



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: I-01	BOARD MEETING: September 22, 2020	PROJECT NO: 19-021	PROJECT COST:
FACILITY NAME: The Rehabilitation Institute of Southern Illinois		CITY: Shiloh	Original: \$30,998,250
TYPE OF PROJECT: Substantive			HSA: VI

PROJECT DESCRIPTION: The Applicants (Encompass Health Corporation, Metro-East Services, Inc., Memorial Regional Health Services, Inc., BJC Health System, and the Rehabilitation Institute of Southern Illinois, LLC) propose to establish a 40-bed freestanding comprehensive physical rehabilitation hospital in Shiloh, Illinois. The cost of the project is \$30,998,250 and the expected completion date is July 1, 2022.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants (Encompass Health Corporation, Metro-East Services, Inc., Memorial Regional Health Services, Inc., BJC Health System, and the Rehabilitation Institute of Southern Illinois, LLC) propose to establish a 40-bed freestanding comprehensive physical rehabilitation (REHB) hospital in 47,749 GSF of space, located at 2001 Frank Scott Parkway East, Shiloh. The cost of the project is \$30,998,250 and the expected completion date is July 1, 2022.

BACKGROUND:

- Encompass Health (f/k/a HealthSouth Rehabilitation) owns/operates 130 inpatient rehabilitation hospitals in the United States and Puerto Rico, accounting for approximately 20% of the licensed acute rehabilitation beds in the nation. BJC Healthcare is a Missouri-based non-profit health care provider.
- Encompass Health Corporation owns and operates comprehensive physical rehabilitation facilities in the Illinois/Missouri area: VanMatre Encompass Health Rehabilitation Hospital, Rockford, Encompass Health Rehabilitation Hospital of Libertyville and The Rehabilitation Center of St. Louis. BJC Healthcare owns and operates hospitals in Missouri and Illinois. The Missouri facilities are Barnes-Jewish Hospital, St. Louis, and St. Louis Children's Hospital. BJC Healthcare owns/operates the following Illinois facilities: Alton Memorial Hospital, Memorial Hospital of Belleville, and Memorial Hospital East in Shiloh.
- This project received an **Intent to Deny at the September 2019 State Board Meeting**. Additional information has been provided to address the intent to deny and is included at the end of this report as is the transcript from the September 2019 State Board Meeting.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The proposed project is classified as substantive and is before the State Board because the project proposes to establish a health care facility.

PUBLIC HEARING/COMMENT:

- No public hearing was requested. Letters of support and no letters of opposition were received by the State Board Staff.

SUMMARY:

- As mentioned above this project proposes to establish a 40-bed freestanding comprehensive rehabilitation hospital in Shiloh (HSA XI).
- There are 34 comprehensive physical rehabilitation beds in the HSA XI Comprehensive Physical Rehabilitation Planning Area as of July 2020. These 34-beds are located at Anderson Rehabilitation Institute in Edwardsville. This Hospital was approved as Permit #19-026 in September 2019 and is currently under construction.
- The Geographical Service Area for this project is 17-miles. There are no inpatient rehabilitation beds/hospitals in this 17-mile GSA.
- The State Board's need methodology estimates **a need for 1-inpatient** comprehensive physical rehabilitation bed in this HSA XI Planning Area by 2022.
- The Applicants provided physician referrals that estimated by CY 2024 (the second year after project completion) 1,051 referrals would be made to the proposed 40-bed hospital. The 1,051 referrals at an ALOS of 14.1 days **would justify 47-beds** at the State Board's target occupancy of 85%.

- The Applicants also provided an alternative need methodology than that utilized by the State Board. That need methodology estimated **the need for 42 rehab beds** in the HSA XI planning area. This need methodology can be found at pages 12-13 of this report.
- The Applicants addressed a total of 19 criteria and have not met the following:

State Board Standards Not Met	
Criteria	Reasons for Non-Compliance
77 ILAC 1110.205 (b) – Planning Area Need	The number of beds requested (40-beds) exceed the number of beds needed (1-bed) in this Planning Area by 39 beds. (page 12 of this report)
77 ILAC 1110.205 (f) – Performance Requirement-Bed Capacity	The Applicants are establishing a 40-bed comprehensive rehabilitation facility. The State Board Standard for these facilities is 100 beds. (Attached to the end of this report is an explanation from the Applicants of why the 100-bed rule is no longer applicable in today’s healthcare environment.)

STATE BOARD STAFF REPORT
Project #19-021
The Rehabilitation Institute of Southern Illinois, Shiloh

APPLICATION/ CHRONOLOGY/SUMMARY	
Applicants(s)	The Rehabilitation Institute of Southern Illinois, LLC BJC Health System d/b/a BJC HealthCare Memorial Regional Health Services, Inc. Metro East Services, Inc. Encompass Health Corporation
Facility Name	The Rehabilitation Institute of Southern Illinois
Location	2001 Frank Scott Parkway East, Shiloh
Permit Holder	The Rehabilitation Institute of Southern Illinois, LLC
Operating Entity/Licensee	The Rehabilitation Institute of Southern Illinois, LLC
Owner of Site	Progress East Healthcare Center
Application Received	May 20, 2019
Application Deemed Complete	June 7, 2019
Financial Commitment Date	July 1, 2022
Anticipated Completion Date	July 1, 2022
Approved for Expedited Review?	Yes
Review Period Extended by the State Board Staff?	No

I. Project Description

The Applicants (Encompass Health Corporation, Metro-East Services, Inc., Memorial Regional Health Services, Inc., BJC Health System, and the Rehabilitation Institute of Southern Illinois, LLC) propose to establish a 40-bed freestanding comprehensive physical rehabilitation hospital in 47,479 GSF of space, in Shiloh. The cost of the project is \$30,998,250 and the expected completion date is July 1, 2022.

II. Summary of Findings

- A. State Board Staff finds the proposed project is **not** in conformance with all relevant provisions of Part 1110.
- B. State Board Staff finds the proposed project is in conformance with all relevant provisions of Part 1120.

III. General Information

The Applicants are Encompass Health Corporation, Metro-East Services, Inc., Memorial Regional Health Services, Inc., BJC Health System, and the Rehabilitation Institute of Southern Illinois, LLC. Encompass Health Corporation is the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. Encompass Health Corporation operates hospitals in 32 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. BJC HealthCare is a regional healthcare delivery system operating in Missouri and

southern Illinois. BJC Healthcare is the sole corporate member of Barnes-Jewish Hospital and Memorial Regional Health Services, which operates Memorial Hospital-Belleville, and Memorial Hospital – East in Illinois. Memorial Regional Health Services is the sole corporate member of Metro East Service, Inc.

The proposed project will be a 50/50 joint venture between BJC HealthCare and Encompass Health Corporation (Encompass). Metro East Services, Inc., a subsidiary of BJC Health System d/b/a BJC HealthCare, will have a fifty percent (50%) ownership interest in The Rehabilitation Institute of Southern Illinois, LLC. Encompass Health also will have a fifty percent (50%) ownership interest in The Rehabilitation Institute of Southern Illinois, LLC. The Rehabilitation Institute of Southern Illinois, LLC is the licensee and Progress East HealthCare Center a wholly owned subsidiary of BJC Healthcare owns the site.

The State Board defines Comprehensive Physical Rehabilitation “*as a category of service provided in a comprehensive physical rehabilitation facility providing the coordinated interdisciplinary team approach to physical disability under a physician licensed to practice medicine in all its branches who directs a plan of management of one or more of the classes of chronic or acute disabling disease or injury. Comprehensive physical rehabilitation services can be provided only by a comprehensive physical rehabilitation facility [77 IAC 1100.220].*” A licensed comprehensive physical rehabilitation hospital is not required to maintain an emergency department [77 IAC 250.710].

IV. Project Details

The 40-bed single-story facility will be comprised of 47,749 GSF of space. 30,667 GSF will be designated as reviewable space while the remaining space (16,987 GSF), will be designated as non-reviewable space. Also included in the reviewable areas of the proposed hospital is a large indoor therapy area, dedicated bariatric rooms, dedicated isolation rooms, and a dialysis unit.

V. Health Service Area

The Hospital will be in the HSA XI Health Service Area and Comprehensive Physical Rehabilitation Planning Area. This Planning Area is comprised of the Illinois counties of Madison, St. Clair, Clinton, and Monroe. These counties comprise the Metro-East St. Louis area. There are 10-hospitals in the HSA XI Health Service Area and one comprehensive physical rehabilitation hospital with 34 comprehensive physical rehabilitation beds (Anderson Rehabilitation Institute, LLC). There is a calculated need for one (1) inpatient rehabilitation bed¹ in this Planning Area as of July 2020.

¹ The HSA XI bed need is calculated by dividing the State’s total patient days for Comprehensive Physical Rehabilitation by the State’s estimated total population to get an overall use rate. This overall rate is multiplied by 0.6 (60%) to establish the *State minimum utilization rate*. The *actual utilization rate* for the planning area is calculated by dividing area base year patient days for Comprehensive Physical Rehabilitation by the planning area total estimated base year population. The actual utilization rate is compared to the State minimum use rate; the *planned use rate* is the greater of the two. The planned use rate is multiplied by the area projected total population five (5) years from the base year to calculate the projected patient days for the planning area. The patient days are divided by 365 to find the Average Daily Census, which is divided by 0.85 (85% utilization target) to determine

The Geographical Service Area (GSA) for a project located in St. Clair County is 17 miles. There **are no comprehensive** physical rehabilitation beds in this 17-mile GSA.

There is **one rehabilitation hospital** in this HSA XI planning area. Anderson Rehabilitation Institute, LLC in Edwardsville is a 34-bed inpatient comprehensive physical rehabilitation hospital. This hospital is approximately 20.6 miles from the proposed hospital, was approved at the September 2019 State Board Meeting, and is not operational.

The State Board is estimating little or no increase in the population in this comprehensive physical rehabilitation area (HSA XI) by 2022.

Year	Population Est.
2017	599,600
2022	605,600
Difference	6,000

VI. Project Uses and Sources of Funds

The Applicants are funding this project with cash and securities in the amount of \$30,998,250.

Use of Funds	Reviewable	Non-Reviewable	Total	% of Total
Site Preparation	\$790,524	\$263,508	\$1,054,032	3.40%
New Construction Contracts	\$13,381,403	\$5,901,343	\$19,282,746	62.20%
Contingencies	\$1,338,140	\$590,135	\$1,928,275	6.30%
Architectural/Engineering Fees	\$1,100,291	\$366,764	\$1,467,055	4.70%
Consulting and Other Fees	\$933,708	\$311,236	\$1,244,944	4%
Movable and Other Equipment	\$3,648,489	\$1,216,163	\$4,864,652	15.70%
Other Costs to be Capitalized	\$808,409	\$348,137	\$1,156,546	3.70%
Total Uses of Funds	\$22,000,964	\$8,997,286	\$30,998,250	100.00%
Cash and Securities	\$22,000,964	\$8,997,286	\$30,998,250	100.00%

the projected number of Comprehensive Physical Rehabilitation beds needed in the planning area. **State Board Staff** notes that in and out-migration for comprehensive physical rehabilitation beds is not considered. Only medical surgical, pediatric, and obstetric categories of service consider in and out migration when calculating bed need.

TABLE TWO				
Project Uses and Sources of Funds				
Total Sources of Funds	\$23,248,687	\$7,749,563	\$30,998,250	100.00%

VI. Background of the Applicants

A) Criterion 1110.110 (a) (1) & (3) – Background of the Applicants

An applicant must demonstrate that it is fit, willing and able, and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. To demonstrate compliance with this criterion the Applicants must provide

- A) A listing of all health care facilities currently owned and/or operated by the applicant in Illinois or elsewhere, including licensing, certification and accreditation identification numbers, as applicable;
- B) A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility;
- C) Authorization permitting HFSRB and IDPH access to any documents necessary to verify the information submitted, including, but not limited to official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide the authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.
- D) An attestation that the Applicants have had no *adverse action*² taken against any facility they own or operate, or a certified listing of any adverse action taken.

1. The Applicants attest that there has been no adverse action taken against any of the health care facilities owned or operated by the Applicants. [Application for Permit page 130-132]
2. The Applicants have authorized the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to have access to any documents necessary to verify information submitted in connection to the Applicants’ certificate of need. The authorization includes but is not limited to official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. [Application for Permit pages 130-132]
3. Licensure and Accreditation has been provided by the Applicants for the health care facilities owned and operated by the Applicants at pages 133-143 of the Application for Permit and additional information provided.
4. The site is owned by BJC Healthcare and evidence of this can be found at pages 71-113 of Application for Permit #19-021 Ground Lease Agreement between BJC Healthcare and The Rehabilitation Institute of Southern Illinois, LLC.

²Adverse action is defined as a disciplinary action taken by IDPH, CMMS, or any other State or federal agency against a person or entity that owns or operates or owns and operates a licensed or Medicare or Medicaid certified healthcare facility in the State of Illinois. These actions include, but are not limited to, all Type "A" and Type "AA" violations.” (77 IAC 1130.140)

5. Certificates of Good Standing have been provided at pages 67-70 of the Application for Permit for all applicants. A certificate of good standing is a legal **status** conferred by a state on a company incorporated within its jurisdiction that allows it to conduct business legitimately. The **status** is granted based on the company's current **standing** related to required state filings, fees and tax obligations.

VII. Purpose of Project, Safety Net Impact Statement and Alternatives

The following three (3) criteria are informational; there are no conclusions on the adequacy of the information submitted.

A) Criterion 1110.110 (b) Purpose of the Project

To demonstrate compliance with this criterion the Applicants must document that the project will provide health services that improve the health care or well-being of the market area population to be served.

According to the Applicants the project will meet a documented need for Rehabilitation beds in the service area. The May 2020 Bed Need Determination shows a need for 1 additional comprehensive physical rehabilitation bed. The applicants have determined that the outmigration of rehabilitation patients from HSA-11 equals the number of patients seeking inpatient rehabilitation services in the service area, and the number of residents traveling outside the service area is increasing. The applicants propose to stem this trend of out-migration through the establishment of a 40-bed freestanding comprehensive physical rehabilitation hospital. The proposed facility will not only stem the outward migration but provide high-quality and cost-effective care to residents of HSA XI.

B) Criterion 1110.110 (c) - Safety Net Impact Statement

To demonstrate compliance with this criterion the Applicants must document that the project will provide health services that improve the health care or well-being of the market area population to be served.

This project is a new collaboration between BJC Healthcare and Encompass Health. Projected Charity Care and Safety Net data for the first two years of operation are provided in Table Three.

TABLE THREE		
Estimated		
Charity Care and Medicaid Information		
Projected Year	2021	2022
Net Patient Revenue	\$14,662,100	\$18,901,300
Amount of Charity care (charges)	\$230,463	\$297,114
Cost of Charity Care	\$145,780	\$169,419
% of Net Patient Revenue	1.00%	0.90%
Charity Care		
Inpatient Number of Patients	9	12
Outpatient Number of Patients	0	0

TABLE THREE		
Estimated		
Charity Care and Medicaid Information		
TOTAL	9	12
Cost Inpatient	\$145,780	\$169,419
Cost Outpatient	\$0	\$0
MEDICAID		
TOTAL	\$145,780	\$169,419
Inpatient Number of Patients	100	127
Outpatient Number of Patients	0	0
TOTAL	100	127
Net Revenue Inpatient	\$1,552,039	\$2,008,533
Net Revenue Outpatient	\$0	\$0
% of Net Patient Revenue	10.59%	10.63%
TOTAL	\$1,552,039	\$2,008,533

C) Criterion 1110.110 (d) - Alternatives to the Project

To demonstrate compliance with this criterion the Applicants must document all alternatives to the proposed project that were considered.

The Applicants considered three alternatives:

1) Maintain Status Quo/Do Nothing

The alternative of doing nothing was immediately rejected, because it would result in continual minimized access for in-state residents seeking inpatient rehabilitation services. This would result in foregoing much-needed rehabilitation services and out-of-state migration for those who wish to receive inpatient rehabilitation services. The applicants also note that doing nothing will encumber existing rehabilitation service providers with a growing need for the service, while the availability of said services remains stagnant. No project costs were identified with this alternative.

2) Submit a CON Application for the Establishment of a Smaller Facility

The applicants initially considered the establishment of a facility containing less than 40 beds but realized any facility under 40 beds would fail to meet the existing and predicted needs for rehabilitation services in the service area. Additionally, the applicants determined a smaller rehabilitation facility would be impractical, because a smaller facility would be cost prohibitive, and most likely result in a facility that lacks services required of a modern physical rehabilitation facility. Lastly, the applicants (BJC Healthcare and Encompass Health) did not consider a facility with less than 40 beds as a viable option for services in the region. No project costs were identified with this alternative.

3) Project as Proposed

The applicants note the project as proposed is the most cost-effective, patient centered alternative available to serve the rehabilitation needs of a growing population in need of these services. The applicants felt a 40-bed facility will enhance accessibility to rehabilitation services while maintaining the economies of scale to make this a viable alternative for all parties and stem the outward migration of physical rehabilitation patients to facilities in neighboring states. Cost identified with this alternative: \$30,998,250.

VIII. Project Scope and Size, Utilization and Unfinished/Shell Space

A) **Criterion 1110.120 (a) - Size of Project**

To demonstrate compliance with this criterion the Applicants must document that the proposed size of the project is in compliance with Part 1110 Appendix B.³⁴

The Applicants are proposing 40-rehab beds in 23,894 gross square footage (GSF) of space or 597 GSF per bed. The State Board Standard is 660 per GSF per bed. Included in the reviewable areas of the proposed hospital is a large indoor therapy area, dedicated bariatric rooms, dedicated isolation rooms, and a dialysis unit (5,957 GSF). The State Board does not have a standard for these areas. The Applicant has successfully addressed this criterion.

³ Reviewable space refers to the Clinical Service Area that is defined as a department or service that is directly *related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility* [20 ILCS 3960/3]. A clinical service area's physical space shall include those components required under the facility's licensure or Medicare or Medicaid Certification, and as outlined by documentation from the facility as to the physical space required for appropriate clinical practice.

⁵ Non-reviewable space refers to a Non-clinical Service Area that is an area for the benefit of the patients, visitors, staff or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture

TABLE FOUR					
Size of the Project					
	Beds	Proposed		State Standard	
	#	Total	Per Bed	Total	Per Bed
Physical Rehab Beds	40	23,894	597	26,400	660
Pharmacy		816	No Standard		
PT/OT/ST		5,957			
Total Reviewable		30,667			
Non-Reviewable		16,987			
Total		47,654			

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SIZE OF PROJECT (77 ILAC 1110.120 (a))

B) Criterion 1110.120 (b) – Projected Utilization

To demonstrate compliance with this criterion the Applicants must document that the proposed project will be at the target occupancy of 80% within two years after project completion.

The Applicants have based the projected utilization on a projected need for 40 additional beds in the service area, based on patient out-migration data, and physician referral letters contained in the application.

The Applicants are estimating 1,015 patients to be referred to the proposed facility two years after project completion. Using an ALOS of 14.1 days the Applicants can justify 47 beds, meeting the requirements of this criterion.

$$\begin{aligned}
 1,015 \text{ patients} \times 14.1 \text{ days} &= 14,312 \text{ days} \\
 14,312 \text{ days} \div 365 \text{ days} &= 39.2 \text{ ADC} \\
 39.2 \text{ ADC} \div 85\% &= 47 \text{ beds}
 \end{aligned}$$

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED UTILIZATION (77 ILAC 1110.120 (b))

C) Criterion 1110.120 (e) – Assurances

To demonstrate compliance with this criterion the Applicants must document that the proposed facility will be at target occupancy two years after project completion.

The Applicants provided the necessary assurance that they will be at target occupancy within two years after project completion. The Applicants have met this requirement. (See Application for Permit page 213)

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.120 (e))

IX. Comprehensive Physical Rehabilitation

A) Planning Area Need

1) Criterion 1110.205 (b) – Planning Area Need

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (Formula Calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

There is a calculated need for one (1) rehabilitation bed in the HSA XI Planning Area. The number of beds requested - 40 beds - exceed the calculated need by 39 beds.

2) Criterion 1110.205 (b)(2) - Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

B) Applicants proposing to add beds to an existing CPR service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing CPR service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The Applicants propose to establish a 40-bed freestanding comprehensive physical rehabilitation hospital in Shiloh, in proximity to the campus of its sister facility, Memorial Hospital-East, Shiloh. The primary purpose for the establishment of this facility is to provide much-needed physical rehabilitation services to the residents of HSA-XI. The applicants provided various letters of support, some including historical discharge data of rehabilitation patients from area hospitals, and projected referral data once the project is completed. The applicants attest that 82% of the discharges identified in these letters originated from within the HSA-XI service area.

3) Criterion 1110.205 (b) (3) - Service Demand –Establishment of Comprehensive Physical Rehabilitation

The number of beds proposed to establish CPR service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the

latest 2-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

The Applicants submitted a combination of support and referral letters for the proposed project on pages 189-199 of the application. Of the 8 letters contained in these pages, three contain referral information that identified patients from the service area who were deemed as eligible candidates for inpatient physical rehabilitation services, but were either discharged to long term care facilities, outpatient rehabilitation, or chose to forego rehabilitation services altogether. The three letters deemed as referral letters outlined historical utilization at their facility, of patients whose residency was within HSA XI.

Table Four identifies the facility, the number of historical patients, and their projected number of referrals to the proposed facility, once completed. Should these referrals materialize the 40-bed rehab facility will be at target occupancy by the second year after project completion.

$$\begin{aligned}
 1,015 \text{ patients} \times 14.1 \text{ days} &= 14,312 \text{ days} \\
 14,312 \text{ days} \div 365 \text{ days} &= 39.2 \text{ ADC} \\
 39.2 \text{ ADC} \div 85\% &= 47 \text{ beds}
 \end{aligned}$$

TABLE FIVE		
Historical Patients /Projected Referrals		
Facility/Location	# Historical Patients for Rehab	Projected Referrals to Rehab Institute
Barnes Jewish Hospital, St. Louis*	227	227
Washington University School of Medicine, St. Louis	500	450
Memorial Hospital, Belleville/Memorial Hospital-East, Shiloh*	4,222	338
TOTAL	4,949	1,015
*Affiliated with Applicants		

The Applicants provided an alternative need methodology that examines 1-year of discharge data of HSA XI patients that would be appropriate for inpatient rehab services. See table below. This estimate **projects a need for 42 inpatient rehab beds at the 85% target occupancy.**

TABLE SIX
Calculations for HSA XI Bed Need Projections
(HSAXI Discharges (July 2017-June 2018) from all Hospitals including
Missouri Hospitals)⁽¹⁾

Acute Care Hospitals Discharges Appropriate for Inpatient Rehab	21,799
<i>Multiplied:</i> by Actual Rehab Discharge Rate for HSA XI patients traveling to Missouri	8%
<i>Equals:</i> Estimate Total HSA XI Discharges in Need of Rehab Bed.	1,744
<i>Minus:</i> Current total discharges to rehab including out of state	1,019
<i>Equals:</i> Incremental HSA XI Discharges in Need of Rehab Care	725
<i>Plus:</i> Rehab Discharges from Southern Illinois Counties (exclusive of HSA XI) ⁽²⁾	157
<i>Equals:</i> Total Projected discharges	882
Multiplied by Current/ (CY 17) Illinois Rehab Patient Length of Stay	14.1
Equals Projected 2024 Rehab Days, HSAXI	12,439
Divided by 365 (Average Daily Census)	35
Target Occupancy	85.00%
Number of Beds Needed	42

1. Discharge Data taken from Illinois Hospital Association, COMPdata Informatics Discharge Database and Encompass Health.
2. Based on the current proportion of patients (22%) from Southern Illinois Counties to HSA XI residents who are currently traveling to the Rehabilitation Institute of St. Louis for care.
3. Source: Page 150 of the Application for Permit

5) Criterion 1110.205 (b)(5) - Service Accessibility

A) Service Restrictions

The applicant shall document that at least one of the following factors exists in the planning area:

- i) **The absence of the proposed service within the planning area;**
- ii) **Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;**
- iii) **Restrictive admission policies of existing providers;**
- iv) **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;**
- v) **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.**

- i) There is one hospital in the HSA XI Comprehensive Physical Rehabilitation Planning Area providing comprehensive physical rehabilitation service. Anderson Rehabilitation Institute, LLC is a 34-bed

rehab hospital approved at the September 2019 State Board Meeting and is not currently in operation.

- ii) No access limitations have been identified by the Applicants.
- iii) No restrictive admission policies of existing providers have been identified by the Applicants.
- iv) No evidence has been provided by the Applicants that 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

Summary

There is a calculated need for one (1) comprehensive rehabilitation bed as of July 2020 in the HSA XI comprehensive physical rehabilitation planning area. The number of comprehensive physical rehabilitation beds being requested exceeds the calculated need by 39 beds. There is no absence of service in the planning area, or evidence of restrictive admission policies at other area providers, or access limitations due to payor status or medical care problems of the area population. The Applicants have not met the requirements of the State Board.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION PLANNING AREA NEED (77 IAC 1110.205 (b) (2) (3)(5))

B) Criterion 1110.205 (c)(1)(2)(3) – Unnecessary Duplication/Maldistribution of Service/Impact on Area Providers

Unnecessary Duplication/Maldistribution – Review Criterion

1) *The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:*

A) *A list of all zip code areas that are located, in total or in part, within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) of the project's site;*

B) *The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and*

C) *The names and locations of all existing or approved health care facilities located within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) from the project site that provide the categories of bed service that are proposed by the project.*

2) *The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:*

A) *A ratio of beds to population that exceeds one and one-half times the State average;*

B) *Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or*

C) *Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.*

- 3) *The applicant shall document that, within 24 months after project completion, the proposed project:*
- A) *Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and*
- B) *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.*

For this criterion the geographical service area (GSA) is a 17-mile radius and the population within the 17-mile radius is 553,093. There are no comprehensive physical rehabilitation beds in the 17-mile GSA. There are 1,614 inpatient rehabilitation beds in the State of Illinois as of July 2020. The 2020 population in the State of Illinois is estimated at 13,129,233.

Area	Population	Beds	Ratio of Beds per 1,000 population
Illinois (2015 est.) ⁽¹⁾	12,978,800	1,614	0.1244
Illinois (2020 est.) ⁽¹⁾	13,129,233	1,614	0.1230

1. Source: Illinois Department of Public Health Office of Health Informatics
Illinois Center for Health Statistics

Based upon the above, there is no maldistribution of service in this 17-mile GSA. Additionally, since there are no rehab beds in this 17-mile GSA the proposed project will not result in an unnecessary duplication of service.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH UNNECESSARY DUPLICATION/MALDISTRIBUTION OF SERVICE/IMPACT ON AREA PROVIDERS CRITERIA (77 IAC 1110.205 (b) (2) (3)(5))

B) Criterion 1110.205 (e) - Staffing

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

BJC Healthcare and Encompass Health currently employ innovative strategies to recruit and retain staff at their hospitals and anticipate using these for recruitment purposes at the Rehabilitation Institute. A combination of competitive compensation and benefits, a national recruitment strategy, and relationships with local colleges and universities present them with an adequate supply of well-qualified Applicants for positions they seek to fill. Additionally, the Applicants staff retention efforts include continuing education, both live and web-based, and clinical career ladders for their clinical staff. Allocations for continuing education funding are maintained, and staff are encouraged to utilize them in their career enhancement. The recruitment strategies are nationwide, with affiliations with nursing, rehabilitation, and speech/language associations. The Applicants are confident the facility will be staffed to applicable standards by project completion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION STAFFING (77 ILAC 1110.205(e))

C) Criterion 1110.205 (f) - Performance Requirements – Bed Capacity Minimums

- 1) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.
- 2) The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.

The Applicants propose to establish a 40-bed comprehensive physical rehabilitation facility, in accordance with the bed need in the planning area. The Applicants have not met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN NOT IN CONFORMANCE WITH CRITERION PERFORMANCE REQUIREMENTS (77 ILAC 1110.205(f))

E) Criterion 1110.205 (g) - Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The Applicants provided the necessary attestation as required at page 213 of the Application for Permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.205(e))

X. Financial Viability

A) Criterion 1120.120 – Availability of Funds

The Applicants are to document the sources of financing for this project.

The Applicants are funding this project with cash/securities in the amount of \$30,998,250. Based upon BJC Healthcare and Encompass Healthcare Corporation audited financial statements the Applicants have enough resources to fund this project. Below is a summary of the projected financial information for Rehabilitation Institute Inc. The assumptions used in preparing the projected information can be found at pages 361-362 of the Application for Permit.

	2018	2017
Cash	\$52,800,000	\$58,800,000
Current Assets	\$1,155,700	\$1,076,900
Total Assets	\$10,152,000	\$10,021,300
Current Liabilities	\$1,366,900	\$1,343,900
LTD	\$1,696,100	\$1,640,700
Net Patient Revenue	\$5,094,300	\$4,799,200
Total Revenue	\$5,326,900	\$4,993,100
Total Expenses	\$5,267,500	\$4,838,800
Loss from Operations	\$0	\$0

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION AVAILABILITY OF FUNDS (77 ILAC 1120.120)

B) Criterion 1120.130 – Financial Viability

The Applicants have qualified for the financial waiver as they have provided evidence that the funding for the project is from internal sources (cash). The applicant is NOT required to submit financial viability ratios if:

- 1) All project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or
HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.
- 2) the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA) or its equivalent; or
HFSRB NOTE: MBIA Inc. is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.
- 3) The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION FINANCIAL VIABILITY (77 ILAC 1120.130)

XI. Economic Feasibility

A) Criterion 1120.140 (a) - Reasonableness of Financing Arrangements

B) Criterion 1120.140 (b) - Terms of Debt Financing

The Applicants are funding this project with cash/securities in the amount of \$30,998,250. Based upon the audited financial statements the Applicants have enough resources to fund this project.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERIA REASONABLENESS OF FINANCING ARRANGEMENTS AND TERMS OF DEBT FINANCING (77 ILAC 1120.140 (a) (b))

C) Criterion 1120.140 (c) – Reasonableness of Project Costs

The costs listed below only relate to reviewable of clinical costs.

Site Preparation Costs are \$653,499 or 4.4% of new construction, and contingency costs. This appears reasonable when compared to the State Board Standard of 5.0%.

New Construction Costs are \$13,381,403 or \$373.65 per GSF. This appears reasonable when compared to the State Board Standard of \$400.74 per GSF (2020 construction mid-point).

Contingencies Costs are \$1,338,140 or 9.9% of new construction costs. This appears reasonable when compared to the State Board Standard of 10%.

Architectural and Engineering Costs are \$1,100,291 and are 6.9% of the new construction and contingency costs. This appears reasonable when compared to the State Board Standard of the 5.76% – 8.66%.

Consulting and Other Fees are \$933,708. The State Board does not have a standard for these costs.

Movable and Other Equipment are \$3,648,489. The State Board does not have a standard for these costs.

Other Costs to be Capitalized are \$808,409. The State Board does not have a standard for these costs.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION REASONABLENESS OF PROJECT COSTS (77 ILAC 1120.140(c))

D) Criterion 1120.140 (d) - Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct costs mean the fully allocated costs of salaries, benefits and supplies for the service.

The operating costs per equivalent patient day is \$891.00. The State Board does not have a standard for these costs. The Applicants have met the requirements of this criterion.

Salaries	\$8,190,300
Benefits	\$2,096,700
Supplies	\$835,100
Total	\$11,122,100
Projected Patient Days	12,483
FY 22 Operating costs per Projected Patient Days	\$891.00

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED OPERATING COSTS (77 ILAC 1120.140(d))

E) Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The total effect of the project on capital costs is \$119.25 per equivalent patient day. The State Board does not have a standard for these costs. The Applicants have met the requirements of this criterion.

Depreciation, Amortization, Interest	\$1,488,600
Total Capital Costs	\$1,488,600
Projected Patient Days	12,483
Capital Costs per Project Patient Day	\$119.25

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS (77 ILAC 1120.140(e))

Note on Migration Factor:

State Board Staff notes that in and out-migration for comprehensive physical rehabilitation beds is not considered. Only medical surgical, pediatric, and obstetric categories of service consider in and out migration when calculating bed need. The formula for medical surgical/pediatric in and out migration is as follows:

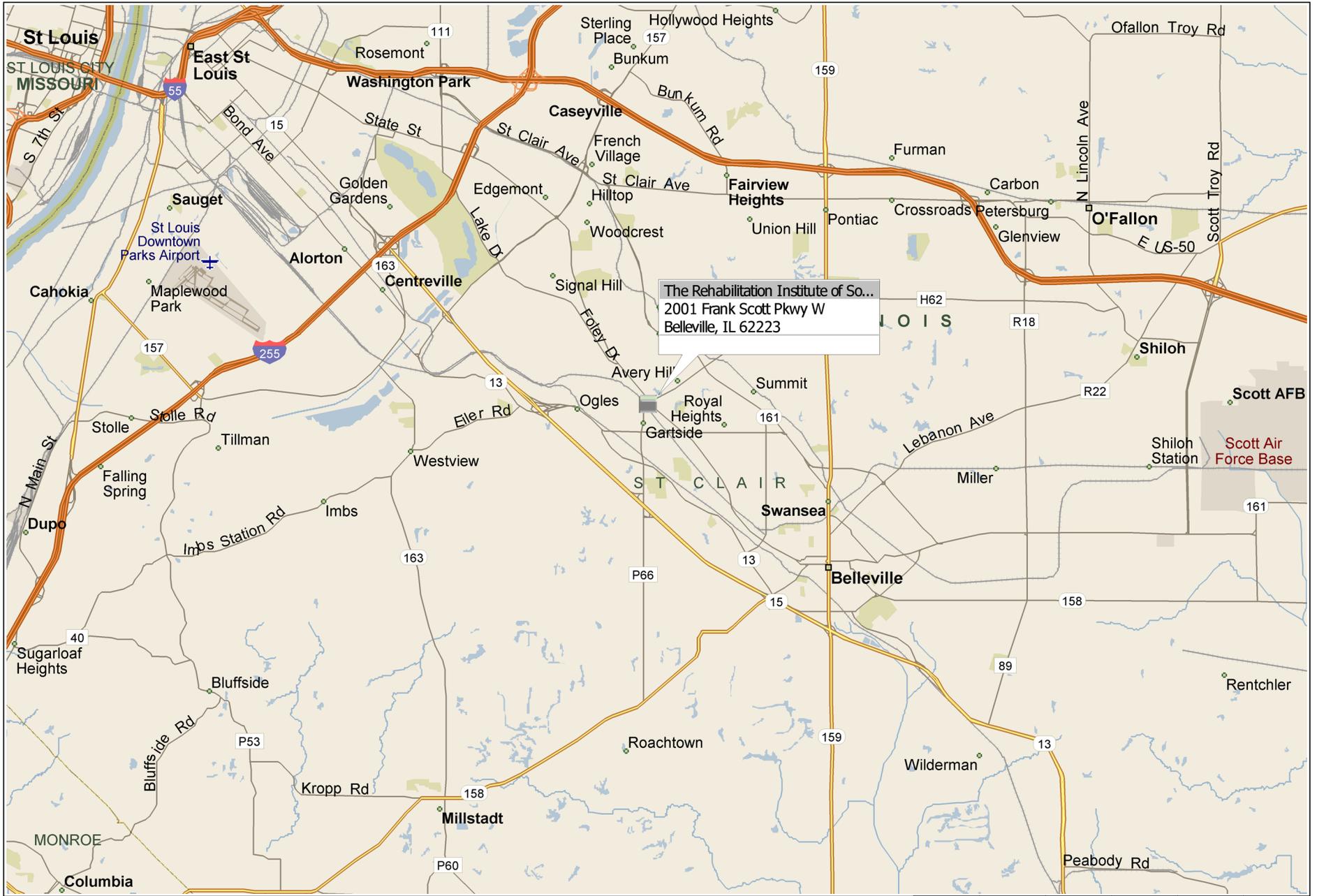
The migration patient days factor is determined as follows for medical surgical:

- A) Subtract the number of medical-surgical and pediatric in-migration admissions (i.e., non-planning area residents who were admitted to planning area facilities) from the number of out-migration admissions (i.e., planning area residents who were admitted to facilities located outside of the planning area) to obtain either a positive or negative net patient migration number;
- B) Multiply the net patient migration number by the State's base year average length of stay for the combined medical-surgical and pediatric admissions to obtain net migration patient days for the planning area;
- C) Multiply the net migration patient days number by .50 (50% statutory adjustment factor) to obtain the migration patient days factor.

When calculating the bed need for medical surgical pediatric and obstetric beds the State Board is required **by statute to** include a migration adjustment factor for the planning area (20 ILCS 3960/12.5). Medical surgical pediatrics and obstetric beds are the only bed categories for which the State Board uses a migration adjustment factor. This is done by subtracting the number of patients from outside the planning area receiving services at area hospitals (in-migration) from the number of area residents receiving services at hospitals outside the planning area (out-migration). The difference between these figures is multiplied by the State average for length of stay for Medical-Surgical and Pediatric patients to calculate *migration patient days*. This is multiplied by an adjustment factor of 0.50. If out-migration exceeds in-migration, the adjusted migration days are added to the projected total patient days for the area. If in-migration exceeds out-migration, the adjusted days are subtracted from the projected total patient days for the planning area.

Previously a migration adjustment factor was not used.

19-021 The Rehabilitation Institute of Southern Illinois - Shiloh



September 1, 2020

VIA EMAIL

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

Re: The Rehabilitation Institute of Southern Illinois, Project #19-021, Response to Request for Information and Modification

Dear Ms. Avery:

We represent the applicants as co-counsel with Polsinelli, in regard to the pending Certificate of Need application for The Rehabilitation Institute of Southern Illinois, Project #19-021. The purpose of this letter is to provide a response to Board Staff's request for additional information related to Board Criterion regarding Performance Requirements-Bed Capacity Minimum ("100-bed rule"). Please accept this letter as our response to this request for information. Furthermore, the applicants are seeking a modification of the pending project pursuant to 77 Ill. Admin Code. Section 1130.650. The applicants are seeking to modify the date of project completion to July 1, 2022.

Performance Requirements-Bed Capacity Minimum for Inpatient Rehabilitation Services

According to Part 1110.205(a)(1)(f) of the Board's rules, the minimum size for an inpatient rehabilitation beds.¹ These minimum size requirements for rehabilitation services have been a State standard for a long time, but do not reflect the current industry standard for this model of care as a freestanding building. Establishing a 40 bed hospital as a collaboration between an acute care hospital provider and a service line specialty management company, like Encompass, a national leader in rehabilitation care, will best address the needs of the communities that this program will serve. Further to our client's position we provide the following information for your consideration. .

¹ Of some interest is the fact that no minimum bed requirement exists for freestanding AMI hospitals other than the 20 bed unit requirements within an MSA and 10 bed unit requirement for programs outside of an MSA. As the Board evaluate updates to the 100-bed rule, we believe it is important to consider a similar minimum bed scheme that is better aligned with current national practices. This 100 bed requirement for freestanding rehabilitation hospitals has likely discouraged the development of needed rehabilitation services in many parts of the State.

Presumably, the 100-bed minimum size was driven in part by the need for a hospital to be large enough to serve sufficient numbers of patients to cover fixed costs. However, in today's healthcare environment, an inpatient rehabilitation facility ("IRF") is typically part of a health system, so individual hospitals benefit from the economies of scale of the system. Thus, support functions such as administration, billing, human resources, and information technology and development are centralized for the system, allowing individual hospitals to benefit from a system's operation costs and thus be smaller than 100 beds to be financially viable.

A 100-bed minimum size does not reflect the shorter length of stay of inpatient rehabilitation facility ("IRF") patients today, which allows for a greater number of patients to be cared for in a smaller facility today than in the past. Given the current 12 to 14 day average length of stay for the majority of today's IRF patients, a 100-bed hospital would require a large urban population to be financially viable. Thus, adherence to this standard would mean that inpatient rehabilitative care would not be available locally to residents in communities outside of large urban areas (such as Chicago).

The ability of providers to develop hospitals less than 100 beds means that Illinois patients outside dense urban cities can access this needed post-acute service locally, benefitting from the rehabilitation care directly as well as the support of their home medical community (*e.g.*, primary care physicians, cardiologist, etc.) and participation of family and friends in their recovery. This point in particular is indicative of the Encompass approach to establishing this type of care in areas of the state that desperately need access to rehab services but are outside of the aforementioned large urban areas.

The previous two projects approved by this Board involving Encompass were for facilities outside of large urban areas (Project #19-036, Encompass Rehabilitation Hospital of Libertyville- 60 beds, and Project #19-059, Quad Cities Rehabilitations Institute, Moline-40 beds) and under 100 beds. The size of these facilities and the one proposed for this project are consistent with other hospitals developed (and under development) by Encompass. The Moline and Libertyville projects like this one in Shiloh involved a careful analysis of patient migration patterns, population demographics, and existing services. The applicants experience operating a joint venture hospital together across the river in St. Louis has informed this application and the projected referrals provided justify a 40 bed facility.

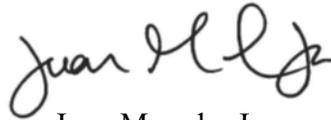
Finally, with the capital investment and service line expertise offered by a partner like Encompass, the model selected for this service will allow BJC to free up resources to focus on its core acute care services and population health management while ensuring that necessary rehabilitation services are available in the immediate community without having to leave the County and the State for care. Not having the resources or space to provide this care directly at St. Elizabeth, the next closest acute care hospital, is precisely why that hospital recently closed its rehabilitation unit as documented in its request to this Board for closure.

Courtney Avery
September 1, 2020
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If you have any questions or need any additional information regarding the project, please feel free to contact me via phone at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

A handwritten signature in black ink, appearing to read "Juan Morado, Jr.", with a stylized flourish at the end.

Juan Morado, Jr.

JM



150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606 • (312) 819-1900

Via Hand Delivery

November 15, 2019

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

RECEIVED

NOV 15 2019

HEALTH FACILITIES &
SERVICES REVIEW BOARD

**Re: Rehabilitation Institute of Southern Illinois, Project 19-021 Submission
of Additional Information**

Dear Ms. Avery:

Polsinelli, as co-counsel with Benesch, submits this letter on behalf of Rehabilitation Institute of Southern Illinois, LLC and the other project Applicants¹ in their proposal to establish a 40-bed inpatient rehabilitation facility in Shiloh, Illinois (the "Rehab Institute"). In this capacity, I am writing to provide additional information subsequent to the Illinois Health Facilities and Services Review Board's (the "HFSRB") September 17, 2019 meeting where the Rehab Institute proposal received four favorable votes, just one vote short of approval.

The Applicants have documented significant community support for the Rehab Institute, and it is not opposed. The project, an extension of the acute care services offered by certain Applicants in St. Clair County, is positioned to fill a void in this planning area left by the closure this month of the HSHS St. Elizabeth's Hospital ("St. Elizabeth's") inpatient rehabilitation unit in nearby O'Fallon. Pursuant to Section 1130.670 of the HFSRB's rules, the Applicants respectfully submit supplemental information regarding the Rehab Institute. This letter:

- 1. Demonstrates there is a Need for 47 Inpatient Rehab Beds in HSA 11.**
- 2. Describes Inpatient Rehabilitation Facilities (IRF) and distinguishes IRF care from Skilled Nursing Facility (SNF) care.**
- 3. Describes how the Rehab Institute is an essential complement to acute care hospital services in the Metro East Region and why the services are needed.**

¹ Encompass Health Corporation, Metro-East Services, Inc., Memorial Regional Health Services, Inc., and BJC Health System dba BJC HealthCare.



Ms. Courtney R. Avery

November 15, 2019

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4. Explains the disparate access to this service that exists between patients residing in the metropolitan Chicago and the Metro East Region (HSA 11) and Central and Southern Illinois, as a whole, and how the Rehab Institute will address this disparate access in HSA 11.

5. Corrects the Rehab Institute's physical plant space allocation to specifically describe sub-departments within clinical areas (specifically therapy space and pharmacy operations).

* * * * *

1. Need for 47 Inpatient Rehab Beds in HSA 11 Based on Current Market Conditions.

Due to three primary factors, there is a need for 47 inpatient rehabilitation beds in HSA 11. According to its October 9, 2019 letter to the HFSRB, St. Elizabeth's will discontinue its 16 bed inpatient rehab unit by November 25, 2019. Importantly, the recently approved Anderson Rehabilitation Hospital ("Anderson") does not expect to serve the same patient base as the St. Elizabeth's program. The Rehab Institute will be available and accessible to patients currently utilizing St. Elizabeth's. Additionally, there is significant outmigration to Missouri for intensive inpatient rehab services that will be addressed by the Rehab Institute. In CY 2018, 635 HSA 11 residents were admitted to Missouri IRFs with the majority of those patients admitted to the Applicants' Missouri inpatient rehabilitation programs. Finally, there are 774 HSA11 patients discharged from general acute care hospitals in need of intensive inpatient rehab care, but for a number of reasons, do not receive that care. Taking into account these factors as well as the recent approval of the Anderson Rehabilitation Hospital, there is a need for 47 inpatient rehabilitation beds. See Table 1 on the following page.

Table 1		
Components of Estimated Demand for Inpatient Rehab Services (HSA11)		
Estimated Demand for Inpatient Rehab Services	CY18 Admissions	Beds Needed at 85% Occupancy
<i>Current Patients Admitted to Rehab Services</i>		
St. Elizabeth's 16-bed Unit, St. Clair County	400	16
HSA11 Patients Served in Missouri Rehab	635	29
<i>Subtotal, Bed Need for Patients Currently Served</i>	<i>1,035</i>	<i>45</i>
<i>Plus Gap in Care: Unrealized Need, HSA11 Patients²</i>	<i>774</i>	<i>36</i>
<i>Equals Total HSA11 Rehab Bed Need</i>	<i>1,809</i>	<i>81</i>
<i>Minus Anderson Hospital, Madison County, Approved 34-bed Rehab</i>	<i>816</i>	<i>34</i>
<i>Equals Net Bed Need, HSA11</i>	<i>993</i>	<i>47</i>
Sources: St. Elizabeth's Hospital Discontinuation Application for Exemption (#E-046-19), Attachment 7, page 39; Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database; and Encompass Health.		
Note: beds needed at 85% occupancy based on statewide average length of stay of 14.1 days.		

2. Inpatient Rehabilitation Facilities Provide Better Functional Outcomes for a Significant Group of Patients and are Necessary to Maximize Those Patients' Recovery.

Nature of IRF Services. Inpatient rehabilitation facilities are inpatient facilities that provide intensive rehabilitation therapy to patients recovering from serious illness, injury, or surgery usually following an acute care hospital stay. IRF patients are individuals who require extensive rehabilitation services in an inpatient setting (typically physical therapy, speech therapy, and occupational therapy) to improve functioning before returning home. Patients admitted to an

² This figure is based on the SNFs operating under the previous SNF reimbursement system that reimbursed SNFs on a fee-for-service basis, rewarding nursing homes that provided a higher number of therapy sessions. With the new reimbursement changes, this figure likely understates future demand for inpatient rehab hospital services due to the new reimbursement system.

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IRF must be able to tolerate at least 3 hours of therapy per day and to have a substantial likelihood of having functional improvements with supportive therapy. IRF care involves more intensive therapy services than that provided at a SNF, home or outpatient setting. Evidence demonstrates there is a direct correlation between daily therapeutic duration and functional gain during an IRF stay.³ Quality measures and outcomes reported to CMS such as the Functional Improvement Measure (“FIM”) also typically demonstrate substantial functional improvements based on an IRF stay.

The average length of stay in an Illinois IRF is approximately 14 days.⁴ Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology, as well as prosthetic and orthotic devices. Nationally, in 2013, IRFs provided 17 percent of post-acute facility care.⁵

Patients Suitable for IRF Services. Rehabilitation services support a patient’s return to activities of daily living after surgery or a catastrophic illness or injury, including but not limited to:

- *Stroke*
- *Brain injury*
- *Neurological conditions*
- *Joint replacement⁶*
- *Orthopedic*
- *Hip fracture*
- *Spinal cord injury*
- *Amputee*

³ Joan E. DeVanzo, Ph.D. et al., Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge (2014). See Attachment – 1.

⁴ Illinois Health Facilities & Services Review Board, Illinois Hospitals Data Summary – Calendar Year 2018 *available at* <https://www2.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Documents/2018%20Hospital%20State%20Summary.pdf>

⁵ Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2013

⁶ Hip or knee replacement when it is bilateral, the patient’s body mass index is greater than or equal to 50, or the patient is age 85 or older.



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- *Parkinson's Disease*
- *Multiple sclerosis*
- *Burns*
- *Pulmonary/respiratory*
- *Pain management*

IRFs have measures in place, based on Medicare rules, to ensure that IRF care is oriented toward those patients who are most appropriate for the setting. To receive payment under the IRF PPS, a facility must demonstrate that it is primarily engaged in furnishing intensive rehabilitation services. The compliance threshold requires that no less than 60 percent of an IRF's patient population (Medicare and other) have as a primary diagnosis or comorbidity at least one of 13 conditions that typically require intensive rehabilitation therapy.

Goals of intensive rehab services are oriented toward returning the patient to his/her highest level of independence and functioning so that the patient can remain an active member of the community, including activities of daily living.

Examples of patient goals include:

- > Individuals being safe at home
- > Self-care (bathing and oral hygiene, dressing/shoes, toileting and eating)
- > Chair/bed transfer and ambulation including walking stairs and gait retraining
- > Functional cognition (temporal orientation, memory/recall)

Without rehabilitation services, many patients discharged may never return to the level of independent function that they had prior to their illness or injury. Functional gain is measured by the Functional Independence Measure, including activities of daily living, mobility, cognition, and the total of the FIM scores.

As more fully described in **Exhibit A**, the SNF setting does not provide a comparable level of rehabilitation support that an IRF provides and as such is not an appropriate setting for a patient who has the ability to return to more independent living and to regain their ability to complete many or all of the essential activities of daily living and remain a vibrant part of his/her community.



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3. *The Rehab Institute is an Essential Complement to Acute Care Hospital Services in the Metro East Region and is a needed service.*

The health planning oversight created by the Illinois Health Facilities Planning Act is “*designed to develop a procedure that establishes an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public especially in areas where the health planning process has identified unmet needs.*”⁷ Implicit in this charge is the expectation that Illinois residents can receive an appropriate level of care in their own communities based on community demographics, availability of resources and other related considerations. As the Applicants previously described and as further discussed in this submission, the need for additional inpatient rehabilitation services in Health Service Area 11, generally, and in this planning area, more specifically, is compelling. Despite strong demand for the services as demonstrated by the outmigration of the cases from the area and the growing utilization of the St. Elizabeth’s program in nearby O’Fallon, the inpatient rehabilitation services in the geographic service area have been pared back over time and now, with the closure of the St. Elizabeth’s program, eliminated. As detailed in **Exhibit B** of this submission, the Rehab Institute will address the current HFSRB calculated need in HSA 11. The need for inpatient rehabilitation services in HSA 11 is understated which significantly disadvantages the residents of this area and exacerbates already existing health care access disparities.⁸ With lack of access to this particular service, patients needing intensive rehabilitation services will lose out on receiving the care they need to return to a normal life after an acute and debilitating illness or injury or after major surgeries.

Memorial Hospital East and Memorial Hospital in Belleville are both operated by the non-profit health system, BJC Healthcare. They are two of the main acute care hospitals in the southern segment of HSA 11. BJC is the only health care system currently seeking to provide an inpatient

⁷ 20 ILSC 3960/2

⁸ Notably, the HFSRB rules (77 IAC 1100.310) recognize that in unique circumstances, provisions will be made in the HFSRB rules for the recognition by the HFSRB of variances to computed need. This rule states that “variances are developed to account for unique needs and resources of a particular area or population.” We note the out-of-state outmigration and gap in care described in this submission are not explicit variances as the rehabilitation bed criteria does not include a variance rule despite the general mandate for variances in the rules. It is, however, essential to ensure access to inpatient rehab services in HSA 11, that the outmigration and gap in care be given attention in order to avoid the further loss of services in Southern Illinois.



Ms. Courtney R. Avery
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rehabilitation service to address the unmet inpatient rehabilitation care needs of these communities. As non-profit community hospital providers, they are responsible for meeting the needs of the constituent communities to the best of their ability to provide an appropriate scope of services in the realm of what is financially feasible and justified based on the requirements of the community.

The role of BJC's two St. Clair County acute care hospitals is essential to the overall delivery of health care services and population health management in the Metro East region of Illinois. The Rehab Institute is a collaborative undertaking between Memorial-East and Memorial Hospital Belleville, as community general acute care hospital providers on one hand, and Encompass Health as a national leader in specialized rehabilitation services, on the other. Together these organizations have designed this service to fill the void that exists in the delivery of essential inpatient intensive rehabilitation services. This collaboration is consistent with the HFSRB's rules "encouraging the development of interrelationships between and among health care providers when such relationships increase efficiency, effectiveness, and quality of care."⁹

4. In the State of Illinois, there are material disparities in access to this service between patients residing in the metropolitan Chicago area compared to many parts of the rest of the State of Illinois, including HSA 11. The Rehab Institute will address this disparate access.

Without the proposed Rehab Institute to ensure access to needed services in the residents' immediate communities, the already limited access to inpatient rehab facility services will worsen. As shown in **Exhibit C**, HSA11 residents have disproportionately low access to rehab beds when compared to virtually every other HSA and to the overall statewide average. There are a variety of factors that have resulted in the loss of services but re-building these services is consistent with the principles articulated in the HFSRB rules that the HFSRB "encourages the maintenance and support of needed health care facilities in order to prevent the loss of essential health care services to Illinois residents."¹⁰

For example, residents in the greater Chicago area have three times the level of access to rehab beds compared to residents of HSA11 (HSA6 and HSA7 statistics combined). Taken individually, Chicago residents have 4.1 times greater access to inpatient rehab services than

⁹ 77 IAC 1110.350.

¹⁰ 77 IAC 1100.410.



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HSA11 residents while suburban Cook and DuPage County residents have 2.2 times greater access to rehab beds than HSA11.

5. Correction of Space Plan.

When reviewing the space plan further, the Applicants recognized the clinical components of the space plan were not delineated between patient bed units, therapy space and pharmacy. The attached **Exhibit D** separately identifies these departments. While completing this analysis to provide more specificity on the space plan, an immaterial rounding difference between the department-specific square foot summary and the total building square footage of 95 GSF was identified. **Exhibit D** provides the updated space program. The Rehab Institute, in fact, complies with Section 1110.120(a) (Size of Project) of the HFSRB rules.

Thank you for your consideration and we look forward to the reconsideration of this project. Please let us know if you require any further information.

Sincerely,

A handwritten signature in black ink that reads "Kara Friedman". The signature is fluid and cursive.

Kara Friedman

Enclosures

Cc: Greg Bratcher, BJC HealthCare
Carey McRae, Encompass Health Corporation
Juan Morado, Benesch
Marty Chafin, Chafin Consulting Group

Exhibit A
Inpatient Rehabilitation Facility Care versus Skilled Nursing Facility Care

- 1. There are important differences in patients and services offered by an IRF to patients in need of intensive rehabilitation following a catastrophic illness or injury, compared to the therapy capabilities of a SNF.***

As otherwise described in this supplemental letter, a SNF is not an appropriate site of service for intensive IRF services.

The physician letters of support for the Rehab Institute repeatedly reference the need for available and accessible intensive inpatient rehabilitation services in HSA 11 that are uniquely offered in comprehensive inpatient rehab programs. In fact, many physicians cited the difference in inpatient rehab services offered by the proposed Rehab Institute and existing “lower level of post-acute care such as a skilled nursing facility” in their letters of support. (See Jin-Moo Lee, MD PhD, Norman J. Stupp Professor, Professor of Neurology, Radiology, and Biomedical Engineering, Director, Cerebrovascular Disease Section, Department of Neurology, Co-Director, Stroke and Cerebrovascular Center, Washington University and Barnes-Jewish Hospital letter of support submitted to HFSRB August 9, 2019, as one example.)

The differences between comprehensive inpatient rehab services and therapies offered in a SNF are illustrated below. As shown, two significant differences are the much higher number of therapy hours per day that a patient receives in the inpatient rehab setting compared to a SNF and the involvement and direction of a physician leading the multidisciplinary team. The national discharge rates further demonstrate significant differences between the two settings, with rehab hospitals returning approximately 77% of patients to the community compared to nursing homes returning only 40% to the community.

Figure 1
Inpatient Rehabilitation is More Intensive, More Comprehensive,
and has Better Outcomes than Skilled Nursing
(Comparison of IRFs to SNFs)

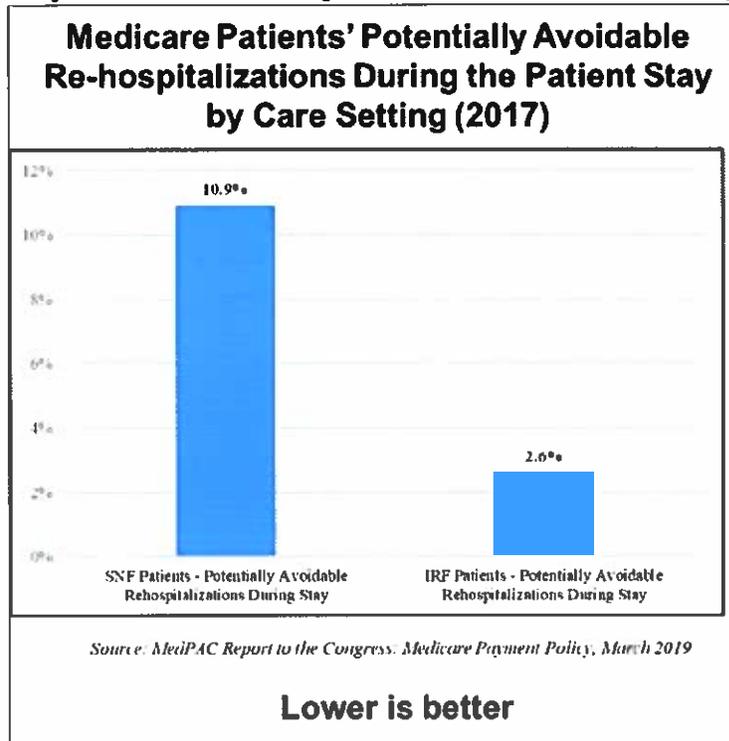
	<i>Inpatient Rehabilitation Facilities</i>	<i>Skilled Nursing Facilities</i>
<i>Required by Medicare</i>		
Close Medical Supervision by a Physician with Specialized Training	✓	✗
24-Hour Rehabilitation Nursing	✓	✗
Medical Care and Therapy Provided by Physician-Led Multidisciplinary Medical Team Including Specialty-Trained Registered Nurses	✓	✗
3 Hours of Intensive Therapy, 5 Days a Week	✓	✗
Patient Condition Requires Hospital-Level Care	✓	✗
Discharge Rate to the Community (2017)	76.9%	39.5%

Source: MedPAC, Medicare Payment Policy, March 2018 pages 215, 219, 226, 278, and 280; American Hospital Association

Encompass' Discharge to Community Rate is 79.9%.

A more recent MedPac study (2019) continues to distinguish clinical outcomes of inpatient rehab facilities and nursing homes, as shown in Figure 2 below.

Figure 2
Rehab Hospitals have lower Hospital Readmissions than Nursing Homes



The differences between the comprehensive inpatient rehabilitation facility and SNF settings is further documented by a 2014 study which found that “when patients are matched on demographic and clinical characteristics, rehabilitation in IRFs leads to lower mortality, fewer readmissions and ER visits, and more days at home (not in a hospital, IRF, SNF or LTACH) than rehabilitation in SNFs for the same condition. This suggests that the care delivered is not the same between IRFs and SNFs. Therefore, different post-acute care settings affect patient outcomes.” (See [Attachment 1](#) for a summary of the report’s findings.)

Despite the differences between therapy services provided in an inpatient rehab program and a SNF, many HSA11 residents who would benefit from intensive rehab services have instead historically received care in the less intensive, suboptimal nursing home setting. This is primarily due to the lack of available and accessible inpatient rehab beds in HSA11 as evidenced by the substantially lower rates of IRF utilization and beds per 1,000 population for the Medicare population.

SNFs serve an important role as a post-acute care provider. Yet the inappropriate substitution of SNF rehab services for comprehensive inpatient rehab care when intensive inpatient rehab care is needed is unfortunate as it severely impacts a patient's functional improvement and return to activities of daily living. Numerous physician letters of support address the use of suboptimal post-acute care because HSA11 residents lack sufficient intensive inpatient rehab beds close to their homes.

For example, for a patient who suffers a stroke, intensive inpatient rehab therapy offers the best chance of the patient returning to his/her highest level of functioning, or as formally stated in the American Heart Association/American Stroke Association's 2016 Guideline, "The provision of comprehensive rehabilitation programs with adequate resources, dose, and duration is an essential aspect of stroke care and should be a priority".¹¹

Encompass has established a national partnership with the American Heart Association/American Stroke Association ("AHA/ASA") to increase patient independence after a stroke and reduce stroke mortality through community outreach and information campaigns. The multi-year project is expected to accelerate adoption of the recent AHA/ASA Stroke Rehabilitation Guidelines, increase patient awareness of post-stroke options, and provide practical support to patients and their families to improve recovery outcomes.

Given the fact that many physicians, nurses, and case managers are aware of the need for the most intensive level of therapy appropriate for a patient who suffered a stroke, the question then becomes, "why would a patient go anywhere else?" Again, the many physician letters provide valuable insight.

For example, David M. Holtzman, MD, Andrew B. and Gretchen P. Jones Professor, Chairman of Neurology, Washington University in St. Louis School of Medicine, and Neurologist in Chief, Barnes Jewish Hospital, states the following in his letter submitted to HFSRB May 24, 2019:

In my capacity, I oversee many neurologists who see thousands of stroke patients annually in addition to patients with a variety of other neurological conditions and other medical problems. Many of these patients are in need of ongoing inpatient medical and nursing care, physical, occupational, and speech therapy after discharge from our hospital to help them recover from their acute illness and to improve the opportunity for them to return to as much independent functioning as

¹¹ Source: *Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association; 2016*. Carolee J. Winstein, Joel Stein, Ross Arena, Barbara Bates, Leora R. Cherney, Steven C. Cramer, Frank Deruyter, Janice J. Eng, Beth Fisher, Richard L. Harvey, Catherine E. Lang, Marilyn MacKay-Lyons, Kenneth J. Ottenbacher, Sue Pugh, Mathew J. Reeves, Lorie G. Richards, William Stiers, and Richard D. Zorowitz and on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research.

they possibly can. We are in dire need of inpatient acute rehabilitation facilities east of the Mississippi river in Southern Illinois.

There are currently very few inpatient rehab beds in the greater metro east area, specifically St. Clair County and several of the surrounding counties. Our patients and families have to travel long distances from their homes to The Rehabilitation Institute of St. Louis which is where we refer most of our patients, however **many of those patients prefer to be closer to their community for rehabilitation. Unfortunately they are not getting the intensity of services in the skilled nursing facilities compared to what they would receive in The Rehabilitation Institute of Southern Illinois.**

The need for the Rehab Institute is illustrated by the number of southern Illinois patients we care for each year. For example, in CY17 we cared for 658 neurology patients from the 4- county HSA 11 area. Of course, when you consider the greater Southern Illinois area (counties such as Randolph, Perry, Washington, Jefferson, etc.) the number of patients who cross the river from East Metro in Missouri is far greater. Thus, of the patients we see annually from the 4-county HSA 11 area plus the greater Southern Illinois area, I would expect that we will annually refer as many as 300 patients for intensive inpatient therapy, with the vast majority of those **patients being referred to the new hospital in Shiloh Illinois since that will be closer to their homes and offer the same high level of care currently offered at The Rehabilitation Institute of St. Louis here in Missouri.**

For all of the reasons cited above, I strongly urge you to provide a Certificate of Need to The Rehabilitation Institute of Southern Illinois, LLC to allow them to start construction of this desperately needed hospital. I am certain it will have an immediate positive impact on our hospital's length of stay, on caregiver education, and patient integration back into the community.” [Emphasis added.]

2. *SNF Reimbursement Changes will Increase the Gap in Care.*

CMS reimbursement changes are expected to reduce therapy services provided in nursing homes. Despite the differences in SNF and IRF therapy services provided, many patients have historically been admitted to a SNF in lieu of an IRF despite the fact that inpatient intensive rehab was the most appropriate service. This fact is discussed in the many physicians' letters of support. Recent reimbursement changes by the Centers for Medicare and Medicaid (“CMS” or Medicare) are expected to drastically reduce the number of therapy sessions provided in nursing homes.

Specifically, effective October 1, 2019, CMS implemented a new payment system for SNFs, the Patient Driven Payment Model (“PDPM”) which significantly changes how SNFs will be paid under Medicare by moving away from a system that determines reimbursement based primarily

on the volume of therapy services a patient receives to one that takes into account a patient's unique health characteristics.¹² Simply put, the proposed PDPM is a total shift of the SNF reimbursement system. Prior to the implementation of the PDPM, SNFs were reimbursed by Medicare based on fee-for-service methodology which financially rewarded SNFs which provided a higher number of therapy sessions. Under PDPM, that incentive is removed and as a result SNF patients are expected to receive fewer individualized therapy sessions.

PDPM replaces the Resource-Utilization Group ("RUG") reimbursement system. The RUG system primarily based SNF reimbursement on the volume of therapy services, such that the more therapy provided to a patient, the higher the Medicare reimbursement. Thus, PDPM is expected to significantly impact SNFs that historically maximized reimbursement by providing higher numbers of therapy sessions.

As a result, nursing homes are already laying off therapists and directing their remaining therapists to provide therapy to residents in group or concurrent sessions rather than individual sessions. Numerous SNF companies around the country have terminated or "transitioned" many of their therapists. Those who remain have been asked to boost their productivity and quickly cycle through patients as well as increase their use of group and concurrent therapy rather than one-on-one sessions because the new reimbursement model allows SNFs to conduct up to 25% of a patient's therapy in group sessions.¹³

In fact, thousands of physical, occupational, and speech therapists were laid off nationally only days after the PDPM reimbursement model took effect.¹⁴ As reported in Modern Healthcare, "just one day after the new Medicare payment model for nursing homes took effect, providers throughout the industry have begun showing signs of changing therapy strategies." Genesis HealthCare, a national healthcare provider with about 400 skilled nursing centers and senior living communities in 26 states confirmed that the company had cut almost 6% of its rehab-focused workforce only days after PDPM took effect.¹⁵

The recently-implemented Medicare payment system is expected to significantly reduce the amount of therapy services (particularly one-on-one sessions) nursing homes provide to their patients in the future. Thus, HSA11 residents who previously utilized the less than optimal rehab services in nursing homes in lieu of the more intensive inpatient rehab hospital care will likely have fewer options for SNF care because of the reimbursement changes.

¹² Source: *Nursing homes brace for new Medicare payment system*, Modern Healthcare; Maria Castellucci, May 25, 2019.

¹³ Source: *Therapists look to CMS for aide as SNFs restructure*, Modern Healthcare; Alex Kacik, October 4, 2019.

¹⁴ Source: *Therapists decry layoffs amid SNF reimbursement overhaul*, Modern Healthcare; Alex Kacik, October 2, 2019.

¹⁵ Source: *Therapy strategies begin to shift post-PDPM as Genesis lays off 5% of rehab staff*; Skilled Nursing News; Alex Spanko, October 2, 2019.

**Exhibit B
Need for the Project**

1. *Recent Market Changes Strengthen the Documented Need for the Proposed 40 Rehab Beds.*

Three significant changes have occurred in the market since the Rehab Institute submitted a CON permit application (#19-021) in May to establish a 40-bed freestanding comprehensive inpatient rehabilitation hospital in Shiloh, St. Clair County:

- a. Despite operating at or near fully capacity, St. Elizabeth’s Hospital in St. Clair County received HFSRB approval to permanently close its 16-bed rehab unit (Project #E-046-19);
- b. Anderson Rehabilitation Hospital (“Anderson”) received HFSRB approval (Project #19-026) to expand and relocate northward its inpatient rehab program to serve the fast-growing I-55 corridor in Madison County¹⁶ and areas beyond HSA11; and,
- c. As discussed in Exhibit A, Medicare implemented a new payment system effective on October 1, 2019 for Skilled Nursing Facilities (“SNF”) that is expected to significantly reduce the amount of therapy (rehab) services nursing homes provide to their patients. This will exacerbate the already existing “gap in care” that many post-acute care patients experience when discharged to a SNF rather than to a rehab facility.

These market changes leave no doubt that there is need for the proposed Rehab Institute.

When considering patients’ need for the Rehab Institute project, inpatient rehab services’ demand can be divided into two categories:

- i. HSA11 residents who currently receive inpatient rehab care, regardless of geographic location of the IRF provider; and
- ii. HSA11 residents discharged from a general acute care hospital in need of intensive inpatient rehab care, but for any number of reasons, do not receive intensive rehab care. We refer to these individuals as patients who are experiencing a “gap in care” or who have an unrealized need for inpatient rehab services.

¹⁶ The HOK Planning Group, Madison I-55 Corridor: Transportation & Growth Management Plan *available at https://www.co.madison.il.us/departments/planning_and_development/1-55_corridor_plan.php*.

The following chart illustrates and quantifies the HSA11 81 rehabilitation bed need based on these two categories using the most recent data available (CY18). Notably, and as further discussed in this submission, the HSA's projected 81-bed need is consistent with Anderson's 80-bed need presented in its application.

Figure 1
HSA11 Rehabilitation Bed Need based on Demand for Inpatient Rehab Services

Components of Estimated Demand – CY 2018		
	<i>Patient Admissions</i>	<i>Beds Needed at 85% Occupancy</i>
1	Current Patient Admissions at St. Elizabeth's 16-bed Unit	400
2	HSA11 Patients Out-migrating to Missouri for Inpatient Rehab Care	635
3	Gap in Care Based on Rehab-Appropriate DRGs from Acute Care Hospital	774
	TOTAL	1,809
	Anderson Hospital	816
	Net Bed Need	993

The total HSA11 bed need is 81 beds. As shown, 45 beds are needed to serve (1) HSA11 patients currently receiving inpatient rehab care at the soon-to-be-closed St. Elizabeth's Hospital and (2) HSA 11 patients traveling to Missouri for inpatient rehab care, the majority of whom are admitted to one of the Applicants' Missouri IRF programs.

Additionally, 36 beds are needed (3) for patients in need of inpatient rehab care but who are currently foregoing intensive rehab care.

The need for at least a 40-bed hospital is further documented by the notarized physician referral letters submitted with the application. As indicated in the physician letters, a significant number of HSA11 patients are currently traveling to Missouri for general acute care services. Those patients in need of inpatient rehab care upon discharge from the acute care hospital then must either (a) remain away from their communities of residence in Missouri for inpatient rehab care; or, (b) receive post-acute care services closer to home, either at a SNF or at home utilizing a home health provider rather than at an inpatient rehab hospital when those services are most appropriate. The physician referral volume for HSA11 patients documents the need for 51.7 inpatient rehab beds to serve patients receiving rehab care in Missouri or foregoing inpatient rehab care altogether.

Thus, regardless of the quantitative analysis considered, HSA11 residents have a need for a minimum of 40 additional rehab beds. Given the significant need in the planning area, the Rehab Institute can be expanded through construction of an additional wing on the facility, when necessary.

Details regarding the recent market changes¹⁷ follow.

a. Discontinuation of St. Clair County's Sole Rehab Program Reduces Already Poor Access to Care.

This month the sole inpatient rehab provider in St. Clair County, St. Elizabeth's Hospital, will discontinue service to its high and increasing inpatient rehab patient population. Consequently, there will be only one inpatient rehab program in the entirety of HSA11, and that program (Anderson) will be located in and primarily serve Madison County and northern communities along the fast-growing I-55 corridor.

With a total HSA 11 population of over 600,000 residents projected in 2020,¹⁸ a single provider in the northern part of the health service area is simply not adequate to address rehab needs of all HSA11 residents. The Rehab Institute proposes to fill the void left in St. Clair County by St. Elizabeth's exit from inpatient rehab market.

¹⁷ St. Elizabeth's closure and Anderson relocation will follow. Information on the Medicare reimbursement change was previously presented in Exhibit A.

¹⁸ Illinois Department of Public Health, Office of Health Informatics, Illinois Center for Health Statistics, Populations Projections – Illinois, Chicago, and Illinois Counties by Age and Sex: July 1, 2010 to July 1, 2025 (2014 Edition) available at https://www2.illinois.gov/sites/hfsrb/InventoriesData/Documents/Population_Projections_Report_Final_2014.pdf

Notably, prior to its closure St. Elizabeth’s inpatient rehab program was highly utilized and increasing. In fact, during the most recent full calendar year, St. Elizabeth’s 16-bed program had an average occupancy of 78%, with a peak census of 16 patients. The program’s high utilization is reflected in its current year average occupancy of 83%.

Table 1 St. Elizabeth's Hospital Inpatient Rehab Program Utilization						
Time Period	Beds	Admissions	% Occupancy	Patient Days	ADC	Peak ADC
CY18	16	400	78%	4,575	12.53	16
CY19TD	16	298	83%	3,225	13.27	N/A

Source: St. Elizabeth's Hospital Discontinuation Application for Exemption (#E-046-19), Attachment 7. CYTD is through August 2019.
 Note: St. Elizabeth's ADC shown in their application for CY18 was 12. The above ADC is calculated based on St. Elizabeth's self-reported patient days. The ADC of 12.5 matches St. Elizabeth's CY2018 Annual Hospital Questionnaire information on file with HFSRB.

According to St. Elizabeth’s closure request (#E-046-19), its hospital “has a need to redistribute existing bed capacity to allow for additional beds in its highly utilized ICU and medical/surgical services.” The ability to re-designate rehab beds “as medical/surgical and ICU without cost and without the time lag of construction” were also cited as factors in St. Elizabeth’s decision to discontinue its highly utilized inpatient rehabilitation program. St. Elizabeth’s also cited “upcoming changes in the acute rehabilitation market” which presumably is the current Rehab Institute application in addition to the approved Anderson Rehabilitation Hospital that will be constructed in the northern portion of HSA11. (See #E-046-19, Attachment 6, CON page 34.)

The decision of a general acute care hospital to prioritize and distribute limited resources to its core services such as medical/surgical and ICU, rather than the more specialized inpatient rehab service, is not uncommon in the industry. In fact, one of the many strengths of the proposed Rehab Institute is that the Rehab Institute can, while leveraging the expertise and resources of an experienced national post-acute care company, focus solely on the post-acute care needs of patients who have a need for intensive therapy services. At the same time, Memorial Hospital East and Memorial Hospital Belleville along with St. Elizabeth’s can focus on acute care services and general population health management. This model has been very successful for the BJC hospitals in Missouri, and bringing the same model to its hospitals in its Illinois markets is a natural extension of this partnership.

b. Anderson Rehabilitation Hospital is Not an Adequate Alternative to the Rehab Institute Project.

The proposed Rehab Institute in St. Clair County will complement the Anderson program which will be located in and primarily serve Madison County residents. Notably, while these applications were pending at the same time, Anderson did not oppose the Rehab Institute and the Rehab Institute did not oppose Anderson's application. The reason for that is simple: HSA11 residents need both programs.

Consider the following:

- a. Anderson documented a need for 80 inpatient rehabilitation beds.** Anderson utilized a similar approach to the Rehab Institute in its quantitative analysis to determine rehab bed need. Their methodology considered: current utilization of programs; unrealized need or a gap in care for patients in need of rehab but who are unable to receive it; and outmigration of patients to Missouri for rehab care. (See Figure 2 on the following page, which is a copy of Anderson's visual presentation to the HFSRB.)
- Though Anderson documented a need for 80 rehabilitation beds (which is approximately the same number of beds the Rehab Institute forecasts is needed), Anderson proposed and received approval to build only a 34-bed facility. Anderson rejected a larger hospital because Anderson had competing priorities for the use of funds, not because of the lack of community need for rehab services. (See CON #19-026 p. 87, Attachment 13.)
- b. Anderson is replacing closed rehabilitation beds in the northern portion of HSA11.** Anderson is proposing to serve the patients of the units that Gateway Regional Medical Center in Granite City and St. Clare's Hospital in Alton closed. In its CON application, Anderson stated, "the location of Anderson Rehab Hospital is closer to Granite City and to Alton, and the patients served by the rehab units at those hospitals than is the existing service at HSHS St. Elizabeth (26 miles from Granite City to O'Fallon, and 34 miles from Alton to O'Fallon)." Thus, based on Anderson's own statements, the patients currently utilizing St. Elizabeth's rehab program are not expected to utilize the distant Anderson program. (See CON #19-026 p. 80, Attachment 12.)
- c. There is minimal overlap in the proposed service areas of the Rehab Institute and Anderson.** Anderson's service area includes only Madison County in HSA11 and extends north along I-55 and east along I-70 into contiguous counties outside of HSA11. (See CON #19-026 p. 80, Attachment 12 and Figure 3 below.) Thus, Anderson does not address the inpatient rehab needs of more than half (55% or 343,528) of the 600,000+- HSA11 residents. Conversely, as shown in

the HSA 11 map, the Encompass/BJC Rehab Hospital is centrally located within the HAS this is accessible to all HSA 11 residents.

As such, Anderson Hospital is not an alternative to the proposed Rehab Institute in St. Clair County.

**Figure 2
Anderson Rehabilitation Hospital's Bed Need Forecast, #19-026**

Components of Estimated Demand		
	Admissions	Beds Needed at 85% occupancy
1	Current Annual Admissions at Anderson Hospital 20-Bed Unit	400
		17
2	Unrealized Need, Based on Rehabilitation Impairment Code Analysis	889
	2,177 admissions calculated total need - 1,288 patients hospitalized from area 889 unrealized hospitalizations	38
3	Reduction of Patient Migration 70% of Area Patients Go to St. Louis .70 x 1,288 = 902 Assume divert 2/3 = 600	600
		25
TOTAL		1,889
		80

Anderson Rehabilitation Hospital forecast is a conservative 816 annual admissions, in 34 beds

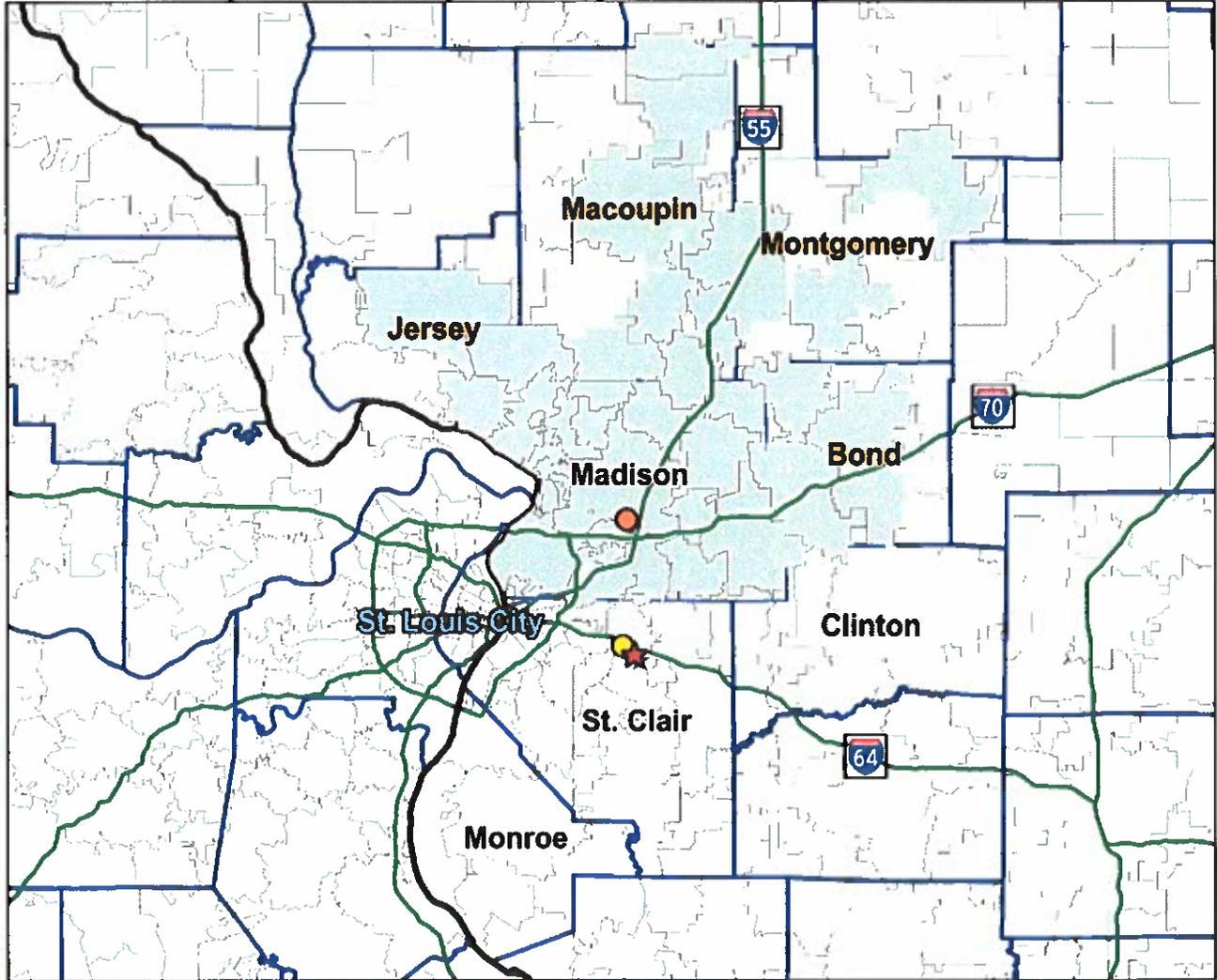
Source: Anderson Rehabilitation Hospital Visual Aid, Presentation to HFSRB Sept. 17, 2019.

Table 2		
Net Bed Need Based on Anderson Rehab Hospital's Estimated Demand		
<i>Calculations</i>	<i>Admissions</i>	<i>Beds Needed</i>
Total, per Anderson Hospital (<i>see</i> Figure 2 above)	1,889	80
<i>Minus</i> Anderson Rehab Hospital's Approved Project	816	34
Unmet Need	1,073	46

Notably:

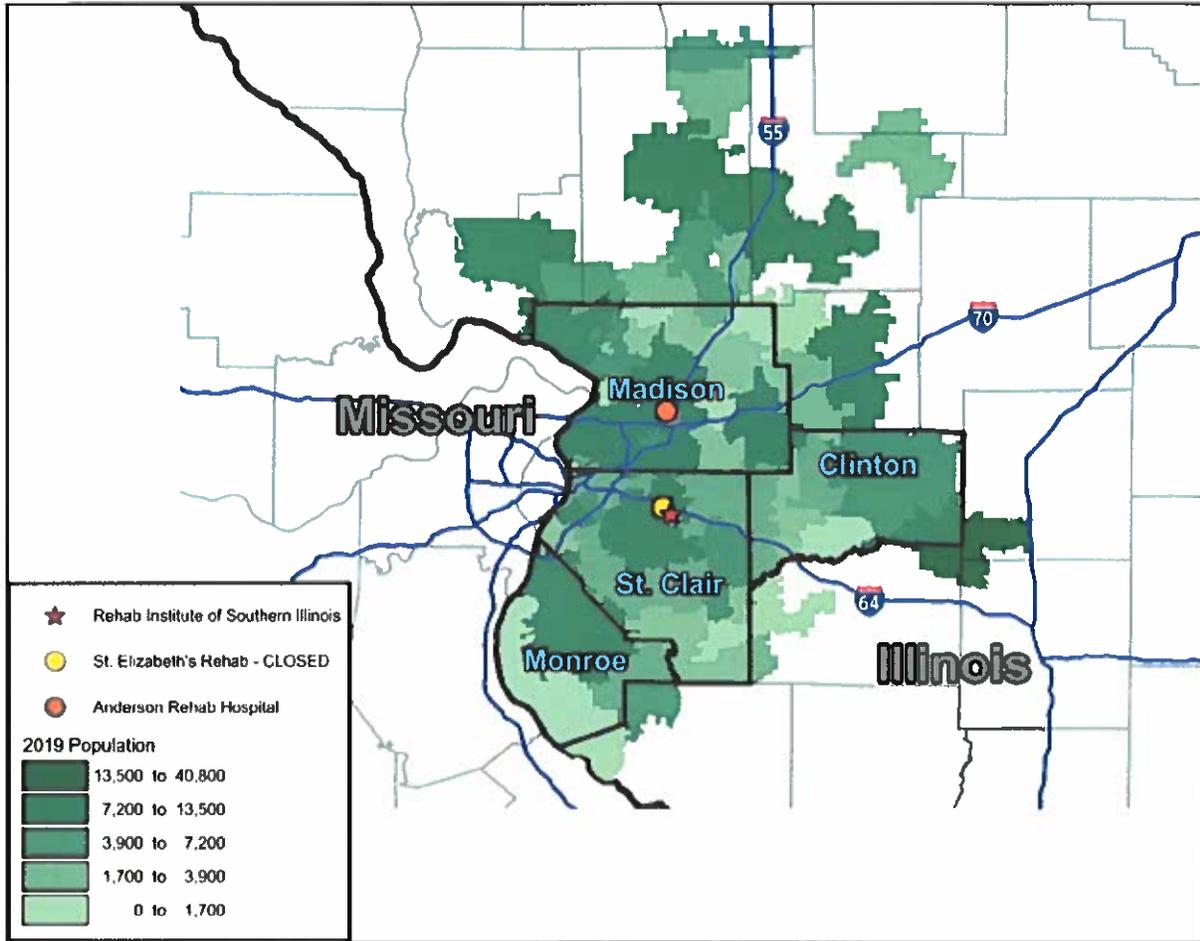
- Rehab Institute projects 800 admissions in Year 1 and 1,015 in Year 2, consistent with Anderson's estimated demand.
- Rehab Institute documented 1,138 physician referrals = 51.7 beds needed to meet HSA11 residents' needs.

Figure 3
Rehab Institute will Uniquely Serve HSA11 St. Clair, Clinton, and Monroe Counties
Anderson Proposes to Serve Only a Portion of HSA11, Focusing on the Northern I-55



- ★ Rehab Institute of Southern Illinois
- Anderson Rehab Hospital and its defined service area (gray)
- St. Elizabeth's Rehab Unit - CLOSED

**Figure 4
HSA 11 Population Map**



2. Additional Beds are Needed in St. Clair County to Ensure Access to Needed Care.

a. Quantitative Bed Need Projections

The Rehab Institute proposes to establish a 40-bed freestanding rehab hospital in St. Clair County in close proximity to St. Elizabeth's O'Fallon campus where the 16-bed highly-utilized rehab program is located. Thus, the Rehab Institute will be available and accessible to patients currently utilizing St. Elizabeth's. Moreover, because of the proposed project's site location on I-64 and its close proximity to State Roads 4, 161, and 159, as well as US Highway 50 and Interstates 55 and 255, the Rehab Institute will be easily accessible to all HSA11 residents.

As discussed previously, HSA11 patients currently in need of rehab care have three options:

- (1) Receive care in the limited number of inpatient rehab beds in HSA11;
- (2) Travel to Missouri for inpatient rehab care; or
- (3) Forego needed inpatient rehab care altogether.

The Rehab Institute’s CON application provides analyses documenting the need for a minimum of 40 additional inpatient rehab beds to meet the needs of HSA11 residents. (See CON #19-021, Attachment 12 pages 7 and 10.) The following analyses reflects the market changes since the CON application was filed, documenting need for a minimum 40 additional beds considering the discontinuation of St. Elizabeth’s program and the relocation and expansion of Anderson’s program.

As shown below, the proposed Rehab Institute project will: (i) fill the void left by St. Elizabeth’s discontinuation of rehab services, (ii) provide a local Illinois option for patients currently traveling outside the state (to Missouri) for inpatient rehab care, and (iii) address the needs of patients who are currently unable to receive needed inpatient rehab care because of the lack of available beds.

b. Documented Physician Referrals and Community Support

In addition to the quantified bed need presented above, physician referral letters document the need for 51.7 beds, as shown below.

Individual Name	Organization/ Title	Organization/Title 2	Documented Referrals
<i>Physician Referral Letters Attesting to Patients in Need of IRF Services</i>			
Dr. David Gates	Medical Director	BJCMG Hospitalist Service (Memorial, Belleville)	338
David M. Holtzman, MD	Chairman of Neurology	Washington Univ.-St. Louis	300
Dr. Grant Bochicchio	Trauma Services	Barnes-Jewish Hospital	200
Dr. Mark Thoeke	Chief of Hospital Medicine	Barnes-Jewish Hospital	150
Dr. Gregory J. Zipfel	Chairman, Neurosurgery	Barnes-Jewish Hospital	150
Total Physician Referrals Documented in the Application			1,138
<i>Multiplied by Average Length of Stay</i>			14.1
<i>Equals Projected Patient Days based on Physicians' Referrals Expected to RISI</i>			16,046
Bed Need at 85% Occupancy			51.7

Community Letters of Support for the Proposed 40-bed St. Clair County Facility

Donna H	Patient Testimonial	TRISL
Dr. Allison Zazulia	Neurologist	Barnes-Jewish Hospital
Dr. Greg Zipfel	Neurosurgeon	Barnes-Jewish Hospital

Community Letters of Support for the Proposed 40-bed St. Clair County Facility

Dr. James F. Alonso	Neurologist	Barnes-Jewish Hospital
Dr. Jin-Moo Lee	Neurologist	Barnes-Jewish Hospital
Dr. Ketan Patel	Emergency Medical Director Memorial B & E	Team Health
Dr. Kevin Barnett	VP Medical Staff	Memorial East
Dr. Kevin Baumer	Section Head Orthopedics	BJC Medical Group
Dr. Keyrouz	Neurologist	Barnes-Jewish Hospital
Dr. Nicole Werner	Neuropsychologist	Barnes-Jewish Hospital
Dr. Oksana Volshteyn	Physiatrist	Barnes-Jewish Hospital
Dr. Paul Santiago	Neurosurgeon	Barnes-Jewish Hospital
Dr. Randy Freeman	President Medical Staff	Memorial Belleville
Herb Roach	Mayor, O'Fallon	
James A. Vernier	Mayor, Shiloh	
Jay C. Hoffman	State Representative	
Lisa L. Atland, RN, MSN	Memorial Hospital/Director Care Mgmt.	
Mark Kern	St. Clair County	
Ronda Sauget	Leadership Council SW Ill.	
Sidney LeGrand	Chamber of Commerce	O'Fallon-Shiloh

Total Number of Letters **25**

As required by the rules, the notarized physician referral letters make clear that the referrals for the Rehab Institute have not been used to support another pending or approved certificate of need permit application. Thus, the 1,138 HSA11 patient referrals attested to by the physicians are specific to the proposed project only. Therefore, without consideration of the reduction of 16 beds due to the closure of St. Elizabeth's, there is sufficient demand for 51.7 additional beds based on the documented referrals alone. (See Staff Report, Docket No. H-03 prepared for the September 17, 2019 HFSRB Meeting, p. 10.)

Exhibit C
State of Illinois Use Rate Disparities

Inpatient Rehab Beds per 1,000 Population, 2020 <i>Ranked Highest to Lowest Beds per Pop</i>				
Rank	HSA	2020 Population	Inpatient Rehab Beds	Beds per 1,000 Residents
1	6	2,562,700	585	0.228
2	7	3,508,600	432	0.123
3	10	207,100	22	0.106
4	2	672,400	66	0.098
5	4	857,900	80	0.093
6	1	711,700	65	0.091
7	9	1,111,300	96	0.086
8	3	575,500	48	0.083
9	5	613,700	39	0.064
10	11	614,100	34	0.055
11	8	1,692,600	58	0.034
Total		13,127,600	1,525	0.116
Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/19 and Addendum to Inventory of Health Care Facilities, HFSRB 10/23/19.				

**Exhibit D
Clinical Department Allocation**

Size of the Project Proposed GSF Compared to State Board Standard						
Reviewable Service	Beds/Rooms/ Unit	Proposed GSF		State Board Std		Met Standard
		Per Bed	Total	Per Bed	Total	
Comprehensive Physical Rehab Beds	40	597.35	23,894	525-660 GSF	26,400	Yes
Pharmacy	1	816	816	N/A	N/A	N/A
PT/OT/ST	N/A	N/A	5,957	N/A	N/A	N/A

Reviewable Space Total	30,667
Non-Reviewable Space	16,987
Total Proposed GSF	47,654

Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge

Study Highlights

Authors: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, Nikolay Manolov, Ph.D.

Contact: Joan E. DaVanzo, joan.davanzo@dobsondavanzo.com; 703-260-1761

Synopsis of Key Findings

We found that patients treated in IRFs had better long-term clinical outcomes than those treated in SNFs following the implementation of the revised 60% Rule. We used Medicare fee-for-service claims data to compare the clinical outcomes and Medicare payments for patients who received rehabilitation in an inpatient rehabilitation facility (IRF) to clinically similar matched patients who received services in a skilled nursing facility (SNF).

- Over a two-year study period, IRF patients who were clinically comparable to SNF patients, on average:¹
 - Returned home from their initial stay **two weeks earlier**
 - Remained home nearly **two months longer**
 - Stayed alive nearly **two months longer**
- Of matched patients treated:²
 - IRF patients experienced an **8% lower mortality rate** during the two-year study period than SNF patients
 - IRF patients experienced **5% fewer emergency room (ER) visits per year** than SNF patients
 - For five of the 13 conditions, IRF patients experienced **significantly fewer hospital readmissions per year** than SNF patients
- Better clinical outcomes could be achieved by treating patients in an IRF with an additional cost to Medicare of \$12.59 per day (while patients are alive during the two-year study period), across all conditions.¹

Matched IRF and SNF Patients: Number of Days during Initial Rehabilitation Stay and Number of Days Treated in the Home¹

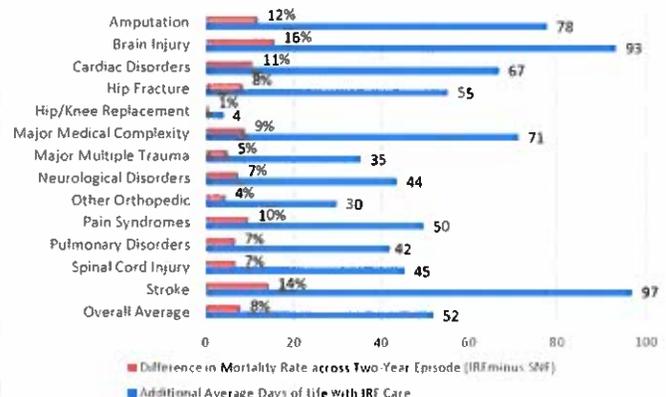


¹Days treated in the home represents the average number of days per patient over two-year study period not spent in a hospital, IRF, SNF, or LTCH.

- This study serves as the most comprehensive national analysis to date examining the long-term clinical outcomes of clinically similar patient populations treated in IRFs and SNFs, utilizing a sample size of more than 100,000 matched pairs drawn from Medicare administrative claims.
- The focused, intense, and standardized rehabilitation led by physicians in IRFs is consistent with patients achieving significantly better outcomes in a shorter amount of time than patients treated in SNFs.

When patients are matched on demographic and clinical characteristics, rehabilitation in IRFs leads to lower mortality, fewer readmissions and ER visits, and more days at home (not in a hospital, IRF, SNF, or LTCH) than rehabilitation in SNFs for the same condition. This suggests that the care delivered is not the same between IRFs and SNFs. Therefore, different post-acute care settings affect patient outcomes.

Matched IRF and SNF Patients: Difference in Mortality Rate¹ across Two-Year Study Period and Resulting Additional Days Alive³ During Episode*



*Difference in the mortality rate of matched IRF patients to matched SNF patients over the two-year study period. As a result of the lower mortality rate, additional average days of life represent the difference in the average episode length (after accounting for mortality) across groups (IRF average episode length in days minus SNF).

¹ Differences are statistically significant at $p < 0.0001$.

² Differences are statistically significant at $p < 0.0001$ with the exception of the number of readmissions per year, which are significant at $p < 0.01$ for five of the 13 conditions.

³ Differences are statistically significant at $p < 0.0001$ with the exception of major multiple trauma, which is significant at $p < 0.01$.

Source: Dobson | DaVanzo analysis of research identifiable 20% sample of Medicare beneficiaries, 2005-2009.

The Issue

To qualify for Medicare payment under the IRF prospective payment system (PPS) at least 60% of an IRF's admissions in a single cost reporting period must be in one or more of 13 CMS specified clinical conditions ("known as the "60% Rule").¹ As a result of this policy, some Medicare beneficiaries with certain conditions previously treated in the IRF are now treated in an alternative setting, such as a SNF. The Medicare Payment Advisory Commission (MedPAC) found, for instance, that the proportion of IRF patients treated for lower joint replacements decreased by 16%, while SNF admissions of this diagnosis increased by the same rate between 2004 and 2011.²

There is a significant difference in medical rehabilitation care practices between the two settings.³ Treatment provided in IRFs is under the direction of a physician and specialized nursing staff.⁴ Care plans are structured, focused, and time sensitive to reflect the pathophysiology of recovery, avoid patient deconditioning, and maximize potential functional gain. On the other hand, SNFs exhibit greater diversity in practice patterns with lower intensity rehabilitation,⁵ possibly due to limited presence of an onsite physician and no regulatory rehabilitation standards.

The implication of the 60% Rule on long-term beneficiary health outcomes and health care utilization has not been thoroughly investigated.

Despite limited information concerning the rule's effect on beneficiaries, policymakers are considering revisions to IRF payment policy. One revision would raise the current compliance threshold from 60% to 75%, a more restrictive standard. Under a second proposal, MedPAC is developing a recommendation to reduce the difference in Medicare payments between IRFs and SNFs by reimbursing IRFs the SNF payment rate for three specific clinical conditions, some of which are included in the 13 conditions under the 60% Rule: major joint replacement without complications or comorbidities (CC), hip fracture with CC, and stroke with CC.

About the Study

The ARA Research Institute (an affiliate of the American Medical Rehabilitation Providers Association – AMRPA) commissioned Dobson DaVanzo & Associates, LLC to conduct a retrospective study of IRF patients and clinically similar SNF patients to examine the downstream comparative

Conclusions in Brief:

- The care provided in IRFs and SNFs differs, as patients treated in IRFs experienced different outcomes than matched patients treated in SNFs.
- Patients treated in a SNF as a result of the 60% Rule who could have otherwise been treated in an IRF might be adversely affected by an increased risk of death, increased use of facility-based care, and more ER visits and hospital readmissions.
- Continuation or expansion of the 60% Rule or aligning the payment across the SNF and IRF PPSs without understanding the impact on patient outcomes is ill advised and could negatively impact Medicare beneficiaries.

utilization and effectiveness of post-acute care pathways, as well as total cost of treatment for the five years following implementation of the 60% Rule.

Using a 20% sample of Medicare beneficiaries, this study analyzed all Medicare Parts A and B claims across all care settings (excluding physicians and durable medical equipment) from 2005 through 2009. Patient episodes were created to track all health care utilization and payments following discharge from a post-acute rehabilitation stay in an IRF and a SNF. Patients admitted to an IRF following an acute care hospital stay were matched to clinically and demographically similar SNF patients. Patient outcomes were tracked for two years following discharge from the rehabilitation stay. This study period allowed us to capture the long-term impact of the rehabilitation, including meaningful differences in mortality, use of downstream facility-based care, and patients' ability to remain at home.

To aid in the interpretation and clinical validation of this analysis, the Dobson | DaVanzo team worked with a clinical expert panel comprised of practicing post-acute care clinicians.

Study Limitations

Medicare fee-for-service claims do not include care covered and reimbursed by Medicaid and third-parties or detailed clinical information. Therefore, non-Medicare services, such as long-term nursing home stays, are not captured in this analysis. This omission may have overestimated the calculated number of days a patient remained at home, and underestimated the cost of their health care to the federal and state governments.

Additionally, the results of this study are not generalizable to the universe of SNF patients within the studied clinical conditions. Analyses suggest that SNF patients who are clinically similar and matched to IRF patients have different health care utilization and Medicare payments than those who were not matched.

¹ The compliance threshold was originally set at 75% and was to be phased in over a three-year period, but compliance was capped at 60% following the Medicare, Medicaid, and SCHIP Extension Act of 2007. While the policy has retained its namesake at the "75% Rule" despite the cap at 60%, this study refers to it as the "60% Rule".

² Medicare Payment Advisory Commission (MedPAC). 2013. *Report to Congress: Medicare Payment Policy*. Washington, D.C.

³ Keith RA. (1997). Treatment strength in rehabilitation. *Arch Phys Med Rehabil*; 90: 1269-1283.

⁴ Harvey RL. (2010, January). Inpatient rehab facilities benefit post-stroke care. *Managed Care*.

⁵ DeJong G, Hsieh C, Gassaway J, et al. (2009). Characterizing rehabilitation services for patients with knee and hip replacement in skilled nursing facilities and inpatient rehabilitation facilities. *Arch Phys Med Rehabil*; 90: 1269-1283.

1 CHAIRMAN SEWELL: Okay. Next on the
2 agenda is H-03, Project No. 19-021, The
3 Rehabilitation Institute of Southern Illinois in
4 Shiloh.

5 May I have a motion to approve this
6 project to establish a 40-bed physical
7 rehabilitation hospital in Shiloh.

8 MEMBER SLATER: I move to approve.

9 CHAIRMAN SEWELL: Is there a second?

10 MEMBER MURRAY: Second.

11 (An off-the-record discussion was held.)

12 CHAIRMAN SEWELL: I'm sorry to have you
13 all at the table. We're going to take a short
14 break.

15 How long is this break? Five minutes? We
16 always say 5 and it takes 10. This break is
17 seven minutes.

18 (A recess was taken from 3:09 p.m. to
19 3:19 p.m.)

20 CHAIRMAN SEWELL: Okay. We're going to
21 come back to order.

22 Did we already get a motion and a second
23 on this?

24 THE COURT REPORTER: Yes, you did.

1 CHAIRMAN SEWELL: Okay.

2 THE COURT REPORTER: Would you raise your
3 right hands, please.

4 (Six witnesses sworn.)

5 THE COURT REPORTER: Thank you. And
6 please print your names.

7 CHAIRMAN SEWELL: State agency report.

8 MR. CONSTANTINO: Thank you, Mr. Sewell.

9 The Applicants are asking the State Board
10 to approve a 40-bed comprehensive physical
11 rehabilitation hospital in Shiloh, Illinois. The
12 cost of the project is approximately \$31 million,
13 and the expected completion date is March 31st,
14 2021.

15 No public hearing was requested, and we
16 did receive several letters of support. No
17 oppositions have been submitted.

18 As noted in your report, the Applicants do
19 not meet all of the State Board criteria.

20 Thank you, sir.

21 CHAIRMAN SEWELL: All right.

22 Do you have comments for the Board?

23 MR. MORADO: We do.

24 Good morning, members of the Board. My

1 name is Juan Morado, Jr., from Benesch. I am
2 counsel for this project, and I'm very happy to be
3 here with this team.

4 The goal of this project is simple: Two
5 world-class health providers, BJC and Encompass,
6 have come together to provide care to Illinois
7 residents -- who are currently leaving the
8 state -- to receive that care in Illinois, and
9 they're going to bring it right back here to
10 Shiloh, Illinois.

11 As we begin, I'd like to say thank you to
12 the Board staff for their overwhelmingly positive
13 report. I'd like to introduce the folks who are
14 with us here today.

15 We have Mark Turner, who is the CEO of the
16 Memorial Regional Health System, who is going to
17 discuss the Shiloh community and the partnerships
18 that BJC has established there.

19 We have Mark Dwyer, who is the CEO of
20 The Rehabilitation Institute of St. Louis, and
21 he's going to be telling you how he's already
22 treating Illinois patients.

23 We have Dr. Elissa Charbonneau, who's
24 going to be discussing the clinical aspects of

1 comprehensive rehabilitation care.

2 Troy DeDecker is with us today, as well,
3 and he's the regional president of Encompass, and
4 he's going to be discussing their model of care.

5 And Lawrence Whatley is with me, who is
6 the VP of design and construction for Encompass,
7 and he's going to touch on the design of our
8 facility.

9 Finally, my colleague Mark Silberman is
10 going to be discussing the findings of
11 nonconformance. He's going to provide you with
12 some additional information so that you can
13 address these findings of nonconformance and give
14 you a strong basis to approve this project. He's
15 going to conclude the formal presentation, and
16 then we'll open it up for questions.

17 This project is a \$31 million investment
18 by BJC and Encompass Health to establish a 40-bed
19 rehabilitation hospital in Shiloh, Illinois. It's
20 considered a substantive project, and the
21 establishment of this type of facility requires
22 this Board's approval.

23 We're very happy to report that the
24 project has successfully addressed 16 of the

1 19 applicable criteria for this type of project,
2 including all the financial criteria.

3 Importantly, I'd like to note that your
4 rules actually encourage Applicants to seek out
5 joint venture partners, and the partnership
6 between BJC and Encompass is just that.

7 This project has received absolutely no
8 opposition during the written comment period.
9 You've already heard about the numerous letters of
10 support that we've received, from stakeholders in
11 the community to elected officials at every level,
12 the mayors, State representatives, and County
13 officials.

14 At this time I'd like to turn it over to
15 Mark Turner, who's going to tell you a little bit
16 more about the Shiloh community and the work
17 that's going on there.

18 Mark.

19 MR. TURNER: Thank you.

20 Good afternoon. It's my pleasure to be
21 here and thank you for your time.

22 I am the president of Memorial Regional
23 Health Services and Memorial Hospital East.
24 I have over 30 years of experience in health care

1 as an executive, primarily had responsibility for
2 most of the types of inpatient and outpatient care
3 that you see in an acute care setting, and I've
4 been with Memorial for over 15 years, moving into
5 the position of president and CEO in 2006.

6 Memorial has a very rich tradition of
7 expanding services to meet the needs of the
8 communities that we serve.

9 In 2011 we opened an 85,000-square-foot
10 orthopedic and neurosciences facility in our
11 Belleville campus because what we learned was that
12 our patients in our community -- there was a
13 significant amount of outmigration in orthopedics
14 to St. Louis, to Missouri, for care. Upon opening
15 the facility and recruiting physicians, we've had
16 tremendous success with that program. We've more
17 than doubled the number of orthopedic surgeons in
18 our community providing care.

19 In 2016, with this Board's approval, we
20 opened Memorial Hospital East, a 94-bed full-
21 service community hospital located in Shiloh,
22 Illinois. We did this in response to our
23 understanding, through our planning process, that
24 many residents of O'Fallon, Shiloh, and Illinois

1 communities to the east were finding it more
2 convenient to get to St. Louis for their care or
3 to Missouri for their care, and so we responded by
4 opening a facility.

5 I'm happy to share with you today, now
6 just really in our third full year of service,
7 that this year, in 2019, by the end of the year,
8 we will treat over 4,000 inpatients, over
9 26,000 visits in the ED; we'll perform over
10 3,000 surgeries at this facility and care for over
11 250,000 outpatients.

12 In 2016 Memorial and BJC came together and
13 completed a strategic affiliation. The -- many
14 objectives but the primary objective of this
15 affiliation was to enhance care and services
16 available in Illinois to Illinois residents.

17 So -- very excited with the progress we've
18 made in our affiliation with BJC. Some of the
19 things that we've been able to do just since 2016
20 is to construct two medical office buildings on
21 the campus of Memorial Hospital East. Each of
22 those buildings is approximately 70,000 square
23 feet. The first building is up and fully leased,
24 many physicians and physician specialties there,

1 some of which we did not have and many of which we
2 did not have enough of to serve our community.

3 The second medical office building will
4 also have medical office space, but it will also
5 house an Illinois location for Siteman Cancer
6 Center. Siteman Cancer Center is an NIH
7 comprehensive cancer center recognized, and it is
8 a joint venture of BJC HealthCare and Washington
9 University School of Medicine.

10 So we're very excited about that, and
11 I can tell you that our board, the original board
12 of Memorial, was very, very excited when this was
13 part of the process and part of the project that
14 BJC wanted to bring to our community.

15 We're continuing to work -- and as you can
16 see Memorial and BJC coming together, BJC and
17 Washington University School of Medicine, and now,
18 with this project, BJC and Encompass, so we have a
19 history -- demonstrated history -- of partnering
20 to work together with other organizations to
21 enhance the care for Illinois residents inside
22 Illinois.

23 So I thank you for your time, and I pass
24 the microphone on to Mark Dwyer for the next stage

1 of our presentation.

2 MR. DWYER: Thank you, Mark.

3 Good afternoon, members of the Board. My
4 name is Mark Dwyer. I'm the chief executive
5 officer for The Rehabilitation Institute of
6 St. Louis, which is an affiliation between
7 BJC HealthCare and Encompass Health.

8 I've been a physical therapist since 1987.
9 I'm a Fellow of the American College of Healthcare
10 Executives, and I've held administrative positions
11 in hospitals since 1991. I joined The
12 Rehabilitation Institute of St. Louis in 2017 as
13 their CEO.

14 The joint venture between BJC HealthCare
15 and Encompass Health is a longstanding one that
16 has been in place since September 8th, 1999. This
17 started out with a unit within Barnes-Jewish
18 Hospital that quickly outgrew its space; hence,
19 the joint venture building in -- or building an
20 80-bed facility in the central west end just a few
21 blocks away from Barnes-Jewish Hospital.

22 The community's need eclipsed the original
23 beds, so the fourth floor was built out and an
24 additional 16 beds were added in 2010, bringing

1 the total bed count to 96.

2 Due to the number of patients who came
3 from the west side of St. Louis, BJC and Encompass
4 Health partnered once again to build a 35-bed
5 rehabilitation satellite that opened in July 2017
6 within Barnes-Jewish St. Peter's Hospital.

7 This joint venture has been successful in
8 that it allows for a top 10 health system in
9 BJC HealthCare to partner with a leading provider
10 of inpatient rehabilitation in the country,
11 Encompass Health.

12 The outcomes we are generating with our
13 patients at The Rehabilitation Institute this year
14 exceed both Midwest region and national
15 performance measures, meaning we are generating
16 more functional improvement with our patients and
17 we are getting more of our patients home.

18 Just as Barnes-Jewish Hospital and other
19 BJC hospitals are sought-after destinations for
20 people to receive health care from throughout
21 Missouri and Illinois, The Rehabilitation
22 Institute has also grown to be a destination for
23 rehabilitation health care due to the outcomes
24 that we generate.

1 The Rehabilitation Institute is accredited
2 by both The Joint Commission and The Commission on
3 Accreditation of Rehabilitation Facilities.

4 We are recognized for multiple specialties
5 in rehabilitation care by The Joint Commission in
6 the form of five disease-specific certifications:
7 Stroke, brain injury, spinal cord injury, amputee
8 rehabilitation, and wound care.

9 The Rehabilitation Institute over the
10 past year and a half has had nearly one-quarter of
11 our total patient population come from Illinois.
12 From January 2018 through August 2019, that
13 equates to 918 patients.

14 Given the opportunity, would these
15 patients and their families prefer to receive
16 their rehabilitation closer to home? Sure, they
17 would.

18 The average length of stay at The
19 Rehabilitation Institute is 14 days. That,
20 coupled with our goal to get the family involved
21 in the patient's rehabilitation as early as
22 possible and throughout their length of stay for
23 family teaching, is asking a lot of families,
24 especially elderly family members, to drive back

1 and forth every day from Illinois to St. Louis for
2 two or more weeks. That family teaching is
3 critical, however, to helping us return our
4 patients to home.

5 Just as we have seen the same strong
6 outcomes in our St. Peter's satellite since it
7 opened a little over two years ago, we have every
8 confidence we will enjoy the same success in
9 Illinois as we have had in St. Louis. With the
10 same partner in BJC and the two Belleville
11 Memorial Hospitals as well as Barnes-Jewish
12 Hospital, we already know how to work together to
13 create the best outcomes for our patients.

14 In fact, we are already serving these
15 patients, but for those in Illinois we are not
16 doing so in a location that is close to where they
17 live. If they are willing to leave the state to
18 obtain care from us, there is no reason to believe
19 they will not seek the same care from the same
20 providers in a new, state-of-the-art facility
21 closer to their home, especially since our
22 Illinois hospital will offer the same advanced
23 therapies that we currently offer in our
24 two St. Louis hospitals.

1 We are excited to bring this important
2 level of care to Illinois to meet the needs of the
3 growing population of the Metro East area.

4 Thank you for your time, and I will now
5 hand it off to Dr. Elissa Charbonneau.

6 DR. CHARBONNEAU: Good afternoon.
7 Thank you for allowing me to speak with you this
8 afternoon.

9 My name is Elissa Charbonneau. I am board
10 certified in physical medicine and rehabilitation,
11 and I've been practicing in inpatient
12 rehabilitation hospitals for approximately
13 27 years. Currently I serve as the chief medical
14 officer for Encompass Health.

15 I wanted to just give you an idea of the
16 kinds of patients that we treat in our hospitals
17 in case you've not had the opportunity to
18 participate or visit one of our hospitals.

19 In general, our patients have had some
20 catastrophic injury or illness which has caused
21 them to lose the ability to function at a level
22 that they could return home, so they come to our
23 hospitals after having had a stroke, a spinal cord
24 injury, a brain injury, or other severe illness or

1 injury.

2 And when they come to our hospitals, they
3 are able to utilize our state-of-the-art gyms,
4 which are large, sunny, beautiful, high-tech areas
5 where they can learn to walk, take care of
6 themselves, or mobilize with a wheelchair or speak
7 again if need be.

8 We have the expertise in our dedicated
9 therapists and nurses who have dedicated their
10 careers to taking care of these kinds of patients
11 that need intensive daily inpatient rehabilitation
12 as well as very close physician oversight due to
13 their medical complexity.

14 We have an electronic medical record
15 throughout all of our 133 hospitals, and we use
16 our electronic medical record to improve our
17 clinical outcomes by providing our clinicians with
18 realtime data so that they can improve the quality
19 of care that they're delivering at the bedside.

20 We also have been able to use our data to
21 develop a predictive analytical model to reduce
22 the chance of acute care transfers for our
23 patients, and we have other various exciting
24 clinical initiatives ongoing, as well.

1 I hope that our residents have access to
2 inpatient rehabilitation when they need it and in
3 their community, and they deserve to have that
4 opportunity.

5 Thank you very much for your attention.
6 And I will now pass it over to Troy DeDecker.

7 MR. DE DECKER: Thank you.

8 Good afternoon. My name is Troy DeDecker.
9 I'm the central region president for Encompass
10 Health.

11 Encompass represents 133 hospitals
12 nationwide. I am responsible for 19 hospitals in
13 the Midwest, including the 2 hospitals in
14 St. Louis that are partnered with BJC HealthCare
15 as well as 1 in Rockford, Illinois, with Mercy
16 Health, so I'm very excited to be here to kind of
17 talk to you about what we do and how we do it.

18 Dr. Charbonneau discussed a little bit
19 about the types of patients we see, and I wanted
20 to just describe briefly for you where we fit into
21 the health care picture.

22 Obviously, patients that are being
23 discharged from the acute care hospital are
24 leaving the acute care hospital much more sick

1 than they ever have before. Oftentimes they're in
2 the hospital for only three or four days and they
3 still need close medical supervision by a
4 physician such as Dr. Charbonneau and they need
5 intensive inpatient rehabilitation services to
6 allow them to gain their function and get back
7 home with their families.

8 At the end of the day, that's the primary
9 purpose of what we try to do, is allow patients to
10 recover medically and, also, gain the function so
11 they can go back home, but an important part of
12 that -- which Mark Dwyer pointed out -- is family
13 involvement.

14 And so when we were looking at kind of our
15 planning processes and we were evaluating the
16 patients that were coming to St. Louis, we quickly
17 identified that many of the patients -- about
18 25 percent of the patients being served in
19 St. Louis -- are from Illinois.

20 And so we knew that if we evaluated --
21 with Barnes-Jewish and Memorial -- a hospital in
22 the Shiloh region, that we could cover and care
23 for those patients closer to home where family
24 members could help participate in the rehab

1 process, which is so important for patients and
2 families.

3 Additionally, we're very focused on taking
4 care of all patients that need inpatient
5 rehabilitation services. As such, 72 percent of
6 the patients that will be treated in our hospital
7 will be covered either by Medicare or Medicaid.

8 Currently the three managed Medicaid plans
9 that are in the area of kind of the west metro we
10 are contracted with currently at the St. Louis
11 hospital, and we will plan to contract with any
12 payer in the market as well as provide care to
13 those patients that are either uninsured or
14 underinsured because it is our goal to make sure
15 that we give all patients the best opportunity to
16 return back home with their family.

17 And with that, I will pass it to Lawrence.

18 MR. WHATLEY: Thank you, Troy.

19 I am Lawrence Whatley, vice president of
20 design and construction with Encompass Health.
21 I'm responsible for overseeing the design and
22 construction for our hospitals, including bed
23 additions, renovations, and new hospitals of this
24 type.

1 I have over 30 years of experience in the
2 construction industry, including 9 years with
3 Encompass Health. We have designed this hospital
4 to meet the needs of our patients and to enhance
5 the patient experience during their stay at our
6 hospitals.

7 Now, how do we do that? We draw on our
8 experiences from operating over 130 hospitals,
9 including over 20 that have been constructed
10 within the last six years.

11 We currently have six hospitals under
12 construction now, and as of this month we opened a
13 hospital of similar type in Houston, another one
14 in Indiana, and today received certificate of
15 approval to occupy and move into a new hospital in
16 Pittsburgh, Pennsylvania.

17 In addition to that, we draw on our
18 experiences from shadowing our nurses and our
19 therapists to get a -- gain a great understanding
20 of how best to design and right-size a hospital of
21 this type. All of this information and knowledge
22 have led us to the design of our hospital today.

23 Today we are presenting to you a
24 40-bed hospital that is expandable, is a

1 single-story hospital that's ADA accessible, that
2 has a large therapy gym, which has been mentioned
3 before, and it has the best-in-class equipment.

4 In addition to that, it has an activities-
5 for-daily-living environment so when our patients
6 are nearing the end of their stay at our hospitals
7 they're able to go into this area and experience
8 cooking again, making their beds again, taking
9 baths by themselves, and all those things they
10 need to function independently when they move or
11 return home.

12 And, finally, we have a full-service
13 kitchen and dining room and day space for our
14 patients and wide corridors to provide access to
15 and from the patient rooms.

16 And with that, I will turn it over to
17 Mark Silberman.

18 MR. SILBERMAN: Thank you.

19 Members of the Board, I think, hopefully,
20 you can tell we're very excited about the
21 prospects of this project and bringing this care
22 to Illinois and, most importantly, bringing an
23 aspect of care that Illinois residents shouldn't
24 have to leave Illinois to be able to get.

1 And while we want to thank the staff again
2 for the overwhelmingly positive report, we thought
3 it would be helpful if we just briefly went
4 through the three criteria with which we weren't
5 in conformance to explain why we believe this
6 project still warrants its approval despite those
7 criteria.

8 All of the issues related directly to the
9 size of this project. The one issue was with the
10 square footage of the project, and our square
11 footage is above the State's average. And the
12 reason for that is simple: There are aspects of
13 our project that are built out, that are designed
14 based on the experience of these providers to meet
15 the needs of the patient.

16 And the determination was we could have
17 made modifications, but it wouldn't have allowed
18 for certain things, like the provision of care to
19 bariatric patients or all the necessary equipment
20 and tech that the providers have determined and
21 fed back that is necessary for the care to these
22 patients. And we decided that the most important
23 thing was to focus on meeting patient positive
24 outcomes and meeting patient expectations.

1 And so we hope the additional size will be
2 acceptable to this Board, especially when you take
3 into consideration we've been able to provide the
4 additional size but still meet the cost
5 requirements identified for the State. So they're
6 getting the benefit of the extra space that's
7 necessary to provide the best care but without
8 increasing the costs.

9 The other two negatives related to the
10 number of beds, and the 40 beds that are proposed
11 come between the 7 beds of identified need and the
12 standard size of project that the Board's criteria
13 identified, and the reason for that is also very
14 simple.

15 We agree. We agree that there's a need
16 for these projects, and the historical method --
17 the historical utilization methodology shows a
18 need for seven beds. We're not asking the Board
19 not to utilize its own criteria, but what we're
20 hoping the Board will do, as it has in other
21 areas, is look to some of the standards that are
22 used around the country in addition to that to see
23 how need is calculated.

24 And when you look at the need, when you

1 look at the demographics of the community and of
2 the Medicaid -- excuse me -- Medicare discharge
3 data, it shows a much higher need for these
4 services.

5 I also think that if you look at the
6 referrals that have been identified for this
7 project from the providers that are already
8 providing care to this patient population, it
9 justifies the 40 beds that we've sought to be at
10 the full utilization identified by the Board's
11 standard.

12 And when you consider that, we believe
13 this 40-bed facility to be the right-sized
14 facility for this community for this time, able to
15 meet the needs from today and tomorrow.

16 The last thing we would point out to you
17 is this: That the best two things you can see as
18 evidence of the need for this level of care in
19 this way is -- you heard testimony from what could
20 be a competitor earlier this morning, where what
21 they testified was, if the project's proposal is
22 approved, what they would do with their inpatient
23 rehabilitation services, not in opposition. There
24 was no opposition to this project, but they

1 identified that if these services were made
2 available, they could better utilize their
3 inpatient rehabilitation space because a dedicated
4 hospital with dedicated staff offers that
5 additional level of care.

6 But the best evidence of the need for this
7 project is that Illinois residents are currently
8 leaving Illinois to obtain this care. The good
9 news is they're leaving Illinois to obtain this
10 care from the world-class providers that are
11 sitting here at this table, who are ready and
12 prepared to provide this care to Illinois
13 residents in Illinois.

14 So with that, we're happy to answer any
15 questions the Board members might have, and we
16 appreciate your consideration.

17 MEMBER SLATER: I'm confused about the
18 request that Anderson Rehabilitation has made.
19 That's the potential competitor of this project;
20 correct?

21 MR. SILBERMAN: No. That was with regards
22 to -- if I understood correctly, there was
23 testimony from HSHS that talked about the idea of
24 repurposing their beds in the event that these

1 projects were approved.

2 MS. AVERY: Yes, that's correct.

3 What are you saying with Anderson? Not
4 them, yes.

5 CHAIRMAN SEWELL: So 40 is too many beds
6 and 40 isn't enough beds?

7 MR. SILBERMAN: Well, we actually think
8 40 is the exact right number of beds.

9 CHAIRMAN SEWELL: Well, somebody, in doing
10 planning for Illinois, I think may have been --
11 and I'm speculating here -- they might have
12 envisioned that comprehensive physical
13 rehabilitation hospitals would be sort of special,
14 strategically located, and of sufficient size to
15 justify some of the things that y'all have been
16 talking about. So that's probably where the --
17 what seems now -- arbitrary 100-bed standard came
18 from.

19 I'm troubled by the fact that we have a
20 need for 7, though, and you're coming in with 40.
21 That's troublesome.

22 MR. DE DECKER: So if I may --

23 CHAIRMAN SEWELL: Yes, sir.

24 MR. DE DECKER: So of our 133 hospitals,

1 only about 10 percent of our hospitals are a
2 hundred beds.

3 CHAIRMAN SEWELL: Uh-huh.

4 MR. DE DECKER: Most of our hospitals --
5 just from an efficiency and access of care -- are
6 40 beds. But even in this project, we can expand
7 this campus up to 80 beds, and we do it as the
8 demand is needed.

9 And I suspect that -- if we are able to
10 provide the same level of care that we have
11 provided to Illinois residents in St. Louis, our
12 preliminary review indicates that perhaps by
13 Year 3 we'll be evaluating do we need to add
14 additional beds. But it's really not necessary to
15 build out the full -- to make the full need right
16 out of the gate.

17 CHAIRMAN SEWELL: No, I'm not suggesting
18 that you should have proposed a hundred. I'm just
19 speculating that in some kind of an ideal, that
20 freestanding comprehensive rehabilitation
21 hospitals would be of sufficient mass that they
22 could support all of the things that are
23 associated with contemporary approaches to
24 substantives.

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1 MR. SILBERMAN: Understood and agreed.

2 And if I could address one aspect.

3 You talk about the methodology showing the
4 need for seven, and we're not challenging that
5 methodology, and I think the Board's finding is
6 accurate.

7 But the one thing that, Member Sewell,
8 isn't factored into that is the patients who are
9 leaving Illinois to get that care in St. Louis
10 don't ever get reflected in the Board's need
11 methodology because they're not receiving care in
12 Illinois.

13 CHAIRMAN SEWELL: Right.

14 MR. SILBERMAN: And so this project is
15 designed to allow those residents to receive care
16 in Illinois, and there's no speculation because
17 the people they're leaving to receive the care for
18 are the providers here, and the documentation's
19 been provided that those patients will be referred
20 here.

21 MEMBER MARTELL: Mr. Chairman --

22 CHAIRMAN SEWELL: Mr. Slater, did you --

23 MEMBER SLATER: A question for you, Mike:
24 How does the Anderson Edwardsville operation fit

1 in with this one?

2 MR. CONSTANTINO: They're both in the same
3 planning area, and they're both proposing rehab
4 hospitals in this planning area.

5 MEMBER SLATER: So the Edwardsville
6 question is still before us? It will be after
7 this one?

8 MR. CONSTANTINO: It will be after these
9 folks, yes.

10 MEMBER SLATER: So is it -- is it --

11 MEMBER MARTELL: When --

12 MEMBER SLATER: -- a choice between Shiloh
13 and Edwardsville that this Board needs to make?

14 MR. CONSTANTINO: That's up to the Board.

15 MS. AVERY: It's individual, stand-alone
16 applications, and you vote for which one you feel.

17 CHAIRMAN SEWELL: Yeah.

18 Dr. Martell.

19 MEMBER MARTELL: Yeah. I want to go back
20 to the projected utilization because I've kind of
21 heard some varying discussion in the formula that
22 you provided.

23 So -- but none of those indicate the
24 number of patients you currently know are in

1 Missouri that would use Illinois services, so that
2 would have been a more realistic kind of
3 assessment versus kind of like a projection.

4 MR. DE DECKER: Mark, did you want to
5 comment?

6 I think Mark --

7 MR. DWYER: For the last year and a half,
8 particularly January 2018 through August 2019, we
9 have serviced 918 patients who live in Illinois
10 who cross the state line and come over and receive
11 their care at The Rehabilitation Institute.

12 MEMBER MARTELL: And how many days of
13 stay?

14 MR. DWYER: Average is 14. That's our
15 average length of stay, 14 days.

16 MR. MORADO: And, Member Martell, those
17 are the same patients that are reflected in the
18 application, in the referral letters that we
19 provided. Part of that process is providing a
20 list of zip codes that all -- in this case --
21 reside within the HSA 11.

22 And I guess I would add one more point for
23 Member Slater.

24 You had some questions about some of the

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1 other things that are up later today. I think it
2 just speaks volumes that there's been no
3 opposition to this project, and I think you can
4 take that for what it's worth.

5 CHAIRMAN SEWELL: Any other questions?

6 (No response.)

7 CHAIRMAN SEWELL: All right. Roll call.

8 MR. ROATE: Thank you, sir.

9 Motion made by Mr. Slater; seconded by
10 Dr. Murray.

11 Senator Demuzio.

12 MEMBER DEMUZIO: I'm going to go ahead and
13 vote yes, based on some of the testimony that I've
14 heard today.

15 MR. ROATE: Thank you.

16 Dr. Martell.

17 MEMBER MARTELL: I'm going to be a
18 qualified no with the understanding that I have
19 concerns about the projections and capacity.

20 MR. ROATE: Thank you.

21 Dr. Murray.

22 MEMBER MURRAY: I'm going to vote yes
23 based upon the testimony about patients presently
24 cared for.

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1 MR. ROATE: Thank you.

2 Ms. Savage.

3 MEMBER SAVAGE: I'm going to vote yes
4 based on the testimony and the staff Board report
5 as well as the project utilization I feel is
6 better than the other proposal.

7 MR. ROATE: Thank you.

8 Mr. Slater.

9 MEMBER SLATER: I vote yes based on the
10 testimony.

11 MR. ROATE: Thank you.

12 Chairman Sewell.

13 CHAIRMAN SEWELL: I vote no based on the
14 planning area need criteria.

15 MR. ROATE: That's 4 votes in the
16 affirmative, 2 votes in the negative.

17 MS. AVERY: You've received an intent to
18 deny. You'll have the opportunity to submit
19 additional information.

20 MR. MORADO: Thank you.

21 MR. DE DECKER: Thank you.

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