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April 6, 2021

VIA E-MAIL

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Quincy Medical Group Hospital, Quincy, Illinois- Project #20-044
Report of Certificate of Need Application Deficiencies

Dear Ms. Avery:

We represent Blessing Hospital, which has been providing safety net services and serving Quincy, Illinois since 1875. We present this submission in opposition to the proposed project to construct an unnecessary second hospital in the small, rural community centered around Quincy, Illinois. Please accept this detailed report as written comment in opposition to Project #20-044.

The Illinois Health Facilities and Services Review Board ("HFSRB") should deny the Certificate of Need ("CON") application for Project #20-044. The applicants seek to establish a second hospital to be named the Quincy Medical Group Hospital ("QMGH"). The following report outlines the deficiencies and inaccuracies on the application. We have organized the materials to track the core statutory requirements established under the Illinois Health Facilities Planning Act ("Act") (20 ILCS 3960), and describe how the filed application fails to meet the basic elements necessary for approval by the HFSRB. Upon receipt of an application for a permit, the HFSRB may approve a proposed project if it finds the following:

(1) that the applicant is fit, willing, and able to provide a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant;
(2) that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community:
(3) that safeguards are provided that assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest: and,
(4) that the proposed project is consistent with the orderly and economic development of such facilities and equipment and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act.

Approval of this Application will Have a Negative Impact on Area Providers

Applicants for the proposed project have demonstrated neither the experience nor requisite qualifications to operate an acute care hospital. They have failed to appreciate or set forth how this proposed project would negatively impact healthcare delivery within this community. The proposed financing for the project is unreasonable in light of market conditions for qualified and worthy borrowers, and the financial projections associated with the project are speculative, at best, and at worst are grossly inaccurate; however, the strongest basis upon which to deny the application is the detrimental impact this project would have on the regional health eco-system and in particular on Blessing Hospital. Independent third-party consultants estimate the financial impact of a second hospital in Quincy would lead to actual losses for Blessing Hospital of $6,900,000 annually, and put at risk another $7,800,000 annually. This financial loss is tied directly to Blessing's role as the sole community hospital in the region. In addition, the proposed facility would lead to increased healthcare costs for the small Quincy community as a whole. When considering patient volume, QMGH projects $55,698,557 in revenue (or possible revenue losses to Blessing Hospital) based on shifting Blessing Hospital patients to the proposed facility.

The Project's Costs Are Unreasonable and the Application is Missing Necessary Applicants

The applicants propose to fund the entirety of the project costs reported in the application through the use of a lease. The total maximum payments proposed by this lease equal $139,006,980, and QMGH is financing this project through multiple layers of Cullinan owned corporations at a total all in interest rate of 9.596%. As noted in the application, QMGH proposes to utilize a lease through Quincy-Cullinan, LLC and/or its managers. We believe the size and nature of the lease warrants close scrutiny by HFSRB to determine the necessity of adding Quincy-Cullinan, LLC as a co-applicant under the regulations.

Establishment of QMGH at the Proposed Site is a Maldistribution and Duplication of Services in the Area

Applicants' claim that this proposed facility will increase access to care to the region is inaccurate and unsupported. Blessing Hospital has ample capacity at its facility to treat additional patients, and QMGH's plan to locate this facility on the same street only 3.5 miles from Blessing Hospital will not increase access to care in the region in any meaningful way. The proposed site of this facility is the very definition of maldistribution of healthcare resources. The applicants also describe a "redeployment" of beds from competitor facilities to justify their project. In fact, to "redeploy" beds to QMGH would actually exacerbate any maldistribution by centralizing even more beds adjacent to the existing hospital while undermining the ability of Blessing Hospital to continue providing safety net services for the community.

The Application Is Dependent on Bed Swapping Not Permitted by Illinois Law

Applicants introduce troubling proposals to coordinate the "redeployment" of beds between rural hospital providers that are not parties to this application. The record documents that at least one hospital CEO has committed to "redeploy" beds and has been promised a seat on the QMGH board. The Illinois General Assembly has expressly not allowed the buying and selling of beds, and this seemingly quid pro quo arrangement between competing hospitals is concerning. We ask that HFSRB closely examine whether the proposals by the applicants are consistent with the legislative mandate of the HFSRB and Illinois law.

Moreover, there has been no analysis as to the rationale, reasoning, or impact upon the smaller regional, rural Critical Access Hospitals and communities that are inexplicably "redeploying" beds for the benefit of a competitor. Prior to approval of this project and considering the existing and proposed referral relationships between the parties, it would be imperative for this Board to better understand how competitors who would presumably be in a position to refer patients to each other (and who have a history and proposed future) of caring for each other's patients can donate something of value without implicating the provisions of the Anti-Kickback Statute (See 42 U.S.C. § 1320a-7b).

Based on the reasons set forth herein and on the weight of the record it would be arbitrary and capricious for the HFSRB to approve this project. Approval of this project would require this Board to accept the variety of erroneous arguments advanced by the applicant which reflect factors the legislature never intended for the Board to consider (e.g., unexplained promises from healthcare entities in underserved communities to "redeploy" beds to a competitor; or the proposal to solve a claimed regional maldistribution by unnecessarily establishing a second hospital within a small community already served by a full-service hospital). Moreover, its approval would entirely disregard an important aspect of the responsible health planning with which this Board is tasked (e.g., ignoring the adverse impact on existing facilities, disregard of the maldistribution issues, and the advancement of unfettered growth with the promise of economic development over those ideals of increasing access to care and lowering health care costs prescribed by the Certificate of Need program).

Simply put, this Board should be hard pressed to present sufficient explanation for the approval of this project that would not run counter to the evidence available. It would be patently insufficient for the Board to justify a project of this nature "based upon the staff report and the testimony of the applicant" as its basis for overcoming the undoubted negative findings, the inconsistencies in the information presented by the applicants, or based upon a preference for increased competition. The reliance on such boilerplate language certainly cannot constitute a basis for which deference should be afforded to the expertise of this Board. Any rationale, to be meaningful, must be explicit and must accompany the consideration of this project.

Accordingly, the HFSRB should deny Project #20-044.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado Jr.

Mark. J. Silberman

cc: Mike Constantino, Senior Project Reviewer
April Simmons, General Counsel

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I. 20 ILCS 3960/6(d)(1) – [T]he applicant is fit, willing, and able to provide a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant[.]

The applicants fail to meet the very basic standard for an applicant seeking to build and operate a new short-term acute care facility. First, the application fails to present evidence that this group of individuals has the necessary experience and qualifications to operate a hospital. Likewise, they fail to cite any external experience being retained to provide the necessary expertise, or the cost associated with obtaining such expertise. While Quincy Medical Group ("QMG") certainly includes physicians with experience in hospital clinical operations, the management and daily operations for a short-term acute care hospital provider go far beyond this set of skills.

The labyrinth of federal, state, and accrediting body rules, regulations, and standards make hospital operations a very challenging and complex operation for even experienced operators and administrators. Many hospitals fail as a result of mismanagement. As is addressed in more detail throughout this response, the failure of the applicant to consider and/or accurately account for some very basic components of hospital reimbursement, expenses, financing, and healthcare planning strongly suggests the applicants do not possess the background or qualifications to build and operate an acute care hospital.

Further, evidence of unsuccessful facility management is part of the recent history for the applicants. In 2006, Blessing Hospital purchased an Ambulatory Surgical Center ("ASC") from QMG, during challenging financial times for QMG, to protect the services for the community. QMG is now opening a new ASC, approved despite Blessing Hospital's objections. While not yet operational, the project has already been subject to budgetary increases abutting the alteration limitations and delays to its scheduled opening in 2021.

In short, QMG's experience operating its clinical practice does not translate into the ability to operate a hospital. The operation and management of these type of disparate healthcare organizations require significantly different skill sets in to be successful. Moreover, QMG's lack of understanding of the impact that this proposed hospital will have on the balance of healthcare services in the community ***is exactly why this Board exists***. Operations for physician group services are subject to much less stringent oversight and complexity from an administrative standpoint than ASCs, and *substantially* less oversight than a short-term acute care hospital. Given these factors, there is a threshold concern about the qualifications of the applicants that the HFSRB should seriously consider in its review of this proposed project.

II. 20 ILCS 3960/6(d)(2) – [E]conomic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community[.]

The applicants' filing fails to demonstrate economic feasibility, whether considering the effects on (1) the existing and projected operating budget of the applicant and the health care facility; or (2) the projected impact on the total health care expenditures in the facility and community.

(1) THE EXISTING AND PROJECTED OPERATING BUDGET OF THE APPLICANT AND THE HEALTH CARE FACILITY

The applicants note only a few very basic details regarding operating budget impact of this project:

- Project Costs: The total project cost is $61,142,058, consisting of Site Preparation / New Construction Contracts / Contingencies / A&E Fees / Consulting Fees / Net Interest Expense / Fair Market Value of Leased Space or Equipment.
- Operating Costs: Start-up costs and operating deficit of $23,000,000 through the second year of operations.
- Source of Funds:
  - Funding of $61,142,058 though "Leases"; and,
  - A Letter of Intent to offer financing in the amount of $23,000,000 in credit from Bank of Springfield at what purports to be a market rate but reflects a rate that is clearly well above normal for this type of project.
- Viability Ratios: The applicants cite projected viability ratios for 2027 without any detail on the underlying figures (Attachment 35 – Page 133). This is in violation of HFSRB rules.
- Revenue: The applicants cite revenues of $27,246,996 in Year 1 and $55,698,557 in Year 2, again failing to document how they arrived at these amounts.

The information provided appears insufficient upon close scrutiny and leaves the members of the HFSRB without the details required to make an informed decision. It is improbable the HFSRB Staff or the public could come to a reliable conclusion that the project is economically feasible. As discussed in Section IV(H) of this report, the applicants fail to provide required information under HFSRB regulations regarding its assumptions. In addition, we note the following concerns regarding the economic viability based upon what we could extract from the record.

QMGH will lease its entire 68,000 square foot facility for $50.39 per square feet plus an allocation of up to 2% a year for rental increases. This amounts to $285,543 per month or $3,426,516 per year for a 30-year initial period plus annual escalations for inflation. It is also leasing furniture, signage, its security system, the nurse call system, and artwork. None of this is reflective of a long-term commitment to the building, let alone the community.

Total construction costs identified in the Project Costs and Source of Funds section of QMGH Application Project #20-044 of $36,658,011 are being financed through a Capital Lease from:

- QUINCY-CULLINAN, LLC, an Illinois limited liability company,
- By: QC Development, LLC, an Illinois limited liability company, its Manager
- By: QCD Manager, LLC, an Illinois limited liability company, its Manager
- By: CULLINAN COMPANIES, LLC, an Illinois limited liability company, its Manager

The fact that there are four layers of corporations involved in this transaction is, in and of itself, alarming. However, when you factor in a total of $139,006,980 in total maximum payments that are proposed by this lease, QMGH is financing this project through these layers of corporations at a total all in interest rate of 9.596%. Moreover, given the source of the funds and the likely control over the property that traditionally accompany such a lease, it is questionable that Quincy-Cullinan, LLC and its subsidiaries are not considered requisite co-applicants to this project.

Given the fact that most tax-exempt financing is under 3% today the patients and employers and governmental payers using this facility will be overpaying on financing by $83,368,386 over the 30-year loan period.

If QMG and QMGH were financially sound they would and should be able to finance this facility at a rate of less than 3%. On top of these lease rates, the lease charges QMGH "building and project operating expenses" of $340,000 per year for the 68,000 square feet QMGH space. QMGH is also being charged $121,000 per year for "Quincy Mall" space. This warrants explanation from the applicants as to what aspect of healthcare delivery will be served by its $121,000 annual outpost at the mall. HFSRB Staff and Board Members should demand a thorough understanding of this arrangement and why it is being undertaken in this manner. The proposed funding for this project is outside of normal standards for similar projects, is not viable in the long-term and is clearly structured to enrich the various Cullinan companies and their real estate interests more so than comply with HFSRB regulations.

As noted in more detail in Section IV(H) below, the applicants also make erroneous assumptions in projecting volume for its services. These errors will have a significant and material impact on the applicant revenue assumptions to support this project.

In summary, the applicants have failed to meet the basic documentation requirements to demonstrate financial viability for the facility. The documentation and facts we can discern show a troublingly high cost of financing and unexpected costs that would not be considered reasonable given existing market conditions for lending to credible borrowers. We believe this, alone, warrants denial of the application.

(2) THE PROJECTED IMPACT ON THE TOTAL HEALTH CARE EXPENDITURES IN THE FACILITY AND COMMUNITY.

The application presents a number of concerns that the proposed hospital will have a significant and detrimental impact on the total health care expenditures in the community. On this basis alone, the applicants fail to demonstrate the economic feasibility of this project and for the following compelling reasons the HFSRB should deny this project.

Our review of the record reveals the following items of concern:

- Loss of the Sole Community Hospital (SCH) + 340B Status
- Duplicative Patient Transfer Costs
- Increased Staffing Costs
- Market Volume + Pricing Impact
- Focus on Economic Development – not Healthcare Costs

Sole Community Hospital (SCH) + 340B Status

Blessing Hospital first raised the loss of Sole Community Hospital ("SCH") status to the HFSRB in a March 22, 2021 opposition letter by its CFO, Patrick M. Gerveler. As documented therein,

the national accounting and consulting firm BKD affirmed the financial impact establishment of an unnecessary second hospital would have on this community. The proposed second hospital will directly cause the loss of ~$6,900,000 annually in federal funding to Blessing Hospital once complete. This funding is irreplaceable for the community. It is concerning that QMGH was either not aware of this impact or chose to disregard the clear negative impact on an area provider by remaining silent on the issue in their application. Either way it clearly implicates issues under the Board's rules.

Relatedly, the loss of SCH status may ultimately lead to the loss of 340B Program eligibility for Blessing Hospital. Although not a definitive outcome (unlike losing SCH status itself), the loss of 340B eligibility could result in lost savings of over $7,800,000 to the community annually. This program is specifically designed for community hospitals like Blessing to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services, which is a goal consistent with the mission and values of this Board. As with the SCH funding, there is no replacement for this funding to support low-margin services offered by Blessing Hospital to the community today. QMGH cannot and will not replace the low-margin service offerings and they will not replace the lost funding. To the contrary, since QMG's hospital seems to be tailored for low-acuity high reimbursement patients, leaving the medically complex, Medicaid, and indigent for Blessing Hospital, its approval will exacerbate the loss of these funds and adversely impact access to care for the indigent and underserved communities.

Duplicative Patient Transfer Costs

The applicants do not hide the fact that this proposed facility will service lower-acuity patients. Blessing Hospital is also concerned that the proposed project will result in significant medical cost increases for hospitalized patients that the proposed hospital will not be equipped to serve. As a lower-acuity hospital ***without an ICU or advanced stroke/cardiac care capabilities***, the facility will rely on Blessing Hospital for the advanced life-saving care patients may require. This reality creates a number of situations where patients will incur increased costs.

For example, whenever a patient presenting to the proposed QMGH emergency department requires care capabilities only available at Blessing Hospital, that patient will be transferred by ambulance. The patient will likely be billed by QMGH for its initial care, by the ambulance for the care/transportation, and then by Blessing Hospital for services rendered. The bill by QMGH and by the ambulance company for the intervening transfer will be costs the patient would have avoided by presenting the Blessing Hospital Emergency Department just 3.5 miles away. While this is just one example of duplicative costs the proposed facility will create for the community and patients, one can imagine this scenario playing out in several different areas. The design of this facility seems to be to allow QMGH to maximize the profits it can obtain for healthier patients and, once the financial commitment becomes too significant or the care requires too high a degree of acuity, these patients will be handed back off to Blessing Hospital.

Staffing Costs

Healthcare staffing availability and costs have been an ongoing source of concern and a driving force of rising healthcare costs throughout the state. This issue has received national attention as the COVID-19 pandemic compounded and heightened the issue of staffing availability and costs during the pandemic. The duplicative service proposed by QMGH at just a mere 3.5 miles from Blessing's inpatient campus will not create more nurses, doctors, or medical professionals. It will only create additional need for qualified staff since QMG is only duplicating high-reimbursement low acuity services (all of which are already available at Blessing). This will further stress an already challenged labor market and risk undermining the primary aspect of access to care -

healthcare professionals. As a primary driver of hospital costs, increased labor expense will further increase costs for both QMGH and Blessing Hospital.

In addition, the loss of revenue and increased costs caused by QMGH will also be a barrier to Blessing Hospital's ability to foster nursing and medical staff education. Each year Blessing invests over $7,200,000 in health care career programs and training opportunities. Blessing supports training and programs for a diverse set of medical professionals, including:

- Advanced Practice Practicum/Clinical
- Family medicine residency
- Nursing
- Emergency Medical Services
- Health Information Management
- Laboratory sciences
- Pharmacy residency
- Radiologic technology
- Respiratory care
- Surgical technology

The loss of tens of millions in revenue will have many unintended consequences for Blessing Hospital and the community, including placing at risk the local medical professional education programs. These programs provide critical job training and develop the next generation of healthcare professionals who serve not only Blessing Hospital but hospitals and clinics throughout the region. This unique investment in medical and healthcare education by Blessing Hospital is important to the region and provides a significant benefit to the local economy.

Market Volume + Pricing Impact

The Market Volume projections used in this filing are the linchpin of QMGH's arguments that this project is needed by the community. As noted in the report commissioned by Blessing Hospital and sent to the HFSRB by Guidehouse, the volume methodology employed by QMGH in this filing is without question unreliable and inaccurate. Any analysis that uses a ***generally accepted healthcare planning methodology*** concludes that ***the market need for additional inpatient beds is projected to be flat and more likely lower than the current need*** in coming years. Simply put, this project is rooted in the fallacy that historical growth will continue unabated and that Blessing Hospital will reach 116% capacity. Such projections are highly questionable and reflect a lack of understanding of healthcare delivery and a willingness to mislead the Board to justify the interests of QMG. Moreover, in the event that additional capacity is, needed in the area, the Board's rules allow for the addition of 60 beds at Blessing Hospital between now and when this proposed project would become operational. Based on these inescapable conclusions, the proposed project is simply offering the community the proposition of adding duplicative services[1] to the service area where no need exists.

To understand how inaccurate patient volume forecasts impact costs, we must first look at why QMGH's position on pricing is also flawed. QMGH claims in its application that Blessing Health charges significantly more than regional competitors in the area and that this project will decrease

[1] QMGH proposes to add 25 med/surg beds, 2 observation bays, 3 obstetric beds, 3 operating rooms, 1 procedure room, 8 ED bays, imaging equipment, and a c-section suite. All these services are offered by Blessing Hospital which has available capacity for additional patients, is located within the HSA and would be negatively impact by this facility.

costs. The only support offered for this position is (1) studies regarding competition decreasing costs; (2) a citation to a non-public report by BSG analytics; and (3) a general statement about employers and commercial payors citing higher than average costs. Nowhere in its application have the applicants provided any reliable data for these general assertions.

Conversely, the Guidehouse research (provided to HFSRB for review) notes that from a charge and cost of care perspective, Blessing Health is within the market 50th percentile across comparable hospitals in surrounding cities (St Louis, Springfield, Davenport). This independent, external, and supported information directly refutes the applicants' undocumented assertions.

Further, we want to note that QMGH supplies no evidence to the HFSRB that it will, in fact, charge less than Blessing Hospital. They provided the HFSRB with zero detailed revenue assumptions, they provide no transparency regarding the proposed charges, and they fail to even document that their existing physician service pricing is more cost effective for patients than other area physicians.

Blessing Hospital has also scored favourably both nationally and within the State of Illinois on the Medicare Spending Per Beneficiary (MSPB) metrics compiled by the Illinois Hospital Association (IHA)[2]. Again, a third-party report provided to the HFSRB clearly evidences the lower costs of care Blessing is able to deliver to patients. The ability to continue providing quality care at a lower cost will be undermined by the approval of this unnecessary second hospital - something fundamentally at odds with the principles espoused by the HFSRB and its Act.

In assessing the overall impact of the project on volume and pricing, Guidehouse came to a disconcerting conclusion, namely that:

- Commercial rates don't tell the whole story. Blessing serves as Sole Community Hospital in a large area surrounding Quincy, Illinois. Considering both the underserved populations Blessing Hospital serves and the critical low-margin high-need services provided to the community, Blessing's average rates are necessary to maintain financial health and maintain its ability to provide safety net services[3] to the community.
- If this CON is approved, a physician-owned hospital would position itself to siphon of higher margin generating lower-cost services from Blessing, without replacing Blessing Hospital's position as a provider of safety net services for the Medicare, Medicaid, and indigent patient populations of the region
- In the worst-case scenario, while all steps would be taken to avoid this result, Blessing would begin to face margin and liquidity issues, and either (1) the eventual reduction or closure of critical services; or (2) higher commercial reimbursement to subsidize these services. This would be a significant detriment to the Quincy community, notably its indigent and underserved communities.

[2] See Attachment 1 for the MSPB Report

[3] 20 ILCS 3960/5.4(b) - For the purposes of this Section, "safety net services" are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. Safety net service providers include, but are not limited to, hospitals and private practice physicians that provide charity care, school-based health centers, migrant health clinics, rural health clinics, federally qualified health centers, community health centers, public health departments, and community mental health centers.

Focus on Economic Development – Not Healthcare Costs

We also want to highlight concerns with the applicants' emphasis on ancillary economic development for the project. The economic impact of the project on the area economy is not a criterion in the HFSRB's review of the establishment of a new healthcare facility. This is with good reason. A project can have a beneficial impact on surrounding businesses, while simultaneously harming the overall healthcare ecosystem, which the Planning Act and this Board are tasked with protecting. Consideration of ancillary economic development reflects factors not considered by the legislature.

For example, on page 71 of the application, QMGH notes that a key purpose of the project is the "*Need for Stimulation of Economic Development in Quincy"*. Further, on page 139 of the application, QMGH notes that:

> *The project will involve relocation of mall tenants, demolition of existing space, construction of the hospital on the vacated space, and integration of the hospital into the Quincy Mall. This makes the project more complex than a typical ground up construction project. While this will add cost to the overall construction budget, it allows for the redevelopment of a portion of the Quincy Mall, which will improve foot traffic, retail sales, and viability of the mall. The hospital will provide access directly into the mall in order to support economic growth for many.*

Economic development is an important and critical goal for every community, but we are concerned the emphasis on economic development is masking the very real and substantial increase in healthcare costs this project will cause for the community. A review of the support letters submitted for this application contain the same belief that this project is needed for economic development but there is no discussion of the negative impact to area providers. The HFSRB cannot justify approval of this project based on the supposed economic developments that construction of the facility will generate. It also, once again, raises the question of whether Quincy-Cullinan, LLC should be further evaluated as a co-applicant to this project.

III. 20 ILCS 3960/6(d)(2) –[S]afeguards are provided that assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest[.]

The concerns regarding compliance with Illinois regulations and the overall accuracy, need, and economic viability of this project are documented within this report. Without repeating those assertions, we note approving the establishment of the proposed hospital is clearly not consistent with the public interest at this time. We also want to separately address another item of concern from the applicants' written and oral testimony record. The application includes an issue we believe warrants close scrutiny by the HFSRB in its review.

As referenced by the applicant in multiple areas of the filing and on page 67:

> *Demonstrating their commitment and support of the project, [Memorial Hospital Association] MHA has committed to redeploy up to eight underutilized med-surg beds to Quincy Medical Group Hospital, and [Sarah D. Culbertson Memorial Hospital] SDCMH has committed to redeploy up to an additional 10 underutilized med-surg beds. Letters of support from MHA and SDCMH evidencing their firm commitment to redeploy the beds are included as Attachment 12-4.*

During oral testimony on January 12, 2021, Ada Bair, CEO of Memorial Hospital Association, further remarked that:

> *While the physician-led hospital will have a board of directors with a majority of physicians, two leaders will serve on the board by the time the hospital is operational. I am honored to be one of those leaders […]*
>
> *[…] Memorial Hospital has committed to redeploy up to eight of our medical-surgical beds to QMG Hospital where we believe they will be utilized efficiently. We believe this redeployment is in the best interest of our residents.*

We are concerned that two regional hospitals are committing to the relocation of their existing beds, which are for the benefit of their communities, without input from their communities or the required approvals from the HFSRB. This is not one parent organization seeking to optimize its care delivery in a region.[4] Rather, we have three separate provider entities colluding to redistribute inpatient beds outside of regulatory purview. Further, at least one CEO of a hospital committing beds to be relocated seems to have been incentivized by being promised a seat on the Board of the proposed hospital – which would be a direct competitor in the region. While it is likely the HFSRB will not consider these 'donated' beds, the fact that this project is built upon the foundation of such a proposal, once again, either reflects a lack of understanding, appreciation or respect for the HFSRB rules and process.

Given the ongoing referral relationships between Quincy Medical Group and Memorial Hospital Association, this alone is a troubling development and possibly non-compliant with the federal Anti-Kickback Statute ("AKS"). The AKS is a criminal statute that prohibits the exchange (or

[4] Applicant makes multiple references to and endeavors to create a parallel with the MercyHealth project (#17-002) in Crystal Lake, even mirroring the 'redeployment' language from that project. Despite such a comparison improperly invoking the prohibition of comparative review, two notable distinctions must be made: (1) the 'redeployment' in that project was one system removing beds from its own facility to establish another facility so as to better serve the community by placing beds where there were none; and (2) that project established an emergency room in a large geographic area that had none - it did not seek to establish a physician-driven, high-reimbursement, ICU-less hospital just a few miles away from an already existing vibrant safety-net hospital.

offer to exchange) of anything of value (remuneration) with the intent of inducing (or rewarding) the referral of federal health care program business. *See* 42 U.S.C. § 1320a-7b.

It is well-established that the buying and selling of licensed beds is not permitted in the state of Illinois. While the applicant describes this action as a re-deployment of beds, the Act does not provide for such an action and approval of the application on this basis would be inconsistent with public policy and an abuse of this Board's discretion. We ask that the HFSRB closely review the applicant's suggested position and ensure safeguards are in place to protect the public interest.

IV. 20 ILCS 3960/6(d)(2) –[T]hat the proposed project is consistent with the orderly and economic development of such facilities and equipment and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act.

For organizational purposes, the applicants' failures to meet defined regulatory standards are addressed below in the order of the attachments for the CON filing:

A. Attachment 2: Proof of Ownership or Control of the Site

This is traditionally a non-issue; however, based upon the decision to locate a hospital within the parking lot of a mall, and to attribute the same address of the mall (3347 Quincy Mall, Quincy, IL 62301) to the facility (3347 Quincy Mall, Quincy, IL 62301), there is a significant issue presented by the "address" of this hospital and the question of who has control over 3347 Quincy Mall, Quincy, IL 62301.

Once again the serious question of whether Quincy-Cullinan should be a co-applicant for this project arises. Quincy-Cullinan unquestionably controls 3347 Quincy Mall, Quincy, IL 62301. It gets, however, even more complicated than that when one factors in healthcare delivery into the equation.

If one is to search on the internet for 3347 Quincy Mall, Quincy, IL 62301 one does not find a hospital, but a mall. Each and every one of the mall's stores have the address 3347 Quincy Mall, Quincy, IL 62301. Whether this address confusion will be acceptable to the Illinois Emergency Management System is a legitimate question. This Board will have to decide whether the risk of delays and confusion is tolerable for facing a medical crisis who look up 'nearby hospital' and enter '3347 Quincy Mall, Quincy, IL 62301' into their GPS and find themselves navigating the series of retail stores in search of the healthcare facility located around back in what was once a parking lot. Considering that CON applications are site specific, this is not an easy problem to fix, as changing the proposed address would require the filing of a complete new CON application.

B. Attachment 8: Project Status and Completion Schedules

The applicants anticipate project completion within approximately 54 months of project approval or September 30, 2025. Four and half years is the outer limit of acceptable health planning timeframes as demonstrated by previous applications approved by this Board. Industry operators and builders are capable of bringing facilities online within 12-24 months from design to completion. While not everyone will operate on the most aggressive timeline, the dearth of reasoning or explanation for such an extended development for what has been described by the applicants as a small low-acuity facility is perplexing. We ask the Board carefully consider and question the applicants regarding how their current expectations (before considering the flawed planning by the applicants) for the market can be relied upon to reflect need nearly five years from today, especially when that need is founded upon questionable health planning principles that ignore the current trends in healthcare delivery.

C. Attachment 12: Project Purpose

The applicants stated project purpose appears to boil down to one preference – choice. QMGH's basic argument is that by building a second hospital the community will reap a litany of benefits. We would not be so vehemently opposed to this filing if we believed this position held any merit. Unfortunately, the applicants throughout their application either omit crucial information that the HFSRB should be considering or make assertions that hold no merit. As noted by the applicants themselves:

> As a rural community, residents in Adams County, including Medicare and Medicaid beneficiaries, face unique obstacles when seeking healthcare services — such as shortages of healthcare services and specialties, an inability to fully benefit from technological and care-delivery innovations, and limited transportation options.

Blessing Hospital leads the community in addressing access to care challenges and fears the short and long-term impact this ill-planned proposal will have on this rural community. We have included commentary in response to the existing issues cited by the applicants as follows:

- **Lack of Competition and Accessibility to Local, Affordable Care:**
  - Hannibal Regional Hospital: The applicants fail to mention Hannibal Regional Hospital anywhere in this filing, which is a full-service acute care hospital about 26 miles away in Hannibal, Missouri. This is despite the fact that QMGH is relying on nearly 19% of their documented referrals to come from Missouri[5]. Additionally, QMG patients within Illinois zip codes are located closer to Hannibal Regional Hospital than Blessing Hospital.
  - Affordable Care: As noted in Section II above and Section IV(F) below, the applicants' false assertions have been exposed by the independent assessment of Guidehouse. We have evidence of Blessing Hospital's cost and pricing competitiveness for the community.
  - Documentation: QMGH fails to provide cited research, studies, or surveys to support its claims.

- **Need and Desire for Improved Care Coordination and Alternative, Physician-Led Hospital.**
  - Physician-Led: Blessing Hospital is already as much a physician-led provider as the proposed QMGH facility. Importantly, Blessing's board also includes community members. ***QMGH's proposed second hospital does not have any community/patient representation on the board.*** QMG physicians lead and actively participate in many Blessing Hospital committees and they have also held medical directorships at Blessing Hospital. This is in addition to the physician representation from Blessing Physician Services and other physician practices. QMG physicians have been partners in working on Blessing Hospital's clinical protocol development, the introduction of new procedures, and introduction and training on new equipment in the hospital. QMG is not the only physician group that Blessing Hospital collaborates with in leading this hospital, they are proud to work with physicians from Southern Illinois University who provide essential leadership at the Hospital.

  - Coordination: Blessing created and maintains a Clinically Integrated Network to coordinate care in the community- ***QMG declined to participate***. Blessing Hospital believes greater coordination is not only possible - it is a necessity. However, building another hospital is not solution, instead it seeks to upend necessary partnership between Blessing and QMG solely to suit the interests of QMG. Blessing stands ready, willing, and able to coordinate care with QMG. This, notably, is an alternative to the project that applicants never considered.

  - Anti-Competitive: QMGH equates physician recruitment by Blessing to anti-competitive behavior. Would the same not apply to QMG's recruitment of physicians

[5] See Project #20-044 – Page 110-111

if true? ***Blessing Hospital already faces a variety of significant competition and welcomes the opportunity to prove that the quality of care we offer sets the bar.*** QMG insists that competition will lead to better healthcare and lower costs for the community. But healthcare is not like other industries. The Quincy healthcare eco-system can adjust to the new cancer center and outpatient services that QMG will provide. However, we anticipate significant negative impacts to Blessing Hospital from the delayed QMG surgery center and those issues will only be exacerbated by this proposed second hospital. History has proven that Quincy can only support one inpatient hospital in the long-term, and the establishment of an unnecessary second hospital would only serve to further dilute precious resources in the community.

- Cost Reduction: Blessing Hospital has aggressively managed and cut costs in recent years to stay cost-competitive, while also delivering a complex suite of services to ensure this community has access to needed services. The application for this facility makes clear that the patients to be served at this facility will be lower acuity and that a second hospital will produce cost savings for patients. However, any cost savings this proposed facility imagines will be most directly tied to the facility not providing high-cost (and less profitable) services. At the end of the day, this hospital ***does not*** increase access to care for those who need it most. ***The sickest and most vulnerable patients will not be served by QMG,*** those patients will still need Blessing Hospital.

- **Shortage of Beds and Efficient Emergency Services Resulting in Delays for Patients.**
  - Guidehouse Report: The straightforward, transparent report from Guidehouse presents a clear and convincing picture for why these assertions are inaccurate at best.

    HFSRB Bed Need**:** Aligned with Guidehouse, the HFSRB's own bed need calculation show an excess and underutilized capacity within the market today.

- **Maldistribution of Healthcare Resources in the Planning Area and Health Services Area.**
  - As noted in Section IV(F)(d), maldistribution is what this project will cause, not rectify.
  - As noted in Section III, we also ask that HFSRB closely examine the proposed bed commitments from other area providers respective to this filing. The applicants 'assertion that there is a need for additional beds in the HSA are simply unfounded. Even with the applicants' proposed manipulation of the state's bed inventory, it does not change the fact that this proposed project adds beds to an already over-bedded HSA.
  - Furthermore, the applicants' claim that this proposed facility will increase access to care to the region is in conflict with their proposed site, which is located only 3.5 miles from Blessing Hospital. The proposed site of this facility is the very definition of maldistribution of healthcare resources. The proposed location, like the remainder of the application, is designed to serve the interests of QMG. To distract from this, they shroud their application in unfounded claims of need, baseless claims of cost-savings, and unsupported conclusions.
  - Finally, Blessing Hospital in 2019 submitted a request to HFSRB to add an additional 20 beds to its bed inventory pursuant to section (5)(c) of the Act. This action was an appropriate use of the Board's rules and established planning process to meet the need of the community. In the five years that it will take to construct the proposed facility, Blessing could add an additional 60 beds to planning area if necessary, and provide care to all patients regardless of their ability to pay and regardless of the patient's

acuity. This is something the proposed facility simply cannot do, and highlights the fundamental lack of need for this facility to meet the needs of anyone other than QMG.

- **Need for Stimulation of Economic Development in Quincy.**
  - As noted in Section II, we are concerned this project will increase healthcare costs for the small Quincy community.
  - This is not an issue that speaks to how the project will provide health services that improve the health or well-being of the market population.

- **Ongoing Need for Enhanced Recruitment and Retention of Skilled Medical Providers**
  - Primary Care, Mental Health, and Dental Care: These are the federal health professional designations cited by QMGH. A short-term acute care facility focused on low-acuity patients duplicating services provided by Blessing Hospital is not going to increase recruitment of these practitioners.
  - As noted in Section II, we are also concerned about the possible increase in costs for a finite labor this proposed project could bring to the hospital market**.**

D. Attachment 13: Alternatives

The CON application for Attachment 13 state: "The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available."

The applicants fail to provide any empirical evidence to support the assertions within Attachment 13, despite the fact they directly state the project will result in quality enhancement such as enhanced patient and provider satisfaction and improvement of care coordination and continuity of care.

On review of their assertions, the absence of empirical data makes more sense. On page 105, the applicants assert that this project was chosen for six (6) key reasons[6]. The record reveals a different conclusion.

(1) This is not a new healthcare delivery model. It is a duplication of existing short-term acute care hospital services in an over-bedded market. The evidence indicates this duplication will increase, not decrease costs.

(2) There is no evidence that building a new hospital will improve care coordination or continuity of care. Instead, it seems QMG is seeking the proposed hospital to reduce the kind of collaboration that the HFSRB encourages among health care providers. This would result in a disparate, non-integrated care continuum for the community.

(3) Enhanced patient and provider satisfaction are great talking points, but there is no evidence this facility will be capable of delivering any improvement over Blessing's excellent services. This is why applicants are required to provide empirical evidence of improved quality.

(4) The project clearly increases maldistribution as defined by the regulations. The removal of beds from underserved rural areas through a bed buying scheme contributes to maldistribution and is prohibited by law. Furthermore, the construction of a second hospital in a community of only

[6] Per QMGH Filing: 1. allows for the delivery of a new healthcare model that will increase accessibility to inpatient and emergency hospital services in the Quincy community and reduce overall healthcare spend; 2. improve care coordination and continuity of care through the deployment of a fully integrated delivery system. 3.enhance patient and provider satisfaction; 4. correct maldistribution of healthcare resources; 5. enhance recruitment efforts and Quincy's ability to retain top medical providers; and 6. invest in the local economy and community.

40,000 people, when the other facility is a mere 3.5 miles away, is the very definition of maldistribution of healthcare services.

(5) The record again provides bare assertions and no evidence a new hospital will enhance recruitment of providers to Quincy or retention of top talent.

(6) The investment of tens of millions of dollars in a new, duplicative hospital at the expense of increasing healthcare costs and weakening the existing care network is a reason to deny, not approve this filing.

E. Attachment 15: Project Services Utilization

The applicants' projected utilization is deficient for a number of reasons. First, the applicants fail to provide the required narrative to support the figures under Section 15. While the applicants attempt to explain their very generous projected utilization in Attachment 18, the applicants miss the mark. The population and patient base that the applicants are using to support this facility does not exist, and population growth trends for this area of Illinois reflect a decrease in overall population.

F. Attachment 18: Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

a. 1110.200(b)(1) - Planning Area Need

The applicants fail to document that the number of beds (25 medical/surgical & 3 Obstetric) are necessary to serve the planning area (E-05) population based on the regulatory requirements.

Specifically, the application fails to document:

(1) The establishment of 25 medical/surgical beds at the new hospital is not in conformance with the projected need in the area given the projected bed **excess** of 75 medical/surgical beds within the planning area; and,

(2) The establishment of 3 Obstetric beds is not in conformance with the projected need in the planning area given the projected bed excess of 14 Obstetric beds within this planning area.

The applicants attempt to circumvent these deficiencies by "redeploying beds" from Memorial Hospital Association (MHA) and Sarah D. Culbertson Memorial Hospital (SDCMH). The application is for the establishment of a new hospital, not the relocation of MHA or SDCMH beds. Moreover, there is no such thing as a "relocation" of beds under the Board's rules and, certainly not relocating the beds of a competitor into your facility. A relocation equals establishment per the HFSRB regulations and must meet the applicable standards. Additional concerns include (1) the legality of the proposed "bed redeployment" commitments (see Section II); and (2) the lack of community input from Carthage or Rushville.

Regardless, the redeployment of up to 18 beds from nearby rural communities only exacerbates any bed excess and distribution concerns within the market. The applicants understand they have a deficient position, and go on to outline their erroneous and counterfactual position that the market is in fact exploding with inpatient growth and need for medical/surgical beds. Again, this has been simply and clearly refuted by a national expert in Guidehouse. Inpatient demand is flat or declining. The applicants made a similar argument in their ASC application, as CMS and other

payers continue to push procedures out of the hospital outpatient departments and into an ASC setting. The bed **excess** under the State regulations will likely increase.

Despite the cherry-picked details by the applicants, the flattening demand was recognized by Blessing in Project #18-013, where Blessing noted "Blessing believes they will continue to see an increase through 2020 when the volume is conservatively projected to flatten." Since that project was filed the population in Quincy has continued to decline. Moreover, if there really was a need for additional beds in the community, those beds could be added without the unnecessary establishment of a new facility at a lower cost, and in a way that would not undermine the safety net facility that has served the Quincy community for almost 150 years.

The statements regarding the obstetric unit need cite irrelevant national statistics with no analysis of local conditions. Despite significant available obstetric capacity located just 3.5 miles from the proposed site, the applicants not only propose three obstetric beds, but future plans to operate a birthing center. Blessing Hospital's obstetric unit currently operates at only 26.2% capacity. By shifting nearly 40% (931/2,340) of the obstetric patient days from Blessing's unit to QMGH, the only hospital that can support complex deliveries for the entire region will be devastated.

b. 1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service

The applicants fail to appropriately document the projected number of referrals for the proposed medical/surgical and obstetric bed categories of service. The regulations require that the applicants submit physician referral letters that include "[t]he physician's notarized signature, the typed or printed name of the physician, the physician's office address, and the physician's specialty."

The applicants' physician referral letters fail to meet this requirement. The single referral letter included with the application fails to meet Board requirements in several aspects:

- The referral letter is not signed by a physician, instead it is signed by a non-physician employee of QMG. Circumventing the physician signature regulation allows for unverified commitments without any certainty the physicians have been consulted or agree with the stated intention of QMG as an organization;
- The referral letter does not contain the office address of any of the referring physicians; and,
- It would appear that the projected referrals for this application may have already been used to justify the Quincy Medical Group Surgery Center, Project #18-042. Board rules prohibit the use of patient referrals used to support another approved CON application for the same services. This is something that the applicant should be required to address, explicitly, to avoid a complete disregard of this aspect of the HFSRB rules.

c. 1110.200(b)(5) - Planning Area Need - Service Accessibility

The applicants fail to document that at least one (1) of the five (5) service restrictions factors outlined within section 1110.200(b)(5) exists within the planning area. As a result, the planning area does not demonstrate a need for the proposed project and the establishment of the medical/surgical and obstetric is unnecessary to improve access for planning area residents.

Specifically, the applicants fail to demonstrate any of the following factors exist:

1. The absence of the proposed service within the planning area;
2. Access limitations due to payer status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;
3. Restrictive admission policies of existing providers;
4. The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population; and,
5. For purposes of this subsection (b)(5) only, all services within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

The applicants try to meet the State requirements by both (1) making an objectively false statement; and (2) referencing invalid volume growth projections. The applicants state on Page 111, "Importantly, the Blessing Hospital project will not increase beds in Planning Area E-05." While that statement made by Blessing was true, this project clearly is adding 25 medical/surgical beds and three obstetric beds. Even if one accepted their "redeployment" position, the project is still adding at least 17 medical/surgical beds and three obstetric beds. We once again reference the Guidehouse report and HFSRB bed inventories to confirm there are no service restrictions based upon the utilization of area providers.

d. 1110.200(c)(2) – Unnecessary Duplication/Maldistribution

The applicants fail to document that the project will not result in the unnecessary duplication and maldistribution of services.

Per section 1110.200(c)(2)(B), maldistribution exists when the historical utilization for existing facilities and services in the identified area are below the established occupancy standards. The existing facilities within the area offer the proposed services and are operating below the established occupancy standards. Per the CY 2019 Hospital Profiles published by the HFSRB, the area facilities have the following utilization levels that fall below the state standards:

Underutilized Medical/Surgical Beds		
Underutilized Facility	CY 2019 (CON Standard)	Distance from Site
Blessing Hospital	67.2% (85%)	3.5 miles

Underutilized Obstetric Beds		
Underutilized Facility	CY 2019 (CON Standard)	Distance from Site
Blessing Hospital	26.2% (75%)	3.5 miles

An increase in medical/surgical and obstetric beds, along with the direct shift of patient volumes, will only cause these utilization levels to fall even further below these standards.

e. 1110.200(d)(3) - Impact of Project on Other Area Providers

Per section 1110.200(c)(3)(B), the applicant must document that the project "Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards." Clearly, Blessing Hospital is operating below the occupancy standards. With no organic market growth forecasted, the inescapable conclusion is that QHMG's commitment to shift 7,301 medical/surgical patient days and 931 obstetric patient days from Blessing Hospital will lower – to a further extent - Blessing Hospital's utilization below the occupancy standards. Not only has no such documentation been presented by the applicants, no such documentation could be presented. Either they are taking patients from Blessing or they are taking patients from one of the hospitals "donating" beds to their redeployment scheme - in either case they have fundamentally ignored the impact of this project on other facilities. Rather, applicants simply elect ***not to even address it***.

f. 1110.200(f) - Performance Requirements

Per section 1110.200(c)(3)(B), "The minimum unit size for a new obstetric unit outside an MSA is 4 beds."

The applicants propose a 3-bed obstetric unit, failing to meet the regulatory standard ***or even address it***. The applicant's failure to address this requirement is missing from the filing and the issue is completely ignored. Again, the application simply presented the conclusion of what is in the best interest of QMG, as perceived by QMG, rather than adhering to the HFSRB rules or offering any justification for their failure to do so.

G. Attachment 30: Criterion 1110.270 - Clinical Service Areas Other Than Categories of Service:

a. 1110.270(b)(1) - Need Determination – Establishment – Service to the Planning Area Residents

The applicants ***fail to meet this standard or even address it*** within Attachment 30 of their filing. One could *possibly* cross reference other areas of the filing to account for documentation that the Emergency Services, Diagnostic Imaging, Laboratory, or Pharmacy services will serve the planning area resident. However, there is clearly no support for the Surgical Services to meet this criterion. Specifically, the Applicants reference "Other Surgical Procedures" and over 1,033 cases by Year 2. We see no evidence of the applicants providing documentation of patient origin for these patients. This criterion requires that "Documentation shall consist of strategic plans or market studies conducted, indicating the historical and projected incidence of disease or health conditions, or use rates of the population." They simply offer the conclusion and hope no one will question their story.

b. 1110.270(b)(2) - Need Determination – Establishment – Service Demand
c. 1110.270(b)(3) - Need Determination – Establishment – Impact of the Proposed Project on Other Area Providers
d. 1110.270(b)(4) - Need Determination – Establishment – Service Demand

Emergency Department Need

QMGH's application makes unsubstantiated claims regarding projected Emergency Department volume.

In 2019, Planning Area E-05 only documented 43,939 Emergency Department Visits[7]. However, QMGH projects 102,896 Emergency Department visits, with 46,339 Emergent, 17,195 Inpatient Admissions, and 39,362 Non-Emergent visits. QMGH fails to document the source or reasoning behind these grossly inflated figures. It is also very disturbing that the applicants are projecting to treat non-emergent patient in the emergency department. This is a clear violation of section 1110.270(b)(2)(D), which requires "[t]he applicant shall submit documentation of incidence of service based upon IDPH statistics or category of service statistics." Furthermore, this is inconsistent with the important work healthcare providers in our state like Blessing Hospital have undertaken to stress the importance of primary care and lowering utilization of emergency rooms to treat non-emergent patients.
If we use QMG's 8% of emergent visits as the assumption and HFSRB's reported volumes in 2019 as the market volume, it is clear the applicants cannot support the planned 8-bay ED.

Facility	# ED Bays	2019 (E-05)	QMGH %	Year 2	State Standard	Met Standard?
QMGH ED	8	43,939	8%	3,515	16,000	No – Below by 12,485

Finally, this will clearly lower the existing utilization of Blessing Hospital by 3,515 (corrected volume) or 16,035 (QMGH application). Blessing Hospital is already underutilized for Emergency Services as seen below.

Facility	# ED Bays	2019	State Standard	Met Standard?
Blessing Hospital	31	39,640	62,000	No – Below by 22,360

Operating / Procedure / C-Suite Room Need

QMGH again fails to provide basic information required to support the application. The applicants project 3,102 surgical procedures at the facility; however, the applicants fail to provide the required verification of historical volume for these proposed cases.

The physician's referral letter included in Appendix I by QMGH (which does not meet regulatory requirements) only documents the 3,144 inpatient admission referrals projected by the applicants. While it appears this 3,144 may include the 1,116 Inpatient Surgery cases QMGH projects, it certainly does not account for the 1,033 "Other Surgical Procedures." Likewise, given the inaccuracies from the Emergency Services outline above, the resulting surgical volume from emergency department admissions are also inaccurate and unsubstantiated.

[7]https://www2.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Documents/2019%20Hospital%20HPA%20Summaries%20rev.pdf

Blessing Hospital is also concerned the referrals committed by QMGH in this category may overlap with referrals committed to the QMG ASTC project that is just about to become operational (assuming that it does not experience any additional costs thereby invalidating the permit the HFSRB granted). This concern is heightened by the fact the QMG has not submitted individual referral letters from physicians in either filing. The lack of transparency for such an essential portion of the application provides for no accountability at the physician level, and leaves HFSRB staff to guess where referrals are being committed for this project.

In Project #18-042, QMG committed 10,712 referrals out of 11,321 historical "ASC procedures" from their physicians. Now they are committing 1,033 of 4,111 "Other Surgical Procedures" to this facility – without any supporting documentation. Given QMGH separately identifies C-Section, ED visit w/surgery, and Inpatient Surgeries, and the limited patient base in the area it seems likely there is overlap with the ASC procedures in this "Other Surgical Procedures" category. Using the same projected referrals for two different CON projects is expressly prohibited by HFSRB regulations.

Consistent with Board rules, staff should require a physician to sign the referral letter(s) for this project and given the speculative nature of these referrals, the individual QMG physicians should be required to account for their historical volume to existing facilities and where they have already committed patients to before this Board. This request is simply in keeping with the regulations, as section 1110.270(b)(2)(B) requires: "Physician Referrals - For CSAs that require physician referrals to create and maintain a patient base volume, the applicant shall document patient origin information for the referrals. The applicant shall submit original signed and notarized referral letters, containing certification by the physicians that the representations contained in the letters are true and correct." Moreover, should the applicant be unable to do so, a compliance action would be in order for the ASC project already underway.

Finally, the surgical transfers from Blessing Hospital will also "[l]ower, to a further extent, the utilization of other area providers that are currently (during the latest 12-month period) operating below the utilization standards." In 2019 Blessing operated below the State utilization thresholds. And this is before QMG opens their new ASC in 2021.

Facility	# ORs	2019	State Standard	Met Standard?
Blessing Hospital	10	12,094	15,000	No – Below by 2,906

Diagnostic Imaging Need

Given the above comments on the Inpatient and Emergency Department Need, the assumptions underlying the Diagnostic Imaging need is also flawed. With a significant reduction in the number of emergency department visits based on correcting the QMGH errors, the X-Ray, Ultrasound, CT, and MRI volumes all drop significantly. Further, the applicants provide no citations or support for their usage assumption based on existing IDPH or category of service statistics, as required by section 1110.270(b)(2)(D).

	Procedure per Admission/ Visit	Revised Year 2 Admissions/ Visits	Revised Year 2 Procedures
X-Ray - Inpatient	1.28	2,766	3,548
X-Ray - ED Visit	0.34	3,515	1,195
Total X-Ray			4,743
Ultrasound - Inpatient	0.24	2,766	667
Ultrasound - ED Visit	0.05	3,515	176
Total Ultrasound			843
CT – Inpatient	0.52	2,766	1,440
CT - ED Visit	0.15	3,515	527
Total CT			1,967
MRI - Inpatient	0.10	2,766	267
MRI - ED Visit	0.01	3,515	35
Total MRI			302

The loss of patients by Blessing Hospital will also "[l]ower, to a further extent, the utilization of other area providers that are currently (during the latest 12-month period) operating below the utilization standards." In 2019 Blessing operated below the State utilization thresholds.

Equipment	Equipment #	Examinations	State Standard	Met Standard
X-Ray	24	52,676	192,000	No – Below by 139,324
Ultrasound	7	10,661	21,700	No – Below by 11,039

Further, Blessing brought online additional General Diagnostic, CT, MRI, and Ultrasound capacity in 2020 as part of Project #18-010 approved by this Board. This approved capacity will be negatively impacted by the proposed QMGH project, which does not account for this expanded market capacity in their filing.

Pharmacy Need

Given the above comments on the Emergency Department need, the assumptions underlying the pharmacy need are also flawed. With a significant reduction in the number of ED visits based on correcting the QMGH errors, the pharmacy projections all drop significantly. Further, the applicants provide no citations or support for their usage assumption based on existing IDPH or category of service statistics, as required by section 1110.270(b)(2)(D).

	Prescription per ED Visit	Revised Year 2 ED Visits	Revised Year 2 Lab Tests
Prescription	1.41	3,515	4,956

Considering the gaps that exist between the state standards and the current utilization it is evident that this project is not about meeting a proposed need, but rather is about advancing the interests of QMG.

H. Attachment 35: Criterion 1120.130 – Financial Viability

The applicants fail to provide required documentation to support the financial viability ratios reported. Shockingly, however, they presented conclusions that would suggest they will be able to meet most, if not all of the financial viability ratios within two years of becoming operational (just in time to seek a positive finding in this staff report). Per section 1120.130(b) "If the project involves the establishment of a new facility and/or the applicant is a new entity, supporting schedules to support the numbers shall be provided documenting how the numbers have been compiled or projected." This project cannot be found to be in compliance with HFSRB standards and criteria based upon the dearth of information provided.

We also reiterate our concerns with the validity of the financial assumptions. We have already documented clear errors in the emergency service volume, the applicants' market volume projections, and possible duplication of referrals with the QMG ASC for surgical volumes. The mounting evidence calls these unsubstantiated financial ratios for 2027 (6 years away) into question.

A. Attachment 36: Criterion 1120.140 – Economic Feasibility

Per the comments in Section II, we feel the intended leasing arrangement is not less costly than other forms of financing as intended under the regulations but would be notably costlier and an irresponsible use of limited healthcare dollars.

The applicants also significantly exceed the project costs for New Construction Contracts by $25.68 Per Square Foot. With a lessor in position to profit from the new facility, it is concerning that the applicants also exceed the state construction threshold.

Finally, the Total Effect on Project Capital Costs reported under Section 1120.140(e) appears to report a very low capital cost figure.

Conclusion

The town of Quincy was once home to two hospitals, Blessing Hospital and St. Mary Hospital. Thirty years ago, community, business, and healthcare leaders undertook an intentional evaluation of the region's healthcare delivery system and decided that a town of 40,000 individuals (the same population today as it was in 1990) could not sustain two hospitals. In the best interest of the community, those two facilities came together to merge and create a stronger and more comprehensive sole community hospital that would be able to provide tertiary level care to all citizens in the region. That hospital is Blessing Hospital. The town of Quincy has roughly the same population that it did in 1990 and it is not experiencing any population growth. Healthcare delivery continues to evolve, and Blessing is at the forefront of that change. Blessing has been the innovative in its approach to healthcare delivery and at the same time has been able to continue in its role as a safety net provider. For all the reasons outlined in this report, we believe this is the wrong project, at the wrong time and proposed in the wrong location. We respectfully request that the HFSRB deny this application.

ATTACHMENT 1