STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO: H-05	BOARD MEETING: September 17, 2019	PROJECT NO: 19-026	PROJECT COST: Original: $25,995,294
FACILITY NAME: Anderson Rehabilitation Hospital		CITY: Edwardsville	
TYPE OF PROJECT: Substantive			HSA: VI

DESCRIPTION: The Applicants (Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital Kindred Healthcare, LLC, and Anderson Rehabilitation Hospital, LLC) propose to establish a 34-bed comprehensive physical rehabilitation hospital in Edwardsville at a cost of approximately $25,995,294. The expected completion date is October 31, 2021.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants (Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital, Kindred Healthcare, LLC, and Anderson Rehabilitation Hospital, LLC) propose to establish a 34-bed comprehensive physical rehabilitation hospital in Edwardsville at a cost of approximately $25,995,294. The expected completion date is October 31, 2021.
- In conjunction with this Application Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital has submitted Exemption #E-033-19 to discontinue a 20-bed comprehensive physical rehabilitation unit at Anderson Hospital in Maryville. Should the proposed project be approved the Applicants will discontinue the 20-bed category of service at Anderson Hospital.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The Applicant propose to establish a health care facility as defined by the Illinois Health Facilities Planning Act (20 ILCS 3960/3).

PUBLIC HEARING/COMMENT:

- A public hearing was offered regarding the proposed project, but none was requested. Letters of support have been submitted from the Mayor of Edwardsville, U.S. Representatives Davis and Shimkus, State Representative Stuart, and OSF Saint Anthony's Health Center in Alton, Community Hospital of Staunton and Carlinville Area Hospital. No letters of opposition were received by the Board.

SUMMARY:

- The Applicant addressed a total of 19 criteria and have not met the following:

Criterion	Reasons for Non-Compliance
77 ILAC 1110.120 (b)- Projected Utilization	The number of projected referrals does not support the 34-beds being requested. (See Page 12 of this report)
77 ILAC 1110.205 (b)(1) – Planning Area Need	The number of beds requested (34-beds) exceed the calculated need of 7 rehabilitation beds. The number of physician referrals do not support the number of beds being requested. (See Pages 13-18 of this report)
77 ILAC 1110.205 (f) – Performance Requirements	The Applicants are proposing a 34-bed comprehensive physical rehabilitation hospital. The State Board Standard is 100-beds. (See Page 20 of this Report)

STATE BOARD STAFF REPORT
Project 19-026
Anderson Rehabilitation Hospital

APPLICATION/CHRONOLOGY/SUMMARY	
Applicant	Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital, Kindred Healthcare, LLC, and Anderson Rehabilitation Hospital, LLC
Facility Name	Anderson Rehabilitation Hospital
Location	Northwest comer of Goshen Road and Gusewelle Road, Edwardsville, Illinois
Permit Holder	Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital Kindred Healthcare, LLC, and Anderson Rehabilitation Hospital, LLC
Operating Entity	Anderson Rehabilitation Hospital, LLC
Owner of Site	Anderson Real Estate. LLC
Total GSF	49,371 GSF
Application Received	June 6, 2019
Application Deemed Complete	June 7, 2019
Review Period Ends	October 5, 2019
Financial Commitment Date	September 17, 2021
Project Completion Date	October 31, 2021
Review Period Extended by the State Board Staff?	No
Can the Applicant request a deferral?	Yes
Expedited Review?	No

I. Project Description

The Applicants (Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital, Kindred Healthcare, LLC, and Anderson Rehabilitation Hospital, LLC) propose to establish a 34-bed comprehensive physical rehabilitation hospital in Edwardsville at a cost of approximately $25,995,294. The expected completion date is October 31, 2021.

II. Summary of Findings

A. State Board Staff finds the proposed project is not in conformance with the provisions of 77 ILAC 1110 (Part 1110).

B. State Board Staff finds the proposed project is in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

The Applicants are Southwestern Illinois Health Facilities, Inc. d/b/a Anderson Hospital, Kindred Healthcare, LLC and Anderson Rehabilitation Hospital, LLC. Southwestern Illinois Health Facilities, Inc. d/b/a Anderson Hospital is an Illinois not-for-profit corporation that primarily earns revenues by providing inpatient, outpatient and emergency care services to patients in Maryville, Illinois and surrounding areas. Kindred Healthcare,

LLC is a healthcare services company that through its subsidiaries operates transitional care hospitals (certified as long-term acute care hospitals under the Medicare program), inpatient rehabilitation hospitals and a contract rehabilitation services business across the United States. In December 2017, Kindred Healthcare Inc. announced that it would be acquired for approximately $4.1 billion by a consortium of three companies: TPG Capital, Welsh, Carson, Anderson & Stowe (WCAS) and Humana. Upon acquisition, Kindred's long-term acute care hospitals, rehab hospitals and contract rehabilitation services businesses would be operated as Kindred Healthcare, a separate specialty hospital company owned by TPG and WCAS. Kindred Healthcare, LLC is a private company and no longer trades on the New York Stock Exchange. The State Board approved this change of ownership in March of 2018. Kindred Healthcare, LLC owns the following health facilities in Illinois.

- Kindred Chicago Lakeshore – 103-SubAcute Beds[1]
- Kindred Hospital Sycamore – 69-LTAC Beds
- Kindred Hospital Peoria – 50-LTAC Beds
- Kindred Hospital – Northlake 94-LTAC Beds
- Kindred Hospital – Chicago – 31-AMI Beds & 133 LTAC Beds
- Kindred Chicago Central Hospital-95 LTAC Beds

Anderson Rehabilitation Hospital, LLC is a joint venture between Southwestern Illinois Health Facilities, Inc. d/b/a Anderson Hospital owning 60% of the venture and Kindred Healthcare, LLC the remaining 40%. The proposed hospital will be adjacent to the multi-specialty ASTC approved by the State Board in December of 2018 as Permit #18-031 at a cost of approximately $7.7 million.

This is a substantive project[2] requiring 120-day review. Financial commitment will occur within 2-years after project approval.

IV. Comprehensive Physical Rehabilitation Health Planning Area

The proposed rehabilitation hospital will be in the HSA XI comprehensive physical rehabilitation planning area. HSA XI consists of the Illinois counties of Clinton, Madison, Monroe, and St. Clair. The 2015 estimated population is 600,046 and 2020 estimated

[1] "Subacute Care" means the provision of medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. Subacute care includes physician supervision, registered nursing, and physiological monitoring on a continual basis. (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35])

[2] "Substantive Projects" means types of projects that are defined in the Act and classified as substantive. Substantive projects shall include no more than the following: Projects to construct a new or replacement facility located on a new site; or a replacement facility located on the same site as the original facility and the costs of the replacement facility exceed the capital expenditure minimum. Projects proposing a new service or discontinuation of a service, which shall be reviewed by the Board within 60 days. Projects proposing a change in the bed capacity of a health care facility by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation of beds from one facility to another by more than 20 beds or more than 10% of total bed capacity, as defined by the State Board in the Inventory, whichever is less, over a 2-year period. [20 ILCS 3960/12]

population in this planning area is 614,100.[3] There is a need for 7 comprehensive physical rehabilitation beds in this planning area as of August 2019.

There are two hospitals in this planning area that maintain comprehensive physical rehabilitation service:

TABLE ONE
Hospitals with Comprehensive Physical Rehabilitation Service in HSA XI

Facility	City	Beds	Occupancy
Anderson Hospital	Maryville	20	60.70%
HSHS St. Elizabeth Hospital	O'Fallon	16	76.80%
Total Beds		36	

V. Project Details

The Applicants are proposing a 2-story facility that will incorporate 49,371 sq. ft of space. A developer to be named will lease the property from land owner Anderson Real Estate, LLC. Anderson Rehabilitation Hospital will enter a building lease with the developer. The proposed 34-bed hospital will include a specialized 12-bed brain injury unit.

VI. Project Uses and Sources of Funds

The Applicants are funding this project with cash in the amount $2,402,500 and an operating lease for the hospital with a Fair Market Value of $23,592,794. The estimated start-up costs and operating deficit is approximately $14.1 million.

TABLE TWO
Project Uses and Sources of Funds

Uses of Funds	Reviewable	Non-Reviewable	Total	% of Total Costs
Preplanning Costs	$125,303	$99,698	$225,000	0.87%
Site Survey	$19,492	$15,509	$35,000	0.13%
Site Preparation	$515,133	$409,868	$925,000	3.56%
New Construction Contracts	$9,815,110	$7,809,890	$17,625,000	67.80%
Contingencies	$874,176	$809,824	$1,684,000	6.48%
Architectural/Engineering fees	$484,503	$385,497	$870,000	3.35%
Consulting and Other Fees	$647,212	$514,957	$1,162,169	4.47%
Movable or Other Equipment	$832,566	$662,435	$1,495,001	5.75%

[3] 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 projected number of Comprehensive Physical Rehabilitation beds needed in the planning area.

TABLE TWO Project Uses and Sources of Funds				
Uses of Funds	**Reviewable**	**Non-Reviewable**	**Total**	**% of Total Costs**
Net Interest Expense During Construction	$594,003	$472,622	$1,066,625	4.10%
Other Costs to be Capitalized	$505,387	$402,113	$907,500	3.49%
Total Uses of Funds	$14,412,883	$11,582,411	$25,995,294	100.00%
Source of Funds				
Cash and Securities	$1,337,952	$1,064,548	$2,402,500	9.24%
Leases (FMV)	$13,074,931	$10,517,863	$23,592,794	90.76%
Total Sources of Funds	$14,412,883	$11,582,411	$25,995,294	100.00%

1. Itemization or Project Costs can be found at page 52-53

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

The information requirements contained in this Section are applicable to all projects except projects that are solely for discontinuation. An applicant shall document the *qualifications, background, character and financial resources to adequately provide a proper service for the community* and demonstrate that the project promotes the *orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of facilities* or service. [20 ILCS 3960/2]

A) Criterion 1110.110 (a) - Background of Applicant

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. [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFSRB shall consider whether adverse action[4] has been taken against the applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed health care facility, or against any health care facility owned or operated by the applicant, directly or indirectly, within 3 years preceding the filing of the application. A health care facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be owned by that person or entity (see 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

The Applicants have provided the necessary attestations that no adverse action has been taken against the Applicants within 3 years prior to filing the application for permit. Anderson Real Estate, LLC owns the property and a ground lease will be executed between the hospital and property owner should this project be approved. The term of the property lease is 50-years. No financial terms were provided in the pro-forma lease agreement. A building lease between the building owner (developer) and the hospital will be executed

[4] Adverse Action" means a disciplinary action taken by Illinois Department of Public Health, Centers for Medicare and Medicaid Services, or any other State or federal agency against a person or entity that owns and/or 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 violations. *A "Type A" violation means a violation of the* Nursing Home Care *Act or* 77 Ill. Adm. Code 300, 330, 340, 350 or 390 that *creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom.* [210 ILCS 45/1-129]

should this project be approved. The building developer has not been selected and no financial terms were provided in the pro-forma building lease agreement. The initial term of the lease is 15 years with 3 extension options of 10 years. (Application for Permit page 160-242).

B) Criterion 1110.110 - Purpose of the Project

The applicant shall document that the project will provide health services that improve the health care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other, per the applicant's definition.

The purpose of the project is to address what the Applicants believe to be a shortage of comprehensive physical rehabilitation beds in the HSA XI Planning Area. In 2017 there were four inpatient rehabilitation units in the HSA XI Planning Area with a total of 78 comprehensive physical rehabilitation beds. Over the past two years, beginning in 2017, two hospitals in HSA XI and within 25 miles of the proposed Anderson Rehabilitation Hospital have closed their rehabilitation units: OSF St Anthony in Alton (22 miles) and Gateway Regional Medical Center (16 miles). OSF St Anthony operated 28 rehabilitation beds; Gateway Regional Medical Center operated 14 rehabilitation beds. Additionally, HSHS St. Elizabeth Hospital in O'Fallon in 2014 reduced their number of rehab bed from 33 beds to 16 beds. This reduction in beds have resulted in the number of rehab bed being reduced from 78 to a total of 36 rehab beds in this Planning Area resulting in a calculated need for 7 rehab beds in this planning area as of August 2019.

With a projected 2020 population of 614,100, the ratio of comprehensive physical rehabilitation beds per 1,000 population in HSA XI is 0.057, the lowest of all Health Services Areas in the State. The proposed location of Anderson Rehabilitation Hospital is closer to Granite City and to Alton, and the patients served by the rehabilitation units at those hospitals than is the existing service at HSHS St Elizabeth (2.6 miles from Granite City to O'Fallon, and 34 miles from Alton to O'Fallon.) Access to rehabilitation care for patients who had the services in their communities is enhanced by the proposed facility in Edwardsville.

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

All health care facilities, except for skilled and intermediate long-term care facilities licensed under the Nursing Home Care Act, shall provide a safety net impact statement, which shall be filed with an application for a substantive project (see Section 1110.40). *Safety net services are the services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation*. [20 ILCS 3960/5.4]

The Applicants provided the required Safety Net Impact Statement at pages 258-264 of the Application for Permit. Table Three below documents the number of charity care patients and charity care expense for Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital and Medicaid Patients and Medicaid Revenue for years 2016-2018. Table Four below documents the number of charity care patients and charity care expense for the Illinois facilities of Kindred Healthcare, LLC and the number of Medicaid Patients and Medicaid Revenue for years 2016-2018.

TABLE THREE Southwestern Illinois Health Facilities. Inc, d/b/a Anderson Hospital Charity Care and Medicaid Information 2016-2018			
	2016	2017	2018
Net Patient Revenue	$131,792,713	$145,275,015	$152,525,154
Charity Care (# of Patients)			
Inpatients	173	152	132
Outpatients	4,404	3,976	2,724
Total Patients	4,577	4,128	2,856
Cost of Charity Care (Costs}			
Inpatients	$349,124	$460,036	$421,064
Outpatients	$901,536	$1,353,923	$1,333,742
Total Patient Expense	$1,250,660	$1,813,959	$1,754,806
Charity Care Expense % of Net Patient Revenue	0.95%	1.25%	1.15%
Medicaid (# of Patients)			
Inpatients	1,720	1,584	951
Outpatients	29,930	30,241	30,270
Total Patients	31,650	31,825	31,221
Medicaid (Revenue}			
Inpatients	$10,137,631	$8,190,571	$6,715,144
Outpatients	$8,485,891	$10,887,987	$13,951,709
Total Patient Revenue	$18,623,522	$19,078,558	$20,666,853
Medicaid Revenue % of Net Patient Revenue	14.13%	13.13%	13.55%

TABLE FOUR Kindred Hospital, LLC Illinois Facilities Charity and Medicaid Information 2016-2018			
	2016	2017	2018
Net Patient Revenue	$157,087,389	$153,092,797	$148,458,897
Inpatient	1	5	0
Outpatient	0	0	0
Total	1	5	0
Charity (cost in dollars)			
Inpatient	$140,419	$195,419	$882,162
Outpatient	0	0	0
Total	$140,419	$195,419	$882,162
Charity Care Expense % of Net Patient Revenue	0.09%	0.13%	0.59%

TABLE FOUR Kindred Hospital, LLC Illinois Facilities Charity and Medicaid Information 2016-2018			
MEDICAID			
Medicaid (#of patients)			
Inpatient	1,046	1,393	1,336
Outpatient	0	0	0
Total	1,046	1,393	1,336
Medicaid (revenue)			
Inpatient	$44,763,544	$51,580,013	$40,943,936
Outpatient	$0	$0	$0
Total	$44,763,544	$51,580,013	$40,943,936
Medicaid Revenue % of Net Patient Revenue	28.50%	33.69%	27.58%

The Applicants expect the payor mix for the proposed rehabilitation hospital to be as follows:

TABLE FIVE Expected Payor Mix	
Medicare	
Medicare	34.20%
Medicare Managed Care	17.80%
Total Medicare	52.00%
Medicaid	
Medicaid	2.20%
Medicaid Managed Care	11.30%
Total Medicaid	13.50%
Commercial	32.10%
Self-Pay	2.50%
Total	100%*

*does not foot because of rounding

D) Criterion 1110.110 (d) - Alternatives to the Proposed Project

The applicant shall document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

1) Alternative options shall be addressed. Examples of alternative options include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Other considerations.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to 3 years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available.

The Applicants considered the following alternatives to the proposed project:

1. Expand the 20-bed unit in contiguous space in Anderson Hospital in Maryville
2. Build on to the Anderson Hospital in Maryville (approximate cost $25 million)
3. Replace the Anderson Hospital 20-bed unit with a 27-bed hospital (approximate cost $22 million) or a 50-60-bed hospital ($35-$42 million) in Edwardsville.
4. Locate the proposed rehabilitation hospital in Maryville.

The first alternative was rejected because there is no existing adjacent space on the floor to accommodate additional rehabilitation beds. The adjacent space is occupied by 18-bed intermediate medical surgical unit. Additionally, the 20-bed unit is comprised of 10 double bed rooms with lacking privacy and patient preference for single bed rooms. Supporting space for physical therapy/occupational therapy, AOL (Activities for Daily Living) and dining are undersized and dated and in need of modernization.

The second alternative was rejected because of the configuration of the current hospital building. The space to support expansion of the 20-bed unit would be located above the emergency room and loading docks. Construction of a second floor to accommodate beds would require adding structural supports in each of those spaces, at great capital cost comparable to the proposed building. Such a project would disrupt current operations to the emergency room and loading area such that those functions would be impossible to maintain during the construction.

The third alternative was rejected because the 27-bed hospital would not meet the economies of scale of the 34-bed or larger rehab hospital. A 34-bed or more hospital would allow the Applicants to maximized efficiency of support staff as well as PT/OT staff and other support staff. The 50-60 bed hospital was rejected because the additional capital costs of between $10 and $15 million could not be justified by the Applicants.

The final alternative was rejected because the site for the proposed hospital is owned by the Anderson Real Estate, LLC and no other sites not owned by Anderson Real Estate, LLC were considered by the Applicants. The location of the proposed hospital in Edwardsville is closer to cities of Alton and Granite City the location of the two hospitals that discontinued a total of 42 rehab beds in past two years.

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

A) Criterion 1110.120 - Size of Project

The applicant shall document that the physical space proposed for the project is necessary and appropriate. The proposed square footage cannot deviate from the square footage range indicated in Appendix B or exceed the square footage standard in Appendix B if the standard is a single number, unless square footage can be justified.

The Applicants are proposing a 34-bed hospital in 27,494 GSF of reviewable space[5] and 21,877 GSF of non-reviewable[6] space for a total of 49,371 GSF of space. The Applicants have successfully addressed this criterion.

TABLE SIX
Size of the Project
Proposed GSF compared to State Board Standard

Reviewable Service	Beds/Rooms/Unit	Proposed Gross Square Footage (2)		State Board Standard		Met Standard
		Per Bed	Total	Per Bed	Total	
Comprehensive Physical Rehabilitation Beds	34 beds	614.38	20,889	525-660 GSF	22,440 GSF	Yes
Pharmacy	1 room	514	514	NA	NA	NA
Physical Therapy/Occupational Therapy			6,091	NA	NA	NA

1. NA-Not Applicable - The State Board does not have a standard for this Service
2. For hospitals, area determinations for departments and clinical service areas are to be made in departmental gross square feet (dgsf). Spaces to be included in the applicant's determination of square footage shall include all functional areas minimally required by the Hospital Licensing Act, applicable federal certification, and any additional spaces required by the applicant's operational program.

[5] 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.

[6] 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

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

B) Criterion 1110.120 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. If the applicant does not meet the utilization standards in Appendix B, or if service areas do not have utilization standards in 77 Ill. Adm. Code 1100 the applicant shall justify its own utilization standard by providing published data or studies, as applicable and available from a recognized source, that minimally include the following:

The Applicants provided physician referral letters that estimated referring 196 patients to the proposed hospital by 2021 the year the proposed hospital would open. This number of referrals would justify 2,568 days or a utilization

196 x 13.1 days = 2,568 days
34 beds x 365 days = 12,410 days
2,568 days ÷ 12,410 days = 21%

(See Application for Permit Appendix A pages 265-332 for physician referral letters and additional referrals provided by the Applicants. At the end of this report is of physicians and the number of estimated referrals – Appendix I)

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION PROJECTED UTILIZATION (77 ILAC 1110.120 (b))

C) Criterion 1110.120 (e) - Assurances

The applicant shall submit the following:

1) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the end of the second year of operation after project completion, the applicant will meet or exceed the utilization standards specified in Appendix B.

2) For shell space, the applicant shall submit the following:

A) Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at that time or the categories of service involved;

B) The anticipated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

C) The estimated date when the shell space will be completed and placed into operation.

The Applicants provided the necessary assurance at page 113 of the Application for Permit.

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

IX. Comprehensive Physical Rehabilitation Service

A) 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.

The Applicants are proposing a 34-bed rehabilitation hospital. As of August 2019, there is a calculated need for 7-comprehensive physical rehabilitation beds in this Planning Area. The number of beds (34-beds) proposed exceeds the calculated need of 7 beds.

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.

The Applicants stated *the Planning Area for the proposed Anderson Rehabilitation Hospital in Edwardsville is composed of Madison County as the Primary Service Area (PSA), and additional zip codes in Jersey, Macoupin, Montgomery and Bond Counties that constitute a Secondary Service Area (SSA). Madison County, the PSA, is the source of 67.3% of the new facility's projected patient volume. The SSA adds 22.4%. Together, the PSA and SSA constitute the Planning Area, the source of 89% of patients. The remaining 10.3% come from outside the Planning Area.*

The Applicants provided documentation that 87% of Anderson Hospital's 20-bed comprehensive physical rehabilitation unit's patients in 2018 resided in the HSA XI Planning Area. The Applicants stated *the Planning Area for the proposed Anderson Rehabilitation Hospital in Edwardsville is composed of Madison County as the Primary Service Area (PSA), and additional zip codes in Jersey, Macoupin, Montgomery and Bond Counties that constitute a Secondary Service Area (SSA). Madison County, the PSA, is the source of 67.3% of the new facility's projected patient volume. The SSA adds 22.4%. Together, the PSA and SSA constitute the*

Planning Area, the source of 89% of patients. The remaining 10.3% come from outside the Planning Area. [Pages 92-95 of the Application for Permit]

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).

A) Historical Referrals

If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of hospital bed service, for each of the latest 2 years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient hospital.

B) Projected Referrals

An applicant proposing to establish CPR or to establish a new hospital shall submit the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients whom the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and

iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

The Applicants provided physician referral letters that propose to refer 196 patients to the proposed hospital. These physician referrals do not justify the 34-bed comprehensive physical rehabilitation hospital.

In response to this sub-criterion the Applicants stated the following:

> *"The physician commitment letters are not, by themselves, sufficient to justify full utilization of the Anderson Rehabilitation Hospital. A significant part of the justification is supported by the analysis of patients who have conditions matching Rehabilitation Impairment Codes (RICs) but are not hospitalized for post-acute rehabilitation. For the Anderson Rehabilitation Hospital, the projection of future referrals to the rehabilitation hospital is supported by an analysis of patients who live within the defined services area for Anderson Rehabilitation Hospital and who matched a RIC code. Matching a RIC code indicates that post-acute care inpatient rehabilitation may be appropriate. This method estimates that there were as many as*

2,177 Illinois residents who should have received hospital-based inpatient rehabilitation care upon discharge from community hospitals in Illinois and Missouri. This analysis was for the most recent 12-month period for which data was available from Illinois Hospital Association."

"Patients with stoke, neurological, brain injury, spinal cord injury, amputation, hip fractures, joint replacement or other orthopedic procedures, and other conditions match a RIC, indicating their eligibility for post-acute treatment in a rehabilitation inpatient unit. Not all these patients receive care in an inpatient rehabilitation unit. Instead, most are discharged to skilled nursing, home care services, LTAC, hospice, home without care services, or other disposition. It is the national experience of Kindred, Anderson Rehabilitation Hospital's partner in the operation of the proposed rehabilitation hospital, that about only 8% of patients matching a RIC code actually are admitted to inpatient rehabilitation."

The analysis of need for this project then applied a conservative estimate of the average length of stay specific to each of the diagnostic categories. This analysis estimates that 2,177 patients with an average length of stay of 13.1 days will produce an acute care discharged generated average daily census of 78.4. The number of beds required to serve the census estimation at an 85% planning occupancy level is 92.2 or ninety-three (93) beds, based solely on utilization of Illinois residents living within the Anderson Rehabilitation Hospital defined services area, originating from community hospitals in Illinois and Missouri current med/surg population. (78.4 Average Daily Census ÷ 85% target occupancy = 93 beds.)

In the 12 months ended 9/30/18, 1,288 patients (only 58% of Anderson Rehabilitation Hospital's defined service area RIC Match potential of 2,177) were actually admitted for hospital rehabilitation. The implication is that a significant number of Anderson Rehabilitation Hospital defined service area inpatients qualifying for and requiring inpatient Comprehensive Physical Rehabilitation were not obtaining that level of care at all or receiving only a lesser level of rehabilitation service in a skilled nursing environment. While the national experience shows that 8.4% of patients matching a RIC code actually are admitted for inpatient rehabilitation,

Anderson Rehabilitation Hospital has conservatively estimated that 3% of patients matching a RIC code would demonstrate a demand for inpatient rehabilitation service. This would equate to an annual demand by 816 patients (3% of 25,843) patients as the need from Table 7 below) for inpatient rehabilitation care.

Without absorbing all of the demand associated with the RIC analysis, 816 patients produce a demand for the 34-bed project. At a length of stay of 13.1

days, these 816 patients generate a demand of 10,600 patient days, exceeding the 85% occupancy level of the 34-bed rehabilitation hospital. It can also be said that Anderson already captures part of the 816 potential, by serving the 386 patients in its current 20 bed unit in Maryville (Year 2018 rehab admissions at Anderson Hospital).” [See Application for Permit pages 96-99]

A summary of this analysis is provided in the table below:

TABLE SEVEN
Applicants’ Summary of Need Methodology

Diagnosis	Rehabilitation Impairment Codes	# of Cases	% req rehab	# Rehab patients	Average Length of Stay	Patient Days
Column		A	B	C	D	E
Stroke - Primary	RIC 1	1,728	28.00%	439	15.4	6,764
Stroke - Secondary	RIC 1	1,402	14.00%	178	15.4	2,749
Brain Injury - Traumatic	RIC 2	331	29.00%	85	14.7	1,256
Brain Injury – Non-Traumatic	RIC 3	527	21.00%	98	12.9	1,269
Spinal Cord Injury -Traumatic	RIC 4	45	49.00%	18	19.4	348
Spinal Cord Injury -Non-Traumatic	RIC 5	298	14.00%	37	16.5	607
Neurological	RIC 6	306	28.00%	74	12.5	922
Fracture	RIC 7	719	8.00%	188	13.8	2,594
Bilateral Total Hip Replacement	RIC 8	132	8.00%	10	10.6	110
Bilateral Total Knee Replacement	RIC 8	69	10.00%	5	10.6	52
Joint Replacement (other)	RIC 8	2,602	16.00%	227	9.1	2,062
Other (Ortho)	RIC 9	584	16.00%	83	11.5	959
Lower Leg Amputation	RIC 10	718	17.00%	112	13.5	1,512
Other Amputation	RIC 11	96	15.00%	12	12.9	159
Osteoarthritis	RIC 12	394	7.00%	24	11.8	288
Rheumatoid	RIC 13	101	8.00%	7	11.5	79
Cardiac	RIC 14	3,991	5.00%	179	11.1	1,990
Pulmonary	RIC 15	1,669	5.00%	76	11.9	903
Pain Syndrome	RIC 16	367	11.00%	33	15	502
MNT	RIC 17	0	NA	19	12.7	241
MNT	RIC 18	0	NA	19	16.9	321
Guillain - Barre	RIC 19	13	28.00%	3	17.9	53
Miscellaneous	RIC 20	9,719	3.00%	244	11.4	2,783
Burns	RIC 21	32	4.00%	7	13.9	99

TABLE SEVEN Applicants' Summary of Need Methodology						
Diagnosis	**Rehabilitation Impairment Codes**	**# of Cases**	**% req rehab**	**# Rehab patients**	**Average Length of Stay**	**Patient Days**
Column		**A**	**B**	**C**	**D**	**E**
Total		**25,843**	**14.33%**	**2,177**	**13.1**	**28,622**

1) Column A: Of the residents of the defined service area, 66,165 patients were admitted to hospitals in Illinois and Missouri from October l, 2017 through September 30, 2018 (inpatients only, excluding observation, maternity and those under age 16), 25,843 inpatients fall into a Rehabilitation Impairment Code (RIC)
2) Column B: Utilizing Kindred's actual experience across the United States in the admission into inpatient Comprehensive Physical Rehabilitation programs, % Requiring Rehab by RIC, and multiplying B by the number of cases in A, yields a total 2,177 Rehab patients to be admitted for inpatient comprehensive physical
Rehabilitation as seen in **(Column C)**
3) Column D: Utilizing Kindred's actual average length of stay (ALOS) by RIC and multiplying the lengths of stay in Column D by the number of Rehab Patients in Column C yields the corresponding Rehab Patient Days. In (Column E)
4) Dividing the total 28,622 Rehab Patient Days in **Column E** by 365 days in a year, yields 78.4 Internally Generated Inpatient IRF ADC
Source: Page 98 of Application for Permit

5) Service Accessibility

The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

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 are <u>two hospitals</u> (See Table Eight) in the HSA XI Comprehensive Physical Rehabilitation Planning Area providing comprehensive physical rehabilitation service.

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;

v) As evidenced in the Table below the two facilities providing comprehensive physical rehabilitation in this planning area are not at target occupancy.

TABLE EIGHT
Hospitals with Comprehensive Physical Rehabilitation Service in HSA XI

Facility	City	Beds	Occupancy [1]
Anderson Hospital	Maryville	20	60.70%
HSHS St. Elizabeth Hospital	O'Fallon	16	76.80%
Total Beds		36	

1. Information from 2017 IDPH Profiles

Summary

There is a calculated need of 7-comprehensive rehabilitation beds as August 2019 in the HSA-XI comprehensive rehabilitation planning area. The number of comprehensive physical rehabilitation beds being requested exceed the calculated need by 27 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 number of physician referrals will not justify the 34-bed hospital. The Applicants relied on a need methodology developed by Kindred Healthcare, LLC (a co-applicant on this project) to justify the need for this project. Kindred's need methodology estimated 2,177 patients could require inpatient rehabilitation services in this planning area and that estimate would justify the need for 93 comprehensive physical rehab beds in this planning area. Based upon the information reviewed the Applicants have not met the requirements of planning area need.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMACE WITH CRITERION PLANNING AREA NEED (77 ILAC 1110.205 (b))

B) Criterion 1110.205 (c) - Unnecessary Duplication/Maldistribution

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 404,360. There is one inpatient rehabilitation unit in this 17-mile GSA- Anderson Hospital with 20 inpatient rehabilitation beds. There are 1,549 inpatient rehabilitation beds in the State of Illinois as of August 2019. The 2015 population in the State of Illinois is estimated at 12,978,800 and 2020 population is estimated at 13,129,233.

The ratio of beds in the 17-mile GSA is .0495 beds per 1,000 population and the ratio of beds in the State of Illinois is .1193 beds per 1,000 population in 2015 and .1180 beds per 1,000 population in 2020.

TABLE NINE
Ratio of Beds to Population

Area	Population	Beds	Ratio of Beds per 1,000 population
17-mile GSA	404,360	20	0.0495
Illinois (2015 est.) (1)	12,978,800	1,549	0.1193
Illinois (2020 est.) (1)	13,129,233	1,549	0.1180

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

Based upon this ratio there is not a surplus of comprehensive physical rehabilitation beds in this 17-mile GSA. The proposed project will not impact any other hospital in the 17-mile GSA because Anderson Hospital (a co-applicant on this project) is the only hospital with comprehensive physical rehabilitation beds in this 17-mile GSA. The Applicants have met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION/MALDISTRIBUTION (77 ILAC 1110.205(c))

C) Criterion 1110.205 (e) - Staffing

1) *Availability*
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.

The Applicants provided a narrative of hos the proposed staffing will be achieved, and staffing model used by Kindred Healthcare, LLC throughout the United States discussing their plan to staff the Hospital should this project be approved. This narrative can be found 108-112 of the Application for Permit. The Applicants expect no problems in staffing the proposed facility and meeting The Joint Commission staffing requirements.

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

D) 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.*[7]
2) *The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.*

The Applicants stated the following

"The proposed size of the Anderson Rehabilitation Hospital is 34 beds. While this is not consistent with the State requirement of a minimum of 100 beds for a new rehabilitation hospital, the project is appropriately scaled for meeting the community need. The new private rooms will have appeal for area residents seeking to receive care closer to home than commuting to St Louis or other facilities outside Madison County. A 34-bed facility also provides the critical mass needed for the development of a broader range of acute rehabilitation care."

The Applicants have not met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS <u>NOT</u> IN CONFORMANCE WITH CRITERION PERFORMANCE REQUIREMENTS – BED CAPACITY MINIMUM (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

[7] Section 1100.510 (c)(6) Planning area boundaries may vary by category of service. HFSRB recognizes that certain services (e.g., neonatal ICU, comprehensive physical rehabilitation, selected organ transplantation, cardiac surgery, etc.) may require a large population base to assure the provision of quality care and to be cost effective.

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 assurance at page 113 of the Application for Permit as required.

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

X. Financial Viability

A) Criterion 1120.120 – Availability of Funds

Applicants shall document that financial resources will be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources

Anderson Hospital and Kindred Healthcare, LLC have operated seven hospitals in this state for several years and both have shown the ability to adequately fund these health facilities. The Applicants are funding this project with cash in the amount of $2,402,500 and an operating lease with a Fair Market Value of $23,592,794. The Applicants have the resources to fund the cash portion of the project and the operating lease. The Applicants have met the requirements of this criterion.

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

B) Criterion 1120.130 – Financial Viability

Applicants that are responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.

The Applicants are funding this project from internal sources cash and an operating lease; the Applicants have qualified for the financial waiver.

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

XI. Economic Feasibility[8]

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

An Applicant must document the reasonableness of financing arrangements.

B) Criterion 1120.140 (b) – Terms of the Debt Financing

Applicants with projects involving debt financing shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

The Applicants are funding this project with cash in the amount of $2,402,500 and an operating lease with a Fair Market Value[9] of $23,592,794. Only a portion of the cost of this project will be capitalized[10] and therefore depreciated. The remaining $23,592,794 of project costs represent the fair market value of the facility lease. The lease expense will be reflected as an expense of operations in the income statement. The financing of the project appears reasonable. The Applicants have met the requirements of these criteria.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION 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 applicant shall document that the estimated project costs are reasonable.

By Statute only clinical costs (reviewable costs) are considered in evaluating the reasonableness of project costs. (20 ILCS 3960/3). The reviewable gross square feet ("GSF") is 27,494 GSF.

Preplanning Costs are $125,303 and are 1.09% of New Construction and Continencies and Movable Equipment not in Construction Costs ($11,521,852). This appears reasonable when compared to the State Board Standard of 1.8% or $207,393.

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[8] "Economically Feasible" means the costs of financing, constructing, acquiring, and operating a proposed project are reasonable and the expected impact of the project's operating and capital costs on the overall costs of health care are reasonable.

[9] "Fair Market Value" means the dollar value of a project or any component of a project that is accomplished by lease, donation, gifts or any other means that would have been required for purchase, construction, or acquisition.

[10] "Capital expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

Site Survey and Site Preparation Costs are $534,625 or 5% of New Construction and Contingency Cost of $10,689,286. This appears reasonable when compared to the State Board Standard of 5%.

New Construction and Contingency Costs are $10,689,286 or $388.79 per GSF ($10,689,286 ÷ 27,494 GSF = $388.79 GSF). This appears reasonable when compared to the State Board Standard of $401 per GSF.

Architectural and Engineering Fees are $484,503 or 4.53% of New Construction and Contingency costs of $10,689,286. This appears reasonable when compared to the State Board Standard of 8.28% or $885,073.

The State Board does not have a standard for the following costs:

- Consulting and Other Fees of $647,212.
- Movable or Other Equipment Costs of $832,566.
- Net Interest Expense During Construction of $594,003.
- Other Costs to be Capitalized of $505,387.

Itemization of these costs can be found at pages 254-255 of the Application for Permit.

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

D) Criterion 1120.140 (d) – Direct 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 Applicants have provided the direct costs per equivalent patient day should this project be approved**.** The State Board does not have a standard for this cost.

TABLE TEN
Operating Costs per Equivalent Patient Days

Total Operating Costs	$14,056,596
Equivalent Patient Days	10,600
Direct Cost per Equivalent Patient Day	$1,333

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS CONFORMANCE WITH CRITERION DIRECT 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 Applicants has provided the total effect of the project on capital costs per equivalent patient day should this project be approved**.** The State Board does not have a standard for this cost.

TABLE ELEVEN **Projected Capital Costs - FY 2023**	
Total Capital Cost	$2,402,500
Useful Life	7 Years
Total Annual Depreciation	$343,214
Equivalent Patient Days	10,600
Capital Costs per Equivalent Patient Days	$33.00

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS CONFORMANCE WITH CRITERION TERMS OF DEBT FINANCING (77 ILAC 1120.140 (e)

Appendix I						
#	Physicians	Number of Referrals		#	Physicians	Number of Referrals
1	Sandhya Grandhi, MD	8		28	Joshua Poos, MD	1
2	Shannon Hopen, MD	10		29	Panka Kaul, MD	1
3	Deborah Bross, MD	8		30	Behfar Dianati	3
4	Stanley Sidwell, MD	12		31	Helal Ekramuddin, MD	1
5	Gary Steinmann, PA	2		32	Jennifer Leonard, MD	1
6	Christopher Farrar, MD **	0		33	Bryan Steele, MD	2
7	Sonda Johnson, NP	3		34	Karna Sherwood, MD	2
8	Connie Marten, NP	3		35	Sonya Schlepper, MD	2
9	Tori Sutton, NP	5		36	Mark Hoofnagle, MD	1
10	Christopher Farrar, MD	21		37	Melissa Stewart, MD	1
11	Rachel Cadmus, PA-C	2		38	Evan Schwartz, MD	1
12	Rachel Hutchens (Cadmus) PA-C	1		39	John Ohman MD	2
13	Kevin Garner, MD	7		40	John Patrick Kirby, MD	1
14	David Ladin, MD	13		41	Joanna Ramiro, MD	1
15	Mohammed Ashraf, MD	17		42	Stephen Eaton, MD	2
16	Paulo Bicahlo, MD	11		43	Salah G. Keyrouz, MD	3
17	Peter Anderson, MD	3		44	Charles Ampadu, MD	1
18	Paul Scherer, MD	2		45	Mukul Shattarai, MD	1
19	Brett Grebing, MD	6		46	Sean English, MD	1
20	Daniel Johnson, MD	1		47	Randall Edgell, MD	5
21	Richard Wikiera, DO	1		48	Bruce Weber, MD	1
22	Syed Ali, MD	2		49	Chizoba Ezepue, MD	4
23	Riaz Naseer, MD	4		50	Steven Homer, MD	1
24	Zohair Karmally, MD	4		51	Behfar Dianati, MD	3
25	Deepak Koul, MD	1		52	Pankaj Kaul, MD	1
26	Robert Craig McKee, MD	1		53	Eric Kim, MD	1
27	Kyle Shepperson, MD	2		54	Ann Peick, MD	1
				55	Adam Ring, MD	1
					Total	196

1. NP = Nurse Practitioner - A **nurse practitioner** (**NP**) is an advanced practice registered nurse classified as a mid-level practitioner. A nurse practitioner is trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose illness and disease, prescribe medication and formulate treatment plans. NP training covers basic disease prevention, coordination of care, and health promotion, but does not provide the depth of expertise needed to recognize more complex conditions. (Source American Association of Nurse Practitioner)
2. DO = Doctor of Osteopathic Medicine
3. PA = Physician Assistant -Certified **physician assistant** or **physician associate** (**PA**) is a health care practitioner who practices medicine in collaboration with or under the (indirect) supervision of a physician, depending on state laws (equivalent to a nurse practitioner). Physicians do not need to be on-site with PAs and collaboration or supervision often occurs via electronic means when consults are necessary. Their scope of practice varies by jurisdiction and healthcare setting. In the United States, PAs are nationally certified, and state licensed to practice medicine at their level. (Source: US Bureau of Labor Statistics)

** Dr. Farrar provided a referral letter that stated the 3-nurse practitioner left the Hospitalist Group and had referred 11 patients for inpatient rehabilitation in the two prior years. Dr. Farrar estimated that the 3 new nurse practitioner that replaced the three that left would refer 11 patients for inpatient rehabilitation service.

APPENDIX II
Anderson Hospital
Financial Ratios

Ratios	State Board Standard	2015	2016	2017	2018	2023
Current Ratio	≥2	1.59	1.6	1.67	1.48	1.49
Net Margin	≥3	7.33%	19.81%	11.34%	71.00%	8.00%
LTD to Total Capitalization	≤50%	24.43%	22.36%	19.12%	18.77%	19.21%
Projected Debt Service Coverage Ratio	≥2.5	4.36	9.75	6.67	2.47	3.85
Days Cash on Hand	≥75	184.35	174.85	198.4	176.2	200
Cushion Ratio	≥7	15.41	17.81	20.15	19.44	23.8
Ratios	State Board Standard	2016	2017	2018	2023	
Current Ratio	≥2	1.79	1.52	1.35	1.39	
Net Margin	≥3	10.56%	-11.57%	-2.73%	1.70%	
LTD to Total Capitalization	≤50%	75.53%	90.05%	55.90%	50.00%	
Projected Debt Service Coverage Ratio	≥2.5	-1.27	-1.47	0.89	3.96	
Days Cash on Hand	≥75	15	12	10	9	
Cushion Ratio	≥7	1.05	0.76	0.63	1.83	

Anderson Hospital stated: *"The only reason for this ratio being below 2.0 is that Anderson Hospital takes an aggressive approach to moving operating cash to long-term investments. All of Anderson Hospital's long-term investments are unrestricted and can be converted to cash within 7 -10 days. As a result, the Current Ratio can be increased to exceed the CON standard within that brief period."* (Application for Permit page 246)

Kindred Healthcare, LLC stated:
"Further note that the presented financial ratios do not appropriately capture Kindred's liquidity. As part of the capitalization of Kindred Healthcare, LLC, completed on July 2, 2018, the company's capital structure includes a $450 million asset-backed revolver (ABL) and a $410 million term loan. We believe these facilities as well as the ongoing cash flows of the company provide ample liquidity for operations." (See Application for Permit page 249).

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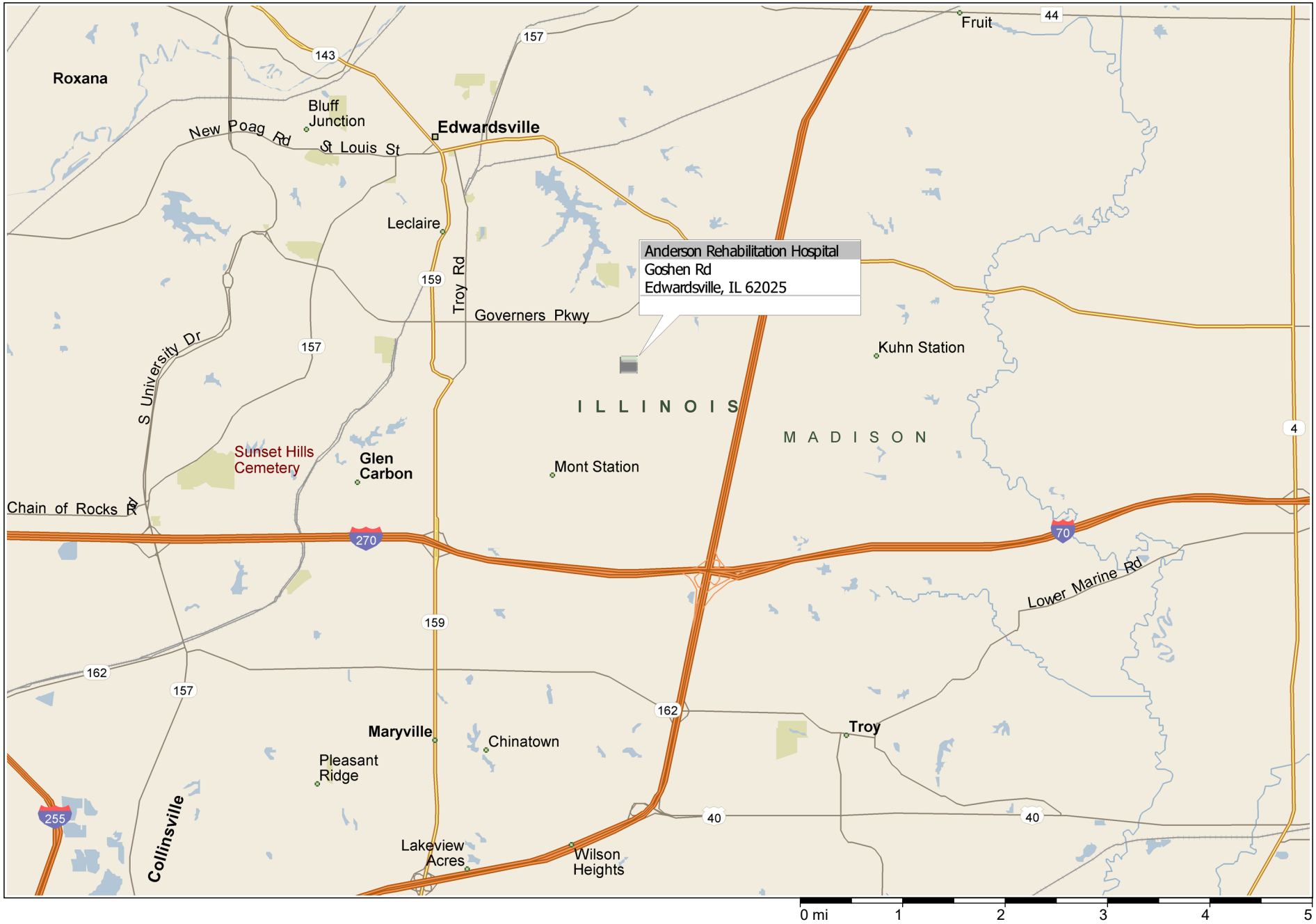

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