09-043

ORIGINAL

ILLINOIS HEALTH FACILITIES PLANNING BOARD

CERTIFICATE OF NEED PERMIT

APPLICATION

February 2009 Edition

TABLE OF CONTENTS

ILLINOIS HEALTH FACILITIES PLANNING BOARD
525 WEST JEFFERSON STREET, 2nd FLOOR
SPRINGFIELD, ILLINOIS 62761
(217) 782-3516

ILLINOIS HEALTH FACILITIES PLANNING BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: ResCare Premier Neuro Rehabilitation Center
Street Address: 1040 Robey Avenue
City and Zip Code: Downers Grove
County: 60516 Health Service Area 7 Health Planning Area: 043

Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Res-Care Premier, Inc.
Address: 9901 Linn Station Road, Louisville, KY 40223
Name of Registered Agent: CT Corporation
Name of Chief Executive Officer: Patrick Kelley
CEO Address: 9901 Linn Station Road, Louisville, KY 40223
Telephone Number: 502-394-2100

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Type of Ownership

- ☐ Non-profit Corporation
- ☑ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Janice Fryklund
Title: Executive Director
Company Name: ResCare Premier Neuro Rehabilitation Center
Address: 1040 Robey Avenue, Downers Grove, Il 60516
Telephone Number: 630-969-9188
E-mail Address: jfryklund@rescare.com
Fax Number: 630-969-6224

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: David Rastoka
Title: Regional Director
Company Name: Res-Care, Inc.
Address: 6170 Bisch Dlvd. columbus, Ohio 43229
Telephone Number: 614-880-3002
E-mail Address: drastoka@rescare.com
Fax Number: 614-880-3014

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name: Janice Fryklund
Title: Executive Director
Company Name: ResCare Premier Neuro Rehabilitation Center
Address: 1040 Robey Avenue, Downers Grove, Il 60516
Telephone Number: 630-969-9188
E-mail Address: jfryklund@rescare.com
Fax Number: 630-969-6224

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Res-Care Premier, Inc.
Address of Site Owner: 9901 Linn Station Road, Louisville, KY 40223
Street Address or Legal Description of Site: 1040 ROBEY AVE. DOWNERS GROVE, IL 60516

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Res-Care Premier, Inc.

Address: 9901 Linn Station Road, Louisville, KY 40223

- ☐ Non-profit Corporation
- ☑ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Organizational Relationships NA

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Flood Plain requirements of Executive Order #5, 2006. Not applicable, this is not a new construction project.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act. Not applicable, no changes are being made to existing structure.

APPEND DOCUMENTATION AS ATTACHMENT-5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
☑ Non-substantive	☑ Category A Project
	☐ Category B Project
	☐ DHS or DVA Project

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center	12				12
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

3. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

ResCare Premier, Inc. ("ResCare") is seeking to obtain the Community Based Residential Rehabilitation license for our current operation located at 1040 Robey Avenue Downers Grove, Illinois. ResCare operates a Residential Neuro Rehabilitation Center dedicated to assisting people with acquired brain injury ("ABI") to achieve their highest level of independence, providing residential post acute rehabilitation, long-term supported living, out patient therapy, and day activity services to adults with ABI. We do this by providing community-based rehabilitation and residential services.

Persons served shall be 18 years of age and older, have a diagnosis of ABI, TBI, or other neurological diagnosis, have a cognitive Level IV or higher on the Rancho Los Amigos Scale, have potential to improve functional status and benefit from services, are medically stable, willing to participate in rehabilitation process, not a present danger to self or others and have appropriate funding sources.

ResCare offers a unique program of specialized rehabilitation services for adults with brain injuries in a home-like environment. We use an interdisciplinary team approach to form an Outcome Goal Plan for each participant. Therapies are functional and occur in the community as much as possible. Nurses are available daily and assess for early changes in participants' medical conditions.

Areas of focus include: Physical Therapy, Occupational Therapy, Speech and Language Pathology, Cognitive Therapy, Job Placement, Vocational Counseling, Job Coaching, Vocational Evaluations, Recreational Therapy, Nursing and Medical Management, Behavioral Supports, Community Inclusion, and Respite Care.

The Supported Living Program is a residential program that provides 24-hour supervision and support within our 16-bed home. Dare structured and participants are encouraged to be as independent as possible while addressing budgeting skills, social interaction, behaviors and community accessibility.

Day activity services provide therapeutic care for adults living in the community with ABI. We offer participants the opportunity to participate in functional, social and recreational activities. The program is cost-effective and funded by the Illinois Brain Injury Waiver Program.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Preplanning Costs			0
Site Survey and Soil Investigation			0
Site Preparation			0
Off Site Work			0
New Construction Contracts			0
Modernization Contracts			0
Contingencies			0
Architectural/Engineering Fees			0
Consulting and Other Fees			0
Movable or Other Equipment (not in construction contracts)			0
Bond Issuance Expense (project related)			0
Net Interest Expense During Construction (project related)			0
Fair Market Value of Leased Space or Equipment			0
Other Costs To Be Capitalized			0
Acquisition of Building or Other Property (excluding land)			0
TOTAL USES OF FUNDS			0
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities			0
Pledges			0
Gifts and Bequests			0
Bond Issues (project related)			0
Mortgages			0
Leases (fair market value)			0
Governmental Appropriations			0
Grants			0
Other Funds and Sources			0
TOTAL SOURCES OF FUNDS			0

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☑ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☑ No

If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☑ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _____
Completed

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON contingencies.
☐ Project obligation will occur after permit issuance.

State Agency Submittals

Are the following submittals up to date as applicable:

☐ Cancer Registry
☐ APORS
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☐ All reports regarding outstanding permits

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
CLINICAL							
Medical Surgical	0						
Intensive Care	0						
Diagnostic Radiology	0						
MRI	0						
Total Clinical	0						
NON CLINICAL							
Administrative	0						
Parking	0						
Gift Shop	0						
Total Non-clinical	0						
TOTAL	0						

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Res-Care Premier, Inc.	**CITY:** Downers Grove				
REPORTING PERIOD DATES:	**From:** January 1, 2008		**to:** June 1, 2009		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	0	0	0	0	0
Obstetrics	0	0	0	0	0
Pediatrics	0	0	0	0	0
Intensive Care	0	0	0	0	0
Comprehensive Physical Rehabilitation	0	4	5531	0	12
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	0	0	0	0	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify)	0	0	0	0	0
TOTALS:	0	4	5531	0	12

Facility Bed Capacity and Utilization
2008

Month	Capacity	Census	Residential Rehabilitation	Supported Living	% Util.	Patient days
Jan	16	13	8	5	81%	403
Feb	16	12	7	5	81%	336
March	16	12	7	5	81%	360
April	16	12	7	5	81%	403
May	16	12	7	5	81%	360
June	16	12	7	5	81%	360
July	16	11	7	4	69%	341
August	16	11	8	3	69%	341
September	16	11	8	3	69%	330
October	16	9	5	4	56%	279
November	16	8	5	3	50%	240
December	16	8	5	3	50%	248

2009	Capacity	Census	Residential Rehabilitation	Supported Living	% Util.	
Jan	16	8	5	3	50%	248
Feb	16	8	5	3	50%	224
March	16	8	5	3	50%	248
April	16	9	6	3	56%	270
May	16	9	6	3	56%	270
June	16	9	5	4	56%	270

***Census is going down due to lack of state license. 5531

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Res-Care Premier, Inc. * **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

Patrick Kelley
SIGNATURE

Patrick Kelley
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4th day of June, 2009

Signature of Notary

Seal

SIGNATURE

Bob Bond
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6th day of July, 2009

Jeanne C Bush
Signature of Notary

Seal

JEANNE C. BUSH
MY COMMISSION EXPIRES
August 28, 2016
NOTARY SEAL
GRANT COUNTY
NOTARY PUBLIC, STATE OF INDIANA

*Insert EXACT legal name of the applicant

SECTION III. - PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable. NA
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application. None.
3. Authorization permitting HFPB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFPB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.

For projects involving modernization, describe the conditions being upgraded. For facility projects, include statements of age and condition and regulatory citations. For equipment being replaced, include repair and maintenance records.

NOTE: The description of the "Purpose of the Project" should not exceed one page in length. Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTERNATIVES There are no alternatives, if not approved facility may have to be closed.

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options include:

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

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

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

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

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

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.
2. If the gross square footage exceeds the GSF standards in Appendix B, justify the discrepancy by documenting one of the following::
    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
    c. The project involves the conversion of existing bed space that results in excess square footage.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFPB has not established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
    a. Requirements of governmental or certification agencies; or
    b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data are available; and

b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFPB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

1. This Section is applicable to all projects proposing establishment, expansion or modernization of **ALL categories of service that are subject to CON review**, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960], WITH THE EXCEPTION OF:
   - General Long Term Care;
   - Subacute Care Hospital Model;
   - Postsurgical Recovery Care Center Alternative Health Care Model;
   - Children's Community-Based Health Care Center Alternative Health Care Model; and
   - Community-Based Residential Rehabilitation Center Alternative Health Care Model)

   If the project involves any of the above-referenced categories of service, refer to " SECTION VIII.- Service Specific Review Criteria" for applicable review criteria, and submit all necessary documentation for each service involved..

2. READ THE APPLICABLE REVIEW CRITERIA FOR EACH OF THE CATEGORIES OF SERVICE INVOLVED. **[Refer to SECTION VIII regarding the applicable criteria for EACH action proposed, for EACH category of service involved.]**

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:** Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

Planning Area_____

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFPB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

1. If establishing or expanding beds/stations/key rooms, 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.

2. If expanding an existing category of service, 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, document that at least 50% of the projected patient volume will be from residents of the

SECTION VIII. - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☐ Medical/Surgical					
☐ Obstetric					
☐ Pediatric					
☐ Intensive Care					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) - Planning Area Need - Service Accessibility	X		
1110.530(c)(1) - Unnecessary Duplication of Services	X		
1110.530(c)(2) - Maldistribution			
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X
1110.530(d)(2) - Documentation			X
1110.530(d)(3) - Documentation Related to Cited Problems			X

P. Community-Based Residential Rehabilitation Center

This section is applicable to all projects proposing to establish a Community-based Residential Rehabilitation Center Alternative Health Care Model.

A. Criterion 1110.2830(a), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan that identifies the number and type of staff positions dedicated to the model and the qualifications for each position; and

2. How special staffing circumstances will be handled; and

3. The staffing patterns for the proposed center; and

4. The manner in which non-dedicated staff services will be provided.

B. Criterion 1110.2830(b), Mandated Service

Read the criterion and provide a narrative description documenting how the applicant will provide the minimum range of services required by the Alternative Health Care Delivery Act and specified in 1110.2820(b).

C. Criterion 1110.2830(c), Unit Size

Read the criterion and provide a narrative description that identifies the number and location of all beds in the model. Include the total number of beds for each residence and the total number of beds for the model.

D. Criterion 1110.2830(d), Utilization

Read the criterion and provide documentation that the target utilization for the model will be achieved by the second year of the model's operation. Include supporting information such as historical utilization trends, population growth, expansion of professional staff or programs, and the provision of new procedures that may increase utilization.

E. Criterion 1110.2830(e), Background of Applicant

Read the criterion and provide documentation that demonstrates the applicant's experience in providing the services required by the model. Provide evidence that the programs offered in the model have been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Brain Injury Community-Integrative Program for at least three of the last five years.

APPEND DOCUMENTATION AS ATTACHMENT-61, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

T. Financial Feasibility

N/A

This section is applicable to all projects subject to Part 1120.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No ☐.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN) (continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

_____ Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

_____ Debt Financing (indicate type(s) _____)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations
Provide a copy of the appropriation act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_____ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

_____ TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☐ No ☐. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

U. Economic Feasibility

N/A

This section is applicable to all projects subject to Part 1120.

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ☐ No ☐. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes ☐ No ☐. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☐ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Criterion 1120.310(b), Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

B. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON) (continued)

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☐ No ☐. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310(f), Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes ☐ No ☐. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT 76, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ResCare Premier
Dedicated to persons with acquired brain injury

Attachment 10

Authorization for Uses and Disclosures
Where Authorization is Required

I hereby authorize the use or disclosure of protected health information about ResCare, Inc. as described below.

1. The name or other specific identification of the person(s) authorized to make the use or disclosure: ResCare Premier

2. The name or other specific identification of the person(s) authorized to receive the information: CARF, IDHS, IDPA HFPB

3. Specific description of the information to be used or disclosed:

Acess to any documents necessary to verify the information submitted, including, but not limited to official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable, the records of nationally recognized accreditation organizations.

4. The information may be used or disclosed for the following purposes:
External audits, emergency medical services, medical consultations

5. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

7. I understand this authorization will expire on (check and complete one):
   - X☐ July 10, 2010
   - ☐ On the happening of the following event:

This form must be fully completed before signing.

James M. Brylland Executive Director — 7/10/09

Signature of Agency Representative
ResCare Premier, Inc.

Date of Signature

ATTACHMENT -11
PURPOSE OF THE PROJECT

Res-Care Premier, Inc. ("ResCare") Neuro – Rehabilitation Center is one of two **Community Based Residential Rehabilitation Center's** in Illinois specializing in Brain Injury. Our target market is any adult ages 18 to 65 with an Acquired Brain Injury ("ABI") needing post acute rehabilitation and long term supported living services.

Need: Of the 1.4 million whom sustain a Traumatic Brain Injury ("TBI") each year in the United States, 50,000 will die, 235,000 are hospitalized and 1.1. Million are treated and released from emergency department. The Centers for Disease Control and Prevention estimates that at least 5.3 million Americans currently have a long term or life long need for assistance to perform activities of daily living as a result of a TBI. According to the National Brain Injury Association's research, about 40% of those hospitalized with a TBI had at least one unmet need for services one year after their injury.

Blasts are a leading cause of TBI for active duty military personnel in a war zone. Some experts have estimated the incidence of TBI among wounded service members to be as high 22%. The Defense and Veterans Brain Injury Center reports that between 2003 and 2008 32% of services members evacuated during the conflicts over seas had TBI.

Financial Accessibility: *ResCare* residents' care is currently funded by worker's compensation, private insurance (Blue Cross Blue Shield ("BCBS"), United, etc.), private pay, and, if participants meet the eligibility guidelines, the TBI Waiver for the day program (via the Illinois Department of Human Services – Division of Rehabilitation Services). We are in the BCBS network for the provision of outpatient therapy and are in the process of applying to join additional insurance networks, including Magellan, as part of the *Illinois Warrior Assistance Program.*

Accessibility: *ResCare* is accredited by Commission on Accreditation of Rehabilitation Facilities. Over the past year, we have experienced many insurance companies and hospitals attempting to send patients to our facility but have been unable to do so due to our licensure status. Interestingly, the current Illinois statute (under the Alternative Health Care Delivery Act) allows only *one* "community-based residential rehabilitation center [which] shall be located in the area of Illinois south of Interstate Highway 70."

December 2007, representatives from the U.S. Department of Veterans Affairs conducted an initial site visit at *ResCare* which is the first step in becoming a provider of services for veterans of the current conflict as well as others who have served. However, similar to our experience with hospitals and insurance companies referenced above, ***ResCare*** must obtain licensure in order to be an option for those veterans participating in the federal program.

Goal 1: In June 2009, HB 2279, Sponsored by Representative Patti Bellock, was signed into law by Governor Pat Quinn. This modification of the Alternative Health Care delivery Act will enable *ResCare* to submit an application for a Community Based Residential Rehabilitation Center license, Administrative code Title 77: part 220. It is the change in the "demonstration program's" statutory language that was needed to allow for greater consumer and family choice in service providers in Illinois.

Goal 2: Once the licensure application is approved and Medicare Certification is achieved, *ResCare* will initiate contact with the local Veterans Hospital's to make available to the community resources for active service members that are in need of Residential Brain Injury Rehabilitation services.

Goal 3: With a change in licensure status, we will increase certification/approval for services from Insurance Providers for Residential Brain Injury Rehabilitation for individuals discharged from Acute Hospitals In 2008, 56% of our requests from individuals with ABI due to motor vehicle accidents or falls were denied services due to licensure status.

ATTACHMENT 12

Alternatives to the Project

There are no alternative to this project as this is an existing facility and program that is now required to obtain a license to continue to operate. If this certificate of need is not granted, this operation and program will not be authorized by IDPH to continue to operate and provide this very needed service to individuals with Acquired Brain Injury.

ATTACHMENT 13
SIZE OF PROJECT

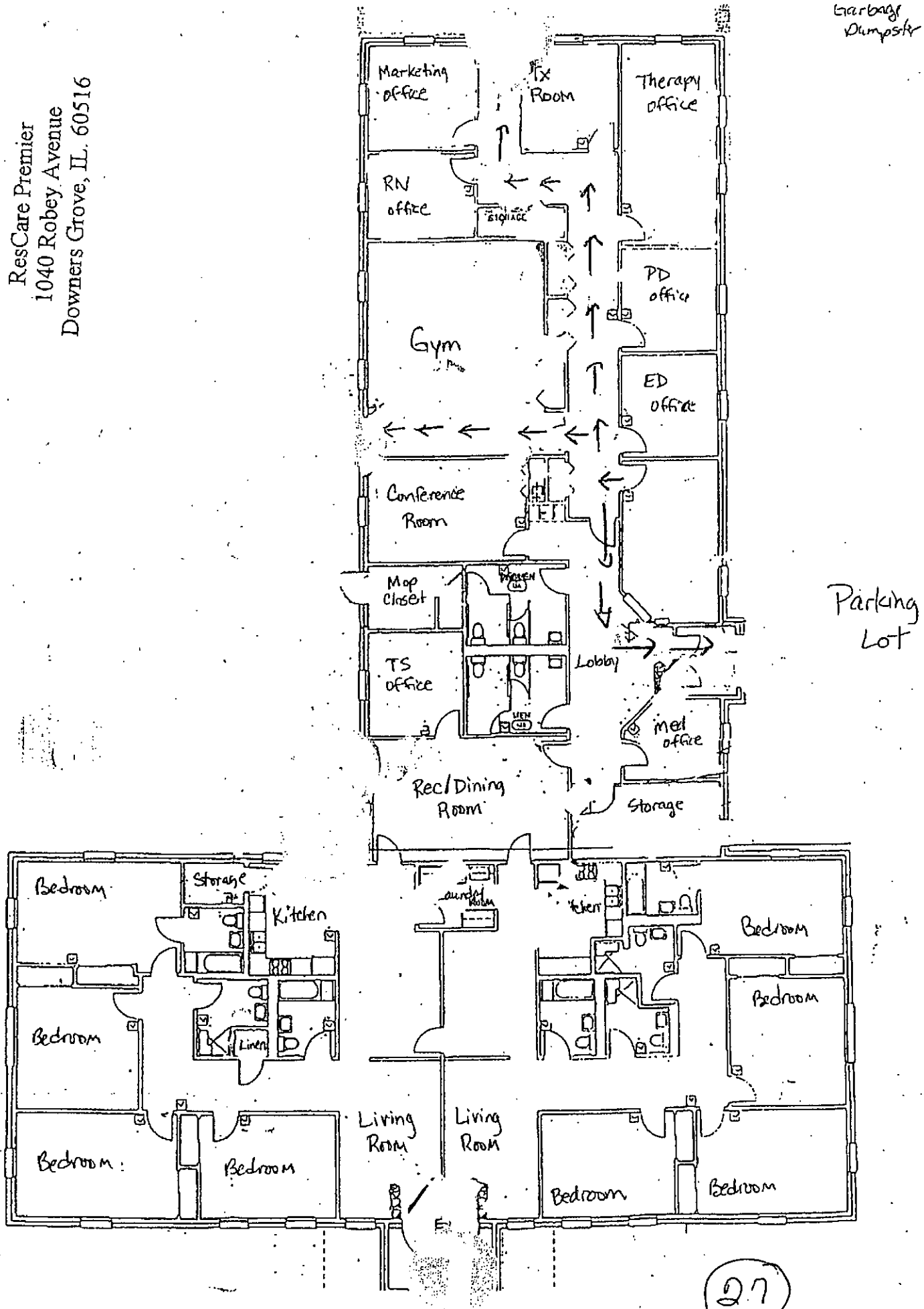
Res-Care Premier, Inc. Residential Rehabilitation Center is an 8900 square foot, 16 bed community based facility located in Downers Grove, Illinois. Our one story sprawling red brick ranch sits on 2.5 acres in a residential community. Each participant shares a semi private room with furnishings provided such as a twin bed, bedside table, chest of drawers, mirror and cloths closet. Private rooms are available for participants as space permits.

The building is designed with an administrative area that includes reception area and business manager's office, conference room, 2 therapy rooms, 5 staff offices, and a gym. The common living space includes a large recreational/program area, two dining rooms, two kitchens, two living rooms and two bedroom wings with each having 8 semi private bedrooms in each wing. The East wing has 4 bathrooms and the West Wing has 3 bathrooms. Seven (7) bathrooms (4 with tubs and 3 with roll in showers) with a toilet, sink, and mirror can be access through the corridor of each wing. Two (2) of the eight (8) bedrooms are special needs rooms with the bathroom attached to the room and are located at the end of each of the two bedroom wings.

Laundry facilities are located on site where participants may do their own laundry or direct care staff may assist them as needed.

A facility layout is attached.

ResCare Premier
1040 Robey Avenue
Downers Grove, IL. 60516



ATTACHMENT 61

A. Criterion 1110.238(a), Staffing

Position	Number of	Qualification
Executive Director	1 FTE	Bachelor Degree req., Masters Preferred.
Medical Director	1 PT	M.D. required, BI rehabilitation experience required.
Human Resource Manager	1FTE	Bachelor Degree required, 3 yrs HR experience preferred
Director of Finance	1 FTE	Bachelor Degree required in accounting, 3 to 5 yrs accounting experience
Case Manager/Program Director	1 FTE per 12 participants	Bachelor Degree required, ABI experience preferred
Director of Nursing	1 FTE	BSN/RN
Shift supervisor/nursing 3 to 11p	1 FTE	LPN
Administrative Clerk	1 PT	Certified Medical Assistant
Day Program Coordinator	1 FTE	Bachelor Degree required, Recreational Degree preferred
Speech and Language Pathologist	1 PT	Licensed by state discipline regulations
Physical Therapist	1 PT	Licensed by state discipline regulations
Physical Therapy Assistant	1 FTE	Certified by state discipline regulations
Occupational Therapist	1 PT	Licensed by state discipline regulations
Vocational Counselor	1 contractual	Licensed by state discipline regulations
Rehabilitation Educators	12 FTE 4 PT/PRN	High School degree required, Certified Nurse Assistant preferred
Maintenance/Building and grounds	1 PT	High school diploma
Housekeeping	1 FTE	High School diploma

The staffing pattern for *Res-Care Premier, Inc. ("ResCare")* is designed around the assessment of the individual's need. One-on-One Licensed Therapy services are based upon the results of a comprehensive assessment in all areas and the development of an individual Out Come Goal Plan for each participant. Levels of supervision are assessed at time of admission and at regular intervals through out the year to determine the direct care, Rehabilitation Educators, staff to participant ratio. Case manager/Program Director Positions are based on a case load of approximately 1: 12 ratio depending also based upon the level of supervision. Nursing coverage is based on the medical status of the participants with the goal of providing nursing coverage a minimum of 8 hours per day, 7 days a week and 16 hours per day 5 days per week. The Director of Nursing works 40 hours per week with a minimum of 5 days per week.

The non-dedicated staff services are provided by the ResCare's Corporate Resource Center staff. These services include but are not limited to the president's office, accounting and treasury, payroll, finance and planning, risk management, compliance, legal, information technology, purchasing, human resource, and regional administration and oversight. These services are available directly and indirectly, all agency policy and procedures are developed and implemented at the corporate level, resources are accessible and available through a web based design.

* see attached Organizational Chart

B. Criterion 1110.2830 (b) Mandated Services

Since 1989, *ResCare* has provided **Community-Based Residential Neuro-Rehabilitation** for individuals with acquired brain injury ("ABI"), traumatic brain injury ("TBI") and other neurological impairments. Individuals discharged from the hospital to our 16-bed post-acute setting in Downers Grove are treated by nurses and therapists with decades of experience. Services are offered 24 hours a day, 7 days per week. The specific needs of each ABI/TBI survivor are taken into account, with the provision of on-site licensed physical, occupational and speech cognitive therapy as well as vocational and neuropsychological services as needed

Nursing and Medication Management: Our nurses are available daily and assess for early changes in participants' medical conditions.

We use an interdisciplinary team approach to form an Individualized Outcome Goal Plan ("OGP") for all participants. Our experienced therapy department works together to meet established goals for each participant. The therapies are functional and may occur in the community as much as appropriate. Within two weeks of admission, each participant will receive a comprehensive evaluation and the development of an individualized OGP. Treatment plans are reviewed monthly for participants in active treatment and quarterly for long term care participants.

ResCare also offers **Long-Term Supported Living** arrangements when a return home is not possible. This program focuses on the maintenance of previous gains and supports the acquisition of new skills while emphasizing quality of life.

As part of the continuum of care, the **Supported Apartment Program** offers support to assist individuals with ABI/TBI in maximizing or maintaining independence. Participants reside in a one bedroom apartment were ResCare provides periodic care at regular intervals dependent upon the specific needs of the participant.

ResCare's **Day Habilitation Program** provides a stimulating environment for each of our residents as well as for brain injury survivors who reside in the community but need care and support during the day. Cognitive activities, pet therapy, socialization, recreation and support are provided each day, with community outings once or twice each week.

Respite Care is provided for ABI survivors needing a short stay, either while recovering from surgery, or to provide a break for family caregivers.

The Outpatient Therapy Program serves community members recovering from ABI/TBI in any stage of their rehabilitation. We offer therapy services that include: Physical Therapy for gait training, strengthening and functional mobility; Occupational Therapy for functional Activities of Daily Living ("ADL") training and cognitive skills retraining; Speech and Language Therapy which includes a comprehensive exam and compensatory speech strategies; and Vocational Evaluation and Job Counseling.

C. Criterion 1110.2830(c), Unit Size

ResCare seeks to license 12 bed of its 16 beds located at the 1040 Róbey Avenue facility as a Community Based Residential Rehabilitation. The remaining 4 beds will be identified and licensed as Shelter Care. The facility located at 1040 Robey Avenue will not exceed 16 beds.

D. Criteria 1110.2830(d), Utilization

It is anticipated that upon approval of a Community Based Residential Rehabilitation Center, ("CBRRC"), license, *ResCare* will be able to increase access for services to individuals with ABI that require sub-acute services within two years of operation as a CBRRC. This is evidenced by the historical data over the last two years where 56% of participants seeking services were denied admission due to licensure status. It is anticipated that insurance providers such as Blue Cross Blue Shield, United Health, etc, and the United States Veteran Hospital's will utilize this very valuable and needed service in the Northern Illinois area. *ResCare* has experienced 96% growth since 2005 and has experienced 100% occupancy. *ResCare* developed a comprehensive

continuum of care that transitions individuals into a less restrictive environment and created the Supported Apartment Program. This action and the ongoing transition of individuals to a least restrictive environment provided for the availability of vacancies in the facility and increased number of persons served. *ResCare* serves approximately 27 individuals annually in the Residential Rehabilitation Program.

In 2008 *ResCare* increased its' nursing staff to include a Director of Nursing and nursing coverage 7 days and 96 hours per week. This strategy also facilitated an increase in admissions of individuals with ABI that are medically stable but require additional nursing management. The additional nursing coverage and the use of a Medical Director, has served as an alternative to skilled nursing care and has increased persons served that would otherwise be admitted to a nursing home due to lack of appropriate services in the community.

* see attached growth chart

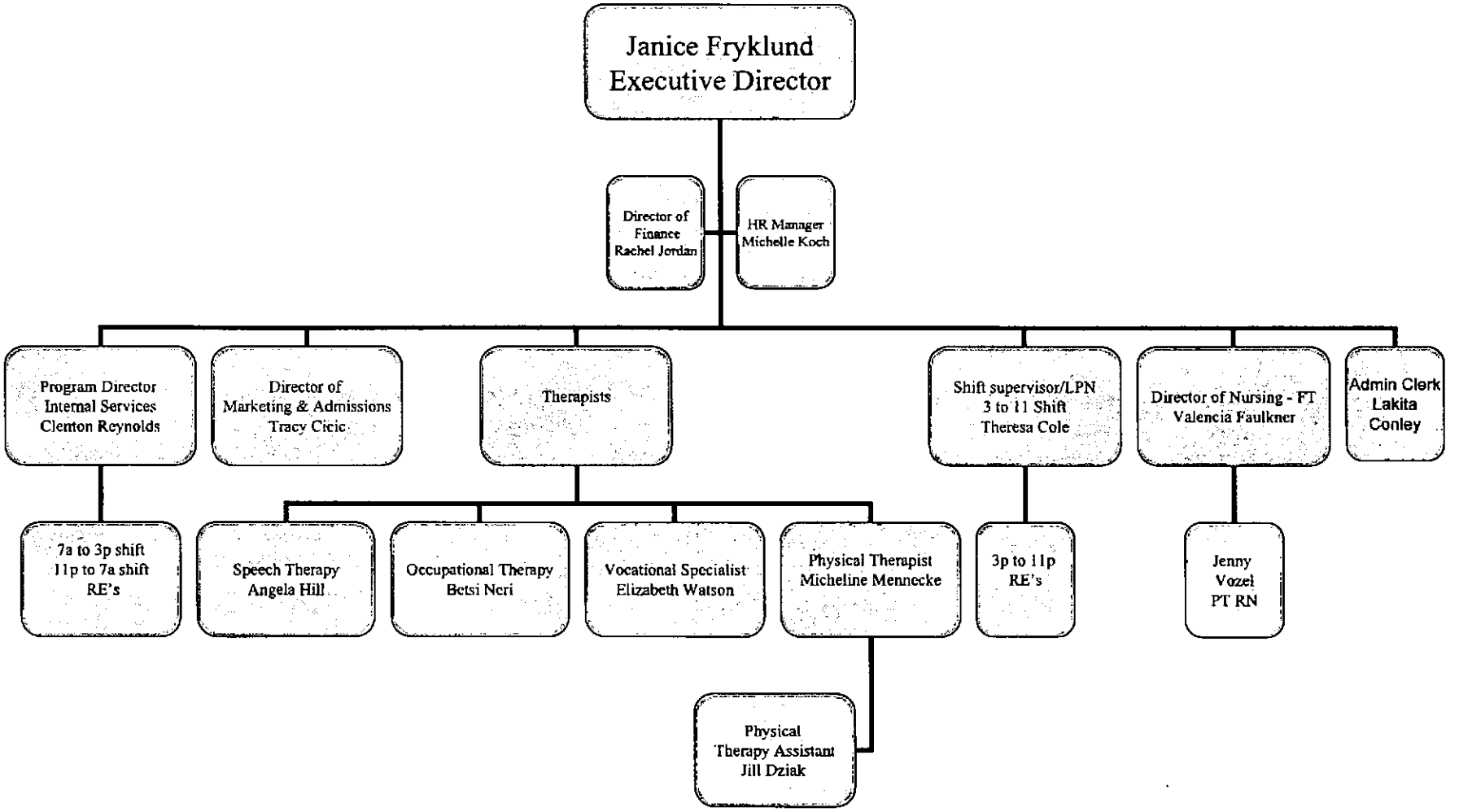
E. Criterion 1110.2830(e), Background of Applicant

Since 1989, *ResCare* has provided **Community-Based Residential Rehabilitation** for individuals with ABI, TBI and other neurological impairments. Individuals discharged from the hospital to our 16-bed post-acute setting in Downers Grove are treated by experienced nurses and therapists. Services are offered 24 hours a day, 7 days per week. The specific needs of each ABI/TBI survivor are taken into account, with the provision of on-site licensed physical, occupational and speech cognitive therapy as well as vocational and neuropsychological services as needed. Registered nurses offer medical management, serving the general needs of each resident as well as those whose circumstances are more medically complicated. Individualized goal plans are designed to help each resident achieve their greatest level of independence.

ResCare has been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Medical Rehabilitation Center and Out Patient Medical Rehabilitation Center for Brain Injury since 1995 and has received renewal of such accreditation until June 2012.

- see attached census chart
- copy of CARF certificates

ResCare Premier
Downers Grove



Year	Budget Revenue	Actual Revenue	Admiss.	Disch.	Person Served Residential	Person Served Day
2004		1417003				
2005	1509942	2050897	7	7	19	7
2006		3053539	9	6	22	6
2007	3518635	2745128	7	8	25	12
2008	3418824	2771020	3	5	19	17

	Rev.growth	percent
2004 to 2005	633894	45
2005-2006	1002642	49
2006-2007	-282519	-9
2007-2008	25892	9

33

	Rev.growth	percent
Overall growth 2004 to 2008	1,352,017	0.95

RESIDENTS OF ResCare PREMIER - 2008

Age

Under 18	0	
18 - 29	2	11%
30-49	7	37%
50-60	6	32%
61 +	4	21%

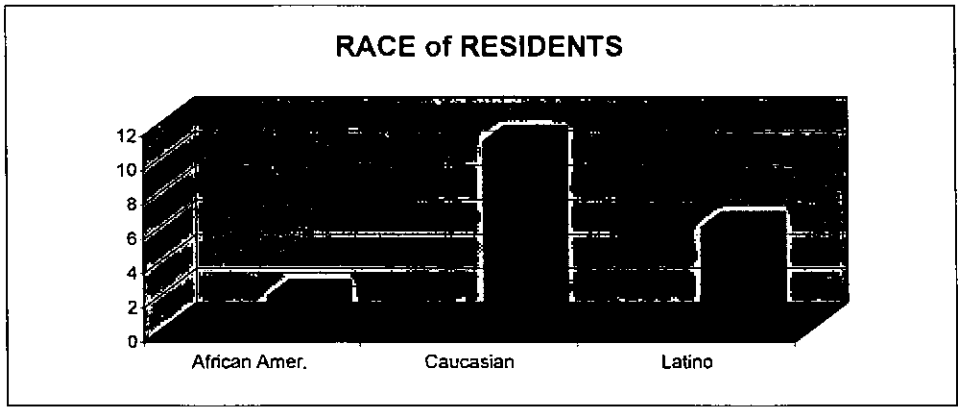
34

Gender

Female	2	11%
Male	17	89%

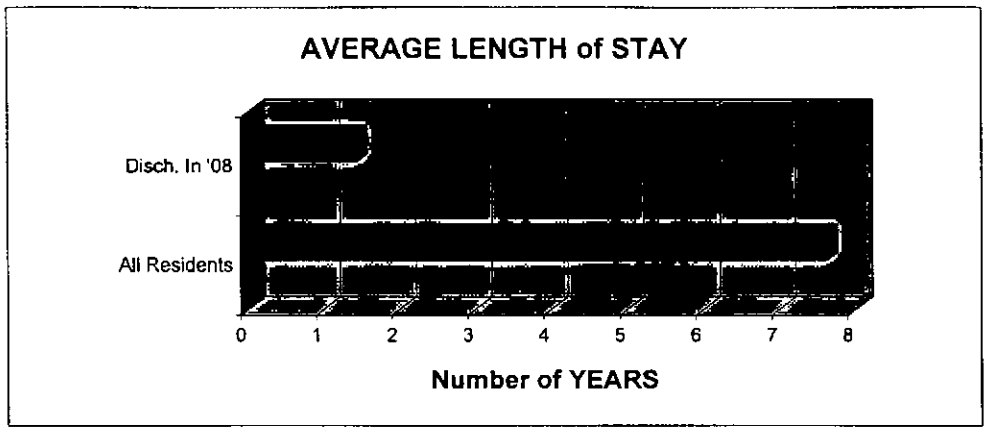
Race

African Amer.	2	11%
Caucasian	11	58%
Latino	6	32%



Average Length of Stay

All Residents	7.63
Disch. In '08	1.45



35

A Three-Year Accreditation is awarded to

ResCare Premier
Sedalia /Downers Grove /St. Louis

for the following identified programs which were surveyed under the 2001 Medical Rehabilitation Standards Manual

Medical Rehabilitation Programs

Brain Injury Programs
Outpatient Rehabilitation Programs (Adults)
Residential Rehabilitation Programs (Adults)
Long-Term Residential Services (Adults)

This organization has met internationally recognized standards of quality in the provision of outcomes-driven programs and services to enhance the lives of the persons served. This Certificate of Accreditation is granted by authority of:

carf...*The Rehabilitation Accreditation Commission*
4891 East Grant Road, Tucson, Arizona 85712 • (520) 325-1044 • www.carf.org

Jane Dorval, M.D.
Chair, Board of Trustees

Brian Boon, Ph. D.
President / CEO

36

carf

enhancing PEOPLE'S LIVES

August 1, 2008

Janice M. Fryklund, M.A.
Executive Director
ResCare Premier - Downers Grove
6200 North Hiawatha, Suite 450
Chicago, IL 60646

Dear Ms. Fryklund:

The purpose of this letter is to inform you that ResCare Premier - Downers Grove has been accredited by CARF for a period of one year for the following programs:

Brain Injury Long-Term Residential Services (Adults)
Brain Injury Outpatient Rehabilitation Programs (Adults)
Brain Injury Residential Rehabilitation Programs (Adults)

The enclosed survey report identifies the basis for this outcome. This accreditation will extend through June 2009. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served.

Your organization should take pride in achieving accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation, and we encourage you to make this accomplishment known throughout your community. Enclosed are some materials that will help you publicize this achievement.

The survey report is intended to support a continuation of the quality improvement of your programs. It contains comments on your organization's strengths as well as suggestions and recommendations. Although there are opportunities for improvement in relation to the standards, there is evidence of your organization's capability and commitment to address these areas and progress toward further improvement. A quality improvement plan demonstrating your efforts to implement the survey recommendations must be submitted within the next 90 days to retain accreditation. Guidelines and the form for completing the plan are enclosed. Please submit this report to the attention of the customer service unit Administrative Coordinator.

Your Certificate of Accreditation is being sent under separate cover. Please note that you may use the enclosed form to order additional copies of the certificate.

CARF INTERNATIONAL
4891 East Grant Road
Tucson, AZ 85712 USA
Toll-free/TTY 888 281 6531 ■ Fax 520 318 1129
www.carf.org

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 209
Washington, DC 20036 USA
Toll-free 866 888 1122 ■ Fax 202 587 5009
www.carf.org/aging

CARF CANADA
10665 Jasper Avenue, Suite 1400A
Edmonton, Alberta T5J 3S9 Canada
Tel 780 429 2538 ■ Fax 780 426 7274
www.carfcanada.ca

Should you dispute the One-Year Accreditation outcome, you are entitled to request an on-site review of the decision. CARF must receive your written request for a review within 30 days of the date of this letter. Please note that the cost of the survey review is the responsibility of the organization. Complete information regarding the "Review of One-Year or Provisional Accreditation Decisions" is found under this topic in the Policies, Procedures, and Processes Section of the standards manual.

If you have any questions regarding your organization's accreditation, you are encouraged to seek support from a Resource Specialist in your customer service unit by calling extension 174.

We encourage your organization to continue fully and productively using the CARF standards as part of your ongoing commitment to accreditation. We commend your commitment and consistent efforts to improve the quality of your programs. We look forward to working with your organization in the future.

Sincerely,

Brian J. Boon, Ph.D.
President/CEO

AEP
Enclosures

CARF INTERNATIONAL
4891 East Grant Road
Tucson, AZ 85712 USA
Toll-free/TTY 888 281 6531 ■ Fax 520 318 1129
www.carf.org

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 209
Washington, DC 20036 USA
Toll-free 866 888 1122 ■ Fax 202 567 5009
www.carf.org/aging

CARF CANADA
10665 Jasper Avenue, Suite 1400A
Edmonton, Alberta T5J 3S9 Canada
Tel 780 429 2536 ■ Fax 780 426 7274
www.carfcanada.ca

carf

enhancing PEOPLE'S LIVES

June 15, 20

Janice M. Fr lund, M.A.
Executive D ctor
ResCare Pr ier - Downer's Grove
6200 North awatha, Suite 450
Chicago, IL 0646

Dear Ms. Fr lund:

It is my plea re to inform you that ResCare Premier - Downer's Grove has been accredited by CARF for a rlod of three years for the following programs:

Outpatie Medical Rehabilitation Programs - Multiple Service: Brain Injury Program (Adults)
Outpatie Medical Rehabilitation Programs - Single Service: Brain Injury Program (Adults)
Residen l Rehabilitation Programs: Brain Injury Program (Adults)

This accredi tion will extend through June 2012. This achievement is an indication of your organization dedication and commitment to improving the quality of the lives of the persons served. Ser es, personnel, and documentation clearly indicate an established pattern of practice exc ence.

Your organi tion should take pride in achieving this high level of accreditation. CARF will recognize th accomplishment in its listing of organizations with accreditation, and we encourage y to make this accomplishment known throughout your community. Communica n of this award to your referral and funding sources, the media, and local and federal gove iment officials will promote and distinguish your organization. Enclosed are some materials th will help you publicize this achievement.

The survey port is intended to support a continuation of the quality improvement of your programs. It ontains comments on your organization's strengths as well as suggestions and recommend ions. A quality improvement plan demonstrating your efforts to implement the survey reco mendations must be submitted within the next 90 days to retain accreditation. Guidelines a d the form for completing the QIP have been posted on Customer Connect, our secure, ded ated website for accredited organizations and organizations seeking accreditation. E-mail notifi tion was previously sent to your organization letting you know that these documents ve been posted. Please submit this report to the attention of the customer service unit Adminis ative Coordinator.

Your Certific te of Accreditation is being sent under separate cover. Please note that you may use the enc sed form to order additional copies of the certificate.

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39

If you have ε y questions regarding your organization's accreditation, you are encouraged to seek suppor rom a Resource Specialist in your customer service unit by calling extension 174.

We encoura ı your organization to continue fully and productively using the CARF standards as part of yc ongoing commitment to accreditation. We commend your commitment and consistent e' ırts to improve the quality of your programs. We look forward to working with your organization ı the future.

Sincerely,

Brian J. Boo Ph.D.
President/Cl)

lmt
Enclosures

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40

INDEX OF ATTACHMENTS

42

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification	
2	Site Ownership	
3	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
4	Flood Plain Requirements	
5	Historic Preservation Act Requirements	
6	Description of Project	
7	Project and Sources of Funds Itemization	
8	Cost Space Requirements	
9	Discontinuation	
23 10	Background of the Applicant	
24 11	Purpose of the Project	
25 12	Alternatives to the Project	
26 13	Size of the Project	
14	Project Service Utilization	
15	Unfinished or Shell Space	
16	Assurances for Unfinished/Shell Space	
17	Master Design Project	
18	Mergers, Consolidations and Acquisitions	
	Categories of Service:	
19	Planning Area Need	
20	Service Demand – Establishment of Category of Service	
21	Service Demand – Expansion of Existing Category of Service	
22	Service Accessibility – Service Restrictions	
23	Unnecessary Duplication/Maldistribution	
24	Category of Service Modernization	
25	Staffing Availability	
26	Assurances	
	Service Specific:	
27	Comprehensive Physical Rehabilitation	
28	Neonatal Intensive Care	
29	Open Heart Surgery	
30	Cardiac Catheterization	
31	In-Center Hemodialysis	
32	Non-Hospital Based Ambulatory Surgery	
	General Long Term Care:	
33	Planning Area Need	
34	Service to Planning Area Residents	
35	Service Demand-Establishment of Category of Service	
36	Service Demand-Expansion of Existing Category of Service	
37	Service Accessibility	
38	Description of Continuum of Care	
39	Components	
40	Documentation	
41	Description of Defined Population to be Served	