to position Blessing's ED admissions rate unfavorably in comparison. As detailed below, we believe this extremely low ED admissions rate for the proposed hospital could only be achieved (if at all) through targeting very low acuity patients and by using the ED as something akin to an urgent care location designed to triage business to QMG's for-profit operations. This is supported by the application's seeming representation that about 72% of the proposed hospital's ED visits will be non-emergent.

- QMG physicians contribute quite disproportionately to Blessing Hospital's current ED admissions rate; for QMG to critique that rate is extraordinarily disingenuous. Blessing's analysis shows that QMG physicians currently have a significantly higher admissions rate from the Blessing ED (about 33%) as compared with employed Blessing physicians (about 21%).[17]

- **Carefully consider the attributes of the safety net for the relevant market, recognizing that Blessing is the primary safety net entity with an aggregate 75% Medicare/Medicaid/charity care inpatient volume.**

  - Blessing is far and away the most significant provider of safety net health services in the region, and the sole non-CAH provider of general acute inpatient safety net services. As demonstrated in the attached 2020 Hospital Profile results published by the Illinois Department of Public Health ("IDPH"),[18] 21% of Blessing Hospital's inpatients are Medicaid beneficiaries, over 52% are Medicare beneficiaries, and 1.7% receive charity care. Stated differently, only about 20% of its inpatients are covered by commercial insurance.[19] . It has

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[17] Blessing Presentation at p.13.
[18] CY 2020 Blessing Hospital Profile, derived from 2020 Annual Hospital Questionnaire, IDPH, Health Systems Development (attached).
[19] On an outpatient basis, almost 18% of patients are Medicaid beneficiaries, about 39% are Medicare beneficiaries, and over 5% receive charity care. Only about 34% of outpatients are covered by commercial insurance.

received Sole Community Hospital designation from the Centers for Medicare and Medicaid Services ("CMS").

- Blessing is the primary source of significant charity care and community benefits in the area. Blessing Hospital's combined inpatient and outpatient charity care expense in 2020 was about $6.6 million, calculated on a cost basis According to the Blessing Hospital Community Benefit Report for Fiscal Year 2020, Blessing Hospital provided community benefits totaling almost $77 million, which constitutes 17% of total net patient revenue.[20] Beyond these compelling statistics, Blessing also provides very substantial financial and operational support to four Critical Access Hospitals ("CAHs"), two of which are in Illinois.

- **Recognize that, in contrast to Blessing Hospital, QMG Hospital would be a very low Medicaid, non-safety net facility.**

  - Even by QMG's own analysis, only 5% of patient volume would be Medicaid[21]. And, the application offers no analysis whatsoever as to how that 5% was calculated.

  - The application provides no factual support for its projected annual charity care and appears not to differentiate between charity care charges as compared with charity care costs.[22] What is clear is that this will be a very low Medicaid facility without rigorous charity care infrastructure or obligations. Significantly, the application does not include a charity care financial assistance policy for the hospital, nor does it acknowledge that as a taxable enterprise, the hospital will not be bound by IRS charity care and community benefit standards.

- **Seek clarity on the perplexing description in the application of the proposed hospital's emergency department ("ED").**

  - How QMG Hospital plans to serve 16,000 ED visits by its second year of operations is not addressed cogently in the application. For starters, are unclear as to the source of the purported current ED "market" data in the application.[23] It does not appear tied to ED statistics produced for any recent years by IDPH for Blessing Hospital, for HPA E-05, or for HSA 3. What is clear is that HPA E-05

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[20] Blessing Hospital FY 2020 Community Benefit Report at p. 8 (attached).
[21] QMG Hospital Application at p. 143.
[22] *Id.*
[23] QMG Hospital Application at p. 122.

had a total of about 36,000 ED visits in 2020, 89% of which were handled by Blessing Hospital.

- The applicants appear to describe an ED that will overwhelmingly service non-emergent visits, and quite likely will serve to funnel clinical business to QMG's for-profit services and facilities.[24] Stated simply, the applicants seem to be proposing an ED patient mix that is about 72% non-emergent, and 28% emergent.[25]

- QMG has no intention of assuming a proportionate burden of emergent ED visits, as its own application clearly shows. Blessing believes that the net effect of this will be even higher overall patient acuity at Blessing, both in the ED and, through ED-generated admissions, in Blessing's inpatients.[26]

- **Undertake an evidence-based assessment of the role health care delivery innovation does or does not play in this application, considering both the applicants' representations as well as information provided by Blessing and others. Carefully consider Blessing's position that QMG Hospital would not represent innovation in any legitimate sense.**

  - A "small format hospital" is not a category of innovation currently recognized by the State of Illinois, and the Board should acknowledge this lack of status for "small format hospitals." This is reinforced in the recent letter for the HFSRB from the Illinois Health and Hospital Association ("IHA"), in which IHA cautions that small format hospitals should be "…part of the local integrated healthcare delivery system in collaboration with the broader healthcare community. Otherwise, there is a great risk of creating a fragmented care delivery system…"[27]

  - QMG Hospital would not qualify as a CAH, a safety net hospital, or a high-Medicaid hospital under federal or Illinois law. As the application itself acknowledges, QMG Hospital would instead use its 25 medical/surgical beds primarily for commercially insured and Medicare patients, with "predominantly"

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[24] *Id.*

[25] Indeed, the application projects that about 72% of its ED visits will be non-emergent in both year 1 and year 2 of hospital operations. In contrast, the application, while confusing and therefore susceptible to misinterpretation, seems to project that only about 4.5% of its ED visits over that same time will result in inpatient admissions, and that only an additional 23-24% of these ED visits (above those resulting in admissions) will be emergent.

[26] See May 2021 Board Meeting Transcript at pp. 122-126 (Applicant representatives Drs. Petty and Noble acknowledging that higher acuity patients will be directed to and admitted to Blessing).

[27] IHA Letter from AJ Wilhelmi to Debra Savage (December 20, 2021) (attached).

low acuity medical and surgical patients, "including, among others, orthopedics and general medical care."[28]

- This boutique hospital would purposefully divert elective and commercially insured procedures and patients from Blessing, while leaving Blessing with an increasingly disproportionate burden for most Medicaid and charity care services, for inpatient psychiatric services, for trauma care, for intensive care, and for complex inpatients with a high degree of acuity. This application does not offer innovation that will benefit the community's access to health care; rather, it is a blatant attempt to cherry-pick the highest margin hospital services from Blessing. Given that the application itself predicts that a low percentage of its ED visits will result in admission to QMG Hospital, the only logical conclusion is that the overwhelming majority of QMG Hospital admissions will be elective/non-emergent.

- As the Board knows well, and as the Act explicitly acknowledges, the ability of a non-public community hospital such as Blessing to deliver essential safety net services, typically at a loss or a low margin, depends primarily on its ability to cross-subsidize this care through commercially insured services. QMG Hospital would drastically undermine Blessing's ability to do that and, over time, would threaten the viability of Blessing Hospital. Indeed, lost inpatient revenue to Blessing could rapidly scale to tens of millions of dollars annually[29].

- QMG Hospital would most assuredly disqualify Blessing Hospital from Sole Community Hospital designation by CMS, which likely also would lose approval for its Section 340B program[30]. The combined effect of this would be a direct annual revenue loss of about $7 million[31].

- The larger overall revenue loss to Blessing from the cherry-picking proposal laid out in the QMG Hospital Application would be devastating[32]. As detailed in the Manatt Memo, the proposed hospital would introduce unnecessary and duplicative inpatient services into the market. The inevitable result would be to "dilute inpatient utilization at Blessing resulting in an immediate and rapid decline in inpatient revenue." If the proposed hospital operates at 75% capacity,

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[28] QMG Hospital Application at p. 66.
[29] Manatt Memo at pp. 5-6.
[30] Letter dated February 8, 2022, to Board from Ronald S. Connelly at Powers, Pyles, Sutter and Verville, PC, concluding that the proposed QMG Hospital, if established, "will result in Blessing losing its SCH status" and could result in the loss of its 340B status (attached).
[31] Manatt Memo at p. 5.
[32] Id. at pp. 5-6.

Manatt has projected an annual revenue loss to Blessing ranging from $12.5 to 18 million (assuming that 50-75% of that volume is diverted from Blessing).[33]

- **Evaluate in detail the many initiatives Blessing has undertaken that constitute real and significant innovation in health care delivery.** As reflected in the attached Blessing Presentation, this includes:

  - Recently launched Blessing Hospital from Home, in partnership with Biofourmis, which will support Blessing's participation in the Rural Home Hospital project in order to provide acute-level care in the home, on a payer and provider agnostic basis. The Rural Home project isa longitudinal research study jointly sponsored by Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. Blessing is one of only two U.S. participants in the Rural Hospital Home project, out of a pool of 700 applicants. Blessing Health System is also one of 92 health systems nationally to have received an Acute Hospital Care at Home CMS Waiver.

  - Robust participation in commercial and Medicare VBC arrangements, including both upside and downside risk, and achieving shared savings for 3 consecutive years.

  - Operation as a Clinically Integrated Network in 3 states.

  - Sponsorship of Current Health Solutions, which assists self-funded employers in providing health care benefits to almost 9,300 members.

  - Operation of 15 outpatient clinics, with over 300 providers and across 3 states.

  - Operation of the Blessing Cancer Center on an outpatient basis.

  - The full spectrum of inpatient to ambulatory comprehensive behavioral health services are offered by Blessing, including child/adolescent and geriatric services.

  - Development of patient-centered medical homes at 7 locations, express drive-through clinics, and employer-based clinics with 83 employers and over 6,000 employees.

  - Sponsorship of 2 Critical Access Hospitals.

[33] Id. at p. 5.

- **There is no question that the overall United States health care delivery system is changing in profound ways, through VBC and other innovations. If the Board wishes to consider these innovations in connection with the CON standard of review, it should initiate rulemaking that allows broader innovation-related policy considerations to inform revisions to the process.**

    - The merits of Board rulemaking to address global changes in the health care delivery system is underscored by the attached IHA letter submitted to the Board on December 20, 2021. As you know, IHA has asked that the Board "defer any Certificate of Need (CON) application for a small format hospital until appropriate regulations are developed, with stakeholder input, that clearly delineate guidelines and criteria for such facilities."[34] Part of IHA's rational for regulatory oversight of small format hospital development is to prevent care delivery fragmentation.

    - Any ad hoc efforts by the Board to consider health care delivery innovation in assessing a new hospital CON application, in advance of rulemaking, must undertake an evidence-based, critical assessment of the merits of a purported innovation model, and its impact on the existing safety net.

    - The QMG Hospital Application does not pass muster as legitimate innovation that advances the interests of the community. It is a cherry-picking proposal for a low Medicaid, low acuity hospital, seemingly emphasizing orthopedics, that will harm the safety net. In contrast, Blessing has implemented VBC and other health care innovations on a widespread basis.

- **In evaluating the larger policy implications at play in this application review, the Board should consider abundant data regarding the fragile state of rural hospitals in Illinois and across the country**.

    - Community hospitals in rural America are closing at an alarming rate and it is widely acknowledged that these hospitals are both essential to the fabric of health care delivery and extraordinarily vulnerable, particularly in the COVID-19 era.[35]

    - At the same time, longstanding concerns about physician-owned hospitals ("POHs"), and their propensity for cherry-picking, continue to be highlighted by

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[34] IHA Letter from AJ Wilhelmi to Debra Savage (December 20, 2021) (attached)
[35] GAO Report, "Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services." GAO – 21-93 (December 2020); "Advancing Rural Health in Communities Across Illinois," Illinois Hospital Association (2018).

leading policy groups.[36] Although the applicants claim that theirs will not technically be a POH, there is no getting around the fact that this would be a physician-controlled hospital. In this climate, the Board should be careful to consider not only the impact of this proposed project on the safety net, but also the potentially disastrous ramifications of providing a template for similar cherry-picking hospital initiatives in similar rural Illinois communities.

- These concerns are amplified when considered in the context of QMG's recent change in control and sponsorship, which we believe will cause QMG to be indirectly controlled by a large, private equity backed organization.[37]

- Blessing, like most hospitals nationwide, is facing critical staff recruitment and retention challenges.[38] If Blessing is forced to compete for staff with another hospital in the same community, however unnecessary that hospital might be, it will destabilize Blessing Hospital[39]. These challenges are particularly difficult in a small community like Quincy, Illinois. When the applicants cite to nurse vacancy rates and turnover, they utterly fail to appreciate this systemic reality across the U.S. healthcare delivery landscape.

- The applicants asserted an 8:1 patient to nurse ratio for Blessing Hospital that bears no relationship to reality and without any citation, and then compared it to an utterly aspirational future 4:1 ratio for the proposed hospital.[40] In fact, Blessing's nurse staffing ratio is quite positive.[41] The publicly available Illinois Hospital Report Card currently indicates the following nurse staffing ratios for Blessing Hospital:

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[36] See, e.g., "Community Hospitals Oppose [Federal Legislation] to Repeal Ban on Self-Referral to Physician-Owned Hospitals," Federation of American Hospitals and American Hospital Association (November 19, 2019) (emphasizing studies finding that POHs:

"• cherry-pick patients by avoiding Medicaid and uninsured patients;
• treat fewer medically complex patients;
• enjoy margins nearly three times those of non-physician owned hospitals;
• provide few emergency services – an important community benefit; and
• are penalized for unnecessary readmissions at 10 times the rate of non-physician owned hospitals.")

[37] See Footnote 2.

[38] FitchRatings, "Not-For-Profit Healthcare Shortage Has Long-Term Effects" (Oct. 27, 2021); Bloomberg, "Vaccine Mandates Hit Amid Historic Health-Care Staffing Shortage" (Oct. 2, 2021).

[39] Manatt Memo at p. 6.

[40] QMG Supplemental Materials, Exhibit A at p.18.

[41] Illinois requires hospitals to report nursing hours per patient day rather than nurse to patient ratios. www.healthcarereportcard.illinois.gov/hospitals/view/101160#

1) RN Nursing Hours per Patient Day (Med/Surg): 5.19 hours

2) Total Nursing Hours per Patient Day (Med/Surg): 9.28 hours

3) Total RN Nursing Hours per Patient Day (Critical Care): 14.19 hours

4) Total Nursing Hours per Patient Day (Critical Care): 17.66 hours

5) Total RN Nursing Hours per Patient Day (Mother/Baby): 11.53 hours

- Blessing actively invests in developing clinical talent for rural communities through the Blessing-Rieman College of Nursing (approximately $2.3 million in 2020 community benefit), and through support of the SIU Residency Program (approximately $4.5 million in 2020 community benefit).[42] QMG does not do this.

## III. Legal Standard of Review

### A. Overview

As indicated above, the Act imposes on the Board the statutory responsibility to review a CON application to determine if the project is: (1) "consistent with the public interest"; (2) "consistent with the orderly and economic development of health care . . . facilities and equipment"; and (3) "in accord with the standards, criteria, or plans of need adopted or approved by the Board."[43] **The statutory requirement for the Board to conclude that a CON project is consistent with "orderly and economic development" of health care facilities is referenced multiple times in the Act,[44] and is tied to avoiding unnecessary duplication of facilities in the stated purpose of the Act.[45]**

The Act emphasizes cost containment and avoiding unnecessary duplication of facilities and services as central to the Board's role, for example:

- "Cost containment and support for safety net services must continue to be central tenets of the [CON] process . . . ."[46]

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[42] Blessing Hospital FY 2020 Community Benefit Report at p. 8.
[43] 20 ILCS 3960/5.
[44] 20 ILCS 3960/2, 5 and 6(d).
[45] 20 ILCS 3960/2 ("This Act shall establish a procedure . . . (2) that promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities . . . .").
[46] 20 ILCS 3960/2.

- "The Act shall establish a procedure that . . . avoids unnecessary duplication of . . . [health care] facilities."[47]

- "The . . . process required under this Act is designed to restrain rising health care costs by preventing unnecessary construction . . . of health care facilities."[48]

The Act also makes clear that the Board's review criteria must examine: (1) the qualifications, background and character of the applicant to provide a proper standard of health care service to the community[49]; (2) economic feasibility of the project in terms of both the applicant and the community[50]; and (3) safeguards that are provided to assure the project is consistent with the public interest.[51]

### B. Emphasis on Community Impact, with Focused Attention on Safety Net Impact

In multiple ways, the Act requires that the Board develop and apply project review criteria that evaluate the impact of a proposed facility on the community, and on the public interest.[52] **Commencing with statutory amendments made to the Act in 2009 ("2009 Amendment"), the Board has a specific and elevated responsibility to assure that any proposed new hospital CON application be evaluated for its impact on existing "safety net services."** Indeed, the 2009 Amendment indicates that: "[c]ost containment and support for safety net services must continue to be central tenets of the Certificate of Need process" (emphasis added).[53]

Through this 2009 Amendment, the General Assembly introduced into Section 2 of the Act language indicating that the Act's purpose and objectives are to, among other things, "maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and the indigent."[54] This same amendment to Section 2

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[47] *Id.*
[48] 20 ILCS 3960/5.
[49] 20 ILCS 3960/2, 6(d).
[50] 20 ILCS 3960/6(d).
[51] *Id.*
[52] 20 ILCS 3960/2, 5 and 6(d).
[53] 20 ILCS 3960/2, 5.4, 12, as amended by P.A. 096-0031 (2009).
[54] 20 ILCS 3960/2, as amended by P.A. 096-0031 (2009) and P.A. 99-0527 (2016). Section 2 of the Act currently reads as follows: "Sec 2. Purpose of the Act. This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; and (3) that promotes planning for and development of health care

added the requirement that "[e]vidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois."[55]

In addition to these significant changes to the purpose and objectives of the Board, including the evidence-based standard of review, the 2009 Amendment also added detailed new provisions requiring that most substantive project applications, including those for new hospitals, include a Safety Net Impact Statement.[56] Importantly, the Board also has an affirmative statutory responsibility to assure that its policies and procedures take into consideration the priorities and needs of the medically underserved, "giving special consideration to the impact of projects on access to safety net services."[57]

**Taken together, we believe various elements of the 2009 Amendment make clear the Board's statutory obligation to assure that its review processes give full weight to the impact a project has on safety net services, including any impediments it creates for other**

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facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs.

The changes made to this Act by the amendatory Act of the 96th General Assembly are intended to accomplish the following objectives: to improve the financial ability of the public to obtain necessary health services; to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; to maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent; to assure that the reduction and closure of health care services or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public; and to assess the financial burden to patients caused by unnecessary health care construction and modification. Evidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois. The integrity of the Certificate of Need process is ensured through revised ethics and communications procedures. Cost containment and support for safety net services must continue to be central tents of the Certificate of Need process". (Source: P.A. 99-527, eff. 1-1-17.)

[55] *Id.* As initially amended by P.A. 96-0031, the Act also was modified to include references to a Comprehensive Health Plan. While these Comprehensive Health Plan provisions were subsequently removed by P.A. 99-0527 (2016), the above provisions emphasizing the impact on the safety net and on access to services for the medically underserved and the indigent, and the requirement for evidence-based review by the Board, remain in full force.

[56] 20 ILCS 3960/5.4.

[57] 20 ILCS 3960/12. This Safety Net Impact Statement must describe, among other things: (1) the project's material impact on essential "safety net services" in the community; and (2) the project's impact on the ability of another provider or health care system to cross-subsidize safety net services. "Safety net services" include services provided by safety net service providers to persons with barriers to mainstream health care due to lack of insurance, inability to pay, or other environmental factors. Safety net service providers include health care organizations that provide charity care. Members of the community, including especially safety net service providers, are entitled to submit Safety Impact Response Statements in connection with a new hospital CON application, to describe how the project will impact safety net services in the community and the ability of providing and health systems to cross-subsidized safety net services. These Safety Net Impact Statements and responses are part of the record the Board must evaluate considering an application.

**providers to cross-subsidized safety net services.** This requires the Board to apply policies and procedures that afford community members, especially safety net providers, the opportunity to be heard by the Board in an effective manner. Moreover, the Board should critically evaluate both the applicant's representations and those of community members, in arriving at an evidence-based decision on the application. And finally, the Board should articulate on the record the factual and legal basis for its conclusion, making clear its application of the evidence-based standard and its consideration of the proposed project's impact on the safety net.

### C. Application of an Evidence-Based Assessment

**As indicated above, the Act requires the Board to undertake an evidence-based assessment of an application, and to make evidence-based decisions, regarding capacity, quality, value and equity in the delivery of health care services.**[58] For reasons we have already articulated, we believe this imposes on the Board the statutory obligation to weigh the credibility of assertions made by the applicants and, in so doing, to give careful consideration to countervailing information offered by Blessing and others. Notably, the Staff Report also offers information contrary to that put forward by the applicants. **Most fundamentally, the applicants have failed to show a need for the proposed hospital.**

Much has been made by the applicants as to the supposed innovation that the QMG Hospital would yield. **In applying an evidence-based standard, we believe the Board has an obligation to critically assess what "innovation" really means, and whether the purported innovations proposed by the applicants would have a positive or negative impact on the community.** An essential component of this Board analysis is the responsibility to carefully evaluate the care delivery innovations already implemented by Blessing. Moreover, the Board should acknowledge the fragility of rural health care facilities in Illinois and consider whether private equity-backed cherry-picking projects such as this have any place in preserving the safety net or in the orderly development of health care facilities.

The Board ideally would embark upon rulemaking if it wished to alter its review criteria to recognize VBC and other innovations in health care delivery. Such a process would allow all impacted parties to be heard across the State of Illinois, including safety net providers and other Sole Community Hospitals, and would be the optimal means for making significant alterations to the CON review standards based on innovation.

Short of that, however, any ad hoc consideration of innovation by the Board in connection with a discrete new facility application must, at a minimum, be rigorous in evaluating the merits of the

[58] 20 ILCS 3960/2.

asserted innovation, and in acknowledging the innovation that Blessing has already implemented.

### D. Demonstrate Factual and Legal Basis for the Decision

**The Act[59] and the Board's rules[60] are clear that the Board must develop an evidentiary record that supports the factual and legal basis for a decision to approve or deny an application.** This not only requires that the Board articulate a sufficient rationale when voting on a project, but also requires the Board's deliberations to support the final decision.

In our view, this legal standard requires that the transcripts of Board meetings at which an application is considered demonstrate evidence-based deliberations and thoughtful conclusions by the Board, taking into consideration the information provided by the applicants as well as others. **Special consideration should be given to information related to the impact of a project on the safety net, and on any detrimental impact the project would have on other providers, including health systems, to cross-subsidize safety net services.**

## III. Conclusion

Like any project opponent, Blessing is in a difficult position when challenging a new proposed health care facility. One essential part of that difficulty is in assuring that its concerns are heard and processed effectively by the Board.

We do not dispute that Illinois caselaw affords the Board discretion in meeting the Act's requirements. However, we respectfully believe the Board, in applying the evidence-based standard of review to this proposed project, which would adversely affect the community safety net, must critically assess both the assertions made by the applicants and those made by Blessing, and should assure that ample deliberation of both occurs on the record.

**For all of these reasons, we believe any decision by the Board to approve the QMG Hospital Application as "a breath of fresh air," or under a vague mantle of "innovation," would utterly fail to meet the evidence-based review standard required by the Act, and similarly would fail to assure mandatory consideration by the Board of the project's impact on orderly and economic development of health care resources on the community as a whole, and on the safety net in particular. This is especially so because there is no demonstrated need for this proposed hospital, and Blessing is already immersed in implementing innovation and is shouldering lead responsibility for the safety net in the region.**

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[59] 20 ILCS 3690/12.
[60] 77 Ill. Admin. Code. 1130.1170. See also 77 Ill. Admin. Code. 1130.655.

Thank you for reviewing these materials. We greatly appreciate your time and attention.

Very truly yours,

Anne M. Murphy

Cc: April Simmons, General Counsel for the Board
Michael Constantino, Supervisor, Project Review Section for the Board

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 (2018)* | National Average (2018)* |
|---|---|---|---|---|---|
| | FY 18 | FY 19 | FY 20 | | |
| **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**

COPY

advis
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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YOUR SMART HEALTHCARE CONSULTANTS

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

COPY

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<br>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<br>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
kDHBcOzYBJVO5LPwIQZOZOsHvZbTLT
oXWS1P62g10L68qi

PI: Date: 12/30/2020 Time: 1:42 pm
H78eCICj:DtxD.SnZbYoWOB2z9pr10
ZlTDO011.evwwiDGSPU6eT8Jy99Z34
jyLbOJ161vO52CD0

(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 | FY19 | FY20 |
|---|---|---|---|
| | Discharges | Discharges | 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 |

BKD
CPAs & Advisors

One Metropolitan Square | 211 N. Broadway, Suite 600 | St. Louis, MO 63102-2733
314.231.5544 | Fax 314.231.9731 | bkd.com

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.

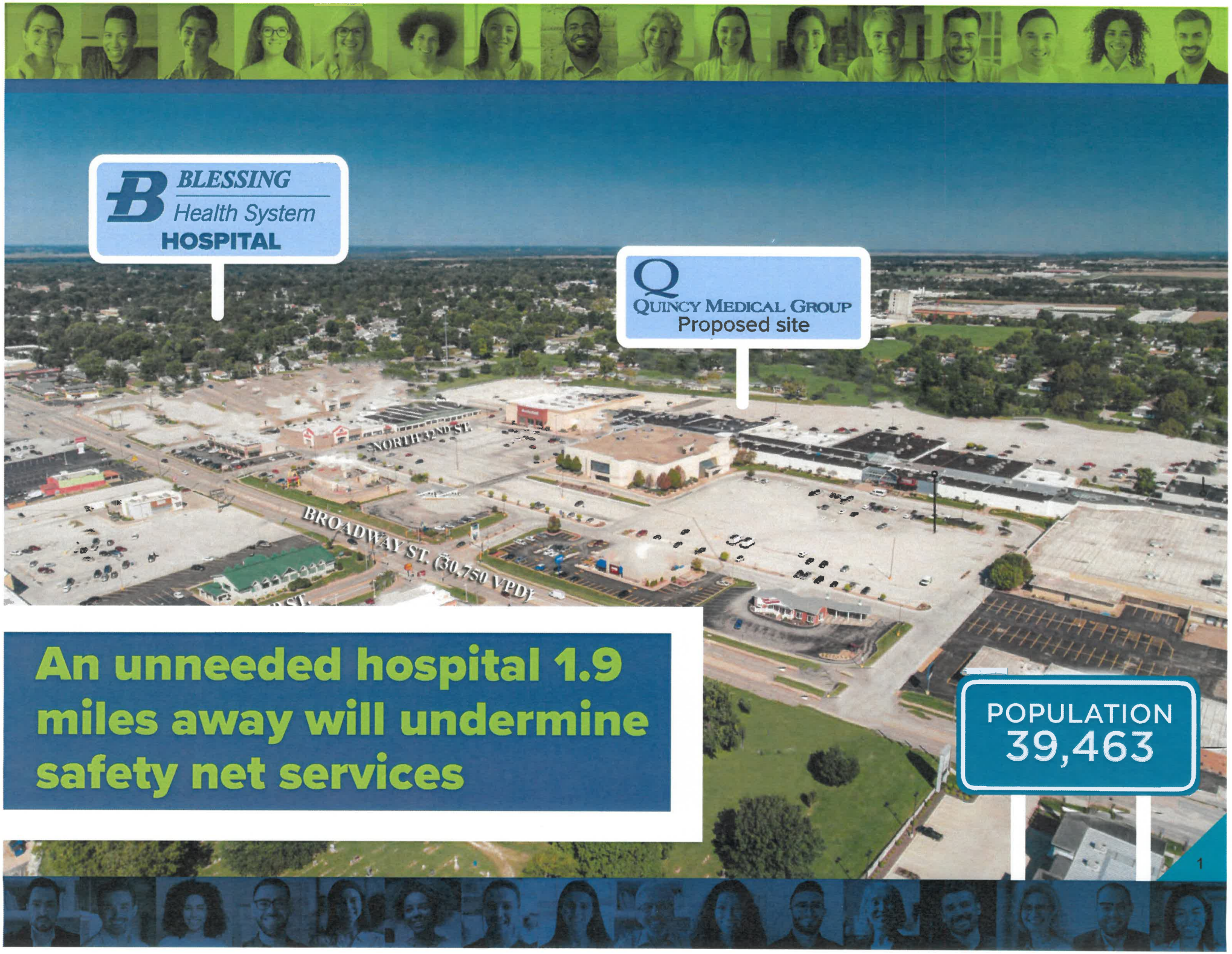
(ii) The MAC makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(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 |




# An unneeded hospital 1.9 miles away will undermine safety net services

# Presentation Outline

BLESSING Health System

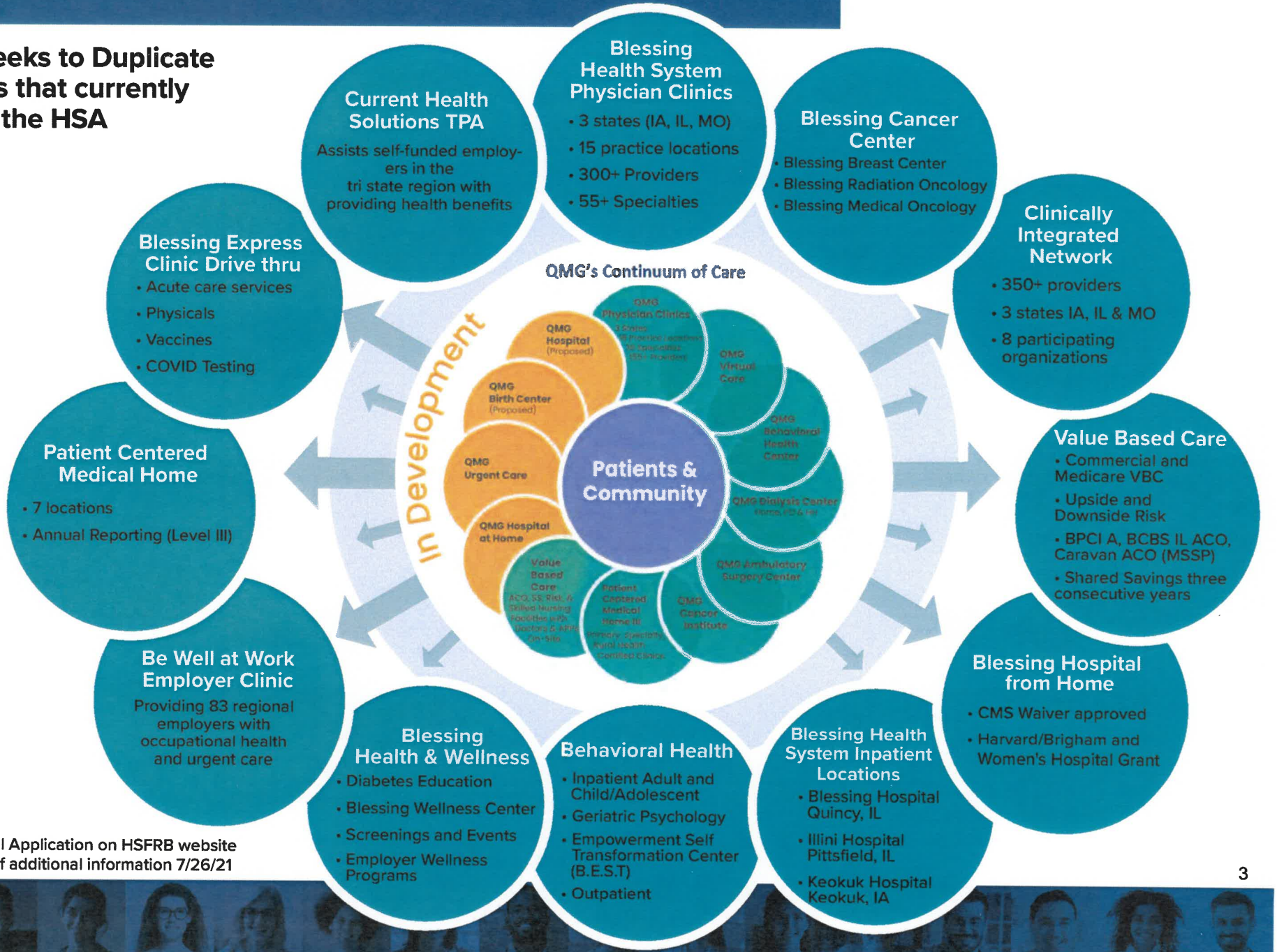
- The market is saturated with an abundance of options
- The local population is declining and demand for in-hospital care is decreasing, locally and nationally
- A new hospital in the community would jeopardize the status of the only Sole Community Hospital in the area
- Losing low acuity patients decreases revenue that is invested in essential community services
- Large segments of the most vulnerable populations will be negatively impacted



# Duplication not Innovation

BLESSING Health System

**QMG seeks to Duplicate services that currently exist in the HSA**




**Source:**
QMG Hospital Application on HSFRB website
Submission of additional information 7/26/21

# Non-profit Feeding For-profit

BLESSING Health System




# Actual Regional Utilization


| Hospital | Beds | Total Patient Days (Inpatient & OBV) | Utilization |
|---|---|---|---|
| Culbertson Memorial* | 22 | 605 | 7.5% |
| Memorial Hospital (Carthage)* | 18 | 2,670 | 40.6% |
| Pike County Memorial** | 25 | 1,422 | 15.6% |
| Hannibal Regional** | 99 | 15,046 | 41.6% |
| McDonough District* | 48 | 4,408 | 25.2% |
| Blessing Health Keokuk** | 49 | 1,229 | 6.9% |
| Blessing Hospital* | 327 | 75,607 | 63.2% |
| Illini Community* | 35 | 3,154 | 24.7% |
| TOTAL | 623 | 104,141 | 45.8% |

*2020 AHQ Data File

**Source: American Hospital Directory (ahd.com)

Hospitals chosen based on original application, page 110.

Effective 2021 Blessing Hospital bed count is 347.



# QMG Hospital = Duplication of Services


## Hospital Planning Area E-05

| Hospital | Beds | Total Patient Days (Inpatient & OBV) | Utilization |
|---|---|---|---|
| Blessing Hospital** | 327 | 75,607 | 63.2% |
| Memorial Hospital (Carthage)* | 18 | 2,670 | 40.6% |
| | | | |
| TOTAL | 345 | 78,277 | 62.2% |

*2020 AHQ Data File

**Source: American Hospital Directory (ahd.com)



# Saturated Market

BLESSING Health System

4 Surgery Centers

8 Hospitals

IOWA

ILLINOIS

MISSOURI

5 Miles 10 Miles 20 Miles 30 Miles 40 Miles 50 Miles

**QUINCY, IL**

Population in 2020: 39,463

**Population: 193,501**

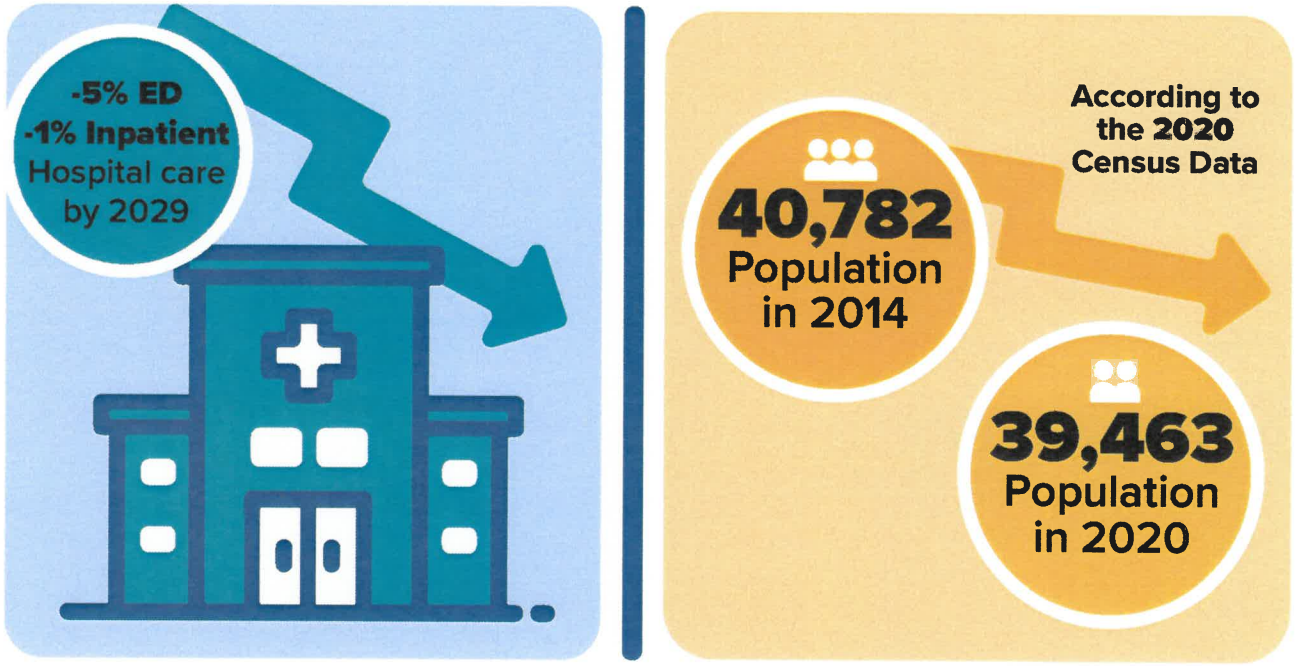
Approximate in the 50 mile radius

According to SEDAC Population Estimation Service

# Regional Trends in Healthcare

BLESSING Health System

As the region's population shrinks, there is a shift away from inpatient hospitalization and increase in services like the Hospital at Home program offered by Blessing.



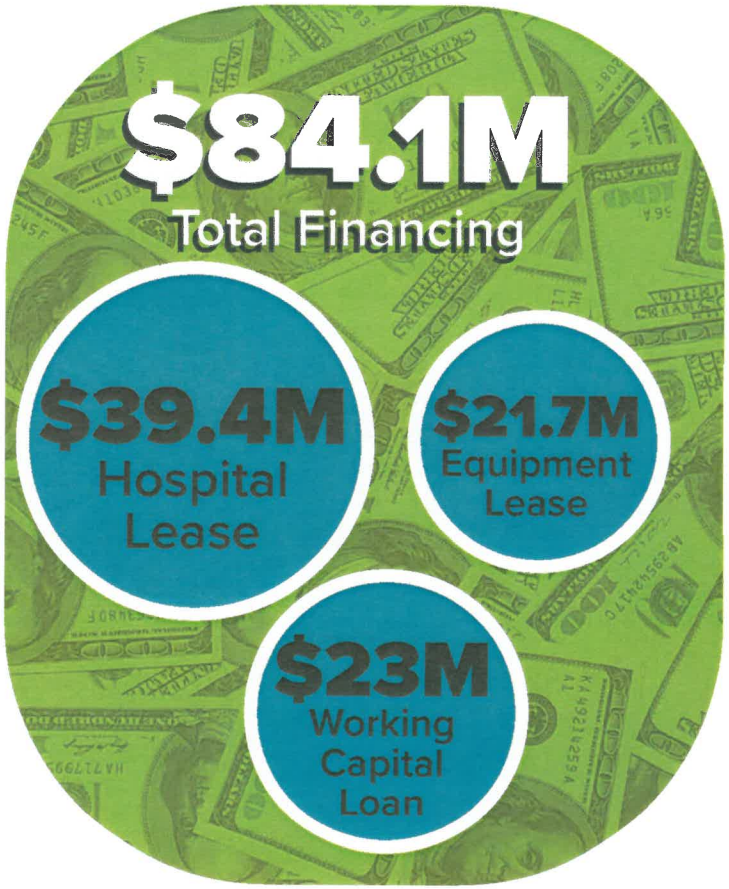

## 2019 Site of Care Volumes and 10-Year Forecast, Impact of Change® 2021 (2019-2029)

**Note:** Analysis excludes 0–17 age group. Sources: Impact of Change®, 2021; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2018. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2018; The following 2018 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2021; Sg2 Analysis, 2021.



# Proposed project is 100% Financed

BLESSING Health System




1) Who is guaranteeing?
2) What is the collateral?
3) How is this financially sound?
4) This does not meet the Board's standard for reasonableness.



# How is it being Financed?

BLESSING Health System

**$39.4M** Hospital Lease

**9.76%*** Interest Rate to Cullinan

*Current market rate 4%

**$235,000,000** in profit leaving the community to a private developer

**$23M** Working Capital

**$21.7M** Equipment Lease

?????

**Terms of loan are unknown**



# Web of Control*

BLESSING Health System

Ares invests in Dupage/Duly **$1.45B** (2017)

DuPage/Duly Borrows **$650M** pays Ares **$209M** A dividend to shareholders (2021)

**Dupage/Duly Combines with QMG** (2021)

**QMG managed by Duly controlled management company**

**Dupage/Duly replaced Unity Point as owner of QMG** (percent not disclosed)

**QMG spins off Non-Clinical assets to Duly controlled management company?**

*See materials attached to public comments to HFSRB dated September 13, 2021, February 7, 2022, and April 1, 2022, including without limitation attachments D, E, and I t February 7, 2022 public comments.



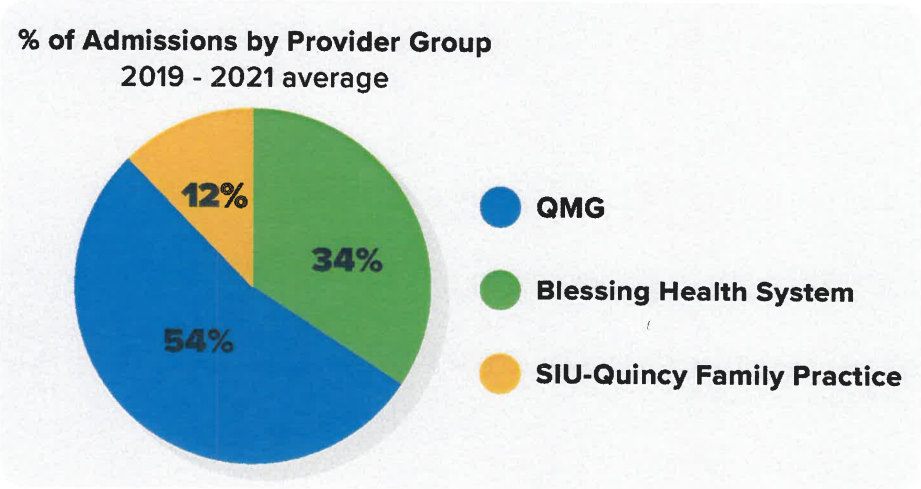
# ED Admissions by Provider Group

BLESSING Health System

QMG is projecting that 5% of ED patients will be admitted to QMG hospital. Blessing Hospital's overall ED admission rate for all provider groups is 43.5%.

| Based on 2019 Discharges | Blessing Hospital | QMG Hospital (projected) |
|---|---|---|
| Avg Length of Stay[1] | 4.6 | 2.6 |
| Star Rating[2] | 4 | 5 goal |
| Patient Satisfaction Rating[2] | 3 | 5 goal |
| ED Admissions[1] | 43.5% | 5% |
| Observation Admissions[1] | 27% | <20% |
| Readmission Rate[1] | 21.3% | < 15% |

QMG admits the highest number of ED patients to Blessing Hospital responsible for 54% of the overall total.




**Source:**
QMG Hospital Application on HSFRB website
Submission of additional information 7/26/21



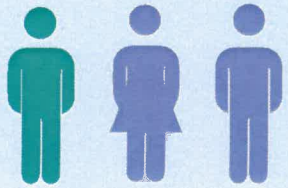
# ED Admission Comparison

BLESSING Health System

## BLESSING HOSPITAL ER

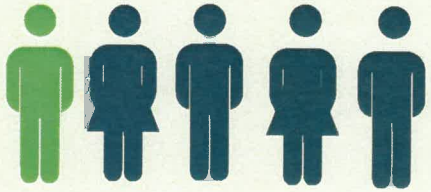
**Quincy Medical Group**
Providers/Patients

**1 in 3 QMG patients seen in the ED are admitted by their QMG provider. 32.8% Admit Rate.**



**Blessing Physician Services**
Providers/Patients

**1 in 5 BPS patients seen in the ED are admitted by their BPS provider. 21% Admit Rate.**



# Real Impact to our Communities

BLESSING Health System

| MYTH | FACT | IMPACT TO OUR COMMUNITY & PATIENTS |
|---|---|---|
| QMG Hospital will only have 5% admission in the ER | QMG doctors drive ER admissions at Blessing and account for over 54% of ER Admissions | There is no statistical basis for QMG's estimated ER admission volume. An ill-equipped and unnecessary ER will only result in patient transfers to Blessing Hospital. |
| QMG Hospital and QMG Birthing Center will not have a negative impact on Blessing Hospital. | There is no statistical need for OB beds in the region.<br>Blessing had 1051 maternity admissions in 2020, and using QMG's projected utilizations by year 2, they project 701 maternity admissions. | The QMG facilities would gut the Blessing OB Unit siphoning over 66% of maternity admissions. |
| QMG Hospital will provide Safety Net Services | QMG says only 5% of their patient volume will be Medicaid without an analysis of how they came to that number.<br>In 2020, Blessing's Medicaid inpatient volume was 21%. | The QMG Hospital proposes to shift insured patients in the community while leaving Blessing to maintain the community safety net. |
| The population is growing in Quincy and the region and there is a need for additional beds. | Quincy's population has hovered near 40k for the last 30 years. The counties in the region have seen population losses ranging between 2.5 and 4% over the last 10 years. | Additional beds in the region will not increase access to care, but will further strain existing providers. |
| QMG Hospital will lower healthcare costs in the community. | QMG Hospital as proposed will be considered by CMS to be a "like hospital" compared to Blessing. | This will result in CMS revoking Blessing's sole community hospital designation and the enhanced reimbursement utilized to cross-subsidize safety net services like inpatient behavioral health services which QMG Hospital will not offer. |
| QMG Hospital will increase access to services in the region. | The proposed facility is a mere 1.9 miles from the underutilized Blessing Hospital. | Placing the proposed facility in such close proximity to an existing facility will have a negative impact on Blessing and will not meaningfully impact access for the communities in the region outside of the Quincy area. |



# Those most affected

BLESSING Health System

- **We have a nationwide staffing crisis**
- **Quincy is a small community that has difficulty competing with other systems for talent**
- **Blessing actively invests in developing clinical talent** (Blessing Reimann College of nursing and residency progams)
- **QMG does not do the above**
- **If you say yes to this hospital,** we will be defunding investment in the development of the next generation of talent. We are jeopardizing the sustainability of our healthcare infrastructure and our community

# Those most affected

BLESSING Health System

## Free Prescription Program

### Michael
(41 yrs)
Diabetic Patient

Working 2 jobs but did not have insurance. He could not afford his insulin at $1,200 per month. Michael began rationing his insulin and became very ill and ended up in the hospital. The doctor and staff were able to help Michael stay healthy by providing him insulin through the Free Prescription Program. Without the assistance of the Free Prescription program Michael would be at risk for hospitalization and death.

## Free Health Screening & Education

### Brooke
(17 yrs)
Cardiac Abnormality

Brooke, a High School Senior and star soccer player attended Blessings Free Adolescent Cardiac Screening. The cardiac screening is one of more than 100 free screenings and educational sessions Blessing offers every year. The screening showed that Brooke had a heart abnormality that could result in a major cardiac episode or sudden death if left untreated. Her chances of experiencing these episodes increased because she is an athlete. Brooke received the intervention and treatment needed and has recently signed with a university where she will continue her soccer career.
Sudden cardiac death is the leading cause of death among U.S. college athletes.

## Free Mental Health Clinic

### Kathleen
(62 yrs)
COVID Induced Depression

Kathleen was one of many suffering from depression and anxiety through the COVID pandemic. She had been experiencing suicidal thoughts and was scared for her own well being. Kathleen has a fulltime job working from home. Her job offered a high deductible plan and Kathleen was not able to afford the mental health care she needed as she could not cover the cost of the high deductible. Kathleen took advantage of the Free Mental Health Clinic funded by Blessing Health System. Kathleen has stated that without the help of the free clinic she is not sure she would be alive today.



# Those most affected

BLESSING Health System

## Adams Co. Health Dept Dental Program

### Erica
(32 yrs)
Thyroid Cancer

Erica was diagnosed with thyroid cancer and needed to start treatment right away. Erica does not have dental coverage and struggles to make ends meet as a single mom of 2. Before she was able to start treatment Erica needed a oral health screening and a tooth extraction. Erica was going to have to save up her money for several months to pay for the dental work prior to treatment. In doing so she would have to delay her treatment putting her at risk for the cancer to spread. The dental program allowed her to have the dental work completed at no charge to her and she was able to start treatment as planned. Blessing Health System provides funding for the Adams Co. Health Dept. Dental program.

## Community Wellness Clinic

### Juan Perez
(53 yrs)
Multiple Health Conditions

Juan had gone more than 10 years without seeing a doctor as he did not have access to insurance and did not feel he could afford the care. Over the past decade Juan developed some serious health issues that had not been diagnosed or managed. Due to these unresolved health conditions Johns quality of life had been deteriorating. Juan was able to seek FREE care at our Community Wellness Clinic funded and staffed by Blessing Health. The FREE clinic worked to establish an integrated care team and treatment plan that would ensure John would receive the care he desperately needed. His integrated care team consisted of his new primary care doctor, cardiologist, endocrinologist, social worker, care manager, financial aid assistant, and Blessing Resource Center representative . Without access and intervention services provided by the FREE Community Health Clinic John would have continued to go without the care he desperately needed. Blessing integrated care approach has allowed John to developed a strong relationships with his care team and has improved his health and quality of life.



## Ownership, Management and General Information

| | |
|---|---|
| **ADMINISTRATOR NAME:** | Maureen Kahn |
| **ADMINSTRATOR PHONE:** | 217-223-1200 |
| **OWNERSHIP:** | Blessing Hospital |
| **OPERATOR:** | Blessing Hospital |
| **MANAGEMENT:** | Not for Profit Other |
| **CERTIFICATION:** | |
| **FACILITY DESIGNATION:** | General Hospital |
| **ADDRESS** | Broadway at 11th Street **CITY:** Quincy **COUNTY:** Adams County |

## Patients by Race

| | |
|---|---|
| White | 94.3% |
| Black | 4.8% |
| American Indian | 0.3% |
| Asian | 0.3% |
| Hawaiian/ Pacific | 0.0% |
| Unknown | 0.3% |

## Patients by Ethnicity

| | |
|---|---|
| Hispanic or Latino: | 1.2% |
| Not Hispanic or Latino: | 98.8% |
| Unknown: | 0.1% |
| License Number: | 0141 |
| Site Number: | 0141 |
| HPA: | E-05 |
| HSA: | 3 |

## Facility Utilization Data by Category of Service

| Clinical Service | Authorized CON Beds 12/31/2020 | Peak Beds Setup and Staffed | Peak Census | Admissions | Inpatient Days | Observation Days | Average Length of Stay | Average Daily Census | CON Occupancy Rate % | Staffed Bed Occupancy Rate % |
|---|---|---|---|---|---|---|---|---|---|---|
| **Medical/Surgical** | 178 | 178 | 162 | 8,727 | 40,074 | 4,869 | 5.1 | 122.8 | 69.0 | 69.0 |
| *0-14 Years* | | | | *0* | *0* | | | | | |
| *15-44 Years* | | | | *1,023* | *3,398* | | | | | |
| *45-64 Years* | | | | *2,576* | *11,658* | | | | | |
| *65-74 Years* | | | | *1,979* | *9,574* | | | | | |
| *75 Years +* | | | | *3,149* | *15,444* | | | | | |
| **Pediatric** | 20 | 12 | 7 | 152 | 295 | 330 | 4.1 | 1.7 | 8.5 | 14.2 |
| **Intensive Care** | 25 | 25 | 25 | 1,937 | 5,968 | 64 | 3.1 | 16.5 | 65.9 | 65.9 |
| *Direct Admission* | | | | *1,461* | *4,248* | | | | | |
| *Transfers* | | | | *476* | *1,720* | | | | | |
| **Obstetric/Gynecology** | 25 | 18 | 16 | 1,051 | 2,110 | 64 | 2.1 | 5.9 | 23.8 | 33.0 |
| *Maternity* | | | | *1,031* | *2,076* | | | | | |
| *Clean Gynecology* | | | | *20* | *34* | | | | | |
| **Neonatal** | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Long Term Care** | 20 | 20 | 20 | 493 | 5,633 | 0 | 11.4 | 15.4 | 77.0 | 77.0 |
| **Swing Beds** | | | 0 | 0 | 0 | | 0.0 | 0.0 | | |
| **Total AMI** | 41 | | | 1,726 | 11,470 | 0 | 6.6 | 31.3 | 76.4 | |
| *Adolescent AMI* | | 15 | 14 | 381 | 3,371 | 0 | 8.8 | 9.2 | | 61.4 |
| *Adult AMI* | | 26 | 26 | 1,345 | 8,099 | 0 | 6.0 | 22.1 | | 85.1 |
| **Rehabilitation** | 18 | 18 | 16 | 311 | 4,730 | 0 | 15.2 | 12.9 | 71.8 | 71.8 |
| **Long-Term Acute Care** | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 | 0.0 | 0.0 |
| *Dedicated Observation* | *0* | | | | | *0* | | | | |
| **Facility Utilization** | **327** | | | **13,921** | **70,280** | **5,327** | **5.4** | **206.6** | **63.2** | |

*(Includes ICU Direct Admissions Only)*

## Inpatients and Outpatients Served by Payor Source

| | *Medicare* | *Medicaid* | *Other Public* | *Private Insurance* | *Private Pay* | *Charity Care* | *Totals* |
|---|---|---|---|---|---|---|---|
| **Inpatients** | **52.3%** | **21.0%** | **1.9%** | **20.5%** | **2.5%** | **1.7%** | |
| | 7286 | 2923 | 271 | 2857 | 353 | 231 | **13,921** |
| **Outpatients** | **38.6%** | **17.6%** | **2.0%** | **34.0%** | **2.4%** | **5.4%** | |
| | 64996 | 29658 | 3433 | 57368 | 3970 | 9100 | **168,525** |

***Financial Year Reported:*** 10/1/2019 *to* 9/30/2020

## Inpatient and Outpatient Net Revenue by Payor Source

| | *Medicare* | *Medicaid* | *Other Public* | *Private Insurance* | *Private Pay* | *Totals* | *Charity Care Expense* |
|---|---|---|---|---|---|---|---|
| **Inpatient Revenue ( $)** | **34.2%** | **19.5%** | **1.5%** | **40.9%** | **4.0%** | **100.0%** | |
| | 70,779,237 | 40,351,310 | 3,121,758 | 84,623,548 | 8,231,805 | 207,107,658 | 4,392,444 |
| **Outpatient Revenue ( $)** | **14.2%** | **14.2%** | **1.4%** | **62.9%** | **7.3%** | **100.0%** | |
| | 31,523,982 | 31,609,108 | 3,176,921 | 139,537,559 | 16,167,733 | 222,015,303 | 2,197,553 |

***Total Charity Care Expense***
**6,589,997**

***Total Charity Care as % of Net Revenue***
**1.5%**

## Birthing Data

| | |
|---|---|
| Number of Total Births: | 1,049 |
| Number of Live Births: | 1,046 |
| Birthing Rooms: | 0 |
| Labor Rooms: | 3 |
| Delivery Rooms: | 0 |
| Labor-Delivery-Recovery Rooms: | 5 |
| Labor-Delivery-Recovery-Postpartum Rooms: | 0 |
| C-Section Rooms: | 2 |
| CSections Performed: | 331 |

## Newborn Nursery Utilization

| | Level I | Level II | Level II+ |
|---|---|---|---|
| Beds | 23 | 2 | 0 |
| Patient Days | 1,875 | 169 | 0 |
| Total Newborn Patient Days | | | **2,044** |

## Laboratory Studies

| | |
|---|---|
| Inpatient Studies | 12,793 |
| Outpatient Studies | 100,588 |
| Studies Performed Under Contract | 0 |

## Organ Transplantation

| | |
|---|---|
| Kidney: | 0 |
| Heart: | 0 |
| Lung: | 0 |
| Heart/Lung: | 0 |
| Pancreas: | 0 |
| Liver: | 0 |
| Total: | **0** |

## Surgery and Operating Room Utilization

| Surgical Specialty | Operating Rooms | | | | Surgical Cases | | Surgical Hours | | | Hours per Case | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient | Outpatient | Combined | Total | Inpatient | Outpatient | Inpatient | Outpatient | Total Hours | Inpatient | Outpatient |
| Cardiovascular | 0 | 0 | 0 | 0 | 685 | 303 | 1673 | 316 | 1989 | 2.4 | 1.0 |
| Dermatology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| General | 0 | 0 | 10 | 10 | 692 | 1162 | 1351 | 1546 | 2897 | 2.0 | 1.3 |
| Gastroenterology | 0 | 0 | 0 | 0 | 30 | 131 | 20 | 56 | 76 | 0.7 | 0.4 |
| Neurology | 0 | 0 | 0 | 0 | 167 | 261 | 657 | 711 | 1368 | 3.9 | 2.7 |
| OB/Gynecology | 0 | 0 | 0 | 0 | 20 | 306 | 29 | 471 | 500 | 1.5 | 1.5 |
| Oral/Maxillofacial | 0 | 0 | 0 | 0 | 7 | 22 | 6 | 32 | 38 | 0.9 | 1.5 |
| Ophthalmology | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 3 | 0.0 | 3.0 |
| Orthopedic | 0 | 0 | 0 | 0 | 499 | 833 | 1049 | 1553 | 2602 | 2.1 | 1.9 |
| Otolaryngology | 0 | 0 | 0 | 0 | 24 | 235 | 29 | 315 | 344 | 1.2 | 1.3 |
| Plastic Surgery | 0 | 0 | 0 | 0 | 4 | 56 | 11 | 129 | 140 | 2.8 | 2.3 |
| Podiatry | 0 | 0 | 0 | 0 | 53 | 46 | 47 | 57 | 104 | 0.9 | 1.2 |
| Thoracic | 0 | 0 | 0 | 0 | 33 | 9 | 69 | 11 | 80 | 2.1 | 1.2 |
| Urology | 0 | 0 | 0 | 0 | 220 | 1221 | 239 | 976 | 1215 | 1.1 | 0.8 |
| **Totals** | **0** | **0** | **10** | **10** | **2434** | **4586** | **5180** | **6176** | **11356** | **2.1** | **1.3** |

**SURGICAL RECOVERY STATIONS** Stage 1 Recovery Stations 10 Stage 2 Recovery Stations 15

## Dedicated and Non-Dedicated Procedure Room Utilzation

| Procedure Type | Procedure Rooms | | | | Surgical Cases | | Surgical Hours | | | Hours per Case | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient | Outpatient | Combined | Total | Inpatient | Outpatient | Inpatient | Outpatient | Total Hours | Inpatient | Outpatient |
| Gastrointestinal | 0 | 0 | 1 | 1 | 315 | 111 | 166 | 49 | 215 | 0.5 | 0.4 |
| Laser Eye Procedures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| Pain Management | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| Cystoscopy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| **Multipurpose Non-Dedicated Rooms** | | | | | | | | | | | |
| | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |
| | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0.0 |

| | | | |
|---|---|---|---|
| **Certified Trauma Center** | | **Yes** | **Total Cardiac Catheterization Labs:** | **3** |
| Trauma Service | **Level 1** | **Level 2** Both Adult and Child | Cath Labs used for Angiography procedures | 0 |
| Operating Rooms Dedicated for Trauma Care | | 1 | Dedicated Diagnostic Catheterization Labs | 0 |
| Number of Trauma Visits: | | 219 | Dedicated Interventional Catheterization Labs | 0 |
| Patients Admitted from Trauma | | 118 | Dedicated EP Catheterization Labs | 1 |
| **Emergency Service Type:** | | **Comprehensive** | **Total Cardiac Catheterization Procedures:** | **2,677** |
| Number of Emergency Room Stations | | 31 | Diagnostic Catheterizations (0-14) | 0 |
| Persons Treated by Emergency Services: | | 32,271 | Diagnostic Catheterizations (15+) | 1,421 |
| Patients Admitted from Emergency: | | 11,874 | Interventional Catheterizations (0-14): | 0 |
| Total ED Visits (Emergency+Trauma): | | **32,490** | Interventional Catheterization (15+) | 447 |
| Beds in Free-Standing Emergency Centers | | 0 | EP Catheterizations (15+) | 809 |
| Patient Visits in Free-Standing Emergency Centers | | 0 | **Total Cardiac Surgery Cases:** | **144** |
| Hospital Admissions from Free-Standing Emergency Center | | 0 | Pediatric (0 - 14 Years): | 0 |
| **Total Outpatient Visits** | | **168,525** | Adult (15 Years and Older): | 144 |
| Outpatient Visits at the Hospital/ Campus: | | 168,525 | Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases : | 138 |
| Outpatient Visits Offsite/off campus | | 0 | | |

| Diagnostic/Interventional Equipment | | | Examinations | | | Therapeutic Equipment | | | Therapies/ Treatments |
|---|---|---|---|---|---|---|---|---|---|
| | *Owned* | *Contract* | *Inpatient* | *Outpt* | *Contract* | | *Owned* | *Contract* | |
| *General Radiography/Fluoroscopy* | 24 | 0 | 23,543 | 20,321 | 0 | *Lithotripsy* | 0 | 0 | 0 |
| *Nuclear Medicine* | 3 | 0 | 654 | 951 | 0 | *Linear Accelerator* | 2 | 0 | 2,925 |
| *Mammography* | 4 | 0 | 6 | 11,023 | 0 | Image Guided Rad Therapy | | | 360 |
| *Ultrasound* | 8 | 0 | 3,036 | 5,401 | 0 | Intensity Modulated Rad Thrpy | | | 2,565 |
| *Angiography* | 1 | 0 | | | | High Dose Brachytherapy | 0 | 0 | 0 |
| *Diagnostic Angiography* | | | 7 | 8 | 0 | *Proton Beam Therapy* | 0 | 0 | 0 |
| *Interventional Angiography* | | | 679 | 250 | 0 | *Gamma Knife* | 0 | 0 | 0 |
| *Positron Emission Tomography (PET)* | 0 | 1 | 0 | 0 | 311 | *Cyber knife* | 0 | 0 | 0 |
| *Computerized Axial Tomography (CAT)* | 2 | 0 | 4,032 | 16,215 | 0 | | | | |
| *Magnetic Resonance Imaging* | 1 | 1 | 1,968 | 1,677 | 445 | | | | |

Source: 2020 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

# BLESSING HOSPITAL

Community Benefit Report 2020

## Total Cost of Community Benefit
## $76,978,334

### Health Professionals Education

| | |
|---|---|
| SIU Residency Program | 4,458,145 |
| Blessing-Rieman College of Nursing | 2,282,109 |
| Preceptors | 941,171 |
| Radiology School | 315,217 |
| Lab School | 58,605 |
| **Total Community Benefit Investment** | **$8,055,247** |

### Subsidized Health Services

| | |
|---|---|
| Care Coordination | 2,487,678 |
| Blessing Home Care | 148,429 |
| Horizons Social Services | 975 |
| **Total Community Benefit Investment** | **$2,637,082** |

### Community Health Improvement Services

| | |
|---|---|
| Psychiatric services | 170,042 |
| • SIU Center for Family Medicine-Quincy | |
| • Chaddock | |
| • Transitions of Western Illinois | |
| Patient Transportation & Lodging | 154,713 |
| Adams Co. Health Dept. Dental Program | 100,000 |
| Charity Pharmacy Prescriptions | 47,498 |
| Medical supplies/Services for patients | 43,252 |
| Health Screenings/Education | 43,146 |
| Mental Health Education Programs | 13,710 |
| Medical Interpreting Services | 2,160 |
| **Total Community Benefit Investment** | **$574,521** |

### In-Kind Contributions/Donations

| | |
|---|---|
| Donations/Sponsorships | 219,160 |

### Community Benefit Operations

| | |
|---|---|
| Community Health Needs Assessment | 62,819 |

### Charity Care

**$6,696,893**

*Uncompensated healthcare to patients who stated **before receiving care** that they had no ability to pay.*

### Bad Debt

**$3,940,251**

*Uncompensated healthcare to patients who stated **after receiving care** that they had no ability to pay.*

### Medicare Funding Shortfall

**$54,792,361**

*The difference between what Medicare paid for patients covered by the program and what it cost Blessing Hospital to provide for their care.*

CONTACT US
Blessing Hospital
11th & Broadway • Quincy, IL
217.223.1200
blessinghealth.org

Illinois Health and Hospital Association

December 20, 2021

Debra Savage
Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson, Second Floor
Springfield, IL 62761

Dear Chairwoman Savage:

On behalf of the Illinois Health and Hospital Association's more than 200 member hospitals and nearly 40 health systems, I write to you on the topic of small format hospitals and the role they play in the healthcare delivery system. There is no question that these types of facilities have been growing in popularity in other parts of the country and we are beginning to see their presence in Illinois. Given that two small format hospital applications have come before the Illinois Health Facilities and Services Review Board ("the Board") in recent years, one which was approved and one issued an intent to deny, IHA believes that additional clarity is necessary in the Health Facilities Planning Act and the Board's rules to appropriately consider such a facility. **As such, we respectfully request that the Board defer any Certificate of Need (CON) application for a small format hospital until appropriate regulations are developed, with stakeholder input, that clearly delineate guidelines and criteria for such facilities.**

Under current state law and regulations, including the Board's rules, a small format hospital must continue to meet the same criteria as any general acute care hospital. The reality is, however, that a small format hospital serves a different purpose within the healthcare delivery system and a community.

Small format hospitals are typically developed in more urban areas, specializing in low acuity care, surgery, and diagnostic services. Whether urban or rural, however, it is important that they be part of the integrated healthcare delivery system in collaboration with the broader healthcare community. Otherwise, there is great risk of creating a fragmented care delivery system that would lead to compromised outcomes with enhanced healthcare costs.

With the appropriate regulatory oversight, small format hospitals can be a critical component of the healthcare delivery system in service to a community. In recognition of the changes taking place in healthcare, and the need for transformative delivery models to assure access to care at the right time and in the right setting, the IHA Board of Trustees supported the following criteria for a small format hospital proposal:



1151 East Warrenville Rd.
P.O. Box 3015
Naperville, IL 60566
630.276.5400

700 South 2nd St.
Springfield, IL 62704
217.541.1150

499 South Capitol St. S.W.
Suite 410
Washington, DC 20003
630.276.5645

833 West Jackson Blvd.
Suite 610
Chicago, IL 60607
312.906.6150

www.team-iha.org

1. It must be owned by a hospital or health system with a general acute care hospital in Illinois;
2. It must be within 50 miles of the general acute care hospital which will serve as its point of transfer for higher acuity cases;
3. It must build upon the current CON criteria to show referrals from physicians affiliated with the hospital or health system;
4. It must establish "Basic Emergency Treatment Services" as outlined in rules;
5. It must be certified by federal CMS and accept public pay patients at the facility; and
6. It must go through the CON process to ensure it meets the appropriate and broader need criteria for the project.

These criteria were developed based on extensive discussions with and broad input from our members regarding the role of small format hospitals in Illinois, with the goal of ensuring they are developed in a way that best serves the patients and the broader community. Without such reasonable guidelines and criteria, there will continue to be no difference in Illinois regulation between a general acute care hospital with hundreds of beds, and a small format hospital with fewer than 25 beds, when in actuality their purpose is markedly different.

As the primary stakeholder on this important issue, we would welcome the opportunity to work with you to develop reasonable guidelines and criteria for small format hospitals. **Until these guidelines and criteria are put in place, however, we again urge you to defer any small format hospital CON application.**

Thank you for your attention to this important issue. We look forward to discussing this with you in the near future.

Sincerely,

A.J. Wilhelmi
President & CEO

Cc: April Simmons
General Counsel, Health Facilities and Services Review Board

Ann Guild
Compliance Analyst, Health Facilities and Services Review Board

POWERS
POWERS PYLES SUTTER & VERVILLE PC
ATTORNEYS AT LAW

RONALD S. CONNELLY
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March 28, 2022

Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

Re: Quincy Medical Group Hospital, Quincy
HFSRB No. 20-044
**Blessing Hospital SCH Analysis**

Dear Board Members:

This letter is to provide the Illinois Health Facilities and Services Review Board (HFSRB) with information on how the opening of a Quincy Medical Group (QMG) Hospital will adversely impact Blessing Hospital and its patients. The federal Centers for Medicare & Medicaid Services (CMS) has granted Blessing Hospital status as a Sole Community Hospital (SCH), which entitles it to favorable reimbursement terms by the Medicare program and more lenient qualification standards for participation in the federal 340B drug discount program. QMG proposes to operate a hospital in Quincy, Illinois, only 1.9 miles from Blessing Hospital. If the HFSRB approves the certificate of need (CON) for the QMG hospital, and if it operates as described in the QMG CON application to the HFSRB, Blessing Hospital will lose its SCH status, leading to significantly reduced Medicare reimbursement and potential disqualification from the 340B program.

## Medicare Sole Community Hospitals

Medicare reimburses most general acute care hospitals using the inpatient prospective payment system (IPPS), which pays hospitals predetermined rates for each patient treated.[1] Congress recognized, however, that certain types of hospitals, especially in rural areas, would struggle financially under IPPS. In order to support rural health care, Congress adopted a modified IPPS payment methodology for SCHs.[2] Medicare reimburses SCHs for inpatient hospital services based on either the federal IPPS rate or the SCH's "hospital-specific" rate for either the hospital's fiscal year 1982, 1987, 1996, or 2006, whichever results in the greatest payment.[3] In very broad terms, the hospital-specific rate is the hospital's costs per inpatient discharge for the applicable fiscal year.[4]

[1] 42 U.S.C. § 1395ww(d).
[2] *Id.* § 1395ww(d)(5)(D)(i).
[3] *Id.*; 42 C.F.R. § 412.92(d).
[4] *See, e.g.*, 42 C.F.R. § 412.73.

SCHs are also able to participate in the federal 340B drug discount program under criteria that is more lenient than the criteria for most hospitals that are not SCHs. The 340B drug discount program provides significant discounts on the purchase of outpatient drugs for qualifying hospitals.[5] Under the 340B statute, an SCH qualifies for the program if it has a Medicare disproportionate share hospital (DSH) payment percentage that is 8% or above.[6] Most other hospitals that do not have SCH designation must have a DSH percentage of above 11.75%.[7]

Medicare reimbursement for certain separately payable outpatient drugs is lower if the drug is purchased at 340B prices than non-340B prices.[8] However, rural SCHs are exempt from this lower reimbursement and receive payment at the non-340B rate.[9]

**Qualification for Medicare Sole Community Hospital Status**

A hospital may be designated as an SCH if it meets one of several tests that measure the distance between the SCH and "like hospitals." Specifically, a hospital is designated as an SCH if it meets one of the following tests: 1) it is located more than 35 miles from other like hospitals; 2) it is located between 25 and 35 miles from other like hospitals and meets certain requirements related to its patient population, number of beds, or accessibility; 3) it is located between 15 and 25 miles from other like hospitals but is inaccessible for at least 30 days in two of every three years; or 4) "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."[10] Medicare regulations define a "like hospital" as follows:

> 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

[5] 42 U.S.C. § 256b.
[6] *Id.* § 256b(a)(4)(O). Rural referral centers also qualify with a DSH percentage of 8% or more. *Id.* Critical access hospital do not receive DSH payments and, therefore, the 340B statute does not include any criteria related to DSH payments for critical access hospitals. *Id.* at § 256b(N). The DSH payment is designed to compensate hospitals for treating a high proportion of low-income and under-insured patients. 42 U.S.C. § 1395ww(d)(5)(F)(vi); 42 C.F.R. § 412.106(b).
[7] 42 U.S.C. § 256b(a)(4)(L).
[8] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals, 86 Fed. Reg. 42,018, 42,134-37 (Aug. 4, 2021).
[9] *Id.* at 42,337.
[10] 42 C.F.R. § 412.92.

> 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.[11]

The 8% test described in the regulation compares the two hospitals' inpatient days that would be payable under the IPPS if a patient is covered by Medicare or the patient were covered by Medicare. In other words, all IPPS-type days are counted, not just those attributable to Medicare beneficiaries. Inpatient days that would not be paid by Medicare are excluded from the calculation, such as days in neonatal units or days in IPPS-excluded rehabilitation, psychiatric, or long-term care units. SCH classification remains in effect "unless there is a change in the circumstances under which the classification was approved."[12]

**Blessing Hospital**

Blessing Hospital was formed from a merger of two hospitals in the early 1990s and has qualified as an SCH for more than twenty years. Currently, there are no other "like hospitals" within 35 miles of Blessing Hospital that would jeopardize Blessing's SCH designation. As an SCH, Blessing Hospital is paid by Medicare using the hospital specific rate based on its costs. Blessing Hospital also qualifies for the federal 340B drug discount program as an SCH. Its DSH percentage is slightly above 11.75%, so it could still qualify for the 340B program as a non-SCH, but it would be in danger of losing 340B status if its DSH percentage were to slip to 11.75% or below. Because it is a rural SCH, it receives significantly higher Medicare reimbursement for outpatient drugs purchased under the federal 340B drug discount program than it would receive as an IPPS hospital.[13]

**The Proposed QMG Hospital Would Be a "Like Hospital" Leading to Loss of Blessing Hospital's SCH Status**

The QMG CON application projects in year two of its operation that the QMG hospital will have 7,301 medical and surgical days and 931 obstetric days.[14] This equals 8,232 patient days that would "provide[] a level of care characteristic of the level of care payable under the"

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[11] *Id.* § 412.92(c)(2).
[12] *Id.* § 412.92(b)(3).
[13] 42 U.S.C. § 256b. The 340B statute requires pharmaceutical manufacturers to provide large discounts on covered outpatient drugs to SCHs that treat a specified percentage of low-income patients. The Medicare program reduces payments to IPPS hospitals for 340B discounted drugs but does not similarly reduce payments to rural SCHs.
[14] QMG Application for Permit #20-044, Attachment 15, https://www2.illinois.gov/sites/hfsrb/Projects/ProjectDocuments/2020/20-044/2020-12-10%2020-044%20Application%20for%20Permit.pdf.

Medicare IPPS.[15] Blessing Hospital reported on its fiscal year 2020 (FY 2020) Medicare cost report that it had 54,535 patient days that were payable under the IPPS.[16] Therefore, based on the most recent available data, the QMG hospital's IPPS eligible days will be 15.09% of Blessing Hospital's IPPS days.

Based on this data, the QMG hospital would be a "like hospital" to Blessing Hospital. Because the QMG Hospital is planned to be located only 1.9 miles from Blessing Hospital, Blessing Hospital would no longer meet any of the distance criteria from "like hospitals" for purposes of SCH status. The existence of a "like hospital" in close proximity to Blessing Hospital will constitute a change in circumstances requiring revocation of Blessing Hospital's SCH designation.[17] Blessing Hospital would, therefore, lose its SCH designation, leading to the following consequences: 1) Blessing Hospital would be paid by Medicare under the IPPS and not the more favorable hospital specific rate; 2) Blessing Hospital would receive significantly lower Medicare reimbursement for certain outpatient drugs purchased under the 340B program; and 3) Blessing Hospital would be at greater risk of losing its 340B status.

**Conclusion**

The proposed QMG hospital, if approved, will result in Blessing losing its SCH status, resulting in significantly lower Medicare reimbursement to Blessing Hospital and potential loss of its 340B status. This loss of SCH status would be compelled by Medicare regulations.

Sincerely,

Ronald S. Connelly
Counsel to Blessing Health System

[15] 42 C.F.R. § 412.92(b)(3).
[16] Blessing Hospital had 69,535 total days in FY 2020, but not all days are counted for the SCH 8% test. Days in nursery, psychiatric, rehabilitation, and long-term care units are not paid under the IPPS and are excluded from the 8% calculation.
[17] 42 C.F.R. § 412.92(b)(3)(i), (ii).