STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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

BOARD MEETING: June 2, 2026	**PROJECT NO:** 26-009	**PROJECT COST:**
FACILITY NAME: Sycamore Specialty Hospital	**CITY:** Sycamore	Original: $11,013,863
TYPE OF PROJECT: Substantive		**HSA:** I

PROJECT DESCRIPTION: Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC (Applicants) seek authority from the Illinois Health Facilities and Services Review Board ("State Board") to establish a long-term acute care hospital with 40 long-term acute care beds and 12 inpatient physical rehabilitation beds at 225 Edward Street, Sycamore, Illinois. The total cost of the Project is $11,013,863. The expected completion date is June 30, 2028.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC (Applicants) seek authority from the Illinois Health Facilities and Services Review Board ("State Board") to establish a long-term acute care hospital with 40 long-term acute care beds ("LTAC") and 12 inpatient physical rehabilitation beds ("IRF") at 225 Edward Street, Sycamore, Illinois. The total cost of the Project is $11,013,863. The expected completion date is June 30, 2028. The Project also includes establishing physical therapy, radiology, pharmacy, and laboratory services.
- The Applicants modified the proposed project, increasing the cost from $10,700,000 to $11,013,863 or $313,863 or 2.93%. The modification also included a fire and life safety code analysis and a hospital leadership curriculum vitae. This modification is considered a Type B modification and does not require the State Board to publish another public hearing notice.

BACKGROUND

- The proposed hospital will be in a structure that was erected in 1949. The facility underwent several significant additions and expansions in 1961, 1980, and 1993. The facility originally served as the local municipal hospital. In 1986, the hospital began operating as a long-term acute care facility under the name Vencor.[1] It reorganized under the Kindred name in 1999. Kindred Hospital specialized in intensive care and rehabilitation for complex medical patients, providing therapies to help patients regain function after intensive care. In March 2025, Kindred Hospital was approved to discontinue operations at the facility (Project 24-038) because of low utilization. The property spans approximately 2.98 acres and includes a 67,585-square-foot main building along with ancillary office and storage buildings.
- At the time of the discontinuation Kindred stated the following "*Kindred arrived at this decision after carefully evaluating the 25% decline in utilization at the Hospital over the past five years (2018 - 2023) (current occupancy is 30.4%), as well as the known availability of beds at facilities within 50 miles, including two long-term acute care hospitals Kindred operates: Kindred Hospital North and Kindred Hospital Chicago Northlake. Both Kindred Hospital North and Kindred Hospital No11hlake operate below the State Board's target occupancy of85% and have sufficient capacity to accommodate the Facility's patients. This decision will best enable Kindred to care for*

[1] Vencor was a healthcare corporation that was once one of the largest long-term care providers in the United States. It operated several specialized hospitals in Illinois before financial and legal troubles. Vencor, Inc. entered the Illinois market in the late 1980s and early 1990s as a niche provider of Long-Term Acute Care (LTAC). The company operated locations in Illinois, including Vencor Hospital – Sycamore. Vencor entered Chapter 11 bankruptcy in 1999, emerged in 2001, and changed its name to Kindred Healthcare.

the greater Chicago community and invest more robustly in the remaining facilities." (Source: Application for Permit #24-038 page 42)

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The project is before the State Board because the project proposes the establishment of a health care facility.

PURPOSE OF THE PROJECT:

- The purpose of the project is to establish a 52-bed long-term acute care (LTAC) hospital, including 40 LTAC beds and 12 IRF Beds, in Sycamore, Illinois.

PUBLIC HEARING/COMMENT:

- No public hearing was requested, and the State Board has received letters of support. The State Board received two letters of opposition. These letters are at the conclusion of this report.

SUMMARY:

- The State Board is mandated to regulate the planning, construction, and operation of health care facilities through the CON program, to ensure services are necessary and accessible, the Applicants are financially viable, and the project is economically feasible while minimizing unnecessary duplication of service.
- The State Board's LTAC and Comprehensive Physical Rehabilitation Planning Area is Health Service Area I. The Geographical Service Area ("GSA") for this project is a 17-mile radius.
- There is a calculated need for 34 LTAC beds and no need for, or excess of, comprehensive physical rehabilitation beds in Health Service Area I. There are no LTAC or IRF beds in the 17-mile GSA.
- The State Board Staff found no evidence of **service demand**. To assess demand, 13 physicians provided referral letters with the Application material, resulting in 1,383 referrals from 16 hospitals. One of the physicians did not provide the required zip code information, and the letter was not accepted. The 12 physician referral letters totaled 874 referrals. Of the 874 referrals, none were to LTAC Hospitals. The State Board requires that the physician referral letters attest to the physician's total number of patients (by zip code of residence) who have received care at existing LTAC Hospitals in the area or have had a stay of over 25 days in a general acute care hospital and have been considered LTACH candidates. The referral letters indicated that physicians were not referring patients to LTAC hospitals, and there was no documentation that patients resided in a hospital for more than 25 days, as required by the service demand criteria. Additionally, all referrals would come from hospitals that were, on average, approximately 50 miles from the Sycamore

location. Based on the review of the application material, the Applicants have not provided evidence that the proposed LTAC service is necessary to meet the needs of the planning area's population or that the existing LTAC facilities are insufficient to meet current demand.

- Board Staff also notes that the previous owner, Kindred Healthcare, discontinued operations at the 64-bed LTAC Hospital in Sycamore due to declining utilization. Over five years (CY2019-CY2023), Kindred Hospital averaged 386 admissions and 43.4% utilization for the 64-bed LTAC Hospital. Additionally, the Board Staff is concerned about the long-term feasibility of establishing an LTAC Hospital in Sycamore, in an industry currently undergoing site-neutral payment reforms that reimburse LTACs at lower rates if patients do not meet strict high-acuity criteria. Site-neutral payment reforms for Long-Term Acute Care (LTAC) hospitals aim to ensure Medicare pays the same amount for similar care regardless of the setting. The primary reform is the dual-rate payment system, which differentiates between patients requiring specialized hospital-level care and those who could be treated in less intensive settings.
- **State Board Staff Notes:** The Applicants' proforma financial information meets the State Board's Financial Viability requirements. The Applicants capitalized the proposed hospital with $16,700,000 in cash. The $16.7 million total capitalization, with $10,700,000 million dedicated to the modernization of a 52-bed Long-Term Acute Care (LTAC) hospital, appears to carry risks. While the modernization budget may be sufficient for renovations depending on the facility's existing condition, the remaining $6 million in working capital ($16.7M - $10.7M), the Staff believes will likely be insufficient to cover the ramp-up phase typical for LTACs, which often operate in the red for the first 12–18 months.
- Operating a combined LTAC and IRF facility introduces compliance requirements that will impact the Applicants' capital.
  - You cannot bill Medicare for LTAC or IRF rates on Day 1. You must admit and treat a baseline number of patients to demonstrate compliance (e.g., maintaining an average 25-day stay in an LTAC and meeting the "60% Rule" in an IRF, where 60% of patients must have specific rehabilitation diagnoses). You must pay for their care entirely out-of-pocket during this survey window.
  - If your 12 IRF beds admit too many general stroke or cardiac patients who do not fit the strict 13 qualifying medical conditions, Medicare will reclassify those beds and pay you at standard acute care rates, destroying your revenue model.
  - If your LTAC average length of stay drops to 24 days, your reimbursement rates plummet retrospectively. Your case management team must actively manage the patient census to prevent massive financial penalties.

- LTAC requires high-acuity ICU nurses and respiratory therapists. IRF requires rehabilitation nurses and intensive physical/occupational therapy staff. You cannot easily cross-utilize these teams, creating two independent, expensive labor pools.
  (Sources: Prior State Board projects and the Illinois Department of Public Health)

Criterion	Reasons for Non-Compliance
77 Ill. Adm. Code 1110.120 (a) – Size of the Project	The Applicants exceeded the State Board Standard for IRF and LTAC Beds. The State Board Standard for IRF beds is 560 DGSF per bed, and 660 DGSF per bed for LTAC Beds. The Applicants are proposing 667 DSGF per bed for both IRF and LTAC beds.
77 Ill. Adm. Code 1110.120(b) – Projected Utilization	The Applicants estimate 5,698 patient-days for the 12 IRF beds (130%) and 20,325 patient-days for the 40 LTAC beds by the second year after project completion (140%) (See Table Five). While the Applicants' projections meet the State Board's 85% target occupancy, Board Staff believe these projections are unrealistic because none of the referrals were from an LTAC Hospital.
77 Ill. Code 1110.265 (b) (1) – Planning Area Need - Formula Calculation	There is a calculated need for 34 long-term acute care (LTAC) beds in the HSA I long-term acute care planning area. The Applicants are proposing 40 LTAC beds. The Applicants have exceeded the calculated need.
77 Ill. Code 1110.265 (b) (2) – Service to Planning Area Residents	The Applicants submitted 13 physician referral letters; 12 were accepted because one did not include zip code information. The 12 physician referral letters totaled 874 referrals. Of the 874 referrals, none were to LTAC Hospital. The Applicants estimated that they would refer 813 patients to the proposed LTAC hospital by the second year after project completion. Additionally, there are 26 zip codes within the 17-mile GSA. Of the 874 referrals, Board Staff identified 50 referrals that came from these 26 zip codes. 75% of the residents are not from the area as required by this criterion.
77 Ill. Code 1110.265 (b) (3) – Service to Demand	We found no evidence in the referral letters that the physicians were referring patients to LTAC hospitals, nor any documentation that the physician patients

Criterion	Reasons for Non-Compliance
	resided in a hospital for more than 25 days. The physician referral letters submitted included the physician's total number of patients (by zip code of residence) for the period 01/01/2024 to 12/31/2024 or 01/01/2025 to 12/31/2025 who had received care at an existing hospital facility in the area, as well as an estimate of the number of referrals to the proposed new hospital. Based on the review of the material, the Applicants have not provided evidence that the proposed LTAC service is necessary to meet the needs of the planning area's population or that the existing LTAC facilities are insufficient to meet current demand.
77 Ill. Code 1110.265 (g) – Performance Requirements	An applicant shall document that the project will result in a facility capacity of at least 50 LTACH beds located in an MSA and 25 LTACH beds in a non-MSA. Sycamore, Illinois, is in the Chicago-Naperville-Elgin, IL-IN-WI Metropolitan Statistical Area (MSA). As the county seat of DeKalb County, Sycamore is part of this larger metropolitan area, which also includes the cities of Chicago, Naperville, and Elgin. The Applicants are proposing 40 LTAC Beds, not 50, as required by this criterion.
COMPREHENSIVE PHYSICAL REHABILITATION REVIEW	
77 Ill. Code 1110.205 (b) (1) – Planning Area Need	There is neither a calculated need nor an excess of inpatient physical rehabilitation beds in the HSA I Comprehensive Physical Rehabilitation Planning Area. Based on the review of the State Board's calculated need for IRF beds, the Planning Area bed capacity remains in equilibrium with patient demand. The State Board's analysis indicates an optimal occupancy rate, with no immediate need to increase the number of licensed beds.
77 Ill. Code 1110.205 (b) (2) – Service to Planning Area Residents	There are 26 zip codes within the 17-mile GSA. Of the 1,383 referrals, Board Staff identified 50 referrals (3.6%) that came from these 26 zip codes (See Table Seven below). Fifty percent of the residents of the 17-

Criterion	Reasons for Non-Compliance
	mile GSA are not from the area, as required by this criterion.
77 Ill. Code 1110.205 (g) – Performance Requirements	The minimum hospital unit size for inpatient physical rehabilitation is 16 beds. The Applicants are proposing 12 inpatient physical rehabilitation beds for this hospital unit. The Applicants have not met the minimum unit size required by this criterion.

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STATE BOARD STAFF REPORT
Project 26-009
Sycamore Specialty Hospital

APPLICATION/SUMMARY CHRONOLOGY	
Applicant(s)	Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC
Facility Name	Sycamore Specialty Hospital
Location	225 Edward Street, Sycamore, Illinois
Permit Holder	Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC
Operating Entity/Licensee	Sycamore Specialty Hospital, LLC
Owner of Site	Accelerated Medical Facilities, LLC
Application Received	February 18, 2026
Application Deemed Complete	February 24, 2026
Anticipated Completion Date	June 30, 2028
Review Period Ends	May 24, 2026
Review Period Extended by the State Board Staff?	No
Can the Applicant request a deferral?	Yes

I. Project Description

Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC (Applicants) seek authority from the Illinois Health Facilities and Services Review Board ("State Board") to establish a long-term acute care hospital with 40 LTAC beds and 12 IRF beds at 225 Edward Street, Sycamore, Illinois. The total cost of the Project is $10,700.000. The expected completion date is June 30, 2028.

II. Summary of Findings

A. State Board Staff finds the proposed project is **not in** conformance with all relevant provisions of Part 1110 (77 Ill. Adm. Code 1110).

B. State Board Staff finds the proposed project **is in** conformance with all relevant provisions of Part 1120 (77 Ill. Adm. Code 1120).

III. General Information

The Applicants are Sycamore Specialty Hospital, LLC, and Accelerated Medical Facilities, LLC. Sycamore Specialty Hospital, LLC is owned by Paraminder Singh (5%), Saifullah Nasir (85%), Kashif Rana (5%), and Gurdial Singh (5%). This is a substantive project subject to review under Parts 1110 and 1120. Financial commitment will occur after permit approval. The State Board Utilization Standard for long-term acute care ("LTAC") and inpatient rehabilitation ("IRF") beds is 85%.

IV. Health Service Area

There are seven hospitals with LTAC beds in the State of Illinois.

TABLE ONE
Hospitals with LTAC Beds in Illinois
2025 Data

	City	Beds	Adm	Days	ALOS	ADC	Occ
Kindred Hospital – Chicago	Chicago	113	483	22,370	46.31	61.9	68.02%
Kindred Hospital – Northlake	Chicago	91	437	13,634	31.20	37.4	41.01%
Prime Holy Family Medical Center	Des Plaines	129	733	17,610	24.02	48.25	37.40%
RML Chicago	Chicago	86	321	11,373	35.43	31.16	36.23%
RML Hinsdale	Hinsdale	115	597	26,515	44.41	72.64	63.17%
Rush Specialty Hospital	Chicago	44	369	9,818	26.61	26.90	61.13%
OSF Divine Mercy Continuing Care Hospital	Peoria	18	213	5,598	26.28	15.34	85.21%
Total		596	3,153	106,918	33.9	292.6	49.09%

There are eleven long-term acute care health planning areas in the State. The proposed hospital will be in the long-term acute care planning area, Health Service Area I. HSA I includes the Illinois Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, and Winnebago. Population projections for this planning area are

presented in Table Two below. The geographical service area for this project is a 17-mile radius. The Applicants are estimating a population of 226,588 residents within this 17-mile radius.

TABLE TWO Estimated Population in the HSA I Long Term Acute Care Planning Area		
County	**2025 Projection**	**2030 Projection**
Boone	53,230	53,880
Carroll	15,395	15,310
DeKalb	105,186	106,450
Jo Daviess	21,594	21,430
Lee	35,943	35,680
Ogle	51,550	51,390
Stephenson	43,060	42,750
Whiteside	54,947	54,420
Winnebago	284,550	283,920
Total	665,455	665,230

V. Project Uses and Sources of Funds

The project is being funded entirely with $11,013,863 in cash. The estimated start-up cost and operating deficit total $945,429.

TABLE THREE Project Costs and Sources of Funds				
Uses of Funds	Clinical	Non-Clinical	Total	% of Total
Modernization Cost	$3,045,000		$3,045,000	27.65%
Contingencies	$455,000		$455,000	4.13%
A&E Fees	$200,000		$200,000	1.87%
Movable Or Other Equipment	$6,252,800	$747,200	$7,000,000	63.55%

TABLE THREE Project Costs and Sources of Funds				
Uses of Funds	Clinical	Non-Clinical	Total	% of Total
Acquisition of Building	$220,455	$93,408	$313,863	2.85%
Total			$11,013,863	100.00%
Sources of Funds				
Cash			$11,013,863	100.00%
Total			$11,013,863	100.00%

VI. Background of the Applicant, Purpose of Project, Safety Net Impact Statement, and Alternatives − Information Requirements

A) 77 Ill. Adm. Code 1110.110 (a) – Background of the Applicant
B) 77 Ill. Adm. Code 1110.110 (b) – Purpose of the Project
C) 77 Ill. Adm. Code 1110.110 (c) – Safety Net Impact Statement
D) 77 Ill. Adm. Code 1110.110 (d) – Alternatives to the Proposed Project

A) Background of Applicant – Review Criteria

1) 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 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 proposed licensee and operating entity, as well as the site owner, are new Illinois limited liability companies that do not own any other health care facilities—the letter from Saifullah Nasir. M.D., Manager of Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC, has certified that no adverse action has been taken against any facility owned and/or operated by the Applicants during the three years before filing this

application. Authorizations permitting HFSRB and the Illinois Department of Public Health access to any documents necessary to verify information have been submitted.

The leadership team for the proposed Sycamore Specialty Hospital.

Dr. Saifullah Nasir (Chairman): Board-certified cardiologist and founder of Sycamore Specialty Hospital. Has led the redevelopment effort for the project, including project funding, physician recruitment, strategic planning, and assembling the hospital leadership team. Brings an extensive physician and hospital network across the Chicagoland area through his experience building and operating a multi-site cardiology and internal medicine practice.

Herschel Carey (CEO): Former CEO and Chief Clinical Officer of Kindred Chicago Central Hospital with over 20 years of healthcare leadership experience in LTACH, acute care, rehabilitation, and respiratory care operations. Extensive background in hospital operations, clinical leadership, physician relations, regulatory compliance, staffing, and business development. Licensed Respiratory Care Practitioner (RCP) and Registered Nurse (RN)

Shijy Alex (COO/CNO): Experienced hospital executive and nursing leader with roles including CEO, VP of Patient Care, VP of Operations, and Director of Clinical Operations. Strong background in hospital operations, nursing leadership, regulatory readiness, workforce development, and service line expansion.

Yevgeniy "Gene" Yakovenko (CFO): Healthcare financial executive with extensive LTACH and acute care hospital finance experience, including prior leadership roles with Kindred Healthcare and Holy Family Medical Center. Expertise includes hospital financial operations, revenue cycle management, budgeting, operational integration, and improving hospital profitability and performance.

Matthew Hamilton: Former CEO, CFO, and CCO with more than 25 years of healthcare executive leadership experience, including LTACH development, hospital turnarounds, CON strategy, financial modeling, and startup operations. Led the development and operation of LTACH hospitals and authored multi-million-dollar healthcare proformas and operational plans.

Naomi Blackburn: Healthcare business development and operations executive with experience in physician relations, strategic planning, hospital growth initiatives, service line development, and healthcare outreach. Has held leadership roles with multiple hospitals and healthcare systems, including work involving physician recruitment, community partnerships, and operational growth strategies.

Omar Darawsha: Administrative and business development support for Sycamore Specialty Hospital, including CON coordination, physician outreach, referral data organization, vendor coordination, and day-to-day project assistance during the hospital redevelopment process.

Dr. Mutazz Darweesh will serve as the Medical Director, and **Shijy Alex** will serve as the Chief Nursing Officer.

The Applicants state that the governing body will be selected by the ownership and leadership team based on individuals' professional experience, qualifications, and ability to support the hospital's operational and clinical goals. The Applicants intend to include members with backgrounds in hospital administration, physician leadership, healthcare operations, finance, compliance, and patient care to ensure appropriate oversight and governance. As the project nears opening, the governing body will be formally organized in accordance with the hospital's bylaws, licensing requirements, and applicable regulatory standards.

Based upon the information received and reviewed, it appears the Applicants are fit, are willing, and able, and have the qualifications, background, and character to adequately provide a proper standard of health care service for the community.

B) Purpose of the Project – Information Requirements

1) The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided should include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project.

The purpose of the project is to establish a 52-bed long-term acute care hospital, including 40 LTAC beds and 12 IRF Beds, in Sycamore, Illinois.

Problem:
The Applicants state that due to the closure of Kindred Hospital – Sycamore, there are no long-term acute care beds or inpatient physical rehabilitation beds in the 17-mile geographic service area. According to the Applicants, patients with chronic, complex, or severe medical conditions who need extended hospital-level treatment or intensive rehabilitation services must transfer to the Chicago suburbs or Rockford or settle for lower-acuity settings. The absence of these services locally can lead to prolonged stays in general acute care hospitals or premature discharge to a skilled nursing facility, neither of which optimally serves patients who require specialized long-term care or intensive rehabilitation.

Solution:
The Applicants state that the primary benefit of the planned Sycamore Specialty Hospital will be the restoration of local access to long-term acute care and rehabilitation beds. Patients and families will no longer have to travel for an hour or more for long-term acute care or rehabilitation services. Access to LTAC and Rehabilitation services close to home is critical for vulnerable patients.

C) Safety Net Impact Statement – Information Requirements

All health care facilities, except 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 provided by health care providers or organizations that deliver health care to people 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]

A Safety Net Impact Statement is provided at the end of this report as required.

D) Alternatives to the Proposed Project – Information Requirements

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.

1. Maintain Status Quo: Do Nothing
2. Construct a Long-Term Acute Care Hospital at Another Location
3. Utilize Other Providers

The Applicants considered three alternatives to the proposed project. All were rejected as either too expensive or failing to address the lack of LTAC and IRF beds in this 17-mile geographic service area.

VII. Project Size and Projected Utilization

A) 77 Ill. Adm. Code 1110.120 (a) – Size of Project
B) 77 Ill. Adm. Code 1110.120 (b) – Project Utilization

A) Size of the Project

The Project proposes to establish a long-term acute care hospital with 40 LTAC beds and 12 IRF beds, along with physical therapy, radiology, pharmacy, and laboratory services. The Applicants exceeded the State Board Standard for IRF and LTAC Beds.

TABLE FOUR
Size of the Project

	Beds	Proposed Total GSF	Proposed GSF per Bed	State Standard Total	State Standard Per Bed	Met Standard
Rehabilitation Beds	12	8,113	676	7,920	660	No
Long-Term Acute Care Beds	40	27,045	676	22,400	560	No
Imaging		906			4,000	Yes
X-Ray Fluoroscopy					1,300	
Ct Scanner					1,800	
Ultrasound					900	
Physical Therapy		1,085		No Standard		
Pharmacy	NA	894		No Standard		
Lab	NA	859		No Standard		

B) Projected Utilization

If the project is approved, the Applicants estimate 5,698 patient-days for the 12 IRF beds (130%) and 20,325 patient-days for the LTAC beds by the second year after project completion (140%) (See Table Five). Board Staff believes these projections are unrealistic and was unable to accept them. The Board Staff bases its reasoning on the fact that the previous owners discontinued the facility due to declining utilization. Over five years, Kindred Hospital average 43.4% utilization (See Table Six).

TABLE FIVE
Projected Utilization

	IRF			LTAC	
Year	2028	2029		2028	2029
Beds	12	12	Beds	40	40
Admits	203	407	Admits	406	813
Days	2,842	5,698	Days	10,150	20,325
Occ%	64.89%	130.09%	Occ%	69.52%	139.21%

TABLE SIX
Kindred Hospital
Historic Utilization

Year	2019	2020	2021	2022	2023	Ave
Beds	64	64	64	64	64	64
Adm	396	423	405	371	337	386
Days	10,462	11,442	10,582	9,591	8,592	10,134
ALOS	26.4	27	26.13	25.9	25.5	26.2
ADC	28.7	31.3	28.90	26.3	23.5	27.7
Utilization	44.84%	48.91%	45.16%	41.09%	36.72%	43.34%

VIII. Long-Term Acute Care

REQUIRED REVIEW CRITERIA		
77 Adm. Code 1110.265	(b)(1)	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
77 Adm. Code 1110.265	(b)(2)	Planning Area Need – Service to Planning Area Residents
77 Adm. Code 1110.265	(b)(3)	Planning Area Need – Service Demand − Establishment of LTAC
77 Adm. Code 1110.265	(b)(5)	Planning Area Need − Service Accessibility
77 Adm. Code 1110.265	(c)(1)	Unnecessary Duplication of Services
77 Adm. Code 1110.265	(c)(2)	Maldistribution
77 Adm. Code 1110.265	(c)(3)	Impact of Project on Other Area Providers
77 Adm. Code 1110.265	(e)(1)	Staffing Availability
77 Adm. Code 1110.265	(f)	Performance Requirements
77 Adm. Code 1110.265	(g)	Assurances

A) Planning Area Need − Review Criteria

The applicant shall document that the number of LTACH beds to be established or added is necessary to serve the planning area's population.

There is a calculated need for 34 long-term acute care beds in the HSA I long-term acute care planning area. The Applicants are proposing 40 LTAC beds. The Applicants have exceeded the calculated number of beds needed.

B) 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 LTACH service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 75% of admissions were residents of the area. For all other projects, applicants shall document that at least 75% of the projected patient volume will come from area residents.

The Applicants provided 13 physician referral letters totaling 1,383 referrals. Only 12 of the referral letters were accepted because one letter lacked zip code information. Of these

12 physician letters, there were 874 referrals. The Applicants estimated that they would refer 813 patients to the proposed LTAC hospital by the second year after project completion. There are 16 zip codes within the 17-mile GSA. Of the 874 referrals, Board Staff identified 50 referrals that came from these 26 zip codes. 75% of the residents are not from the area as required by this criterion.

TABLE SEVEN
Zip Codes within the 17-mile GSA and Number of Historical Referrals

Zip Code	City	Number
60109	Burlington	
60110	Burlington	
60111	Clare	
60112	Cortland	
60113	Creston	
60115	DeKalb	18
60119	Elburn	
60124	Elgin	
60129	Esmond	
60135	Genoa	5
60140	Hampshire	
60144	Lily Lake/St. Charles	
60145	Kingston	4
60146	Kirkland	2
60148	Lombard - edge of radius	2
60150	Malta	
60151	Maple Park	3
60175	St. Charles - Western part	
60177	St. Charles - Western part	
60178	Sycamore	12
60511	Big Rock	4

TABLE SEVEN Zip Codes within the 17-mile GSA and Number of Historical Referrals			
60520	Hinckley		
60530	Lee		
60550	Shabbona		
60556	Waterman		
61008	Belvidere		
		Total	50

In response to this criterion, the Applicants state there is a service gap in the community. The planned Sycamore Specialty Hospital will be a dual-service hospital offering both LTAC and inpatient rehabilitation (IRF) services. The proposed hospital anticipates 813 LTAC admissions annually. Assuming an average length of stay of 25 days, annual inpatient days would be 20,325 (or an average daily census of 55.7), which is sufficient to justify the 40 LTAC beds.

We found no evidence in the referral letters that 75% of the referrals came from the 17-mile GSA; therefore, the Applicants did not meet this criterion.

C) Service Demand – Establishment of LTACH Service

The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the last 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.

B) Projected Referrals

An applicant proposing to establish a category of service or 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 LTACH facilities located in the area or had a length of stay of over 25 days in a general acute care hospital and were considered to be LTACH candidates, annually over the latest 2-year period before submission of the application; and an estimate as to the number of patients that will be referred to the applicant's facility;

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

iii) Each referral letter shall contain 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 estimate that 813 patients will be referred to the proposed LTAC hospital. **The Applicants state,** in response to this criterion, that the planned Sycamore Specialty Hospital will focus on patients with complex medical conditions requiring extended acute care (with an average length of stay greater than 25 days), such as ventilator dependence, respiratory failure, complex wounds, sepsis recovery, and other multisystem illnesses. The planned hospital's service area will include DeKalb County and adjacent counties in north-central Illinois. Local acute care hospitals currently have limited capacity to transfer their chronically ill patients to nearby facilities. Among the seven hospitals within 20 miles, none have long-term acute care beds.[2] Accordingly, patients requiring LTAC services frequently transfer to LTAC hospitals in the Chicago area (over 50 miles away) or out of state. The Applicants believe that population aging will increase demand for post-acute services. Over the past ten years (2013 - 2023), while the overall population of the Sycamore geographic service area decreased 8.6%, the age 65+ cohort increased 35%.

TABLE EIGHT
Sycamore 17-mile Geographic Service Area Population

Age	2013	2021	2022	2023	Change
0-14	44,960	37,818	36,869	37,982	-15.50%
15-44	94,959	73,524	73,658	74,277	-21.80%
45-645	55,481	57,293	57,047	56,203	1.30%
65-74	13,631	19,740	19,582	19,711	44.60%
75+	9,591	10,996	11,845	11,646	21.40%

2 7- hospitals within approximately 20 miles
- NM Kishwaukee Hospital
- Advocate Sherman Hospital
- Prime Saint Joseph Hospital – Elgin
- NM Delnor Community Hospital
- Rochelle Community Hospital
- Prime Mercy Medical Center - Aurora
- NM Valley West Community Hospital

TABLE EIGHT Sycamore 17-mile Geographic Service Area Population				
218,622	199,371	199,001	199,819	-8.60%

We found no evidence in the referral letters that the physicians were referring patients to LTAC hospitals, nor any documentation that the physician patients resided in a hospital for more than 25 days. The physician referral letters submitted included the physician's total number of patients (by zip code of residence) for the period 01/01/2024 to 12/31/2024 or 01/01/2025 to 12/31/2025 who had received care at an existing hospital facility in the area, as well as an estimate of the number of referrals to the proposed new hospital. Based on the review of the material, the Applicants have not provided evidence that the proposed LTAC service is necessary to meet the needs of the planning area's population or that the existing facilities are insufficient to meet current demand.

D) Service Accessibility

The number of beds being established or added in each service category is necessary to improve access for residents in the planning area. 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) meets or exceeds the utilization standard specified in 77 Ill. Adm. Code 1100.

The State Board defines service accessibility as geographic access to necessary healthcare for residents within a specific area, such as a planning or geographical service area. There are no LTAC Beds in the HSA I LTAC Planning Area, and the State Board has calculated the current need for 34 LTAC beds in this Planning Area. The Applicants have met one of the requirements of this criterion.

E) Unnecessary Duplication/Maldistribution − Review Criteria

1) The applicant shall document that the project will not result in 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) for the project site provides the categories of bed service 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 before submission of the application) for existing facilities and services that are 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) below the occupancy standards.

There are no LTAC beds in this 17-mile geographic service area. The estimated population of this 17-mile geographical service area is 226,588. The ratio of LTAC beds per 1,000 population in this geographical service area is zero. The estimated population in the State of Illinois is 12,778,100 residents. There are 596 LTAC beds in the State of Illinois. The ratio of LTAC beds per 1,000 population in the State of Illinois .042. per thousand. Based on this comparison, there is no service maldistribution (surplus) in this 17-mile geographic service area.

F) Staffing Availability − Review Criterion

The applicant shall document that relevant clinical and professional staffing needs for the proposed project are considered, and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant should document that the necessary staffing is available by providing letters of interest from

prospective staff members, completed employment applications, or a narrative explanation of how the proposed staffing will be achieved.

According to the Applicants, the daily operations of the planned Sycamore Specialty Hospital will be led by a cohesive executive and clinical leadership team. A chief executive officer will oversee the entire hospital, and a Director of Nursing will supervise the LTAC program and report to the chief executive officer. Physician coverage will include on-site and on-call physicians 24/7. Because many LTAC patients are transferred from general acute care hospital ICUs, the LTAC unit will mirror a "downgraded ICU" with intensive or internal medicine physicians rounding daily and available for acute issues, high nurse-to-patient ratios, and respiratory therapists on duty each shift. A multidisciplinary team with daily huddles will manage each LTAC patient's care, addressing progress and any issues as they arise. These huddles are integral to preventing complications given the long stays. There will be a strong emphasis on discharge planning from day one for the LTAC unit. Case managers will coordinate with families and post-discharge providers to ensure smooth transitions, whether to home, outpatient therapy, or a skilled nursing facility. Collaboration between the LTAC and IRF will allow intra-hospital transfers when appropriate. For example, an LTAC patient who recovers medically and has rehabilitation needs will be evaluated by the rehab team and transferred to the IRF unit, shortening wait times and avoiding external transfer.

According to the Applicants, the typical staffing pattern on the LTAC unit is a nurse-to-patient ratio of about 1:4 or 1:5. LTAC nursing emphasizes critical care competencies, such as ventilator management and complex wound care. The Applicants state that nursing staffing will meet or exceed minimum standards and adhere to best practices. All clinical staff will participate in ongoing professional development and quality-improvement programs to maintain excellence in care delivery. (See Page 74 of the Application for Permit)

TABLE NINE
Proposed Staffing

Role	Coverage	Description
Hospitalist	7/days/week	Daily Rounding
Respiratory Therapist	24/7	Ventilator Management
Critical Care RN	1:4 ratio	Complex Medication Management

TABLE NINE Proposed Staffing		
LPNs/CAN	Based on the Census	Supportive Care/mobility/ADLs
Wound Care Nurse	5 days/Week	Specialized Debridement NPWT
Pharmacist	On-site & On-Call	IV/PO therapy management
Case Manager/Social Worker	1 per 15 patients	Discharge Planning
Infection Control RN	.5-1.0 FTE	Compliance Settlement
LTAC Medical Director	.5-1.0 FTE	Strategy, peer review, utilization

The Applicants state that the proposed Sycamore Specialty Hospital plans to recruit experienced LTAC staff through various incentives and to partner with local nursing schools. It will offer loan forgiveness programs for hard-to-fill roles, such as respiratory therapists. The Applicants state that, to provide greater staffing flexibility to address census fluctuations and reduce the risk of understaffing, certain nurses will be cross-trained for both the L TAC and IRF units, and respiratory therapists will be able to support both units. LTAC and IRF patients. Finally, digital onboarding and AI-enabled charting tools will reduce training friction and documentation time.

G) Performance Requirements

1) Bed Capacity Minimum

An applicant shall document that the project will result in a facility capacity of at least 50 LTACH beds located in an MSA and 25 LTACH beds in a non-MSA.

2) Length of Stay

A) An applicant proposing to add beds to an existing service shall document that the average length of stay (ALOS) for the subject service is consistent with the planning area's 3-year ALOS.

B) Documentation shall consist of the 3-year ALOS for all hospitals within the planning area (as reported in the Annual Hospital Questionnaire).

C) An applicant whose existing services have an ALOS exceeding 125% of the ALOS for area providers shall document that the severity or type of illness treated at the applicant facility is significantly higher than the planning area average. CMMS or other objective records shall provide documentation.

D) An applicant whose existing services have an ALOS lower than the planning area ALOS shall submit an explanation as to the reasons for the divergence.

3) Be certified by Medicare as a Long-Term Acute Care Hospital within 12 months after the date of project completion.

Sycamore, Illinois, is in the Chicago-Naperville-Elgin, IL-IN-WI Metropolitan Statistical Area (MSA). As the county seat of DeKalb County, Sycamore is part of this larger metropolitan area, which also includes the cities of Chicago, Naperville, and Elgin. The Applicants are proposing 40 LTAC Beds, not 50, as required by this criterion. The discontinued Kindred Hospital in Sycamore had a 5-year average length of stay of 27.2 days. The Applicants state that they will be Medicare-certified within 12 months of project completion.

I) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, within 30 months 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 occupancy standard for both LTAC and IRF beds is 85%. The Applicants have attested that the proposed LTAC unit will be at the 85% utilization within 30 months of operation.

IX. Comprehensive Physical Rehabilitation Service

REQUIRED REVIEW CRITERIA		
77 Adm. Code 1110.205	(b)(1)	Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
77 Adm. Code 1110.205	(b)(2)	Planning Area Need – Service to Planning Area Residents
77 Adm. Code 1110.205	(b)(3)	Planning Area Need – Service Demand − Establishment of CPR
77 Adm. Code 1110.205	(b)(5)	Planning Area Need − Service Accessibility
77 Adm. Code 1110.205	(c)(1)	Unnecessary Duplication of Services
77 Adm. Code 1110.205	(c)(2)	Maldistribution
77 Adm. Code 1110.205	(c)(3)	Impact of Project on Other Area Providers
77 Adm. Code 1110.205	(e)(1)	Staffing Availability
77 Adm. Code 1110.205	(f)	Performance Requirements
77 Adm. Code 1110.205	(g)	Assurances

A) Planning Area Need − Review Criteria

The applicant shall document that the number of IRF beds to be established or added is necessary to serve the planning area's population.

There is neither a calculated need nor an excess of inpatient physical rehabilitation beds in the HSA I Comprehensive Physical Rehabilitation Planning Area. Based on the review of the State Board's calculated need for IRF beds, the Planning Area bed capacity remains in equilibrium with patient demand. The State Board's analysis indicates an optimal occupancy rate, with no immediate need to increase the number of licensed beds.

B) 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 come from area residents.

The Applicants provided 13 physician referral letters totaling 1,383 referrals. Of the 1,383 referrals, 36 (2.6%) were to an LTAC hospital (Prime Holy Family Medical Center). There are 16 zip codes within the 17-mile GSA. Of the 1,383 referrals, Board Staff identified 50 referrals that came from these 26 zip codes (See Table Seven above). 50% of the residents are not from the area as required by this criterion.

The Applicants state that the purpose of the Project is to restore and repurpose the former Kindred Hospital in Sycamore to address all service gaps in the Community. The planned Sycamore Specialty Hospital will be a dual-service hospital offering both 40 LTAC beds and 12 IRF beds. The planned hospital anticipates 407 inpatient rehabilitation admissions annually. Assuming an average length of stay of 14 days, total inpatient days would be 5,698 (at an average daily census of 15.6), which is sufficient to justify the 12 IRF beds.

C) Service Demand – Establishment of Inpatient Rehabilitation Service

The number of beds proposed to establish a new category of hospital bed service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the last 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 state the planned Sycamore Specialty Hospital will provide intensive rehabilitation, typically two to three weeks of inpatient therapy, to patients recovering from serious injuries, strokes, surgeries, or debilitating illnesses, patients who can benefit from at least three hours of therapy in a hospital-like setting. The Applicants state it will benefit hospitals like West Suburban Medical Center, which is a primary stroke center but lacks an inpatient rehabilitation unit to provide long-term intensive rehab until patients are medically stable.

There is an additional inpatient physical rehabilitation hospital in the HSA I Comprehensive Physical Rehabilitation Planning Area – Van-Matre Encompass Rehabilitation Institute with 65 beds in Rockford, Illinois.

TABLE TEN Van-Matre Encompass Rehabilitation Institute					
Year	**2020**	**2021**	**2022**	**2023**	**2024**
Beds	65	65	65	65	65
Admit	1,467	1,508	1,545	1,567	1,692
Days	19,522	19,828	20,097	20,158	19,963
ALOS	13.3	13.1	13	12.9	11.8
ADC	53.3	54.3	55.1	55.2	54.7
Utilization	82.10%	83.60%	84.70%	85.00%	84.15%

As noted, 50 referrals (3.6%) of the projected referrals come from the 17-mile GSA. The State Board's bed needs analysis notes that there is no need for comprehensive physical rehabilitation beds in the HSA I Comprehensive Physical Rehabilitation Planning Area. Based on the accepted and reviewed data, there does not appear to be sufficient demand for these 12 comprehensive physical rehabilitation beds.

D) Service Accessibility

The number of beds being established or added in each service category is necessary to improve access for residents in the planning area. 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) meets or exceeds the utilization standard specified in 77 Ill. Adm. Code 1100.

There is no absence of IRF services in the HSA I IRF Planning Area. There is one IRF hospital in the HSA I Comprehensive Physical Rehabilitation Planning Area: Van-Matre

Encompass Rehabilitation Institute, which has 65 IRF beds. The State Board Staff has found no evidence of restrictive admission policies or access limitations by existing providers based on patients' payor status within the planning area. Board Staff does not believe access will improve when only 3.6% of the referrals or demand came from this 17-mile radius.

E) Unnecessary Duplication/Maldistribution − Review Criteria

1) The applicant shall document that the project will not result in 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) for the project site provides the categories of bed service 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 before submission of the application) for existing facilities and services that are 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) below the occupancy standards.

There are no IRF beds in this 17-mile radius. The estimated population of this 17-mile geographical service area is 226,588. The ratio of rehabilitation beds per 1,000 population in this geographical service area is zero. The estimated population in the State of Illinois is 12,778,100 residents. There are 1,678 inpatient physical rehabilitation beds in the State of Illinois. The ratio of these beds per 1,000 population in the State of Illinois is 0.1313.

Based on this comparison, there is no maldistribution of services in this inpatient physical rehabilitation geographical service area, as there is no calculated need or excess IRF beds.

F) Staffing Availability − Review Criterion

The applicant shall document that relevant clinical and professional staffing needs for the proposed project are considered, and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant should document that the necessary staffing is available by providing letters of interest from prospective staff members, completed employment applications, or a narrative explanation of how the proposed staffing will be achieved.

The Applicants stated that a cohesive administrative and clinical leadership team will lead the daily operations of the planned Sycamore Specialty Hospital. A chief executive officer will oversee the entire hospital, with the Director of Nursing and the Rehabilitation Program Director supervising the IRF program, reporting to the chief executive officer. Physician coverage will include on-site and on-call physicians 24/7.

Rehabilitation physicians (physiatrists) will lead care at the IRF unit, conducting frequent rounds and weekly team conferences with the physiatrist, therapists, nurses, and case management. Case managers will set functional goals and plan discharge. There will be a strong emphasis on discharge planning from day one for IRF units. Case managers will coordinate with families and post-discharge providers to ensure smooth transitions, whether to home, outpatient therapy, or a skilled nursing facility. Co-location of the LTAC and IRF will allow intra-facility transfers when appropriate, e.g., an LTAC patient who recovers sufficiently may be evaluated by the return team and transferred to the IRF unit. This shortens waiting times and avoids external transfer.

The typical staffing ratio will be 1:5 or 1:6 for nurses to patients on the IRF unit, where patients are more stable but still require considerable care. Nurse staff will meet or exceed Illinois minimum standards and follow best practices, e.g., nurse coverage in the IRF unit will be 24/7, with nurses trained in rehab techniques and pain management. All clinical staff will undergo ongoing professional development and quality improvement programs to maintain excellence in care delivery.

TABLE ELEVEN

Role	Description	Coverage
Rehabilitation Physician	oversees each IRF patient's POC	3visits/week/patient
PT/OT/ST Therapists	direct functional improvement	≥15 hours/week/patient
Rehab Nurse - CRRN preferred	delivers outcome-driven rehab	24/7 coverage
Neurologist/Psychologist	TBI, stroke, cognitive evals	As Needed
IRF Program Coordinator	QA, IRF-PAI oversight, transitions.	Realized
FIM/Data Specialist	Outcomes Scoring for CMS	IRF-PAI Compliance

1. IRF – Inpatient Rehabilitation Facility
2. POC – plan of care
3. TBI – traumatic brain injury
4. FIM – Functional Independence Measure
5. PAI – Personal Activity Intelligence

Sycamore Specialty Hospital plans to recruit experienced IRF staff through various incentives and to partner with local nursing schools. It will offer loan forgiveness for hard-to-fill roles, such as respiratory therapists. To provide greater staffing flexibility to address census fluctuations and reduce the risk of understaffing, certain nurses will be cross-trained for both the LTAC and IRF units, and respiratory therapists will support patients in both units. Finally, digital onboarding and adapted charting tools will require training, introduce friction, and increase documentation time.

Based on the staffing narrative provided by the Applicant, the project appears to indicate that the Applicant has a sufficient understanding of the needs of the 12-bed IRF unit and the requirements of both Medicare and IDPH. The Applicant has successfully addressed this criterion.

G) Performance Requirements

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

The Applicants are proposing 12 inpatient physical rehabilitation beds for this hospital unit. The Applicants have not met the minimum unit size required by this criterion.

H) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, within 2 years 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 have provided the required assurance that, within 2 years of operation following project completion, they will achieve and maintain an occupancy rate of 85% for inpatient physical rehabilitation beds. (See page 68 of the Application for Permit)

X. Clinical Service Areas Other than Categories of Service

77 Adm. Code 1110.270 - Need Determination

1. Emergency Services and/or Trauma

The Applicants state that the planned Sycamore Specialty Hospital will initially provide standby emergency treatment services.[3] The Applicants state the hospital will not have emergency stations but will have a designated area for the evaluation and treatment of patients presenting to the hospital who require immediate first aid and emergency care. A registered nurse will always be on duty in the hospital and available for emergency services, and a licensed physician will always be on call. If a patient presents to the hospital requiring immediate cardiac surgery or complex ICU care beyond the scope of an LTAC hospital, Sycamore Specialty Hospital will have transfer agreements in place to rapidly transfer patients to short-term acute care hospitals as needed.

2. Diagnostic and Interventional Radiology

The Applicants state imaging is one of the services associated with the planned Sycamore Specialty Hospital for which the HFSRB has established utilization standards in 77 Ill. Admin Code 1100. The Applicants have met the utilization standard for diagnostic and interventional radiology.

[3] Under the Ill. Adm.77.250.710 An Illinois Standby Emergency Department is a hospital facility licensed to provide initial medical stabilization, basic triage, and emergency services where a registered nurse is on duty 24/7, but a licensed physician is "on call" rather than physically present in the department at all times

TABLE TWELVE Diagnostic Requirements				
Equipment	# of Units	Projected Utilization	State Standard per unit	Justified?
X-Ray	2	1,021 procedures	8,000 procedures	Met
Fluoroscopy	1	511 procedures	6,500 procedures	Met
CT Scanner	1	511 visits	7,000 visits	Met
Ultrasound	1	1,021 visits	3,100 visits	Met

3. Laboratory

The Applicants state that the planned Sycamore Specialty Hospital will include a laboratory. The laboratory volume will be based on 20-40 tests per LTAC admission and 10-20 tests per IRF admission, for a total of 12,660-25,320 lab tests annually (LTAC: 10,000–20,000; IRF: 2,660-5,320). There is no State Standard for laboratory services.

4. Pharmacy

The planned Sycamore Specialty Hospital will include a pharmacy. The pharmacy prescriptions will be based on 15 prescriptions per LTAC admission and 10 prescriptions per IRF admission, or a total of 10,160 prescriptions annually (LTAC - 7,500 prescriptions, IRF 2,600 prescriptions). There is no State Standard for pharmacy services.

5. Occupational Therapy/Physical Therapy

a. Service to Planning Area Residents

There are no rehabilitation beds within the 17-mile geographic service area. According to the Applicants, the planned Sycamore Specialty Hospital will fill the gap in inpatient rehabilitation services in Sycamore and the surrounding communities left by Kindred Hospital Sycamore's closure. The IRF unit will consist of 12 beds, focusing on patients recovering from stroke, traumatic brain injuries, spinal cord injuries, major orthopedic surgeries, amputations, and other conditions requiring intensive rehabilitation. Each IRF

patient will receive at least 3 hours of physical therapy per day, 5 days a week, in physical, occupational, and/or speech therapy modalities, consistent with federal IRF standards.

b. Service Demand
c. Impact of the Proposed Project on Other Area Providers
d. Utilization

The Applicants state the primary purpose of the Project is to restore and repurpose the former Kindred Hospital Sycamore to fill critical service gaps in the community. The planned Sycamore Specialty Hospital will be a dual-service hospital offering both LTAC and inpatient IRF services. The planned hospital anticipates 266 IRF admissions annually. Assuming an average length of stay of 14 days, annual inpatient days would be 3,724 (or an average daily census of 10.2 days), which is sufficient to justify the 12 IRF beds.

Should the State Board approve this project, the Applicants have met the requirements of clinical services other than the categories of service.

XI. Financial Viability and Economic Feasibility

Criterion 1120.110 – Availability of Funds
Criterion 1120.120 – Financial Viability
Criterion 1120.140 (a) – Reasonableness of Financing Arrangements
Criterion 1120.140 (b) – Conditions of Debt Service
Criterion 1120.140 (c) – Reasonableness of Project Costs
Criterion 1120.140 (d) – Projected Operating Costs
Criterion 1120.140 (e) – Effect of the Project on Capital Costs

A) 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.

The Applicants are proposing a 52-bed LTAC Hospital. The total cost of the project is estimated at $11,013,863. Accelerated Medical Facilities, LLC acquired the building from Vencor for $313,863.05. The cost of the modernization is estimated at $10,700,000.

The Applicants provided letters from banks indicating that three members of Sycamore Specialty Hospital, LLC (Rani, Singh, and Singh) had funds available totaling up to $4 million each to fund the modernization project. These three members individually have a 5% ownership interest in this LLC. Dr. Nasir, the Managing Member, provided a letter attesting that no debt will be used to fund this modernization. The Applicants capitalized the proposed hospital with $16,700,000 in cash.

The $16.7 million total capitalization, with $10,700,000 million dedicated to modernization of a 52-bed Long-Term Acute Care (LTAC) hospital, appears to carry risk, the staff believes. While the modernization budget may be sufficient for renovations depending on the facility's existing condition, the remaining $6 million in working capital ($16.7M - $10.7M), the Staff believes will likely be insufficient to cover the ramp-up phase typical for LTACs, which often operate in the red for the first 12–18 months.

Concerns: Operating a combined LTAC and IRF facility introduces compliance requirements that will impact the Applicants' capital.

- You cannot bill Medicare for LTAC or IRF rates on Day 1. You must admit and treat a baseline number of patients to demonstrate compliance (e.g., maintaining an average 25-day stay in an LTAC and meeting the "60% Rule" in an IRF, where 60% of patients must have specific rehabilitation diagnoses). You must pay for their care entirely out-of-pocket during this survey window.
- If your 12 IRF beds admit too many general stroke or cardiac patients who do not fit the strict 13 qualifying medical conditions, Medicare will reclassify those beds and pay you at standard acute care rates, destroying your revenue model.
- If your LTAC average length of stay drops to 24 days, your reimbursement rates plummet retrospectively. Your case management team must actively manage the patient census to prevent massive financial penalties.
- LTAC requires high-acuity ICU nurses and respiratory therapists. IRF requires rehabilitation nurses and intensive physical/occupational therapy staff. You cannot easily cross-utilize these teams, creating two independent, expensive labor pools.

(Sources: prior State Board projects and the Illinois Department of Public Health)

B) Financial Viability

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 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.

The Applicants provided pro forma financial information for the first three years of project operations. Based on the pro forma financial information provided by the Applicants, they have met all financial ratios required by the State Board.

Ratios	State Standard	Projected Year 1	Projected Year 2	Projected Year 3
Current Ratio	**≥1.5**	7.6	7.6	9.1
Net Margin %	**≥3.5%**	16.50%	21.20%	33.90%
Long-term Debt to Capitalization	**50%**	NA	NA	Na
Projected Debt Service Coverage	**≥1.5**	NA	NA	NA
Days-Cash-on-Hand	**≥45 Days**	271.3	262.8	302.9
Cushion Ratio	**≥3.0**	NA	NA	NA

XII. Economic Feasibility

A) Reasonableness of Financing Arrangements
B) Conditions of Debt Financing

The Applicants are financing this modernization with cash. The Applicants have met the requirements of this criterion.

C) Reasonableness of Project and Related Costs − Review Criterion

The applicant must demonstrate that the estimated project costs are reasonable and must also document compliance with the following:

Modernization Costs total $3,045,000, or $78.27 per GSF. This appears reasonable when compared to the State Board Standard of $417.19

Contingency Costs are $455,000 and are 14.94%. This appears reasonable when compared to the State Board Standard of 15%.

Architectural and Engineering Fees are $200,000, representing 5.71% of modernization and contingency costs. This appears reasonable when compared to the State Board Standard of 7.02%.

Movable Equipment Costs are $6,252,800. The State Board does not have a standard for these costs.

Acquisition of Building or Other Property is $220,455. The State Board does not have a standard for this cost.

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, and for no more than two years following project completion. Direct costs mean the fully allocated costs of salaries, benefits, and supplies for the service.

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 are projecting $728.64 in operating expenses per patient-day in the first year after project completion, $662.53 in the second year after project completion, and $46.09 in capital costs per patient-day for the first full fiscal year at target utilization. The State Board does not have a standard for these costs.

Safety Net Impact Statement

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

As noted throughout this application, there is no LTAC or IRF hospital within the B-04 Health Planning Area or the 17-mile geographic service area. The planned Sycamore Specialty Hospital will fill the gap in access to LTAC and I RF services that result from the closure of Kindred Hospital Sycamore.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

The Project will not affect the ability of other providers or health care facilities to cross-subsidize safety-net services. As noted above, the planned Sycamore Specialty Hospital will address the gap in access to LT AC and IRF services resulting from the closure of Kindred Hospital Sycamore.

3. Has the discontinuation of a facility or service might impact on the remaining safety net providers in each community, if reasonably known by the applicant.

The Project is for the establishment of a hospital location, not for the discontinuation of a facility or service. Accordingly, this criterion is not applicable.

4. Safety Net Information

The planned Sycamore Specialty Hospital will be **a** new health care facility and has no historical Medicaid or charity care to report. The projected payor mix of the planned hospital is:

	LTAC	IRF
Medicare	70%	60%
Medicaid	10%	14%
Commercial	10%	13%
Other	10%	13%

PROPOSED REFERRALS

Physicians	Total Referrals	Advocate Condell Medical Center	Advocate Lutheran General	Advocate Illinois Masonic	Alexian Brothers Medical Center	UC Medicine AdventHealth Bolingbrook	UC Medicine AdventHealth Glen Oaks	Community First Medical Center
Dr. Prasad	215							
Dr Ahmed	13							
Dr Singh	70							
Dr Mohiuddin	21		6					
Dr. Tahir	77					77		
Dr. Falouji	21		21					
Dr. Zeater	122							
Dr Rubin	72					72		
Dr Ahluwalia	-509		**-33**	**-11**	**-65**			**-115**
Dr Ahmed	92						92	
Tracy CEO	25							
Dr. Chuang	108	63	18					
Dr. Mohan	38							
Total	980	**63**	**12**	**-11**	**-65**	**149**	**92**	**-115**
	Miles	**61.3**	**55.2**	**63.8**	**45**	**50.7**	**34.6**	**58**

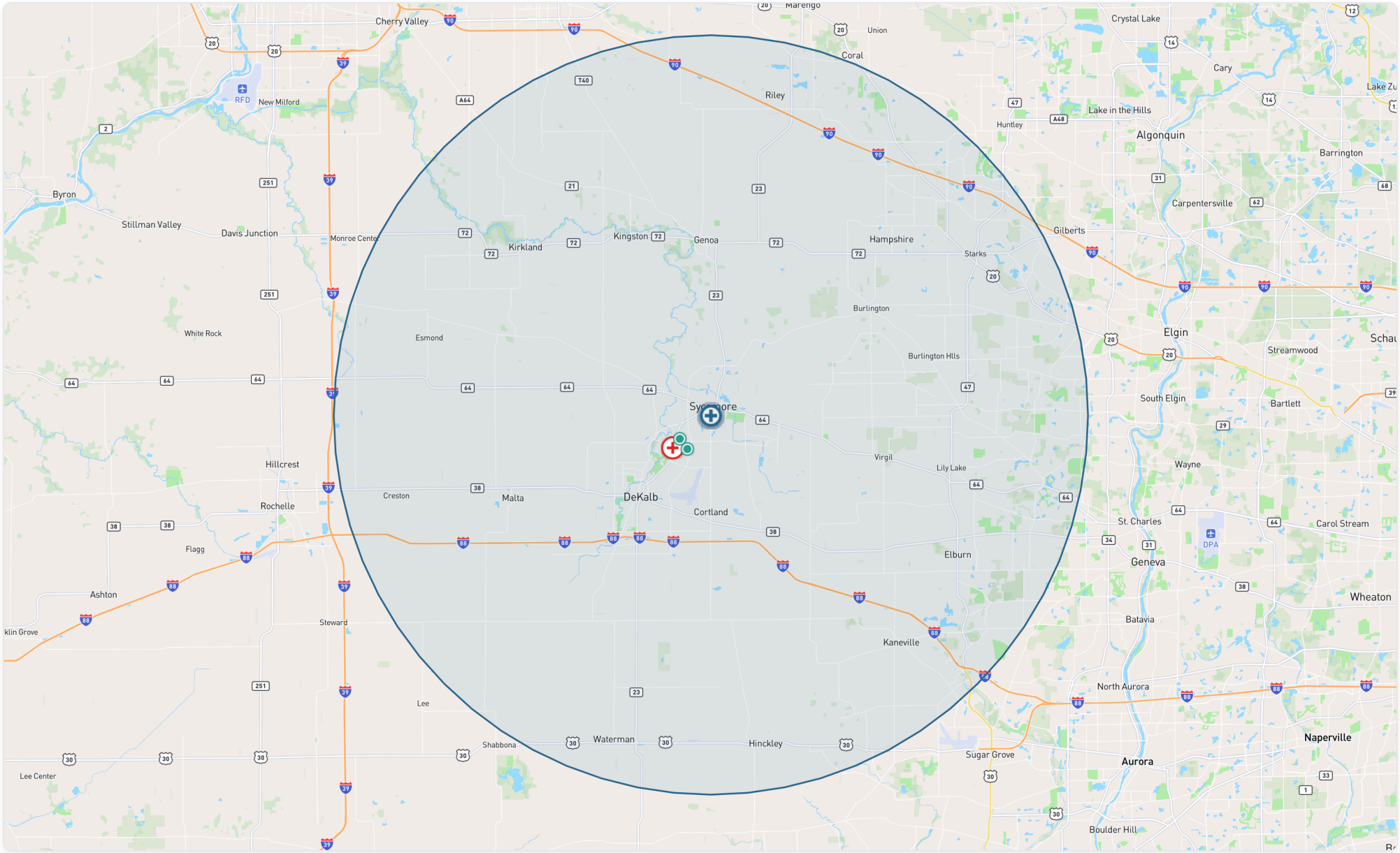
PROPOSED REFERRALS

Physicians	Total Referrals	Encompass	Endeavor Northwest Community Hospital	Gottlieb Memorial Hospital	Mount Sinai Hospital	Prime Holy Family Medical Center	Resurrection Medical Center	Rochelle Community Hospital	West Suburban Hospital	UW Heath SwedishAmerican Hospital
Dr. Prasad	215								215	
Dr Ahmed	13									13
Dr Singh	70									70
Dr Mohiuddin	21				15					
Dr. Tahir	77									
Dr. Falouji	21									
Dr. Zeater	122									122
Dr Rubin	72									
Dr Ahluwalia	-509		**-89**	**-26**		**-36**	**-9**		**-125**	
Dr Ahmed	92									
Tracy CEO	25							25		
Dr. Chuang	108	27								
Dr. Mohan	38									38
Total	980	**27**	**-89**	**-26**	**15**	**-36**	**-9**	**25**	**90**	**243**
	Miles	**30.8**	**45.3**	**57.7**	**63.3**	**49.5**	**54.5**	**25.6**	**59.8**	**39.8**

Radius Analysis Report

Geographic inventory of licensed hospital facilities within statutory radius

CENTER POINT	COUNTY	CLASSIFICATION	STATUTORY RADIUS	HSA	HPA
41.9829°N, 88.6887°W	Dekalb	Mid-size County (17-mile radius)	17 miles	1 - Rockford	B-04



Data sourced from 2024 Annual Hospital Survey. For planning purposes only.

Health Planning Area (HPA) B-04

Lee County East + DeKalb

Bed Category	Authorized	Need	Gap	% of Need
Med-Surg/Pediatric	107	107	0	100.0%
Obstetrics	11	12	(1)	91.7%
Intensive Care Unit	20	14	+6	142.9%
TOTAL	138	133	+5	103.8%

Health Service Area (HSA) 1

Rockford

Bed Category	Authorized	Need	Gap	% of Need
Rehabilitation	65	65	0	100.0%
Acute Mental Illness	66	73	(7)	90.4%
TOTAL	131	138	(7)	94.9%

Methodology Notes

→ **Statutory Radius:** Per 77 Ill. Adm. Code 1100, radius is determined by county classification: 10 miles (Metro - Cook, DuPage, Kane, Lake, Will), 17 miles (Mid-size counties), 21 miles (Rural counties).

→ **Gap Analysis:** Positive values (+) indicate surplus; parentheses indicate shortage. Need calculated per State Health Plan formulas.

→ **Data Source:** 2024 Annual Hospital Survey responses submitted to HFSRB.

7,222	1	2	4,158	3,064
TOTAL SURGICAL CASES	HOSPITALS	ASTCS	HOSPITAL CASES	ASTC CASES

Volume by Surgical Specialty

Within 17-mile radius of Dekalb County

Surgical Specialty	Hospitals	ASTCs	Total Cases
OPHTHALMOLOGY	0	2,051	**2,051**
General	1,314	0	**1,314**
Orthopedic	983	0	**983**
Urology	897	0	**897**
ORTHOPEDIC	0	749	**749**
OB/GYN	387	1	**388**
Podiatry	358	0	**358**
Otolaryngology	195	0	**195**

Top Facilities by Volume

Ranked by total surgical cases (2024)

#	Facility	Type	Cases
1	Kishwaukee Community Hospital - DBA Northwester...	Hosp	**4,158**
2	Dekalb Surgical Services, LLC - DBA Hauser Ross Am...	ASTC	**2,051**
3	The Midland Surgical Center, LLC - DBA Northwester...	ASTC	**1,013**

Data Notes

Hospital Cases: Combined inpatient and outpatient surgical cases from 2024 Hospital Annual Survey.
ASTC Cases: Class C operating room cases (general/regional anesthesia) from 2024 ASTC Annual Survey.
Specialties: 14 standard surgical specialty categories tracked by HFSRB for both facility types.

Facilities Within 17-Mile Radius of Dekalb County (1 Hospitals, 2 ASTCs)

#	Type	Facility Name	City	Dist	M-S	ICU	OB	PED	NICU	AMI	REH	Total
1	ASTC	The Midland Surgical Center, LLC - DBA Northwestern Medicine Surgery Center Sycamore	Sycamore	1.7	—	—	—	—	—	—	—	—
2	ASTC	Dekalb Surgical Services, LLC - DBA Hauser Ross Ambulatory Surgical Center	Sycamore	1.8	—	—	—	—	—	—	—	—
3	Hosp	Kishwaukee Community Hospital - DBA Northwestern Medicine Kishwaukee Hospital	DeKalb	2.3	80	12	11	—	—	—	—	103
			TOTAL (1 Hosp, 2 ASTC)		80	12	11	—	—	—	—	103

Beds shown are authorized beds per 2024 HFSRB Annual Hospital Survey.

City of Sycamore
ILLINOIS

OFFICE OF THE MAYOR
308 W State St
Sycamore, IL 60178
(815) 895-4515
FAX (815) 899-2054

Steve Braser
Mayor

January 21, 2026

RECEIVED
FEB 19 2026
HEALTH FACILITIES &

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Savage:

I am writing this letter in support of the application submitted on behalf of Sycamore Specialty Hospital for approval to establish a long-term acute care hospital (LTACH) and inpatient rehabilitation facility to serve Sycamore and the surrounding region.

This project represents an important advancement in meeting the healthcare needs of our community and northern Illinois as a whole. Long-term acute care hospitals play a critical role in treating medically complex patients who require extended hospital-level care, and there is currently no LTACH facility located in or near the City of Sycamore. As a result, patients and families are often required to travel significant distances to receive appropriate care, placing additional strain on individuals during already challenging circumstances.

I am confident that the establishment of Sycamore Specialty Hospital will significantly improve access to essential post-acute services while strengthening coordination with area hospitals, physicians, and healthcare providers. The ability to deliver this level of care locally will allow patients to remain closer to home and family while supporting better continuity of care across the healthcare system.

In addition to its clinical importance, this project will generate meaningful economic benefits for the City of Sycamore and the surrounding region. The development and operation of the hospital will result in the creation of numerous permanent jobs, including clinical, administrative, and

support positions. These employment opportunities will contribute to workforce development and provide stable, skilled jobs for local residents.

I am also encouraged by the long-term investment this project represents in our community. Facilities of this nature support local businesses, vendors, and service providers, and align with the City's goals of responsible economic growth and improved access to essential services.

For these reasons, I support the effort to establish Sycamore Specialty Hospital in our community and am pleased to endorse this application. I believe this project will deliver lasting healthcare and economic benefits to the City of Sycamore and the broader region it will serve.

Sincerely,

Steve Braser

Steve Braser
Mayor, City of Sycamore

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Savage,

I am writing to express my strong support for the reopening of long-term acute care services at the former Kindred Sycamore facility, proposed to operate as Sycamore Specialty Hospital. I worked at Kindred Sycamore from 2008 through 2025, where I spent many years caring for patients who required extended medical treatment and recovery. Based on my firsthand experience at this facility, there is a clear and ongoing need for this level of care in the community.

During my time at the hospital, I treated patients who were often coming from prolonged and complex hospitalizations. Many arrived medically fragile and uncertain about their recovery. The care provided focused not only on managing serious medical conditions, but also on helping patients regain stability, function, and independence. I worked closely with nursing staff, therapists, and case managers to support patients through long recoveries and help prepare them for life beyond the hospital.

One patient's recovery journey was later shared publicly through a local news story. The news feature can be viewed here:
https://www.wifr.com/video/2021/02/21/rockford-woman-returns-home-after-battle-with-covid/. I was directly involved in caring for patients like this and witnessed how specialized long-term acute care played a critical role in helping individuals recover from severe illness and return home. Stories like this reflected the everyday work being done within the hospital and the meaningful impact it had on patients and families.

Families frequently expressed appreciation for the continuity of care and the individualized attention their loved ones received. Many shared that they felt reassured knowing their family member was in a setting focused on recovery rather than short-term treatment alone. One patient's husband even documented their journey in a book titled *Tragedy or Blessing? A Life-Altering True COVID Story*. From my perspective as a physician, this hospital served as an essential bridge between acute hospitalization and a patient's return to daily life.

My involvement at this facility spanned an extended period, and I was actively engaged in the care of patients with complex medical needs throughout that time. Based on my experience, access to long-term acute care services remains essential for the health and well-being of the community.

For these reasons, I strongly support Sycamore Specialty Hospital and the continued provision of long-term acute care services.

Thank you for your time and consideration.

Sincerely,

RECEIVED
FEB 19 2026
HEALTH FACILITIES

Dr. Mutazz H. Darweesh, MD

Mutazz H Darweesh (Feb 10, 2026 13:33:25 CST)

Mercyhealth
A passion for making lives better.

Corporate Office
3401 N. Perryville Rd., Ste. 303
Rockford, IL 61114

Office of the President

02/17/2026

Ms. Debra Savage
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

RE: Letter of Support for Sycamore Specialty Hospital

Dear Chairwoman Savage:

Mercyhealth is writing in regard to the planned reopening of the 52-bed hospital consisting of 40 long term acute care beds and 12 inpatient rehabilitation beds hospital to be operated as Sycamore Specialty Select Hospital in Sycamore, Illinois.

As a regional health system, Mercyhealth provides care to patients with a wide range of medical and surgical needs. In certain circumstances, patients who no longer require tertiary or trauma level services continue to need extended hospital level care. Access to long term acute care services is an important component of the overall continuum of care for these patients.

The availability of a long-term acute care hospital in Sycamore would provide an additional option within the region for clinically appropriate patients requiring extended acute level services. Access to these services locally may support continuity of care and allow patients and families to remain closer to their home communities when appropriate.

Mercyhealth supports efforts that enhance access to appropriate levels of care and contribute to a strong regional healthcare delivery system.

Sincerely,

Javon R. Bea
President and CEO

Exhibit 1
Anticipated Case Volumes by Patient Zip Code of Residence
Javon Bea Hospital – Riverside → Sycamore Specialty Hospital
January 1, 2025 – December 31, 2025

Patient Zip Code	Anticipated Cases
61111	12
61115	10
61103	8
61101	7
61073	6
61114	6
61107	5
61008	5
61108	4
61072	4
All other ZIP Codes	39
TOTAL:	106

The total patient volume referenced above is based on historical inpatient discharge data for Javon Bea Hospital – Riverside. Patient ZIP code distributions shown in Exhibit 1 were derived by applying historical inpatient patient origin patterns for the relevant service area to the projected referral volume, for healthcare planning purposes.

5601 South County Line Road
Hinsdale, Illinois 60521

3435 West Van Buren Street
Chicago, Illinois 60624

630-286-4000
rmlspecialtyhospital.org

May 13, 2026

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

SENT VIA ELECTRONIC MAIL TO Mike.Constantino@illinois.gov

RE: Written Comment – Sycamore Specialty Hospital
Certificate of Need Application for Permit – Project Number 26-009

Dear Chairwoman Savage:

I am the President and Chief Executive Officer of RML Specialty Hospital ("**RML**"), a long-term acute care hospital ("**LTACH**") with two campuses in the Chicago metropolitan area (one near the *Illinois Medical District* on the west side of Chicago, "**RML Chicago**," and one in suburban Hinsdale, "**RML Hinsdale**"). RML is a not-for-profit limited partnership and leader in the LTACH industry (both locally and nationally). RML Chicago is a *Medicaid High Volume Provider*, with nearly 60% of its patients being Medicaid beneficiaries. I submit this written comment for your consideration with respect to the Certificate of Need ("**CON**") application for permit filed with the Illinois Health Facilities and Services Review Board (the "**Board**") by Sycamore Specialty Hospital, LLC and Accelerated Medical Facilities, LLC (together, the "**Applicants**") for Project Number 26-009 (the "**Application**"). As you are aware, the Applicants submitted a proposal to recommission the former Kindred Hospital Sycamore LTACH ("**Kindred Sycamore**") as a new 52-bed hospital with 40 long-term acute care ("**LTAC**") and 12 inpatient rehabilitation ("**IR**") beds at a cost of $10.7 million (plus another $0.9 million in start-up costs).

RML OPPOSES APPROVAL OF LTAC COMPONENT OF APPLICATION

While I agree with the Applicants' assertion (repeated throughout the Application) that LTACHs provide a valuable health care service to the community (including easing *Intensive Care Unit* capacity constraints at nearby short-term acute care hospitals), that the care provided by LTACHs to patients with complex medical needs is superior to that provided by most skilled nursing facilities, and that having an LTACH geographically closer to one's residence is preferable (all else being equal) to having one farther away, the Application includes no substantive evidence that a need exists for the 40 proposed LTAC beds in the planned geographic service area. Conversely, the lack of such need is evidenced by ScionHealth's decision

to close Kindred Sycamore in early 2025 (noting that such decision was just recently approved by the Board at its March 2025 meeting, and that there have been no substantive changes in the Chicago area LTAC market since then). If approved, a large unnecessary investment in duplicative LTAC services would occur (counter to the express intent behind enactment of the State's CON program) and there would be a negative impact on other (already financially challenged) existing area LTACHs. For this reason, RML opposes approval of the LTAC component of the Application.

SIGNIFICANT EXCESS LTAC BED CAPACITY ALREADY EXISTS

The core purpose of the State's CON program is to encourage health care providers to engage in cost containment, better management, and improved planning. To be issued a permit by the Board for proposed construction projects, as well as major medical equipment acquisitions, an applicant must justify that its proposed project is needed. The Applicants have not justified such need in the Application with respect to the LTAC component of their proposed project. Instead, they merely *suggest* (based on there being no LTAC beds available in the 17-mile-radius geographic service area of their proposed new hospital) there is significant unmet need for the recommissioning of Kindred Sycamore as a new LTACH. Contrary to the Applicants' assertion, there is a significant overcapacity of LTAC beds in the Chicago metropolitan area today and little to no chance of the current supply/demand imbalance being corrected by market growth; as national data trends confirm, there has been a marked decrease in utilization of LTAC services across the country (i.e., fewer patients being directed to an LTAC level of care) since the pandemic.

As the Board is acutely aware, three Chicago area LTACHs were recently closed (Kindred Hospital Chicago Central, Kindred Hospital Chicago Lakeshore, and Kindred Sycamore) due to excess LTAC bed capacity. Offsetting any positive effect of those closures on the remaining Chicago area LTACHs is the negative impact of the Board's recent approval of yet another new LTACH (Rush Specialty Hospital). If approved, the proposed new project would only further harm the already precarious financial operations of the Chicago area's other existing LTACHs (contrary to the Applicants' assertion that approval of its project would have no impact on other area LTACHs).

LETTERS OF SUPPORT INCLUDE INVALID INFORMATION

The Applicants submitted (with the Application) twelve letters of support from physicians and one letter of support from a nearby community hospital as their "evidence of need" for their proposed LTAC and IR beds; three additional letters of support (including one from another community hospital) were subsequently submitted directly to you. Most of these letters of support include invalid information and should be disregarded for the following reasons:

- It is unclear how the purported referrals/admissions were identified by each physician/hospital, as no patient selection criteria was presented. As you know, Medicare's requirement that patients have at least a 3-day ICU stay or be on a ventilator for more than 72 hours is typically used as a

key criterion to identify potential LTACH patients. This requirement was not referenced in any of the letters of support submitted, suggesting that the supposed referral/admission volumes presented are grossly overstated.

- The Applicants inappropriately use the terms "referrals" and "admissions" interchangeably throughout the Application. In fact, only a small fraction of patients "referred" to an LTACH (or IR facility) are actually "admitted" to one (due to not meeting payer criteria, as described above, family preference, change in condition prior to discharge, etc.). Since the Applicants inappropriately assumed the vast majority of (if not all) referrals would be converted to admissions, the supposed admission volumes presented are grossly overstated.

- One letter of support, which represented 34% of the total purported referrals/admissions identified (509 out of 1,490[a]), did not include a geographic breakdown of communities/zip codes from which the identified patients would be referred/admitted. However, based on the locations of the referring hospitals identified, most such patients would likely be unwilling (or unable) to travel to the Applicants' proposed new LTACH in Sycamore, given there would likely be other existing LTACHs located much closer geographically to them. For the other letters of support, each of which did include a geographic breakdown (i.e., except for 123 referrals/admissions, representing an additional 8% of the total purported referrals/admissions identified, where the zip code specified was simply "Other"), many of the communities/zip codes from which the Applicants suggest patients would be referred/admitted are similarly dubious. The Applicants' supposition that so many patients who live so far away from Sycamore (and who have such easy access to other existing LTACHs located much closer to them) would travel to their proposed new LTACH directly contradicts their own core argument (repeated throughout the Application) that a new LTACH is needed in Sycamore so that patients do not need to travel so far to access LTAC services. For this reason, the supposed referral/admission volumes presented are even further grossly overstated.

[a] Includes 106 additional supposed referrals/admissions identified in one of the letters of support submitted to you directly after the Applicants filed the Application.

SUPPOSED ADMISSION VOLUMES ARE GROSSLY OVERSTATED

As described above and delineated below, the supposed annual LTACH admission volumes presented by the Applicants as evidence of the need for their **40** proposed LTAC beds are grossly overstated.

	Modified Analysis	Per Application
Total Annual Referrals per Letters of Support [b]	1,490	1,383
Less: Total Referrals Attributable to Communities Near Other Existing LTACHs [c]	(1,049)	
Total Referrals Attributable to Communities Near Proposed New LTACH	441	
LTACH Portion of Referrals [d]	77%	
LTACH Referrals Attributable to Communities Near Proposed New LTACH	340	59%
Typical LTACH Referral to Admission Conversion Rate [e]	33%	
Supposed LTACH Annual Admissions based on Letters of Support	**112**	**813**
Average Length of Stay for Proposed New LTACH (per Application)	25 days	25 days
LTACH Bed Need Supported by Letters of Support	**7.7 beds**	**55.7 beds**

[b] Includes both LTAC and IR-related referrals. The total shown here includes information contained in letters of support submitted directly to you after the Application was filed, and exceeds the sum of the individual letter of support totals by one referral due to a mathematical error on Exhibit 1 of one letter of support. One letter of support submitted by the Applicants included 509 (34% of the total) supposed referrals from nine referring hospitals, but no Exhibit 1 with a breakdown of patient zip codes was provided. The other letters of support also included 123 (an additional 8% of the total) supposed referrals for which "Other" was specified as the patient zip code. Rather than exclude all these supposed referrals entirely (due to them representing a considerable 42% of the total), the applicable referring hospital's zip code was assigned to them.

[c] See **Exhibit A** for a map of total purported referrals by patient zip code, including identification of those referrals attributable to communities near the proposed new LTACH (441) and those attributable to communities nearer other existing LTACHs (1,049).

[d] Since the Applicants did not provide an LTAC/IR breakdown of supposed referrals, total referrals were allocated based on the requested bed ratio (40 LTAC and 12 IR).

[e] The actual LTACH referral to admission conversion rate is likely lower than the generous 33% assumption used here for illustration purposes.

As further evidence that the purported referral/admission volumes presented are grossly overstated, we compared the aggregate total annual supposed referrals/admissions from several of the identified referring hospitals (as presented in the letters of support submitted) to each such hospital's total 2025 discharges to an LTACH or IR facility (as reported by the Illinois Hospital Association's COMPdata division). The table below clearly illustrates that the supposed referrals/admissions from many of the identified referring hospitals are grossly overstated:

Referring Hospital	Aggregate Total Annual Supposed Referrals/Admissions (per Letters of Support)	Total 2025 Discharges to an LTACH or IR Facility (per IHA COMPdata)
Bolingbrook	149	39
GlenOaks	92	55
West Suburban	340	44

SERVICE SPECIFIC REVIEW CRITERIA OMITTED FROM APPLICATION

The Applicants did not address any of the following impactful *Maldistribution of Services* items under the *Unnecessary Duplication of Services* item in the *Service Specific Review Criteria* section of the Application (see Section VI (2) on page 72) with respect to their **40** proposed LTAC beds:

(a) **Ratio of Beds to Population** – Since Kindred Sycamore closed in 2025, the Applicants simply stated, "The ratio of beds to population is 0% of the State Average. There are no LTAC beds in the Sycamore Specialty Hospital geographic service area." However, if one were to look at what the LTAC "beds to population" ratio in the geographic service area would be if the proposed project is approved, they would find that it would be **355%** of the State Average. The maximum number of new LTAC beds that could be approved without exceeding 150% of the State Average (i.e., the threshold used to define a *maldistribution of services*) would be **17**.

(b) **Historic Utilization of Existing Hospitals** – Since Kindred Sycamore closed in 2025, the Applicants simply stated, "There are no LTAC beds in the Sycamore Specialty Hospital geographic service area. Accordingly, there is no historical utilization data for existing hospitals." However, if one were to look at Kindred Sycamore's historical utilization prior to its closure, they would find that Kindred Sycamore's average daily census was only **23.7** in 2023 and **18.3** in 2024.

(c) **Sufficient Population to Achieve Target Utilization** – Since Kindred Sycamore closed in 2025, the Applicants simply stated, "There are no LTAC beds in the Sycamore Specialty Hospital geographic service area. Accordingly, sufficient population exists to achieve target utilization." By this reasoning, a population of "1" would support the Applicants' proposed new hospital. Conversely, if one were to look at the 2023 population in the geographic service area (199,819 as provided by

the Applicants in Table 1110.230(b) on pages 69-70[f]), they would find that the geographic service area population does not support a 40-bed LTACH.

Age	Population	Average Annual LTACH Utilization Rate	Estimated Annual LTACH Admissions
0-14 Years	37,982	n/a [g]	-
15-44 Years	74,277	0.06% [h]	78
45-64 Years	56,203		
65-74 Years	19,711	0.12% [i]	38
75+ Years	11,646		
Total	199,819		116

Based on an LTACH average length of stay of 25 days (as presented by the Applicants), the population in the market area will only support an **8-bed** LTACH.

(d) **Impact on Other Providers** – Since Kindred Sycamore closed in 2025, the Applicants simply stated, "There are no LTAC beds in the Sycamore Specialty Hospital geographic service area. Accordingly, the establishment of the planned Sycamore Specialty Hospital will not lower the utilization of other area providers below State Board's occupancy standards." However, by their own admission (as described above regarding the communities from which they expect their referrals/admissions to come), the Applicants expect 70% of their referrals/admissions to come from communities near other existing LTACHs. Due to the widely acknowledged excess LTAC bed capacity that exists today in the Chicago metropolitan area, it is extremely disingenuous for the Applicants to suggest that diverting LTAC patients from other existing LTACHs to their new proposed hospital would not negatively impact such other LTACHs (especially given most already operate below the Board's occupancy standard).

COST ASSUMPTIONS ARE GROSSLY UNDERSTATED

Finally, the cost assumptions presented by the Applicants in the Application (operating and capital costs of $142.13 and $46.09 per patient day, respectively) are grossly understated (and even less than those of a typical skilled nursing facility). The Applicants indicated that a nurse-to-patient ratio of 1:4 or 1:5 would

[f] Although Table 1110.265(c)(1)(A) on page 71 of the Application (as provided by the Applicants) shows a market area population of 226,588, the values from Table 1110.230(b) were used here (since that table included a breakdown by age).

[g] LTACHs are not typically licensed to admit pediatric patients.

[h] Estimated as 50% of the Medicare FFS utilization rate described in the footnote below.

[i] Based on the average annual LTACH qualifying stay utilization rate indicated for Medicare FFS beneficiaries in the July 2025 MedPAC data book.

be utilized; however, if true, direct nursing costs alone would total at least $320 per patient day. The financial assumptions provided by the Applicants are underdeveloped and indicate a lack of understanding of the complexity and costs associated with caring for LTAC (and IR) patients.

CONCLUSION

I urge the Board to independently evaluate the need for additional LTAC beds in the Chicago metropolitan area, especially given its recent approval to close three Chicago area LTACHs (including Kindred Sycamore). Since there is no need currently for another LTACH in the Chicago area, and because the Application lacks substance overall, RML recommends that the Board deny the LTAC component of the Applicants' proposed project. If approved, a large unnecessary investment in duplicative LTAC services would occur.

If you have any questions and/or would like additional information regarding RML's position with respect to the Application, please feel free to contact me via email at jprister@rmlsh.org or by phone at 630-286-4120. Thank you in advance for your consideration.

Sincerely,

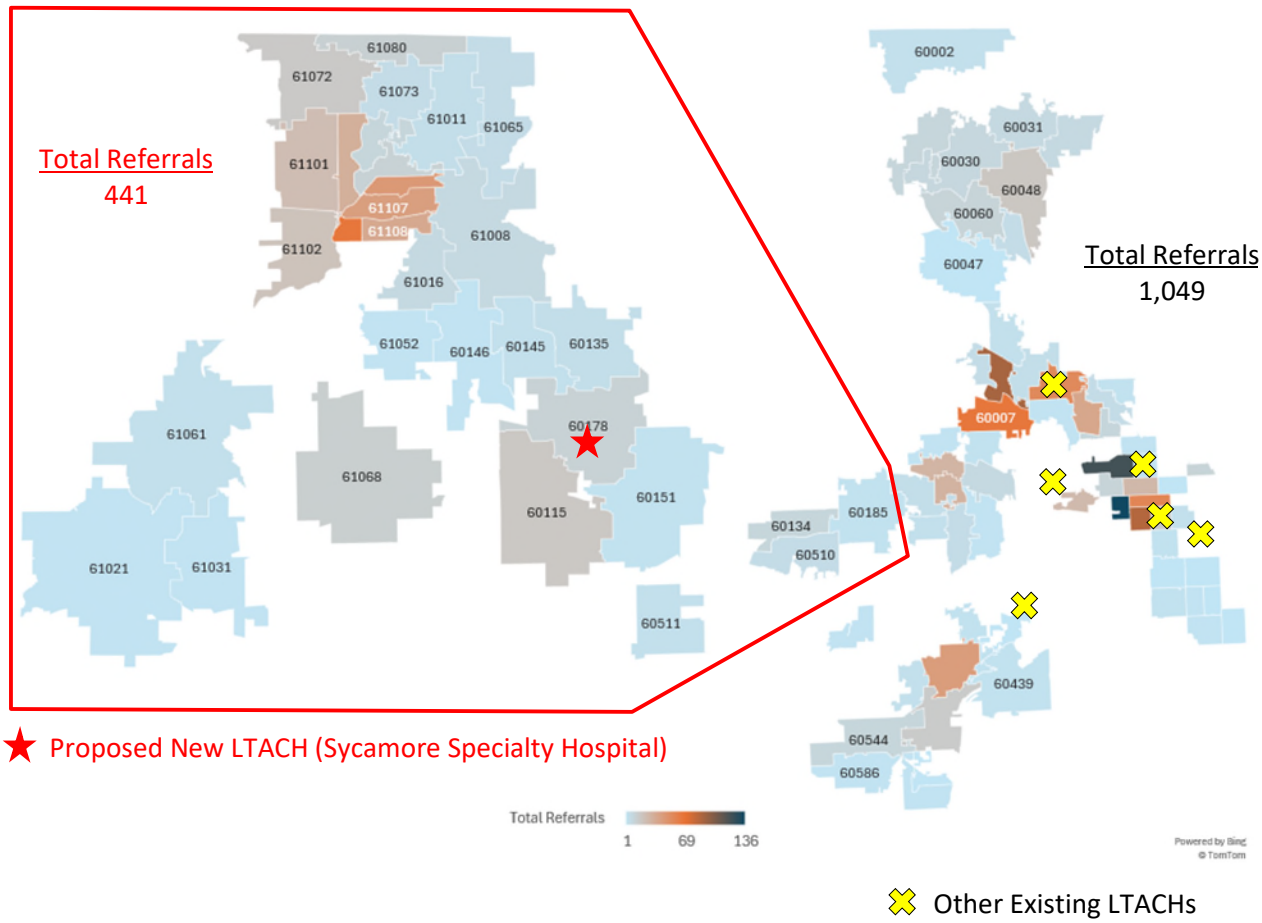
James R. Prister
President and Chief Executive Officer

Exhibit A

Map of Total Purported Referrals (LTAC and IR) by Patient Zip Code [j]

Attributable to Communities Near Proposed New LTACH

Attributable to Communities Near Other Existing LTACHs



[j] Based on physician and community hospital letters of support submitted. Includes purported referrals for both LTAC and IR services. For those referrals for which no patient zip code was identified, the referring hospital's zip code was used.

JOSEPH HYLAK-REINHOLTZ
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May 12, 2026

VIA ELECTRONIC MAIL

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

RE: Letter of Opposition – Sycamore Specialty Hospital (Project 26-009)

Dear Administrator Kniery,

I represent Kindred Healthcare Operating, LLC ("Kindred"), a provider of long-term acute care hospital ("LTACH") services in the State of Illinois. Kindred submits this letter in opposition to the certificate of need ("CON") permit application filed by Sycamore Specialty Hospital, LLC ("Applicant"), Project No. 26-009. Kindred opposes the application for three independent reasons. First, according to the most recent bed inventory published by the Illinois Health Facilities and Services Review Board ("State Board"), there is no identified need for additional LTACH beds within Health Service Area 1. Second, on March 18, 2025, the State Board unanimously approved the discontinuation of Kindred's LTACH located at the exact same address proposed in the present application, thereby expressly recognizing that LTACH services were not needed at that location in Sycamore. Third, the application is legally defective because it was prepared by attorney Anne Cooper, Kindred's former legal counsel, in violation of Illinois Supreme Court Rule 1.9. That rule prohibits an attorney from representing another party in the same or a substantially related matter where the new client's interests are materially adverse to those of the former client absent informed consent. Kindred did not provide such consent.

The State Board Should Oppose the Permit Application Because a Surplus of LTACH Beds Exists in HSA 1.

The Applicant's proposal is inconsistent with the State Board's own need methodology and should be denied because Health Service Area 1 ("HSA 1") already contains a substantial surplus of long-term acute care hospital ("LTACH") beds. According to the State Board's most recent Inventory of Health Care Facilities and Services and Need Determinations report, HSA 1 currently contains 54 existing LTACH beds despite a calculated need for only 34 beds. Thus, HSA 1 already has a surplus of 20 LTACH beds before any additional beds are approved. Adding more beds would only exacerbate the surplus.

The State Board Should Oppose the Permit Application Because its Members Already Approved the Discontinuation of an LTACH at the Exact Same Location Last Year.

The proposed long-term acute care hospital ("LTACH") at the subject address in Sycamore should be denied because the application is fundamentally inconsistent with the State Board's recent findings regarding need and viability at this exact location. In 2025, the State Board expressly approved the discontinuation of a Kindred LTACH operating at the same address, 225 Edward Street, Sycamore, Illinois (Project 24-038), reflecting a determination that continuation of LTACH services at this site was no longer justified under applicable planning standards and community need considerations. The fact that the former operator of the same facility now opposes the reestablishment of substantially similar services at the identical location further underscores the absence of sustainable demand and the operational challenges historically associated with this site. Approving a new LTACH immediately after authorizing the closure of the prior facility would create an arbitrary and inconsistent regulatory outcome, undermine the integrity of the State Board's prior findings, and risk unnecessary duplication of specialized healthcare services without sufficient evidence of changed circumstances or unmet regional need.

Furthermore, the utilization data from the nearest operational LTACHs further confirms the absence of need for additional capacity. See Table One below. Specifically, Kindred Chicago Northlake reported a 2023 utilization rate of just 34.3%, Kindred Chicago North reported 43.7%, RML Hinsdale reported 72.9%, and Ascension Holy Family Hospital reported 56.7%. Each of these facilities therefore operated well below the State Board's regulatory benchmark requiring LTACH facilities to maintain an annual occupancy rate of at least 85%. These underutilization figures demonstrate that existing LTACH providers in and around HSA 1 possess more than sufficient capacity to accommodate current patient demand. Approving additional LTACH beds under these circumstances would unnecessarily duplicate existing services, further dilute utilization among current providers, and directly conflict with the State Board's established planning standards and need determinations.

TABLE ONE
Closest LTACHs to Former Kindred Hospital Sycamore/Proposed LTACH

			2021		2022		2023	
LTACH	**Miles**	**Beds**	**Patient Days**	**Utilization**	**Patient Days**	**Utilization**	**Patient Days**	**Utilization**
Kindred Chicago Northlake	58	91	12,014	35.0%	12,205	36.7%	11,407	34.3%
Kindred Chicago North	61	133	23,193	47.8%	20,425	49.5%	20,425	43.7%
RML Hinsdale	50	115	35,732	85.1%	30,818	73.4%	30,593	72.9%
Ascension Holy Family	50	129	30,915	65.7%	28,404	60.3%	26,716	56.7%

The State Board Should Reject This CON Permit Application Because it is Tainted Work Product Developed by an Attorney with a Clear Conflict of Interest and a Blantant Violation of Supreme Court Rule 1.9.

Ms. Anne Cooper formerly represented Kindred Health, most recently acting as Kindred's legal counsel for CON Permit Application 24-038, in which Kindred sought State Board approval to discontinue an LTACH at the exact same location proposed now by SHC. Ms. Cooper now represents SHC. Ms. Cooper's representation of SHC in connection with its pending CON permit application before the State Board violates Illinois Supreme Court Rule 1.9(a) and warrants disqualification, as well as rejection of the application itself.

Rule 1.9(a) prohibits a lawyer from representing a new client in the same or a substantially related matter in which that client's interests are materially adverse to those of a former client, absent informed consent. See Exhibit A, Illinois Supreme Court Rule 1.9. Here, Ms. Cooper previously represented Kindred in matters involving its LTACH at 225 Edward Street in Sycamore. She now represents SHC in seeking approval to establish an LTACH at that identical location, in direct competition with Kindred's prior and continuing interests. The matters are plainly substantially related because they involve the same facility site, the same regulatory framework governing LTACH services, and overlapping issues concerning need, utilization, and operational feasibility in Health Service Area 1. SHC's interests are also materially adverse to Kindred's, as SHC seeks to occupy the same market position and regulatory space formerly held by Kindred at the very same address.

No informed consent was provided by Kindred for Ms. Cooper's subsequent adverse representation. Under Illinois law, where a substantial relationship exists between successive representations, courts presume that confidential information was shared and may be used to the disadvantage of the former client. Given Ms. Cooper's prior representation of Kindred, she necessarily had access to sensitive and confidential information regarding Kindred's LTACH operations, regulatory strategy, financial performance, utilization, and State Board engagement—information directly relevant to SHC's current CON application.

Disqualification is therefore required to protect Kindred's continuing rights to confidentiality and loyalty and to preserve the integrity of the administrative process. In addition, SHC's CON application should be withdrawn or stricken in its entirety because it constitutes tainted work product arising directly from an impermissible conflict of interest. Allowing SHC to proceed on the basis of an application prepared through representation that violates Rule 1.9(a) would improperly permit SHC to benefit from conflicted legal services, risk the use or appearance of use of confidential former-client information, and undermine the fairness and credibility of the State Board's review process. Accordingly, Ms. Cooper should be disqualified from further participation in this matter, and SHC's application should be

rejected or required to be withdrawn and resubmitted through unconflicted counsel as a condition of any further consideration.

If you have any questions or need any additional information regarding the project or this opposition letter, please feel free to contact me via phone at 630-464-4514 or e-mail at JHRlaw2017@gmail.com. Thank you for your attention to this matter.

Respectfully,

Joseph Hylak-Reinholtz
Legal Counsel for Kindred

Enclosures

EXHIBIT A

Illinois Supreme Court Rule 1.9

(see attached)

RULE 1.9: DUTIES TO FORMER CLIENTS

(a) A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent.

(b) A lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client

(1) whose interests are materially adverse to that person; and

(2) about whom the lawyer had acquired information protected by Rules 1.6 and 1.9(c) that is material to the matter; unless the former client gives informed consent.

(c) A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:

(1) use information relating to the representation to the disadvantage of the former client except as these Rules would permit or require with respect to a client, or when the information has become generally known; or

(2) reveal information relating to the representation except as these Rules would permit or require with respect to a client.

Adopted July 1, 2009, effective January 1, 2010.

Comment

[1] After termination of a client-lawyer relationship, a lawyer has certain continuing duties with respect to confidentiality and conflicts of interest and thus may not represent another client except in conformity with this Rule. Under this Rule, for example, a lawyer could not properly seek to rescind on behalf of a new client a contract drafted on behalf of the former client. So also a lawyer who has prosecuted an accused person could not properly represent the accused in a subsequent civil action against the government concerning the same transaction. Nor could a lawyer who has represented multiple clients in a matter represent one of the clients against the others in the same or a substantially related matter after a dispute arose among the clients in that matter, unless all affected clients give informed consent. See Comment [9]. Current and former government lawyers must comply with this Rule to the extent required by Rule 1.11.

[2] The scope of a "matter" for purposes of this Rule depends on the facts of a particular situation or transaction. The lawyer's involvement in a matter can also be a question of degree. When a lawyer has been directly involved in a specific transaction, subsequent representation of other clients with materially adverse interests in that transaction clearly is prohibited. On the other hand, a lawyer who recurrently handled a type of problem for a former client is not precluded from later representing another client in a factually distinct problem of that type even though the subsequent representation involves a position adverse to the prior client. Similar considerations can apply to the reassignment of military lawyers between defense and prosecution functions

within the same military jurisdictions. The underlying question is whether the lawyer was so involved in the matter that the subsequent representation can be justly regarded as a changing of sides in the matter in question.

[3] Matters are "substantially related" for purposes of this Rule if they involve the same transaction or legal dispute or if there otherwise is a substantial risk that confidential factual information as would normally have been obtained in the prior representation would materially advance the client's position in the subsequent matter. For example, a lawyer who has represented a businessperson and learned extensive private financial information about that person may not then represent that person's spouse in seeking a divorce. Similarly, a lawyer who has previously represented a client in securing environmental permits to build a shopping center would be precluded from representing neighbors seeking to oppose rezoning of the property on the basis of environmental considerations; however, the lawyer would not be precluded, on the grounds of substantial relationship, from defending a tenant of the completed shopping center in resisting eviction for nonpayment of rent. Information that has been disclosed to the public or to other parties adverse to the former client ordinarily will not be disqualifying. Information acquired in a prior representation may have been rendered obsolete by the passage of time, a circumstance that may be relevant in determining whether two representations are substantially related. In the case of an organizational client, general knowledge of the client's policies and practices ordinarily will not preclude a subsequent representation; on the other hand, knowledge of specific facts gained in a prior representation that are relevant to the matter in question ordinarily will preclude such a representation. A former client is not required to reveal the confidential information learned by the lawyer in order to establish a substantial risk that the lawyer has confidential information to use in the subsequent matter. A conclusion about the possession of such information may be based on the nature of the services the lawyer provided the former client and information that would in ordinary practice be learned by a lawyer providing such services.

Lawyers Moving Between Firms

[4] When lawyers have been associated within a firm but then end their association, the question of whether a lawyer should undertake representation is more complicated. There are several competing considerations. First, the client previously represented by the former firm must be reasonably assured that the principle of loyalty to the client is not compromised. Second, the rule should not be so broadly cast as to preclude other persons from having reasonable choice of legal counsel. Third, the rule should not unreasonably hamper lawyers from forming new associations and taking on new clients after having left a previous association. In this connection, it should be recognized that today many lawyers practice in firms, that many lawyers to some degree limit their practice to one field or another, and that many move from one association to another several times in their careers. If the concept of imputation were applied with unqualified rigor, the result would be radical curtailment of the opportunity of lawyers to move from one practice setting to another and of the opportunity of clients to change counsel.

[5] Paragraph (b) operates to disqualify the lawyer only when the lawyer involved has actual knowledge of information protected by Rules 1.6 and 1.9(c). Thus, if a lawyer while with one firm

acquired no knowledge or information relating to a particular client of the firm, and that lawyer later joined another firm, neither the lawyer individually nor the second firm is disqualified from representing another client in the same or a related matter even though the interests of the two clients conflict. See Rule 1.10(b) for the restrictions on a firm once a lawyer has terminated association with the firm.

[6] Application of paragraph (b) depends on a situation's particular facts, aided by inferences, deductions or working presumptions that reasonably may be made about the way in which lawyers work together. A lawyer may have general access to files of all clients of a law firm and may regularly participate in discussions of their affairs; it should be inferred that such a lawyer in fact is privy to all information about all the firm's clients. In contrast, another lawyer may have access to the files of only a limited number of clients and participate in discussions of the affairs of no other clients; in the absence of information to the contrary, it should be inferred that such a lawyer in fact is privy to information about the clients actually served but not those of other clients.

[7] Independent of the question of disqualification of a firm, a lawyer changing professional association has a continuing duty to preserve confidentiality of information about a client formerly represented. See Rules 1.6 and 1.9(c).

[8] Paragraph (c) provides that information acquired by the lawyer in the course of representing a client may not subsequently be used or revealed by the lawyer to the disadvantage of the client. However, the fact that a lawyer has once served a client does not preclude the lawyer from using generally known information about that client when later representing another client.

[9] The provisions of this Rule are for the protection of former clients and can be waived if the client gives informed consent. With regard to the effectiveness of an advance waiver, see Comment [22] to Rule 1.7. With regard to disqualification of a firm with which a lawyer is or was formerly associated, see Rule 1.10.

Adopted July 1, 2009, effective January 1, 2010.

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OUR FILE NUMBER: 106305-000100

May 18, 2026

Via E-Mail

Blanca Dominguez
General Counsel
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Sycamore Specialty Hospital (Proj. No. 26-009)

Dear Ms. Dominguez:

I am writing in response to counsel for Kindred Healthcare Operating, LLC's ("Kindred") letter dated May 12, 2026, regarding, among other things, my representation of Sycamore Specialty Hospital, LLC ("Sycamore") for the above-referenced project. Initially, I disagree with Kindred's incorrect position that representation of Sycamore Specialty Hospital is adverse to Kindred, given Kindred's exit from the Sycamore, Illinois market and confirmed with the Illinois Attorney Registration & Disciplinary Commission that my representation of Sycamore does not constitute a violation of the Illinois Rules of Professional Conduct. Nevertheless, Sycamore and I wish to avoid wasting the parties' and the Board's time and resources in "satellite litigation" regarding alleged conflicts and disqualification. To eliminate purported conflict of interest concerns and to allow the project to move forward without delay, I am, therefore, withdrawing as counsel for Sycamore effective immediately and transitioning the matter to Juan Morado, Jr. at Benesch Friedlander Coplan & Aronoff LLC

During the course of my representation of Kindred, I was not privy to any confidential information related to Kindred's operations, regulatory strategy, financial performance, utilization, or State Board engagement. My understanding of the Kindred situation was limited to what was articulated in the Kindred Hospital Sycamore certificate of need application, which is publicly available on the Illinois Health Facilities and Services Review Board (the "State Board") website. Preparation of the Sycamore certificate of need application did not involve my knowledge or use of any Kindred confidential information. Accordingly, and contrary to Kindred's assertions, my representation of Sycamore did not at any time involve risk of utilizing confidential information obtained from a former client. For this reason, and the lack of actual adversity of interests between

Sycamore and Kindred at the time the Application was prepared and submitted, Kindred's objection to the Application on the basis of a purported conflict of interest is unfounded.

Please note that this correspondence does not constitute Sycamore's comprehensive response to Kindred's objections. New counsel for Sycamore will separately respond as appropriate to Kindred's counsel's May 12th letter and objections. Sycamore reserves all rights to address Kindred's objections as needed.

Thank you for your understanding. If you have any questions regarding the above, please feel free to contact me.

Sincerely,

Anne M. Cooper

Anne M. Cooper

cc: Saifullah Nasir, M.D.
Juan Morado, Jr., Benesch Friedlander Coplan & Aronoff LLC