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Via Federal Express

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Department of Public Health
Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

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**HEALTH FACILITIES &
SERVICES REVIEW BOARD**

**Re: Holy Cross Hospital (Proj. No. 13-076)
Opposition Letter**

Dear Mr. Constantino:

Pursuant to Section 1130.950 of the Illinois Health Facilities and Services Review Board rules, Polsinelli PC submits the following comments to Holy Cross Hospital's certificate of need ("CON") application to establish a new 50-bed acute mental illness ("AMI") unit at Holy Cross Hospital ("HCH"). This letter is written on behalf of St. Bernard Hospital and Health Center, Loretto Hospital, South Shore Hospital and Roseland Community Hospital. Each of these hospitals are safety net hospitals in the area which are currently providing inpatient behavioral health services to the community and which would be directly and adversely affected if the project is approved. Thus, they oppose the proposal. To highlight the deficits of the proposal based on the purposes of the Health Facilities Planning Act and the technical requirements of the Health Facilities and Services Review Board (the "CON Board"):

- The proposed behavioral health program at HCH is not needed;
- The proposed program duplicates existing services which have adequate capacity;
- HCH's proposed program will not improve health care delivery or access;
- Opening an unnecessary program in the City of Chicago which has a steadily declining population, will jeopardize the City's other existing safety net hospitals; and
- The proposed expenditure of Sinai Health System's ("SHS") capital is a waste of health care resources for a health system which by its own admissions is financially challenged and has been cited as sometimes measuring its cash on hand in hours not days.

1. Alternatives (Criterion 1110.230(c))

Maintaining the status quo is the best option, not the establishment of an additional program. That alternative was not appropriately considered. Pursuant to Section 1100.400 of the CON Board rules, “[h]ealth care services should be appropriately located to best meet the needs of the population.” 77 Ill. Admin. Code 1100.400. As long as residents are not required to travel excessive distances, i.e., 30 minutes, and there is capacity for additional patients, there is no justification for additional services. The existing providers of behavioral health services in the planned geographic service area have capacity and provide options for inpatient behavioral health services. Other than discussing its own capacity for the service, which is not even located in the same planning area as the proposal, the Applicants fail to acknowledge the existence of other inpatient behavioral health providers in the market area operating below target utilization nor do they cite any inability of these providers to adequately serve the residents of the market area. All of the communities in the proposed HCH market area are within 30 minutes normal travel time of an existing hospital with adequate inpatient behavioral health capacity and a significant subset of those communities are within 15 minutes normal travel time of these services.

St. Bernard Hospital and Health Center, South Shore Hospital, Roseland Community Hospital and Mercy Hospital and Medical Center are the closest hospitals to HCH. Collectively, these hospitals have 65 AMI beds and would readily accept AMI patients from HCH and Mount Sinai Hospital Medical Center (“MSH”) emergency departments. Based upon the letters from the HCH and MSH emergency department medical directors, HCH and MSH collectively referred three AMI patients from their emergency departments to these four closest hospitals. (See App. pp 118-123). Importantly, HCH or MSH have not contacted these hospitals or requested arrangements to be made to admit or transfer AMI patients from their emergency departments to the hospitals’ inpatient AMI units. Rather HCH and MSH elected to transfer patients to hospitals outside of HCH’s service area. The lack of coordination with the closest hospitals does not support HCH’s assertion of its difficulties in attempting to transfer AMI patients from its emergency department to an available hospital for inpatient behavioral health services.

Further, the trend for utilization of inpatient behavioral health services does not support additional AMI beds in the HCH service area. As shown in Attachments 1-3, utilization of inpatient behavioral health services decreased from 2010 to 2012 for existing hospitals in HCH’s service area, from 60% utilization in 2010 to 55.6% in 2012. Importantly, there are no signs suggesting an increase in inpatient behavioral health services in the near future. To the contrary, health reform initiatives focus on providing behavioral health services in the most community-

integrated settings possible and lowering the inpatient utilization rates for behavioral health services. Further, according to the last Census, the population of Chicago has decreased significantly in recent years. From 2000 to 2010, the City of Chicago population has decreased by 6.9% overall and, importantly, in areas within the geographic service area of HCH such population decreases have been much larger. For example, the population of Englewood decreased by 24%, West Englewood by 20%, Auburn/Gresham by 16% Roseland by 18%, and Grand Crossing by 15%. The city-wide decline represents a decrease of 200,418 people which continues a trend of population decline in the City that began in 1950.

2. Planning Area Need – Service Demand (Criterion 1110.730(b)(3))

The Planning Area Need – Service Demand criterion requires an applicant proposing to establish a new AMI unit to document the proposed project is necessary to accommodate the service demand as evidenced by projected referrals. While the applicant submitted many letters written by physicians indicating that referrals to a HCH program would be forthcoming, the letters were deficient in several respects and fail to justify the need for the proposed HCH AMI unit.

First, to support a behavioral health unit, a referral letter documenting need for such services should be from physicians in a position to admit patients to the proposed HCH AMI unit. Importantly, only psychiatrists can admit patients to an inpatient AMI unit. The applicants submitted 39 physician referral letters; however, only 8 were from psychiatrists and only accounted for 505 of the projected patients, or 2,929 patient days (assuming a 5.8 day average length of stay). Thirty-one letters were from inappropriate referral sources, which included 15 internists, 5 family medicine physicians, 3 ob/gyns, 2 psychologists, a nephrologist, pulmonologist, trauma surgeon, neurologist, hospitalist, and cardiologist. None of these specialists is in a position to refer to the proposed HCH AMI unit and should not be factored when determining whether there is sufficient demand for the proposed HCH unit.

Further, the proposed referrals from these physicians may be duplicative of the proposed referrals from the HCH and MSH emergency department medical directors. Most patients are admitted for inpatient behavioral health services through the emergency department. Therefore, it is unclear whether the historical and projected referrals were included in both the emergency department and the physician referral letters.

Finally, 250 of the proposed referrals will come from MSH. Utilizing the applicant's average length of stay of 5.8 days, the proposed HCH AMI unit will adversely impact the MSH AMI unit, lowering utilization to 69 percent, which is below the CON Board standard of 85

percent. Therefore, the proposed HCH AMI unit will adversely affect the existing MSH AMI unit.

3. Unnecessary Duplication of Services (Criterion 1110.730(c)(1))

This criterion requires an applicant to document that its proposed project will not result in an unnecessary duplication of services. The applicants state the project will not result in an unnecessary duplication of services based upon the number of patients that have had to leave HCH's service area for an AMI bed. The applicants' basis for determining the proposed project will not result in an unnecessary duplication of services is inaccurate and misleading.

The applicants identified 11 hospitals within 30 minutes of HCH that provide inpatient behavioral health services. As shown in the Table 1110.730(c)(1), only MSH is operating close to the CON Board's 85% utilization standard. The remaining facilities are operating significantly below the CON Board standard and collectively have 223 available AMI beds, which is more than sufficient to accommodate the proposed referrals to the HCH AMI unit.

Table 1110.730(c)(1)						
	Authorized AMI Beds	Admissions	Inpatient Days	Observation Days	Occupancy	Available Beds
St. Bernard Hospital	40	1,587	11,958	0	81.9%	7
South Shore Hospital	15	0	0	0	0.0%	15
Roseland Community Hospital	30	352	3,763	0	34.4%	20
Mercy Hospital & Medical Center	39	1,082	5,996	0	42.1%	23
Jackson Park Hospital	86	4,110	18,337	0	58.4%	36
St. Anthony Hospital	42	1,367	11,698	0	76.3%	10
Rush University Medical Center	70	1,812	16,165	0	63.3%	26
Mount Sinai Hospital	28	1,479	8,602	0	84.2%	4
Advocate Christ Medical Center	39	1,314	9,009	0	63.3%	14
Little Company of Mary	24	798	4,570	10	52.2%	11
MetroSouth Medical Center	14	2	5	0	0.1%	14
Loretto Hospital	76	1,890	11,975	0	43.2%	43
Total	427	13,903	90,103	17	57.8%	223

Illinois Health Facilities and Services Review Board, 2012 Individual Hospital Profiles *available at* <http://hfsrb.illinois.gov/pdf/2012%20Hospital%20Profiles%2010-10.pdf> (last visited Mar. 13, 2014).

Importantly, with the exception of South Shore Hospital, which was not operating its AMI unit in 2012, utilization largely remained the same from 2012 to 2013. Therefore, the number of underutilized AMI beds in the HCH service area has not changed significantly within the last year to justify a new AMI unit at HCH

4. Maldistribution (Criterion 1110.730(c)(2))

The maldistribution criterion requires an applicant to document that a proposed project will not result in maldistribution of services. Maldistribution exists when the identified service area has an excess supply of facilities, bed and services. (77 Ill. Admin. Code 1110.730(c)(2)). A maldistribution exists when (1) the ratio of bed to population exceeds 150 percent of the State average; (2) historical utilization of existing facilities is below the CON Board standard for the most recent 12 month period; or (3) insufficient population exists to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards. In asserting the project would not create or contribute to a maldistribution of services, the Applicants completely ignore the fact that every facility with an AMI unit within HCH's service area is operating below the State's 85% utilization standard. Further, based on the fact that a large portion of the Applicant's purported physician referral letters are not valid, the Applicants have only documented 1,363 projected referrals to the HCH AMI unit.¹ Utilizing the Applicants' average length of stay of 5.8 days, these AMI referrals will result in 7,905 AMI patient days which does not support their proposal particularly since the Applicant's seek to draw patients from underutilized programs at safety net hospitals. As noted in the table above, there are 223 available AMI beds in HCH's service area, which is more than sufficient to accommodate the area's demand for inpatient behavioral health beds. Due to the underutilization of existing providers and an insufficient patient base to support the proposed HCH AMI unit, the proposed project would contribute to a maldistribution of services if approved.

5. Impact of Project on Other Area Providers (Criterion 1110.730(c)(3))

This criterion requires the applicant to document the proposed project will not lower utilization of existing providers below the CON Board standard or will not lower to a further extent utilization of other area providers operating below the CON Board standard. Importantly, the applicants neglected to address this criterion.

¹ Letters from psychiatrists project 505 AMI referrals, MHS emergency department projects it will refer 362 AMI patients and HCH emergency department projects 496 AMI referrals for a total of 1,363 projected referrals.

The CON Board standard for AMI units is 85 percent. As of 2012, the last year for which data is available, all of the hospitals within HCH's service area operated below 85% with only MSH operating just below the CON Board standard at 84.2%. As documented in the referrals letters from the 8 psychiatrists and the HCH and MSH emergency departments, 1,363 patients that had been previously referred to existing hospital AMI units are projected to be referred to the proposed HCH unit. One hundred twelve of these projected referrals will come from existing hospitals within HCH's service area. This will further reduce AMI utilization at existing hospitals below the CON Board standard.

Separately, since the Applicants have not documented a sufficient need for services in the communities it intends to serve. If the unit is approved and opened, HCH will be forced to use aggressive methods to cannibalize patients from other existing providers that already serve the inpatient behavioral health needs of the communities so that it can obtain a return on the large investment that it proposes to open this unit.

6. Availability of Funds (Criterion 1120.120(a))

This criterion requires the applicant to document financial resources shall be available to fund the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources. HCH and SHS indicate on pages 7 and 18 of the application the project will be funded by cash and securities; however, they only provide audited financial statements from June 30, 2012. While the HCH financial statements show sufficient cash on hand as of June 30, 2012 to finance the proposed project, these financial statements are over 18 months old and were prepared prior to the HCH merger with SHS. Importantly, they do not provide evidence sufficient cash is currently available to fund the project. The CON Board staff should request the applicants provide copies of their June 30, 2013 audited financial statements and letters from financial institutions where they have accounts to document sufficient funds are available to fund the project prior to consideration of this application at the April 22, 2014 CON Board meeting.

7. Financial Viability (Criterion 1120.130(b))

The applicants claim they are eligible for the financial viability waiver because they propose to fund the proposed project entirely with internal resources. SHS and HCH failed to sufficiently document cash is available to fund the proposed project. Therefore, they should not be entitled to a waiver of the financial viability criteria. The financial viability ratios are important criteria that measure the financial strength of an applicant and its ability to fund a project. Financial viability ratios calculated based upon the SHS and HCH June 30, 2012

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financial statements demonstrate the applicants are not in a financially strong position and call into question whether SHS and HCH have the resources available to finance the proposed project and whether it is the most prudent use of their scarce financial resources. (See Attachments 4 – 8).

Thank you for consideration of our comments to the Holy Cross Hospital CON application to add a 50-bed AMI unit. We believe the State Agency Report for this proposal should reflect the failure of the Applicants to meet the numerous criteria applicable to their proposal as discussed in this letter.

Sincerely,



Anne M. Cooper

AMC
Attachments
cc: Charles Holland

Attachment – 1

2012 Existing Facility Utilization

	Authorized AMI Beds	Admissions	Inpatient Days	Observation Days	Occupancy
St. Bernard Hospital	40	1,587	11,958	0	81.9%
South Shore Hospital	15	0	0	0	0.0%
Roseland Community Hospital	30	352	3,763	0	34.4%
Mercy Hospital & Medical Center	39	1,082	5,996	0	42.1%
Jackson Park Hospital	86	4,110	18,337	0	58.4%
St. Anthony Hospital	42	1,367	11,698	0	76.3%
Rush University Medical Center	70	1,812	16,165	0	63.3%
Mount Sinai Hospital	28	1,479	8,602	0	84.2%
Advocate Christ Medical Center	39	1,314	9,009	0	63.3%
Little Company of Mary	24	798	4,570	10	52.2%
MetroSouth Medical Center	14	2	5	0	0.1%
Loretto Hospital	76	1,890	11,975	0	43.2%
Total	503	15,793	102,078	10	55.6%

Attachment – 2

2011 Existing Facility Utilization

	Authorized AMI Beds	Admissions	Inpatient Days	Observation Days	Occupancy
St. Bernard Hospital	40	1,546	11,497	0	78.7%
South Shore Hospital	15	0	0	0	0.0%
Roseland Community Hospital	30	0	0	0	0.0%
Mercy Hospital & Medical Center	39	1,214	6,612	0	46.4%
Jackson Park Hospital	86	3,073	17,184	0	54.7%
St. Anthony Hospital	42	969	9,048	0	59.0%
Rush University Medical Center	70	1,607	15,388	0	60.2%
Mount Sinai Hospital	28	1,444	8,197	0	80.2%
Advocate Christ Medical Center	51	1,453	9,588	0	51.5%
Little Company of Mary	24	742	4,279	0	48.8%
MetroSouth Medical Center	0	0	0	0	0.0%
Loretto Hospital	76	3,173	21,628	0	78.0%
Total	501	15,221	103,421	-	56.6%

Attachment - 3

2010 Existing Facility Utilization

	Authorized AMI Beds	Admissions	Inpatient Days	Observation Days	Occupancy
St. Bernard Hospital	40	1,546	11,334	1	77.6%
South Shore Hospital	15	0	0	0	0.0%
Roseland Community Hospital	30	0	0	0	0.0%
Mercy Hospital & Medical Center	39	1,393	8,475	0	59.5%
Jackson Park Hospital	86	3,731	21,390	0	68.1%
St. Anthony Hospital	42	1,005	8,979	0	58.6%
Rush University Medical Center	70	1,498	15,894	0	62.2%
Mount Sinai Hospital	28	1,388	8,082	0	79.1%
Advocate Christ Medical Center	51	1,633	9,450	0	50.8%
Little Company of Mary	24	699	4,151	0	47.4%
MetroSouth Medical Center	0	0	0	0	0.0%
Loretto Hospital	76	3,052	21,968	0	79.2%
Total - GSA	501	15,945	109,723	-	60.0%

Attachment – 4

**Holy Cross Hospital
Financial Viability Ratios
2011-2012
(Dollars in Thousands)**

	Standard	2012	2011	Standard Met	Standard Met
Current Ratio					
Current Assets	>2	\$33,908	\$29,949	No	No
Current Liabilities		\$18,955	\$18,273		
Net Margin Percentage					
Net Income	>3%	\$1,195	\$1,856	No	No
Net Revenue		\$116,273	\$120,450		
Long Term Debt to Capitalization					
Long-Term Debt	<50%	\$0	\$46	N/A	Yes
Long-Term Debt + Net Assets		\$19,940	\$33,101		
Projected Debt Service Coverage					
Net Income + Depreciation + Interest + Amortization	>2.5	\$6,467	\$7,632	Yes	No
Principal Payments + Interest		\$1,513	\$13,086		
Days Cash on Hand					
Cash + Investments + Board Designated Funds	>75 days	\$19,418	\$15,473	No	No
Operating Expenses - Depreciation		\$121,309/365 days	\$113,181/365 days		
Cushion Ratio					
Cash + Investments + Board Designated Funds	>7.0	\$19,418	\$15,473	Yes	No
Principal Payments + Interest		\$1,513	\$13,086		

Attachment – 5

**Sinai Health System
Financial Viability Ratios
2011-2012
(Dollars in Thousands)**

	Standard	2012	Standard Met	2011	Standard Met
Current Ratio					
Current Assets	>2	\$94,097	1.0	\$89,964	1.0
Current Liabilities		\$92,407	No	\$92,710	No
Net Margin Percentage					
Net Income	>3%	(\$2,468)	-0.6%	\$398	0.1%
Net Revenue		\$383,824	No	\$409,092	No
Long Term Debt to Capitalization					
Long-Term Debt	<50%	\$98,023	86.9%	\$100,011	88.8%
Long-Term Debt + Net Assets		\$112,761	No	\$112,634	No
Projected Debt Service Coverage					
Net Income + Depreciation + Interest + Amortization	>2.5	\$15,998	6.4	\$18,721	5.3
Principal Payments + Interest		\$2,499	Yes	\$3,527	Yes
Days Cash on Hand					
Cash + Investments + Board Designated Funds	>75 days	\$8,851	9 days	\$10,758	10 days
Operating Expenses - Depreciation		\$372,578/365 days	No	\$395,727/365 days	No
Cushion Ratio					
Cash + Investments + Board Designated Funds	>7.0	\$8,851	3.6	\$10,758	3.1
Principal Payments + Interest		\$2,449	No	\$3,527	No

Attachment – 6

**Consolidated Sinai Health System & Holy Cross Hospital
Financial Viability Ratios
2011-2012
(Dollars in Thousands)**

	Standard	2012	Standard Met	2011	Standard Met
Current Ratio					
Current Assets	>2	\$128,005	No	\$119,913	No
Current Liabilities		\$111,362	1.1	\$110,983	1.1
Net Margin Percentage					
Net Income	>3%	(\$1,273)	No	\$2,254	No
Net Revenue		\$500,097	-0.3%	\$529,542	0.4%
Long Term Debt to Capitalization					
Long-Term Debt	<50%	\$98,023	No	\$100,057	No
Long-Term Debt + Net Assets		\$132,701	73.9%	\$145,735	68.7%
Projected Debt Service Coverage					
Net Income + Depreciation + Interest + Amortization	>2.5	\$22,465	Yes	\$26,353	No
Principal Payments + Interest		\$4,012	5.6	\$16,613	1.6
Days Cash on Hand					
Cash + Investments + Board Designated Funds	>75 days	\$28,269	No	\$26,231	No
Operating Expenses - Depreciation		\$493,887/365 days	21 days	\$508,908/365 days	19 days
Cushion Ratio					
Cash + Investments + Board Designated Funds	>7.0	\$28,269	Yes	\$26,231	No
Principal Payments + Interest		\$3,962	7.1	\$16,613	1.6

Attachment – 7

**Impact of Proposed Project on Consolidated Sinai Health System and Holy Cross Hospital
Financial Viability Ratios
2012
(Dollars in Thousands)**

	Standard	2012	Standard Met
Current Ratio			
Current Assets	>2	\$119,205	1.1
Current Liabilities		\$111,362	No
Net Margin Percentage			
Net Income	>3%	(\$1,273)	-0.3%
Net Revenue		\$500,097	No
Long Term Debt to Capitalization			
Long-Term Debt	<50%	\$98,023	73.9%
Long-Term Debt + Net Assets		\$132,701	No
Projected Debt Service Coverage			
Net Income + Depreciation + Interest + Amortization	>2.5	\$22,465	5.6
Principal Payments + Interest		\$4,012	Yes
Days Cash on Hand			
Cash + Investments + Board Designated Funds	>75 days	\$19,469	14 days
Operating Expenses - Depreciation		\$493,887/365 days	No
Cushion Ratio			
Cash + Investments + Board Designated Funds	>7.0	\$19,469	4.9
Principal Payments + Interest		\$3,962	No

Attachment – 8

Analysis of Holy Cross Hospital & Sinai Health System Financial Viability Ratios

Based upon the June 30, 2012 audited financial statements provided by the HCH and SHS, HCH meets only two of the financial viability ratios in 2012 (Projected Debt Service Coverage and Cushion Ratio) and one ratio in 2011 (Long-Term Debt to Capitalization). (See Attachment 4). SHS meets only the Projected Debt Service Coverage ratio in 2011 and 2012. (See Attachment 5). Combining the HCH and SHS financial statements, the applicants still fail to meet most of the financial viability criteria, only satisfying the Projected Debt Service Coverage and Cushion Ratio in 2012 and none of the viability ratios in 2011.

Importantly, the applicants fail to meet the current ratio, which is a measure of a company's short-term financial strength. A current ratio of 1.5 to 3.0 is considered an indication a company is financially healthy. The Board's current ratio requirement for not-for-profit hospitals and hospital systems is 2.0. HCH and SHS have a combined current ratio of 1.1, indicating its short-term financial strength is not strong.

The net margin percentage is an indication of how much of a company's revenue is retained as net income, and in the case of a not-for-profit, available to reinvest in the company. HCH, SHS and the combined SHS and HCH fail to meet the Board's requirement of at least 3 percent net margin in both 2011 and 2012. In fact, in 2012 the combined SHS and HCH had a net loss of \$1.2 million, which reduced the net assets (or reserves) of the combined entity.

The long-term debt to capitalization is a measure of a company's financial leverage. The higher the debt-to-capital ratio, the more highly leveraged the company. The combined SHS and HCH have a long-term debt to capital ratio of 73.9 percent, compared to the CON Board standard of 50 percent.

Days of cash on hand measures how long a company can meet its operating expenses without receiving any new income. The CON Board standard is 75 days. The combined SHS and HCH had only 21 days (or less than one month) of cash on hand in 2012. Further, assuming no changes from 2012 to 2014, the \$8.8 million in cash proposed for the HCH AMI unit, would lower the days of cash on hand to just 14 days. The days of cash on hand analysis demonstrates the use of cash to fund the HCH AMI unit is not a prudent use of resources.

The cushion ratio measures the ability of a company's current cash and near-cash holdings to cover its debt obligations. The higher the cushion ratio, the better positioned a company is to meet its debt obligations. The CON Board standard is 7.0. While the combined SHS and HCH met the CON Board standard in 2012, the proposed project will lower the cushion ratio from 7.1 to 4.9. This is another indication the proposed project would adversely affect the applicants financial strength and is not a prudent use of scarce resources.